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Moving Toward Person-Centered and Recovery-Oriented Services and Systems

SAMHSA's Working Definition of Recovery

By Paolo del Vecchio, MSW, Director
Center for Mental Health Services
Substance Abuse and Mental Health
Services Administration (SAMHSA)

Paolo del Vecchio, MSW

For over 20 years, the Substance Abuse and Mental Health Services Administration (SAMHSA) has fostered recovery and social inclusion for Americans with mental and/or substance use disorders. Over the years, it has become increasingly apparent that a practical, comprehensive working definition of recovery would enable policy makers, providers, and others to better design, deliver, and measure integrated and holistic services to those in need.

In 2011, SAMHSA released a working definition to help translate recovery from a worthy ideal to a concrete reality. In collaboration with stakeholders in the field, SAMHSA led an effort to develop a working definition of recovery, along with four dimensions of recovery and 10 guiding principles.

The definition is the product of a year-long effort by SAMHSA and a wide range of partners in the mental health and addiction fields to develop a working definition of recovery that captures the essential, common experiences of those recovering from mental disorders and substance use disorders, along with major guiding principles that support the recovery definition. SAMHSA led this effort as part of its Recovery Support Strategic Initiative.

SAMHSA's working definition of recovery from mental disorders and substance use disorders is as follows:

"A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."

The first step in developing the recovery definition occurred in August 2010 when SAMHSA convened a meeting of peer leaders from the mental health and addiction recovery communities. Together, these leaders developed a draft definition and principles of recovery to reflect common elements of the recovery experience for those with mental disorders and/or substance use disorders.

In the months that followed, SAMHSA worked with the behavioral health community and other interested parties in reviewing drafts of the working recovery definition and principles with stakeholders at meetings, conferences, and other venues. In August 2011, SAMHSA posted the working definition and principles that resulted from this process on the SAMHSA blog (http://blog.samhsa.gov/2011/05/20/recovery-defined-a-unified-working-definition-and-set-of-principles/) and invited comments from the public via SAMHSA Feedback Forums. The blog post received 259 comments, and the forums had over 1000 participants, nearly 500 ideas, and over 1,200 comments on the ideas. Many of the comments received have been incorporated into the current working definition and principles.

Through the Recovery Support Strategic Initiative, SAMHSA has also delineated four major dimensions that support a life in recovery:

Health: Overcoming or managing one's disease(s)—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem—and, for everyone in recovery, making informed, healthy choices that support physical and emotional wellbeing;

Home: A stable and safe place to live;

Purpose: Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and

see SAMHSA on page 34

Recovery-Oriented Practice and Health Care Reform

By Larry Davidson, PhD, Professor of
Psychology, Department of Psychiatry,
Yale School of Medicine

Larry Davidson, PhD

One common criticism of the concept of recovery is that, while it has offered a hopeful—even inspiring—vision for persons with mental illnesses and their loved ones, it has not provided concrete guidance for how mental health care needs to change in order to be more effective in promoting it. The 2003 Presidential "New Freedom" Commission on Mental Health had argued that a systemic transformation of mental health practice was needed to re-orient care to promoting recovery, and most states have since undertaken efforts to do so. Such efforts have been limited, though, by a lack both of resources and of a coherent conceptual framework concrete enough to operationalize recovery in practice. In this article, I will suggest that health care reform can provide the robust vehicle that has thus far been missing for informing and implementing the fundamental changes required to make the lofty vision of recovery an everyday reality.

In making this suggestion, I am arguing that health care reform will not replace recovery as the guiding vision for mental health services, as some have worried. Rather, my impression is that the kind of mental health care envisioned by health care reform is remarkably recovery-oriented in its nature and in its implications for practice. Here, I will limit my discussion to three areas in which this convergence of recovery and reform seem most substantive, but points of agreement are not limited to these.

1. "An illness like any other." One basic premise of the recovery paradigm is that mental health conditions are, in fact, health conditions. This means that so-called "normal" people develop mental health conditions just like they develop other, traditionally-defined "physical" health conditions, and that they can learn to live with, and often recover from, these conditions given timely and effective care. People are not responsible for having a mental health condition, any more than they would be for having asthma or cardiac disease (i.e., mental illness is a "no fault" disease), but they are responsible for learning about the condition they have, for accessing and appropriately utilizing available services and supports, and for exercising self-care.

Based on the provisions of the Affordable Care Act, in combination with the federal parity legislation passed in 2008, we can now expect mental health care to begin to resemble primary care in these and other ways. As encouraged by Frank and Glied in their 2006 book *Better but Not Well: Mental Health Policy in the*

see Reform on page 35

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Table of Contents

Mental Health News
2013/2014 Theme and Deadline Calendar

Summer 2013 Issue:

"Mind Over Body:
Understanding and Treating Eating Disorders"

Deadline: April 23, 2013

Fall 2013 Issue:

"Housing and Employment: How Are We Doing?"

Deadline: July 23, 2013

Winter 2014 Issue:

"Living With Emotional and Physical Pain"

Deadline: October 23, 2013

Spring 2014 Issue:

"Perspectives from Policy Leaders
on the Transition to Managed Care"

Deadline: January 23, 2014

Themes subject to change pending the launch of Behavioral Health News (see p. 5).

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A Handshake that Inspired a Recovery: The History and Future of Mental Health News

By Ira Minot, LMSW
Founder and Executive Director
Mental Health News

Let me tell you a true story about a simple handshake that saved the life of a young man from New York suffering with mental illness. The year was 1987 and he was 38 years old. He had always been a happy and productive person throughout his entire life. He had earned a master's degree and worked for many years helping others by raising funds for charitable organizations. Suddenly he began to experience severe anxiety and depression. His mother had lost a heroic battle with cancer only a few months before, and he had just been separated from his 8 year old son due to a recent divorce.

In a matter of weeks he was in the throes of a most severe form of depression that would last 10 years. His illness caused him to endure such despair and hopelessness that he tried to end his own life on several occasions. He watched in horror as his life slipped away from him, and was further tormented knowing that his young son—the love of his life—was growing up under the shadow of his illness. In the end, he was left homeless and destitute. During his last inpatient hospitalization before his health insurance ended, he was offered Electroconvulsive Therapy (ECT) as a last chance to save him from being sent to a nearby state hospital. Fortunately in his case, the ECT worked and over the coming months he felt the dark curtain of his depression lifting.

It was now 1997 and he was living in supportive housing and attending a nearby consumer-run drop-in-center to help him find the direction he so badly needed to recover and regain his place in the community. One day while at the drop-in center, the center's founder was giving a tour of the facility to a supporter who happened to be one of the most respected bankers in the county. Seeing the two men dressed in business suits walking through the center reminded him of how he used to dress and collaborate on fundraising projects with community leaders. He became nervous when the director and banker came over to where he was sitting.

The banker smiled at him, shook his hand, patted him on the shoulder, and told him, "Keep up the good work." They sat down and the banker listened with interest as the man told him about his battle with depression and how much he was being helped at the drop-in-center.

For many years after that day, the man in recovery often referred to that kind banker and his reassuring handshake. "It made me feel like things were going to be OK and I would finally get well again." You see, that man was ME.

Because that banker treated me with such respect, I was able to remember what "normal" used to feel like. He didn't make me feel the stigma of my illness that I had felt for so many years from friends, and family. It was a good feeling that changed my life in many ways and was a turning point in my life.

Ira Minot, LMSW

The History of Mental Health News

In many ways I credit that handshake at the drop-in-center with inspiring my recovery. My depression was lifting following my ECT, I continued to attend outpatient treatment, but I was at a complete loss as to what I would do with my life now that I was getting better. It became apparent to me that I would have to start my life all over again.

I often believe that things happen for a reason. I have no other explanation for how and why I had the idea to start this newspaper. I only knew that I wanted to create something that would help others find their way back from the shadows of mental illness. I was filled with the memory that outside of the few hours a week I attended treatment, I was isolated and alone in my tiny supported housing apartment. No one was reaching out to me where I lived, to give me hope and bring me out of the shadows and into the community.

Because of this, I wanted to provide a roadmap of mental health services in the community for people with mental illness and their families. In addition, the newspaper would include articles from leaders in the field of mental health, from consumers and family members, and from service providers about how they were helping people and saving lives each and every day. That idea broadened to include articles that would report on the latest innovations and advances in mental health research and evidence-based treatments. I insisted there be a message of *hope* in every issue. Articles would explain that mental illness isn't anyone's fault, that people can recover, and that we all must advocate for the elimination of stigma and for increased funding of mental health services in the community.

Finally, the newspaper had to be readily available to everyone. I would distribute bundles of the newspaper to hospitals, clinics, consumer-run programs, and college campuses. We would have a website where anyone could read it for free!

Over the next two years and with the assistance of many people, I learned how to develop a business plan, the basics of publishing layout and design, and met with over 100 leaders within the metro-NY mental health community. I told the story of my illness to each of them and how I wanted to help others walking the same path. I would call the publication *Mental Health News*.

The mental health organizations I had met with saw the need for the project, believed in me, and pledged to submit an article and advertise their programs and services in the newspaper—even though the first issue had not even been published. In the fall of 1999 the first quarterly issue of *Mental Health News* was published.

Several mental health leaders who had helped me launch the project thought that *Mental Health News* needed to take the next step and become a nonprofit organization. In 2001 we were granted our nonprofit status under the name *Mental Health News Education, Inc. (MHNE)* and we were officially registered with the NYS Charities Bureau. We were now eligible to raise funds for our organization and expand our mission to provide thousands of free newspapers to people with mental illness throughout New York State and beyond.

During the early years of the publication, I was often invited to speak to community groups. *Mental Health News* received awards from: The NYS Office of Mental Health, The Coalition of Behavioral Health Agencies, The American Association for Psychosocial Rehabilitation, The Association of Hispanic Mental Health Professionals, The National Alliance for Mental Illness of NY State, The Center for Career Freedom, Search for Change, and Silver Hill Hospital. This was quite an achievement for me since for so many years I had been embarrassed and ashamed of my illness and how my life had turned out.

However, my greatest reward came when my son David (then in college) began to read *Mental Health News*. He told me that in watching me rebuild my life while creating the newspaper and reading the articles of hope and inspiration, he now understood that my illness wasn't my fault *or his fault*. During the years I struggled with depression, David grew up with the pain of seeing his father suffer as any child in a similar situation would. I knew that had to be so hard on him when he was just a youngster who could not fully understand the hopelessness and despair his father was exhibiting for so many years. I knew he would carry emotional scars from this and perhaps believe he was to blame for my condition. It brought tears to my eyes when he told me that he now understood—thanks to *Mental Health News*.

Inspired by our mission of providing vital community education, David joined MHNE in 2007 to launch and publish *Autism Spectrum News*. With guidance from some of the nation's leading minds in the field of autism and leaders of many of the northeast's most respected autism organizations, *Autism Spectrum News* premiered in the fall of 2008. It quickly set a new standard for science and evidence-based community education. *Autism Spectrum News* provides readers with a trusted source of educational articles and a roadmap to community resources and has become a "must read" and vital resource for families with children on the spectrum as well as for the treatment professionals and service providers that care for them.

Today, both *Mental Health News* and *Autism Spectrum News* each reach over 160,000 consumers, families, treatment professionals, service providers, educators, and decision makers in New York State and across the nation.

The Future of Mental Health News:
~ Behavioral Health News ~

We are now in the exploratory stages of a new project which would enable us to transition *Mental Health News* into a publication called *Behavioral Health News*. *Behavioral Health News* would cover the substance use disorder/chemical dependency community and the mental health community in one new unified format.

Today's changing times demand a changing format. For over twelve years, *Mental Health News* has been the community's trusted source of news, education and resources from the world of mental health. However, as times are changing, healthcare reform and service integration are pointing us in a new direction, and *Behavioral Health News* would respond to this need. We are working with leaders from the mental health and substance use communities to bring you the very latest news, clinical best practices, advocacy, and resources in the tradition of our award-winning format. In addition to behavioral health, we will cover key issues in the integration of primary care and behavioral health services.

The need for Behavioral Health News is evident. 93% of the heaviest Medicaid users in New York City have either a mental health or substance use diagnosis. Of these, 65% have a co-occurring mental health and substance use diagnosis. For mental health consumers, the hospital readmission rate is higher for medical rather than psychiatric reasons.

The creation of Health Homes highlights the challenge and promise of integrated mental health, substance use, and primary healthcare. As the healthcare system moves toward integrated managed care, these issues will need to be addressed on a regular basis. In each issue of *Behavioral Health News*, these and other practice and policy issues will be addressed by leaders from the field. *Behavioral Health News* will keep all stakeholders informed and prepared for the upcoming January 1, 2014 rollout of integrated managed care in New York State and beyond.

We are now in the process of seeking the funding required to help us meet the challenge of reaching out to a significantly expanded readership—the substance use disorder/chemical dependency community of New York State and beyond.

If you would like to participate in our project, email me at iraminot@mhnews.org, call me at (570) 629-5960, or fill out the form across on page 5. With your help I know we will succeed.

BEHAVIORAL HEALTH NEWS™

From the *Mental Health News* Board of Directors: For the past 18 months, the Board has been closely monitoring the vision and roll-out of Federal and State healthcare reforms. One of the striking aspects of this current reform is that it has propelled both policy-makers and providers to adopt a new view of mental health and substance use services as integrated *behavioral health services.* While consumers, families and providers have advocated for years for more and better integration of mental health and substance use services, the healthcare reforms underway will make such integration a reality. Given the changing healthcare landscape, the Board has moved to expand the scope and purview of *Mental Health News* to include the full spectrum of behavioral health services. We are enormously excited about this new phase in our publication's history and are certain consumers, families, providers and advocates will join us in supporting this new effort. We invite you to share your thoughts with us on our new *Behavioral Health News project. Please send us the tear-out questionnaire below.*

An Exciting New Project to Transition Mental Health News into Behavioral Health News

We Are Currently in the Feasibility Study Phase of the Project and Invite Your Participation

Changing Times Demand a Changing Format

For over twelve years, *Mental Health News* has been the community's trusted source of news, education and resources from the world of mental health. However, as times are changing, healthcare reform and service integration are pointing us in a new direction, and *Behavioral Health News* will respond to this need beginning in the Fall of 2013. We are working with leaders from the mental health and substance use communities to bring you the very latest news, clinical best practices, advocacy, and resources in the tradition of our award-winning format. In addition to behavioral health, we will cover key issues in the integration of primary care and behavioral health services.

The Need for Behavioral Health News

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- Of these, 65% have a co-occurring mental health and substance use diagnosis
- For mental health consumers, the hospital re-admission rate is higher for medical rather than psychiatric reasons

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- Become a Sponsor of *Behavioral Health News (see p. 2)*
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A Sample of Upcoming Behavioral Health News Quarterly Themes

- Perspectives from Policy Leaders on the Transition to Managed Care
- Models that Help Reduce Emergency Room and Inpatient Utilization
- Promoting Recovery in a World of Managed Care
- Models of Primary Care Integration for Behavioral Health Providers

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A Person-Centered Spiritual Recovery Tool For Hospitalization and Beyond

**By Lynne M. Mikulak, MDiv, MSW,
Coordinator of Pastoral Care and
Education, NewYork-Presbyterian
Hospital - Westchester Division**

The enormous charge to the mental health care system to keep hospital length-of-stays brief while delivering Person-Centered care grows increasingly complicated. One key to meeting regulatory mandates while focusing on long-term healing is to use simple spiritual recovery tools that people can learn and practice daily.

Spiritual care givers, especially chaplains working in tandem with other clinical disciplines in mental health care settings, can teach a variety of accessible spiritual recovery tools, including during a brief hospitalization. Goals of such tools are that people's long-term spiritual, emotional and cultural needs could continue being met upon discharge, that they maintain consistency in positive coping mechanisms, and that they foster lasting supportive connections to care teams' efforts.[1]

One example of how such a tool can be used from the time of admission to discharge and beyond might include such a scenario: A person might be troubled by a persistent thought, such as "God has abandoned me." This thought is usually complexly a symptom of a mental illness and related to painful past experiences. Especially damaging for many people are the feelings of abandonment and rejection that can stem from disconnects with spiritual and religious leaders who are not equipped to address mental illness and crises. A trained spiritual care giver in mental health issues can provide presence and a listening ear, while a person discusses a baseline spiritual problem. Such spiritual care and counseling is vital in the moment. That is the "being with" aspect of spiritual care. However, an action step is also required. If the person is discharged from a facility after 10 days, and they have had clear insight into and pastoral counseling about their spiritual pain, it is likely that such a spiritual problem will not disappear upon discharge. Even with significant relief of psychiatric symptoms through medication and a multi-disciplinary treatment plan to addressing psycho-social stressors, a persistent spiritual problem needs a consistent, long-term plan. A spiritual recovery tool that can be taught and integrated during a hospital stay and practiced daily afterward can have enduring effects.

Many Spiritual and Pastoral Care Departments in healthcare settings develop their own tools, or use any number of helpful tools that can be found through literature reviews. The Department of Pastoral Care and Education at NewYork-Presbyterian has developed a spiritual screening tool, C.A.R.E.S.©,[2] that is two-fold: firstly we use it to assess people's spiritual, emotional and cultural needs, and secondly it becomes part of the treatment plan, and like many aspects of a mental health treatment plan, it is a tool or resource that a person can take home with them to continue to practice and develop positive coping habits.

Lynne M. Mikulak, MDiv, MSW

C.A.R.E.S.: The New York Presbyterian Spiritual Screening Tool. Assessment and Treatment – When to call a chaplain, and when a person or their loved one(s) has spiritual **CARES**:

Compromised coping
Asking "Why?"
Religious needs
Emotional Suffering
Support

This model breaks down into what the chaplain or a member of the multi-disciplinary team screens for: *Compromised coping*: The person or family has experienced major loss within the last one to three years; *Asking "Why"*: The person is asking questions of meaning or purpose, or has a pervasive sense of loss of meaning and purpose; *Religious needs*: The person requests specific religious, sacramental or cultural needs; *Emotional suffering*: The person is struggling with pervasive emotional suffering, such as hurt, fear, current or previous losses; and *Support*: The person has limited or no external support.

By exploring these areas in depth, spiritual care givers can aid a person in assessing what coping is working well, what is lacking, and what approaches can bolster spiritual, emotional and cultural needs. By identifying and naming strengths and concerns in each of the C.A.R.E.S. categories, a person and a spiritual care giver can outline an action/treatment plan that the person can take ownership of and be responsible for after discharge. The person and the spiritual care giver can make a covenant (contract) that the person will continue to practice this tool by self-assessing how and where they are in each of the C.A.R.E.S. categories and then act accordingly if something is not being addressed. The person can practice self-assessment and action in their own prayer or meditation time, or ask family, loved-ones, and trusted members within a community-based support network to participate and provide support.

In looking at ***C**ompromised coping*, a person might get more deeply in touch with forms of denial, unresolved losses, or behaviors that continue to enable compromised coping. Such behaviors might bring momentary relief, but the person may later experience more negative feelings about their overall health. For instance, choosing integrative medicine practices, such as gentle relaxation techniques, tracing a finger-labyrinth, or using aromatherapy to soothe, can lead to small but significant steps in forming new habits that can eventually replace ineffective coping mechanisms.

***A**sking "why?"* is vital to anyone's mental health. Repressing sadness, anger, or any strong emotions can lead to a greater sense of disconnect from the whole. Asking the difficult questions can create fresh insights and awareness, and provide an opening for releasing pent-up emotions. Starting such a conversation with a psychiatrist, social worker, chaplain, or any health care worker, clergy person, 12-Step sponsor, community liaison, etc., can keep the doors open to a "why" stance that can help someone safely explore questions that can lead to continued understanding and meaning-making.

People can identify a ***R**eligious need* while hospitalized, and in the process might become reacquainted with a beneficial practice through attendance in a spirituality group or worship service.[3] However, as is common for those who left a religious community behind, the person might be baffled about how to continue the newly-learned spiritual practice upon discharge. The aspect of the C.A.R.E.S. model that leads to creation of a spiritual treatment plan can connect the dots from the current care being received at the hospital to the post-discharge possibilities of numerous outside resources. The chaplain can research and contact outside resources, and provide a list for the person, much like what any other member of the clinical care team might do related to their discipline and a person's healthcare needs. This can provide an uninterrupted sense of spiritual care after discharge.

***E**motional suffering* takes a toll on mind-body-spirit health in whatever degree it is felt. Trusting another person to listen to feelings and thoughts, whether with a mental health care-giver, community support, friend, or family member, can assist in putting problems in perspective and prioritizing what to address and how, if necessary. If a person talks with a chaplain while in the hospital, the benefits of the conversation will give the person a model for what they might desire after discharge, perhaps as a daily practice or as needed.

***S**upport* is the keystone to healthy mind-body-spirit living. A daily practice of a gratitude list for all of one's supports, or perhaps a "wish" list of supports not yet in place, will keep a person attuned to the need for support and the dangers of isolating. In order for the health care system to deliver quality Person-Centered Care, the mental health consumer will experience a greater wholeness, whether through an immediate crisis or life-long symptoms, if they remain committed and curious as to who can assist, when and how. Remembering that there is always help nearby, even if the first step is the hospital emergency room, can assure the person through their fears and doubts that supportive help is on the way.

The Rev. Lynne M. Mikulak is the Coordinator of Pastoral Care and Education at the Westchester Division of NewYork-Presbyterian. She is a board certified chaplain through the Association of Professional Chaplains and a certified supervisor through the Association for Clinical Pastoral Education, Inc. She is an ordained minister in the United Church of Christ. She has a Master of Divinity from Yale University Divinity School and a Master of Social Work from the University of Connecticut School of Social Work.

Footnotes

1. Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals, Oakbrook Terrace, IL: The Joint Commission, 2010. Regarding assessment, Ch. 2, p. 15 states, "identify patient cultural, religious, or spiritual beliefs and practices that influence care", and regarding a treatment plan, Ch. 3, p. 21, states, "Accommodate patient cultural, religious, or spiritual beliefs and practices."

2. © 2009 New-York Presbyterian Hospital, Rev. Dr. Beth Faulk Glover, Corporate Director of the Department of Pastoral Care and Education

3. The Joint Commission's Standards Supporting the Provision of Culturally and Linguistically Appropriate Services, 2009, states that inclusion of spirituality groups can address the following needs: Standard PC.1.10, Element of Performance EP 8 – After screening, clients are matched with the care, treatment, and services in the organization most appropriate to their needs; Standard PC.4.50, EP 1 – Clients are encouraged to participate in developing their plan for care, treatment, and services, and their involvement is documented, & the organization has a process for involving clients in their care, treatment, and service decisions; Standard PC.6.10, EP 2 – The client receives education and training specific to the client's needs as appropriate to the care, treatment and services provided, & the assessment of learning needs addresses cultural and religious beliefs, emotional barriers, desire and motivation to learn, physical and cognitive limitations, and barriers to communication as appropriate; Standard RI.2.10, EP 2 – Each client has a right to have his or her cultural, psychosocial, spiritual and personal values, beliefs, and preferences respected.

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BEST HOSPITALS U.S.News & WORLD REPORT HONOR ROLL 2011-12

NewYork-Presbyterian Hospital, created through the merger of New York Hospital and The Presbyterian Hospital benefits from the collaboration of two extraordinary programs, offering the highest level of psychiatric services by experts who are recognized leaders in their respective specialties. NewYork-Presbyterian Hospital's Behavioral Health program is consistently ranked among the nation's best, and is considered a premier program in the New York metropolitan area.

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Ascent Into Love: Surviving Schizophrenia

By Susan Weinreich
Artist, Advocate, Lecturer,
Peer Wellness Coach

Every person needs to be touched, supported and nurtured by the environment in which they live in order to grow. The earth's immense force of gravity, whether physical or psychological, is too much for us to bear alone. Each of us takes a turn at holding each other's weight, much like the spine that supports the brain or the soil that holds the roots of a tree. It is an embrace that gives definition to the unique aspects of our nature, the armature that holds our very essence. Life becomes formless without this critical structure that assists in our development and defines what lives and what dies away. To be held, to be touched, is necessary for survival. A deprivation of this leads to death…mentally, physically and spiritually. I am not sure in my case, which was worse, the downward course of my own schizophrenia or the absence of human contact as a result. Both were lethal, and as a dying leaf turns to fire in the fall before crumbling under foot, it sends out a putrid smell of decay. My body did the same. Flaming from the disease that had invaded my brain, my pores sent out an odor of cumulative sweat and filth. As a result, I pushed people away and kept them safe at a distance. All of this, especially the illness itself, added to my isolation and complete withdrawal from humanity.

Susan Weinreich
Artist, Advocate, Lecturer

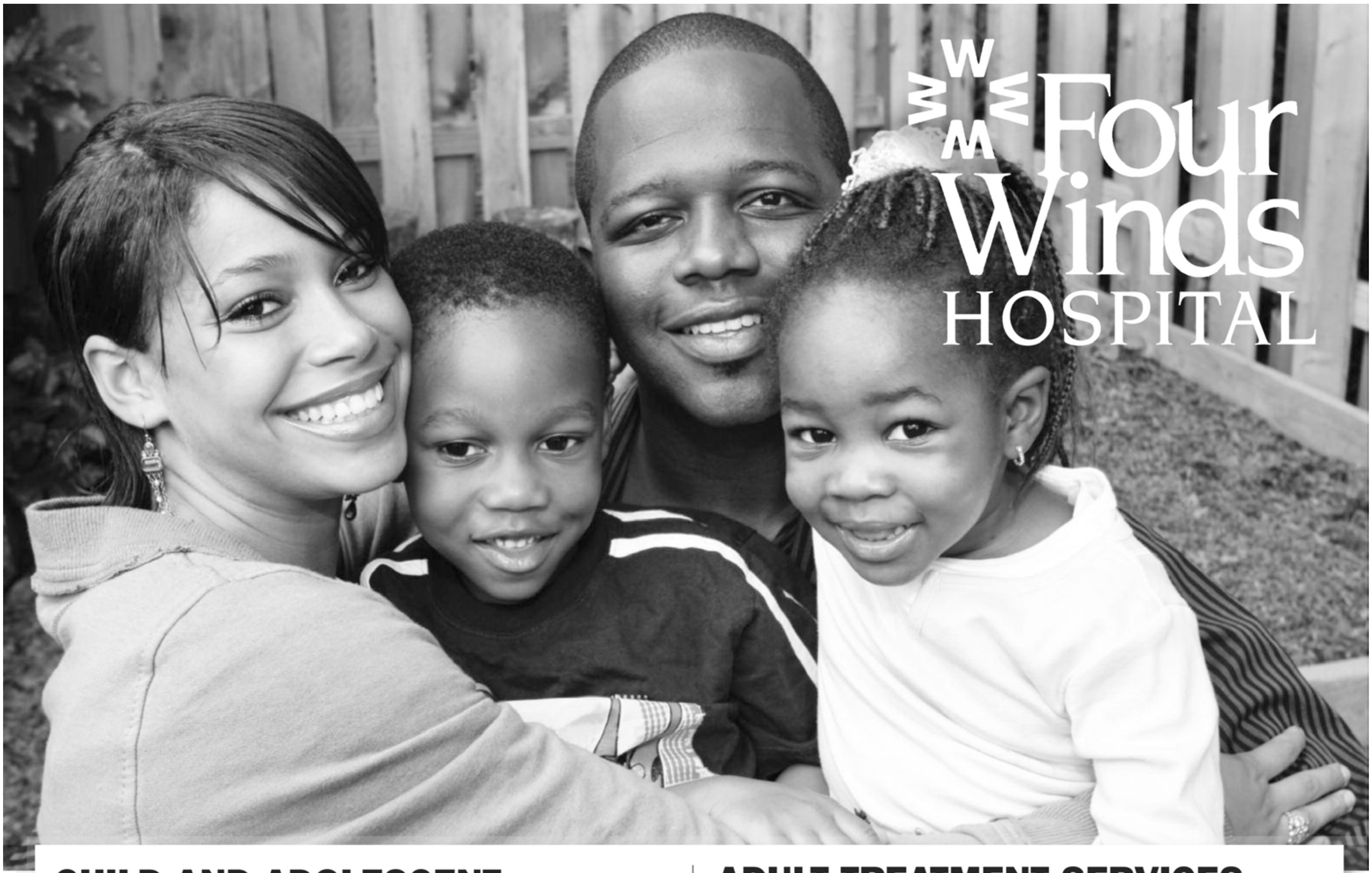
Beyond popular belief, Schizophrenia does not have to be a dead end, nor is it fruitless. Recovery is possible and recent studies have shown that people can and do recover. Every individual is different and therefore each recovery is unique. The world is full of individuals who are surviving this devastating disease to the best of their capabilities. They are courageous, magnificent and strong in their striving to function in a society that marginalizes them. The days of Schizophrenia being a "death sentence" are over. There is Hope and there are countless individuals like myself who have broken the hold of Stigma as well, and who have come forward to share remarkable stories of Triumph. If you listen to them speak, their recovery is almost always about connection with others and freedom from isolation.

"Ascent Into Love"
Oil on Canvas 40" X 30"

I have often been asked, why do some people rise above their impediments and others stay stuck? Resilience is more than just a random, enigmatic concoction of genetic makeup responsible for survival. We all possess in us the seed of resilience in one form or another. However, this potential for growth is not enough by itself. The key to recovery is to nurture that seed. The way to do that is through connection, through human relationship.

Art is the language I used when I was severely disabled as a result of my illness and had no voice to express myself. It was the only way I had to connect with the outside world. For someone else in my situation, it could have been baking muffins, playing ball or writing poetry. During the early years of my recovery, making art helped me to express constructively my stopped up, often confusing and chaotic feelings that frightened me. Putting them on paper or canvas helped to defuse these internal conflicts as they spun notoriously out of control. Seeing these images with my own eyes and separate from my body helped to distance myself from the horrific anguish that I suffered from inside, giving me a sense of perspective and creating an opportunity for productivity and validation, recognition and acceptance. It was a place to begin the

see Surviving on page 36


Four Winds HOSPITAL

The Evolution of Recovery-Oriented Services in NYC and at MHA-NYC

Michelle DesRoches, LMSW, Director of Adult Services and Quality Improvement and Kathryn M. Salisbury, PhD
Vice President of Programs
MHA-NYC

New York City has a long and proud history of providing a wide range of recovery oriented programs for individuals with serious and persistent mental illness. Following in the activist path of Clifford Beers who started the modern mental health movement in 1909, six former psychiatric patients and two volunteers formed Fountain House, a clubhouse program, in 1948 to combat the loneliness and stigma of experienced by people living with mental illness. With the introduction of psychotropic medication in the mid-1950s, the achievement of the dream for people with serious mental illness to have a productive and integrated life in the community came within closer reach.

As a result of these advances in psychiatric care, the tireless efforts of mental health advocates, and advances in the evidence base of support and care in the community, the care of people with mental illness has undergone a series of transformations over the past 50 years. We have seen the growth of clubhouses alongside of the growth of community mental health centers as well as a variety of employment related programs.

As national views coalesced around the principles of recovery, federal, state and local government funding priorities followed suit. In New York State, the conversion from traditional clubhouse, employment programs and other psychiatric rehabilitation programs to Personalized Recovery Oriented Services (PROS) programs began in 2003, with implementation delayed in NYC until 2010.

The Mental Health Association of New York City (MHA-NYC) converted its Harlem Bay Clubhouse and Fast Track to Employment Programs to a Medicaid funded and licensed PROS program in 2011. MHA-NYC is an organization that prides itself on being an innovator in mental health and is at the forefront of developing or adopting best practices. Yet, staff members were, initially, somewhat reluctant to embrace the conversion. The Fast Track to Employment programs that they staffed produced good outcomes and the consumers who frequented the Harlem Bay Clubhouse found a place where they had their own community. The leap from a grant funded program where the funding was predictable to a program whose survival and growth would depend on billable visits was also challenging for staff. They feared that these new demands, particularly regarding the increase in additional documentation needed for Medicaid, would divert attention from serving program participants. Although peer support, strength based work and an empowerment model were already integrated into their program models, movement to a more goal oriented and classroom based approach to services required staff to make a paradigm shift from thinking about the Clubhouse as a "clubhouse for life" to a program that helps its participants reach life goals and build a life in the community.

Looking back over the first year of Harlem Bay PROS's operation, we can say with confidence that the experience of working with consumers in PROS has put most of these concerns to rest. Key elements to our successful start include:

Preparation of staff and consumers: Our staff, received additional intensive training on best practice techniques such as motivational interviewing, Wellness Recovery Action Planning (WRAP), assessment, documentation standards for Medicaid reimbursement and concurrent Documentation which gives consumers input into every aspect of their programming. In keeping with principles of recovery, consumer involvement was also an integral part of the program development and transition process. This involvement in the identification and planning of courses was instrumental in getting the buy-in of consumers who were not familiar with the program model.

Consumer Choice and Voice: Maximizing ongoing consumer choice and voice has been a critical part of matching consumer needs and interests with program offerings that keep them coming. Harlem Bay PROS staff have risen to the challenge of keeping consumers engaged by translating consumer input into the development of classes like "What's Your Story" and "Finding My Mojo" that catch and keep their interest. Consumers are also involved in the entire process from assessment to goal setting to what is written into the charts. In a program that depends on utilization for reimbursement this level of engagement is crucial.

Staff Flexibility: Because the participants' needs change as they progress through the program, staff must continually assess the classes that are offered and make changes regularly. Classes are offered in 12 week sessions, and as the interests and needs of the participants change, new classes must be developed and older classes put on the shelf until the need for them arises again.

Connection to Community: The ultimate goal of the program is to help people become so connected to life outside of the program that they no longer need the intensive supports that the program provides. Although consumers may need ongoing psychiatric services, when it is possible to connect participants to ongoing support from a family or others in the community, participants become less dependent on the "program" for a sense of belonging and support. The availability of psycho-education and support for family members and members of the participant's support system also helps to pave the way. The progression from dependence on a program to more independence is often seamless and through a "graduation" acknowledgement from the program, others still working on their goals are left with a sense of hope.

In the process of converting our clubhouse and employment programs to PROS, it appears that MHA-NYC's staff have themselves become converts—one only needs to walk into the program space to see why.

Harlem Bay PROS is a place that is alive and buzzing with excitement. If you catch the program at a moment between classes, the hallways are full of people, talking, laughing, or hurrying to catch up with their counselor before the next class. There is a sense of hopefulness in the air. When you stop to chat with somebody conversations often turn quickly to their primary life goal in the community and you learn how close they are to getting housing or how it felt to reconnect with a child.

During class, group participation is high and discussion flows freely, with participants and staff working together to help people move forward in their lives. Moments of insight and connection occur as one person's story helps another understand something about his symptoms or why a job interview didn't go so well and how it can be done differently the next time. Conversations now reflect a desire to be a part of the community outside the program. As one participant, Della C, said so clearly, "They make you feel like you are somebody here, that you can do something with your life."

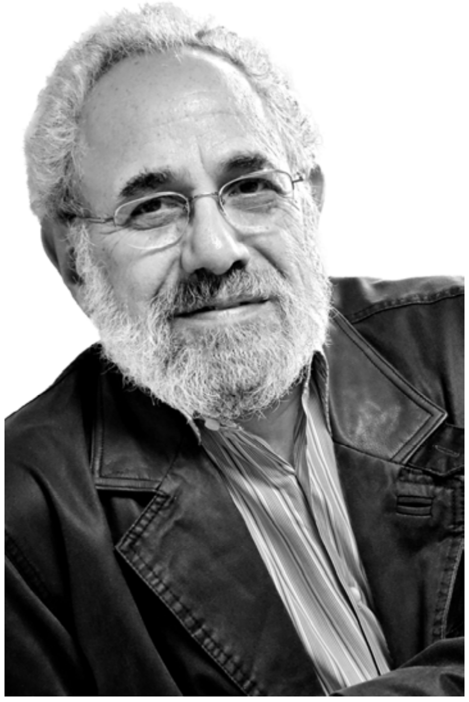
Murders and Mental Health Advocacy: Opportunity or Temptation to Resist?

By Michael B. Friedman, MSW
Mental Health Policy Advocate

From time-to-time, a person with a severe mental illness (or assumed to have a mental illness) commits a heinous act that makes headlines. The reactive call for better mental health services is entirely predictable, not only on the part of those who are trying to distract us from issues such as gun control but also by mental health advocates who see these events as opportunities to get public support for improvements in mental health policy. It is true, of course, that these are moments when the public will pay attention, but should those of us who care about the well-being of people with serious mental illness take advantage of these opportunities or resist the temptation?

Throughout my career—over 30 years of mental health advocacy—I have refused to use public fear of people with mental illness as an opportunity to seek a better mental health system.

I am not surprised when advocates who believe that deinstitutionalization was a mistake and that we need a more coercive mental health system use these events to advocate for their point of view. But I am always surprised and a bit distressed when colleagues who support community-based mental health policy, who fight stigma and especially the myth that people with mental illness are violent, see this as an opportunity to ask for more money for community mental health generally or for specific needs such as housing, assertive community treatment, family support, screening, early intervention, preventive interventions, and more.



Michael B. Friedman, MSW

Some of the people who do this really believe that increased funding for more and better community mental health services will result in reduced incidence of killings by people who are mentally ill. But most, I think, know that these events are so rare and that we know so little about them there's little reason to believe that any of the recommended changes—which may be valuable for other reasons—will affect the rare incidence of murder by people with serious mental illness.

But they know that powerful people listen when they are barraged by headlines crying for them to do something to prevent dreadful events. When President Obama says in response to the murders of children and teachers in Newtown, CT. that there should be "as much access to mental health services as to guns," something extraordinary has happened. A President is thinking about mental health policy.

Sometimes getting this kind of attention makes a positive difference. For example, when Kendra Webdale was pushed to her death in front of a subway by a psychotic man, Governor Pataki, who previously had opposed any growth of mental health funding, added $200 million or so to the mental health budget in New York State. In theory, the additional funding was to pay for services for people who were subject to New York's new involuntary outpatient commitment law; but in fact most of the funding went for housing, assertive community treatment, and other critical community-based services. Public fear had resulted in a significant gain for mental health.

So maybe I'm wrong. Maybe we should take advantage of public fear to draw attention to the inadequacies of the mental health system. Let me explain why I am not convinced.

First, playing on public fear is tantamount to confirming the myth that people with mental illness are dangerous. We should instead provide data about how rare murder by people with severe mental illness is. For example, a meta-analysis Nielson, et al published in the *Schizophrenia Bulletin* in 2011 estimated that there is one murder of a stranger(s) by a psychotic person per 14 million population per year.[1] That is a murder rate of between .3 and .7 per 100,000 people with a psychotic disorder. Each event, of course, is awful, but statistically there are far too few to warrant fear of the entire population of people with even the most severe mental disorders.

Second, public fear fuels a demand that the mental health system somehow prevent these very rare acts of homicide and invites increased coercive interventions—especially easier involuntary inpatient and outpatient commitment. There are arguments to be made for re-examining criteria for coercive interventions; but they have little to do with murder, and there are very important questions to be raised about how big a net should be spread over the population of people with serious mental illness in the hope of preventing exceedingly rare acts of homicide. Let's not forget how much abuse there used to be of the governmental power to commit people to psychiatric hospitals.

see Advocacy on page 32

Peer Counseling Effectiveness in Acute Care at Kings County Hospital

By Jonathan P. Edwards, LMSW, Director of Peer Counseling, and Janine Perazzo, LCSW, Director of Wellness, Recovery, and Community Integration, Kings County Hospital Center

Peer counseling is not new to Kings County Hospital Center (KCHC). In fact, it began more than ten years ago when a former patient—a tireless advocate and pioneer of the consumer mental health recovery movement—was hired as a part-time intern to work on inpatient services. In 2004, through a New York City Health and Hospitals Corporation (HHC) Foundation grant, four peer counselors were hired to function as case managers helping consumers bridge the much-too-frequent gap between acute and after care. Today, there are 22 full-time peer counselors working in inpatient, outpatient, primary care, partial hospitalization, and emergency care services at KCHC. A licensed professional who is also a peer supervises them.

Peer counseling is engagement used not only in mental health, but also in education, substance abuse treatment, and HIV services (Ault, 2006). Peer counselors use their personal experience to provide companionship, compassion and hope; they are ambassadors of empathy, and foster identification between themselves and consumers.

Jonathan P. Edwards, LMSW

Janine Perazzo, LCSW

Peer counselors receive training from advocacy organizations and human service programs, and/or have commensurate experience working in a human service field such as teaching or nursing. They also receive additional training at their work site once hired. The scope of their work is extensive. They orient consumers to the service setting and care they will receive; facilitate recovery-oriented groups to improve adult living, coping, and relapse prevention skills; assist consumers in setting meaningful goals and developing action plans. They focus on helping others feel empowered by sharing resources that will connect them with their community after discharge. Peer counselors also convey, in plain, non-clinical language, consumers' experiences to other staff helping to widen the lens through which traditional providers may have been trained to view people living with mental illness. Above all, peer counselors carry the message that recovery is possible. They are the evidence.

Peers facilitate integration of a recovery model in behavioral health services at KCHC. They exemplify and articulate Guiding Principles of Recovery (SAMHSA, 2011) such as hope, self-determination, personal responsibility, and person-centeredness. They play a crucial role in preparing consumers for and representing them in treatment and aftercare planning. Several processes have been created to ensure the inclusion of peer input. The Patient Assessment and Goals PAG) form, for example, is a document that is completed by a consumer prior to his or her treatment-planning meeting. Peer counselors assist consumers, making themselves available to advocate during treatment team at the consumer's request. Their input in the treatment process illustrates one of several inherent paradoxes they experience being both advocate and team member. This dichotomy also suggests that one does not become a peer counselor simply to have a job; rather, it is a calling. People are driven to do this type of work because of a deep passion to help others believe in themselves.

Studies indicate consumers who receive peer support experience fewer hospitalizations, use fewer crisis services,

see Peer Counseling on page 24

Parachute NYC: A New Approach For Individuals Experiencing Psychiatric Crises

By Steve Coe, Chief Executive Officer, Community Access, Inc.

Think back to the last time you had a really bad day. One that even now you shudder to recall—a day characterized, perhaps, by heartache, or disappointment, or loss. Or even physical pain. A day you were glad to get to the end of, which left a mark on you somehow, and which you hope never to repeat.

Imagine that day also involved police officers in your home, handcuffs, hours spent restrained in a chaotic hospital emergency room, transfer to a slightly less chaotic locked hospital ward, and a heavy dose of a tranquilizing drug: a day defined by a profound loss of control, privacy, dignity, and respect.

You have just imagined the very scenario that thousands of people in the U.S. experience every day. Too often, an emotional crisis overshadows the person, becoming the catalyst for treatment options that typically emphasize short-term stabilization (medication), rather than long-term recovery and wellness.

The trajectory of treatment that follows is familiar: more, and extended, hospital stays, deteriorating physical health, loss of connection to friends and family, and what insiders often refer to as "professional patient-hood." Considerable funds and expertise are expended throughout – but at what cost to both the mental health system, at large, and the person who is trapped in a debilitating cycle? And, indeed, what kind of "recovery" is made possible as a result? As a lead partner in Parachute NYC, we at Community Access are taking a leadership role in changing the course of this trajectory.

Parachute NYC, a major new citywide project, is poised to provide some compelling answers. Over time, as its services are launched in four phases between now and the winter of 2014, it may even change the way we frame how these issues are discussed. "It is a bold person-centered approach," says Pablo Sadler, Project Director of Parachute NYC and Medical Director of the Bureau of Mental Health at the NYC Department of Health and Mental Hygiene, "that will create new networks and possibilities for program participants, while at the same time maximizing existing resources."

Funded by a three-year, $17.6 million Healthcare Innovation grant from the Center for Medicare and Medicaid Services, Parachute NYC will provide a "soft-landing," community-based alternative to emergency hospitalization treatment as usual for individuals experiencing psychiatric crises.

Parachute NYC is projected to reduce gross Medicaid expenditures by $50 million over the next three years for individuals receiving these services, while also improving the care and health of participants. It will do so through an integrated series of interventions that will form a new type of response to psychiatric crises—one that relies less on medication management and more on engaging the participant and the family in developing a comprehensive recovery plan.

Led and coordinated by New York City's Department of Health and Mental Hygiene, Parachute NYC involves the collaboration of the New York State Office of Mental Health and several voluntary organizations, including Community Access, Inc., the Visiting Nurse Service (VNS), the Mental Health Association of New York (MHA), Services for the Underserved, Transitional Services of New York, Inc., Riverdale Mental Health Association, Community Healthcare Network, The Coalition of Behavioral Health Agencies, Woodhull Hospital, and trainers and consultants from around the country and the world. Program evaluation is being conducted by the Nathan Klein Institute.

Parachute NYC has several unique features. First and foremost, continuity of care will be of paramount importance—there is no hand-off between one provider and another. Second, trained peers will constitute a significant proportion of the Parachute workforce, leveraging their personal experiences to help participants more effectively engage with the health care system and other community resources.

Third, using the principles of the Need Adapted Treatment Model (NATM) and Intentional Peer Support (IPS) – both described in more detail below – Parachute services will support participants in the pursuit of self-indentified wellness and recovery goals. There will be an emphasis

see Parachute on page 38

Peer Training and Empowerment at the Howie the Harp Advocacy Center: Keeping Pace with a Bigger, Stronger Peer Movement

By Jon Curtis, Communications Specialist, Community Access, Inc.

Without meaning to stretch the analogy too far, there was perhaps something rather apt—albeit unfortunate—about the 17th Annual Howie the Harp Advocacy Center (HTH) Graduation Ceremony being delayed three months because of Hurricane Sandy. It was originally scheduled for October 29, 2012, the day Sandy hit New York. As with countless other buildings across the East Coast, NYU's Kimmel Center, the venue for the ceremony, ended the day without heat or power.

Apt, because HTH graduates (up to now there have been more than 800 in total) are more keenly aware than most that life seldom follows a linear path with clear signposts along the way. Circumstances often conspire to get in the way of where we aim to go, and detours, delays, and frustrations are not always possible to avoid. Yet apt, too, because setbacks need not be final: just as power is fully restored in the wake of a storm, experiences, both good and bad, are all learning opportunities that may shape a brighter future.

The HTH Center, located in Harlem and operated by Community Access, Inc., is an empowerment and job training center for peers, which offers participants six months of in-class training, connection to three-month internship programs at numerous health and human services organizations throughout New York City, and support services relating to job placement and retention. Its graduation ceremony honors the achievements of up to 60 participants per year: individuals who complete one of two annual training cycles, fully equipped for an ever-growing number of roles within the mental health workforce and beyond.

This year's ceremony may have been later than planned but, in common with its 16 predecessors, was a joyful occasion nonetheless. Peers graduate from HTH to a soundtrack of generous and heartfelt applause. It's a tremendous landmark on the road to recovery, made still more resonant by many and varied hardships leading to it. As Lynnae Brown, HTH's Coordinator of Education and Training, explains, "we see huge transformations between day one of class and graduation. People who start out feeling a bit shaky, doubting their ability to be effective in the world, who go on to be connected, team players enthusiastic about what's coming next."

"There are so many ways to serve in the peer movement today," Brown continues, "and that range of possibilities is growing all the time. That's exciting – we get to see people's stories go from tragic to triumphant." Indeed, with an increasingly widespread appreciation of how valuable peers in the workforce can be, more and more employers are learning to regard a wider spectrum of experiences as potential assets. The majority of HTH graduates have, in various combinations, histories of homelessness, mental illness, substance abuse, and incarceration. Through access both to opportunity and new networks of support, however, powerful new modes of thinking are encouraged: recovery is not only possible, it is also an outstanding 'qualification' for helping others to recover too.

Taking full account of this potential is a task that reverberates throughout the entire mental health community. New initiatives such as Parachute NYC (described in more detail opposite) are not just seeing peers as *valued added* but as essential. That's why—to meet this growing demand—HTH is expanding to become both a bigger, more wide-ranging program, and a model for other providers to replicate, in other parts of the US as well as internationally (Pameijer, a human services organization in Rotterdam, the Netherlands, started using the HTH model, under license from Community Access, in 2012).

Says Community Access Deputy CEO Alysia Pascaris, "Over 17 years, we've seen from experience what works and what doesn't. We know what we want to achieve and how to achieve it – and that's why we made a concerted effort to standardize our curriculum, making it as current and as effective as possible."

"We're more than a training center," Pascaris continues, "graduates don't just walk away with facts and skills, but also grow as people." As such, HTH increasingly combines bedrock principles – foremost, the importance of self-advocacy and maintaining wellness – with areas of specialization that more effectively accommodate different life goals and individual needs. Different tracks at HTH, for example, emphasize working with the LGBTQI community, veterans, and individuals with forensic histories.

Over the next couple of years, Recovery Connections, a major new HTH program, will take these approaches a step further still, initially serving residents of Manhattan and the Bronx, and then all five boroughs thereafter. Described by Pascaris as a "center without walls," it will provide peer-driven services that help peers to make and keep social connections within their communities, and better access a wider range of mainstream resources – through mutual support, education and information sharing, reigniting interests and aspirations lost by peers during incarceration and engagement with the traditional mental health system.

As with the peer movement, generally, Recovery Connections promises to be an initiative that organically sustains its own continuing growth. Literally, through facilitating meetings, hosting events, and making referrals to vocational and educational programs – but also symbolically, by more firmly positioning peers within society as a whole.

NYSPA Report: How Will New York State's Transition To Medicaid Managed Care Impact Those With Serious Mental Illness?

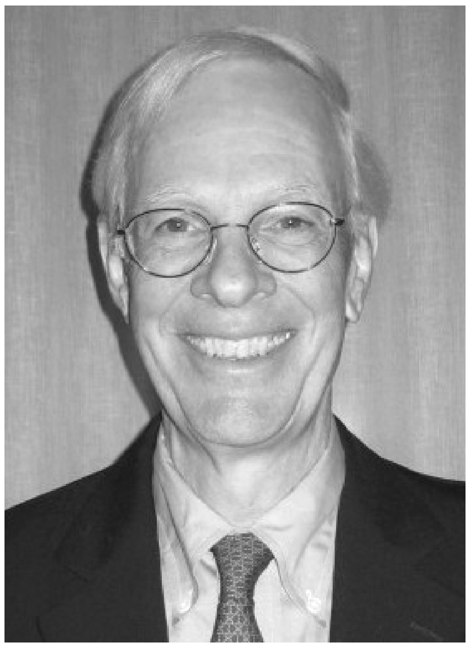
By Barry B. Perlman, MD
and Henry Harbin, MD

Skepticism, not cynicism, will be in order during the coming year as New York State's efforts to place all of its Medicaid enrollees, including those with serious and persistent mental illness, into Medicaid Managed Care Plans (MMCPs) is realized. Reaching this goal is an important part of the Cuomo administration's Medicaid Redesign initiative, set in motion to reduce the state's disproportionate Medicaid expenditure. By doing so, NYS will join with the many other states, including Kentucky, Tennessee, Illinois, and Florida which have taken this step. To its credit, NYS did not rush to make the change prematurely but is now forging ahead rapidly. It started by designating regional Managed Behavioral Health Organizations (MBHOs) to gather data about the residual Medicaid Fee for Service population's use of mental health services and provide the state with specialty behavioral managed care experience. The expectation is that the information obtained will help shape the managed care model to be created. While this is a good plan we think that the state should also be collecting similar data on those consumers with MHSU Disorders who have been receiving their behavioral care within the MMCPs. Data collected in many states show that there are more patients being treated within the general medical system as compared to the specialty behavioral system even when the behavioral benefit is "carved out."

The state has signaled that it would like to move all behavioral care under the broader Managed Care Organizations (MCOs) . The actual clinical outcomes of this devolution to MMCPS remain to be ascertained. Nationwide it is not uncommon to have Medicaid MCOs manage a limited Mental Health/ Substance Use (MHSU) Disorder benefit. However moving very vulnerable persons with serious and persistent mental disorders (SPMIs) into MMCPs carries a greater risk for these enrollees than for those whose use is more limited. Based on the NYS experience and that in other states with MHSU Disorder managed care, the concern of patients, families, providers and advocates seems well justified.

I am very pleased that Dr. Henry Harbin has agreed to coauthor this article with me because he knows the subject of behavioral managed care as well as, and perhaps better than, most others. The reason that his thoughts on this subject are so highly valued is that he served as the CEO of 2 national managed behavioral health care companies, Greenspring Health Services and Magellan Health Services, which at the time was the largest nationally with 70 million covered lives. He spent 10 years in the public mental health system in Maryland including serving as its Commissioner of Mental Health. Also, he served as a Commissioner on the President's New Freedom Commission during 2002 – 3. He has been an early proponent for improved integration of mental and general health care.

Barry B. Perlman, MD



Henry Harbin, MD

Dr. Harbin has had experience with Medicaid management models in many states. He informs that there is little to no scientific evidence that moving the SPMI cohort into Medicaid MCOs will improve their clinical outcomes or reduce costs. He explains that states may undertake the transformation to entirely managed systems for financial, organizational, or clinical reasons. The consequence for enrollees may well depend on which motivation primarily drives the change.

It is our purpose in this piece to articulate principals based on which consumers, their families, providers, and advocates will be able to make informed judgments about the managed care scheme the state lays out for the care of those with significant mental health care needs.

The following are some matters worthy of consideration:

Many state Medicaid directors would like to move all patients and the premiums to support those patients under one administrative umbrella, the Medicaid MCO, hoping for administrative simplicity, and cost predictability and effectiveness as compared to contracting with many regional MBHOs. Given the vast amounts of money involved many Medicaid MCOs are lobbying to have all disease groups, especially those with chronic high cost illnesses, including behavioral, placed entirely under their control. Furthermore, many states are expecting that having all specialty behavioral services under the broader health management entity, the Medicaid MCO, will allow for better integration of medical and behavioral care. Based on experience, Dr Harbin believes that there is minimal if any data to support the expectation that this will be more cost effective nor is there research or experience that shows that clinical care will be better "integrated" or "coordinated" when all MHSU Disorders benefits are put under the same management entity. Rather, almost all of the research around improved clinical and financial outcomes for integrated care is based on clinical interventions like Collaborative Care within primary care. Given the huge financial forces which come into play around these realignments, providers, patients and families hope their interests will be taken into account as these high level decisions are taken. While fearing a harsher system, they hope the system will not be made even less user friendly than it currently is. At best, perhaps they can hope for some improvement.

Part of the problem is that administrators and planners confuse administrative and financial integration with clinical integration. The field now has a solid research base that supports a clinical evidenced based model called "Collaborative Care for Mental Health in Primary Care". It is effective both in terms of significantly improved clinical outcomes but also in reducing medical costs. Most of this research was done with MHSU Disorders in the mild to moderate levels of need. There an increasing research base suggesting that this clinical model works with more serious conditions as well.

This clinical model works whether the financial management of the entire healthcare benefit is under a single insurance entity or separate entities including MBHOs. For an insurer to implement an evidenced based Collaborative Care program requires flexible reimbursement of several key services and most of the cost savings accrue due to reduced medical, not behavioral, costs!

One of the approaches that interested parties in NYS could advocate for during this period of transition would be that NYS DOH require all Medicaid MCOs to begin implementation of the Collaborative Care Model for non SPMI MHSUD patients who receive part or all of their behavioral care within primary care setting. Most of these patients never receive treatment within the specialty mental health system. This would allow the state and advocacy organizations to judge the competence and effectiveness of a Medicaid MCOs to improve the outcomes of the MHSUD patients that are already under their management authority before moving SPMI patients who require a more complex set of interventions under their span of control. If an MCO is unwilling or unable to implement a well documented clinical intervention that is low cost and effective then it is unlikely they will be able to manage a more complex set of patients.

see Transition on page 32

It's On My Plate

By Akavar Dylutra, Volunteer with the *In Our Own Voice* Program
NAMI of Mercer County New Jersey

Akavar Dylutra

One morning in May of 2009 I woke up in the inpatient psychiatric ward of a regional medical center in western New Jersey. I had admitted myself through the ER the night before - after a suicide attempt. I would be diagnosed with major depression, general anxiety disorder, and substance abuse issues.

As I learned about the behaviors associated with my illness, I realized that I exhibited most of the behaviors related to major depression as a five year old child. I was fifty six years old. This meant that I had been living with major depression for over fifty years.

All of us who are challenged with a mental illness eventually have to wrestle with the question of nature versus nurture. Did the mental illness come from my genes? Is it some sort of behavior that I learned? Here is how I have come to peace with this dichotomy.

It appeared to me that most of my behavior was learned. Even though my family has a history of alcoholism, it seemed that most of my behavior was learned maladaptive reactions to a very toxic family situation. My isolating behavior in childhood was an attempt to shield myself from a toxic family situation. My near suicidal behavior at five years old was a desire for physical sensation in a very cold physical and emotional family environment.

In recovery, I began learning skills to modify these lifelong behaviors through intense talk therapy.

One day I thought "What if these behaviors come from my genes and DNA?" The response to this thought was to look at someone with a congenital disability like blindness. There are many individuals with congenital blindness that learn to adjust and live a happy, productive life.

This pointed me back to using the skills I was learning in talk therapy. For me, even if the cause of the behavior is my genetic inheritance, just like someone who is congenitally blind, I should be able to learn the skills required for a happy and productive life.

Another concern I had was that if I accepted that my behaviors were from genetic inheritance, I might give up. My apprehension was that I might not take responsibility for my behaviors. After all, if they come from my genes, I can't change them anymore than I can change my genes.

One final thought I had about genetic inheritance was that maybe what we are really describing is behavioral inheritance. The infant spends most of their waking hours observing the parents and those around them. They attempt to learn and imitate the physical behaviors that they perceive - walking, talking, etc.

How do we know that they are not doing the same thing with the emotional behaviors they observe? The infant assumes that the physical behaviors around them are normal and should be learned, why should they not assume the same thing about the emotional behaviors around them?

For my recovery I decided that I could not let the fact that my behaviors might be genetic in origin get in the way of my finding a happy and productive life. I would take my meds to keep me stable, but they would only provide stability. I would use that stability to concentrate on learning the skills required to learn to be at peace with myself.

I progressed through my recovery in that fashion. The meds were keeping me stable. However, once I was stable they could not teach me the skills of self-advocacy, setting boundaries, being able to trust, and learning to discuss and deal with my emotions. That learning had to come from therapy and my use of my newly found skills in my daily life.

Then a few months ago I had a flash of insight that put it all in perspective.

At the end of the day it does not matter what the source of the behavior is. It does not make any difference if I was born with genes that caused my behavior or I learned maladaptive behaviors as a very young child.

The important factor is that **it is on my plate.** Since it is on my plate I have to deal with it. Whether someone came by and served me a salad or I went up to the salad bar and made it myself makes no difference. The operative concept is that I have the challenge now. And I am the only one who can do anything about that challenge.

The therapists can describe the healthy behaviors to me. They can reinforce my progress and point out when I go off the track. The meds can keep me stable enough to learn those healthy behaviors and consolidate my progress. However, the problem is on my plate and I have to deal with it as best as I know how.

This understanding has given me great peace. It has also been very powerful. It has helped me to realize that at the end of the day **I** am responsible for my successful recovery. Not the meds, not the therapists, not my genes. Me.

I now look forward to each day. I ask "What can I learn today that will help my recovery?" That attitude is so much healthier than the more than fifty years I spent waking up each morning with an absolute dread of the new day.

Recovery 101: For Those Who Thought They Couldn't Recover

By Julie Kipp, PhD, LCSW
Director, Bronx REAL PROS
JBFCS

Advocate for the mental health recovery movement Pat Deegan wrote, "The professionals called it apathy and lack of motivation. They blamed it on our illness. But they don't understand that giving up is a highly motivated and goal-directed behavior. For us, giving up was a way of surviving. Giving up, refusing to hope, not trying, not caring—all of these were ways of trying to protect the last fragile traces of our spirit and our selfhood from undergoing another crushing."

Staff who work in programs treating people with mental illness are often frustrated by their clients' apparent and troubling lack of desire to get better or set any goals. In fact, such amotivation is considered pathognomonic of schizophrenia. However, as Deegan, who has personally experienced mental illness, eloquently points out, such lack of motivation may serve a purpose in the life of the person with mental illness. How can we promote the growth of those fragile traces of spirit and selfhood? How do we create an environment where people can feel strong enough to risk the crushing that living can deliver?

Before making an attempt at answering these questions, I need to take a step back and describe the setting in which I lead a team of staff working with people with serious mental illness in a PROS program in the Bronx, New York.

In New York State, mental health services are being reinvigorated by an approach that recognizes that people can and do recover from mental illness. An extensive body of research over the past 50 years has shown that many people who have had mental illness, even the most severely ill, get much better over time—and even fully recover. The still relatively new PROS (Personalized Recovery Oriented Services) program puts that philosophy of recovery into operation and has almost completely replaced the day programs that previously served adults with a serious mental illness.

At Bronx REAL, a site of JBFCS (Jewish Board of Family and Children's Services), we had a CDT (Continuing Day Treatment) program for many years which provided daily structure, stabilization, and support to people with mental illness in a milieu setting, which included groups and individual psychotherapy and case management. We also had an IPRT (Intensive Psychiatric Rehabilitation Treatment) program, providing rehabilitation services to clients who, having achieved psychiatric stability, and had a goal they wished to pursue. In June 2010, these two programs were combined into a new PROS program, with all the chaos and excitement of creating a whole new service.

What makes PROS different than the old CDT/IPRT? In some basic ways the community of staff and participants is similar. We didn't have to be told—although it is always a good reminder—that treatment should be person-centered. We had a tradition of working to understand the personal elements of someone's illness, the meaning of delusions or hallucinations, say, to the person him or herself. We paid attention to our clients' life experiences, including trauma or neglect, in many cases severe enough that it would have been hard for anyone to keep his or her sanity.

We also recognized and celebrated people's progress toward health, which often comes in very small steps. Someone who has been withdrawn and isolated raises his hand in community meeting and offers an opinion, even if its off-topic! Someone who has a great deal of trouble getting along with others, tends to be hypersensitive, and is always getting into arguments, and one day, in one of the meetings we always have when conflicts arise, she is able to acknowledge the other person's point of view. We recognized these small but crucial steps forward.

We have always individualized treatment; that is, we looked for challenges for people that fit their current strengths and difficulties, from, say, cutting a carrot for lunch to being the team leader of a kitchen team that makes lunch for 150.

While we had a rare few people over the years who left the program to get a master's degree, find a job, get married, and have children, we thought that for most of

see Recovery 101 on page 32

How Can We Fight the Prejudice and Discrimination of Psychiatric Labels?

By Susan Rogers, Director,
National Mental Health
Consumers' Self-Help Clearinghouse

Raptly watching President Obama's inaugural address on January 21, I was struck by his acknowledgement – on equal terms – of three stunning civil rights milestones: Seneca Falls, Selma, and Stonewall. The Stonewall Inn, of course, is the gay bar where, in 1969, a police raid sparked several riots, which launched the modern gay rights movement. As if mentioning Stonewall—in the same breath as Seneca Falls and Selma!—were not enough, the President continued with an affirmation of LGBT (lesbian/gay/bisexual/transgender) rights.

Although I found the President's support of LGBT equality moving, I could not help feeling envious. The modern crusade for social justice by individuals with mental health diagnoses began at just about the same time. It was not catapulted into existence by a defining event like Stonewall; instead, it started with meetings in church basements of people helping each other heal from emotional trauma, and the creation of peer-run services (as described in Judi Chamberlin's seminal work, On Our Own: Patient-Controlled Alternatives to the Mental Health System). Yet, more than 40 years later, does the general public even know that our movement exists? More importantly, what about those among our natural allies and compatriots who would join us if they knew?

Susan Rogers

When I was locked up on the psych ward of a general hospital decades ago in New York City, my roommate received a visitor: Howie the Harp, one of the early organizers of our movement. It was Howie who let me know that there WAS such a movement, and this very knowledge gave me hope.

I have been involved in this movement since 1984 and have seen massive gains during that time. These include the closing of state hospitals; legislation such as the Protection and Advocacy for Individuals with Mental Illness Act and the Americans with Disabilities Act; the Olmstead decision, which mandated community inclusion; and acknowledgement by the powers-that-be that most individuals with psychiatric diagnoses are trauma survivors http://www.samhsa.gov/nctic/ and that peer support is a vital component of recovery (http://store.samhsa.gov/shin/content//SMA05-4129/SMA05-4129.pdf). In fact, the Substance Abuse and Mental Health Services Administration – the federal behavioral health authority – now accepts that individuals with psychiatric diagnoses DO recover and lead meaningful lives as contributing members of the community.

At the same time, we are still feared and objectified by many. So how do we create the same level of awareness of our movement that the LGBT movement has achieved?

In 2010, syndicated columnist Dan Savage created a campaign to inspire hope among young people who faced harassment because of their gender or sexual identities. According to its website, "The It Gets Better Project™ has become a worldwide movement, inspiring more than 50,000 user-created videos viewed more than 50 million times." Indeed, President Obama contributed a video to the campaign.

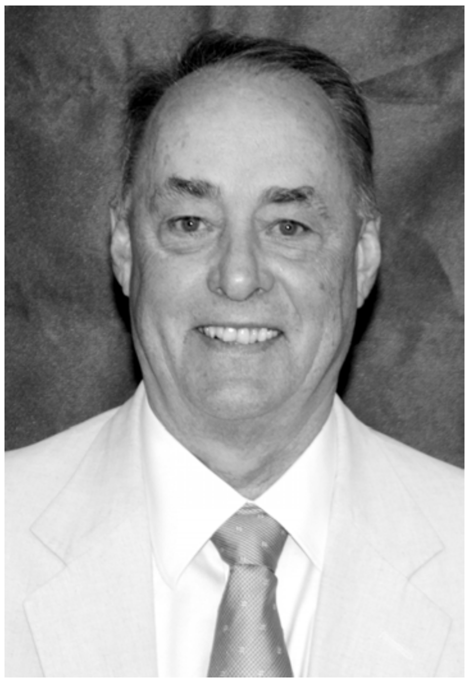
Last year, David Oaks, founder of MindFreedom International, created the I Got Better (http://igotbetter.org/) campaign, with a similar goal: "to challenge the dominant narrative of hopelessness in mental health care by making stories of hope and mental wellness widely available through a variety of media." We should support this campaign and other media campaigns that spread messages of hope and recovery.

We also need to come together as a movement, despite our differences. A house divided against itself cannot stand, but the people united will never be defeated. These words have survived because they are true.

President Obama gave his 2013 inaugural address on the day we celebrated the birth of the Rev. Martin Luther King, Jr. In the Rev. King's galvanizing 1967 oration opposing the Vietnam War, he spoke of the "fierce urgency of now" and continued, "In this unfolding conundrum of life and history there is such a thing as being too late." Our movement needs to consider these words. If not now, when?

Building a Wellness Culture for Staff To Promote a Recovery Culture for Consumers

By Roy Starks, MA, Director, Rehabilitation Services and Reaching Recovery, Mental Health Center of Denver



Roy Starks, MA

The Mental Health Center of Denver has worked for many years to create a Recovery Culture which supports the people we serve to live a full life in spite of a mental illness. (Seven Key Strategies that Work Together to Create Recovery Based Transformation, Community Mental Health Journal, Volume 48, Number 3) We also have developed a systematic method for measuring the success of this recovery system. As with many community mental health providers, our initial focus was on the people we serve and how to help them achieve their life goals. Subsequently we began to more fully understand that our measures of recovery are really measures of human happiness and that, in short, consumer recovery is aligned with staff goals for happiness. This led to the understanding that the promotion of a wellness culture for staff is critical to the successful development of a recovery culture for the people we serve.

In fostering a wellness culture for staff we strive to bring out the best in ourselves and others by 1) Seeing everyone's strengths, 2) Supporting and encouraging one another, 3) Celebrating staff, accomplishments, and diversity, 4) Respecting ourselves and others, 5) Listening to each other, 6) Creating an environment of healthy and positive relationships and community partnerships, 7) Believing everyone wants to be great, 8) Being passionate about our mission and having fun in the process, and 9) Believing anything is possible. Our entire staff collaborated to generate this nine-point Wellness Culture Statement at an all-staff meeting during which our staff members worked in groups to identify the key values of a wellness culture. As an aside, I find it interesting that these statements correlate well with the Core Principles and Values of the United States Psychiatric Rehabilitation Association.

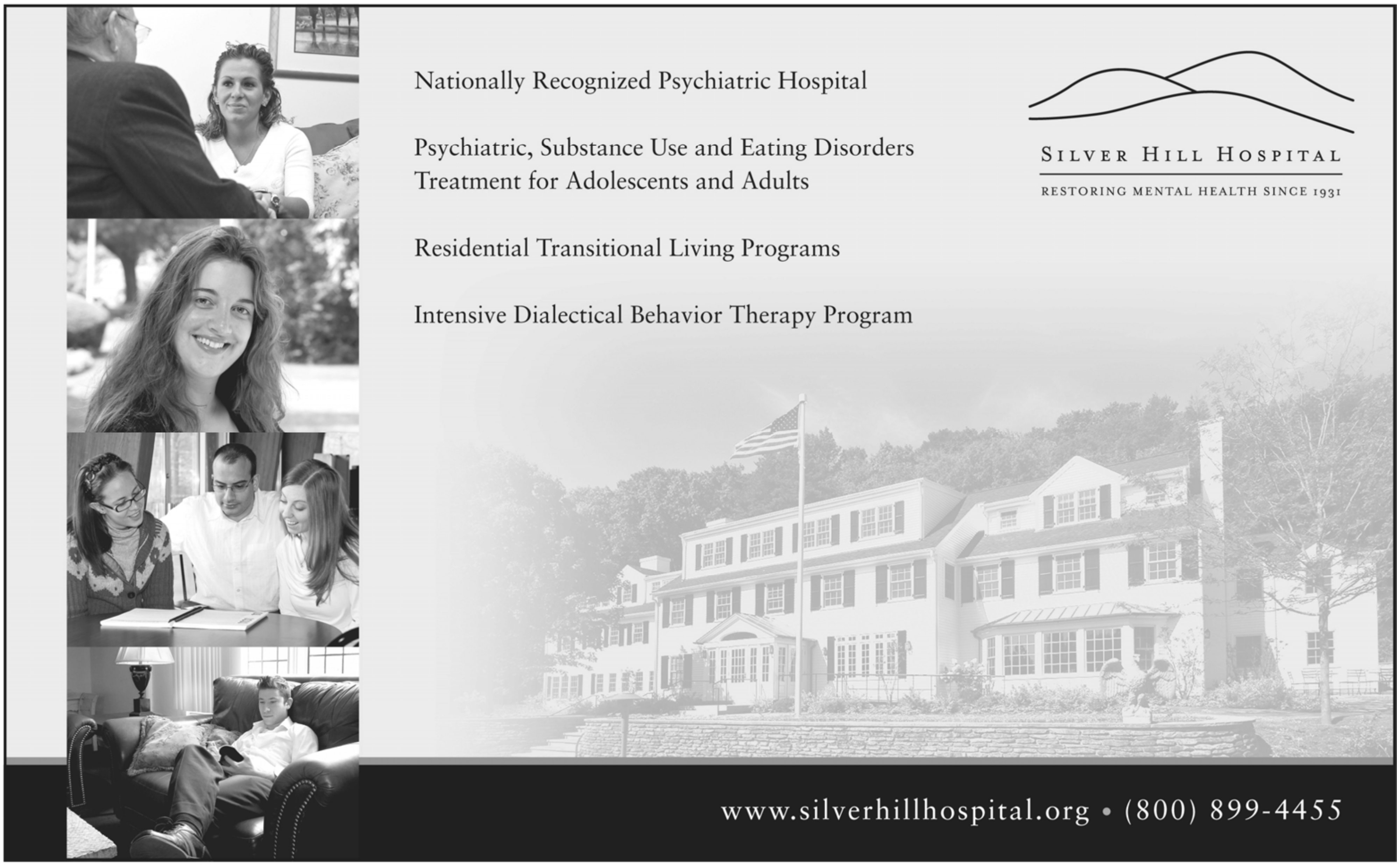
There are five main pillars supporting our wellness culture: Pathways to Leadership training (*Stomp the Elephant in the Office*, by Steven Vannoy and Craig Ross); StrengthsFinder assessment (*Strengths Finder 2.0* by Tom Rath; Catalytic Coaching (*Catalytic Coaching: The End of the Performance Review* by Gary Markle); employee recognition programs; and wellness promoting activities and trainings.

1. The Pathways to Leadership training, which is provided by the firm Verus Global, inculcates in our staff a set of communication and interpersonal skills and tools to promote positive, constructive and collaborative interactions that bring out the best in ourselves and our colleagues. Specifically, the training prepares our employees to: (A) Approach situations – even setbacks and disappointments – in positive, nonjudgmental ways; (B) Value collaboration to set and achieve common goals; (C) Focus on and celebrate one another's strengths; (D) Communicate constructively; and (E) Repair relationships that have come under stress.

The training is conducted offsite in groups of 20 over a three-day period. Formed from staff members across the organization, these groups forge a unique identity, keep in contact after the training, and reconvene periodically for follow-on activities to reinforce and further embed the lessons and skills they have learned. Additionally, each training group subdivides into four POIS groups (it stands for Pathways Ongoing Integration and Sustainability) that likewise sustain the benefits of training through continued communication and activity.

2. Developed by the Gallup organization, StrengthsFinder is an assessment tool to identify an individual's top strengths, whether they be social, intellectual, motivational or organizational. Within two months of hire, in addition to learning about the wellness culture during orientation, each new employee reads the book *StrengthsFinder 2.0* and takes the accompanying online assessment. Managers incorporate these findings in the Catalytic Coaching process (described below) conducted individually with team members to create and implement individual staff

see Wellness on page 36



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Recovery: A Personal Perspective

By Jeffrey V. Perry, CPRP, MSM
Program Manager, Baltic Street, AEH, Inc.,
Bridger Program, Kingsboro PC

Are recovery-based services having a positive effect on mental health? Has the mental health system actually improved? How well has the recovery model worked to improve the lives of people with mental illness? As a consumer and peer provider working in the mental health system for the past 15 years, these are the questions I often ask myself.

A great deal of scrutiny has come forth on how well recovery-based services have or have not improved the mental health system. I believe that numerical data can be useful in monitoring positive or negative effects. However, we must also take into account the true nature of such data which may often be presented to suit the agenda of those who present them—be they for or against a recovery oriented model of care.

Sometimes the data is limited because we are measuring people, and there are untold variables that numbers cannot account for. As imperfect as the data compiling efforts may be, the fact that psychiatrists, consumers, agency staff, and policy makers are involved indicates to me that the new recovery oriented system has certainly affected a change from our past system of care.

The concept that the recovery model has moved mental healthcare forward, is an accepted understanding shared but most people. The recovery model which "empowers" recipients of mental health services just makes sense on so many levels. Our need for offering something new and "good" to our mental health system is an enormous accomplishment, because so much about mental illness involves people feeling hurt, hopeless or lost —and aren't we all working to relieve that "hurt." In the final analysis can't we simply evaluate the recovery model by asking, "are consumers generally feeling and doing better and/or sooner than in the past?"

Jeffrey V. Perry, CPRP, MSM

I believe that recovery-based services are succeeding because first and foremost, they have included consumers in the mix—whether they are peer providers or are asked to be more involved in their own treatment process. In addition, there are more mental health conferences, discussion and focus groups, surveys, and a lot more opportunities for learning and sharing of ideas going on—and that's a good thing!

How is this directly impacting the consumer? As a *Peer Bridger* I hear more consumers speaking about getting discharged from the hospital, and fewer consumers saying they need to stay in the hospital for a longer period of time. There now seems to be greater integration and more consumers having a more positive outlook on moving back into the community. This has caused more consumers to realize that a better life outside the hospital is possible and more reachable for them. While, some consumers talk about "finding employment," more people seem to just have a "hope for something." In spite of the fact that psychiatric medications have improved over the years, I know of many consumers, even peers providers, who still have symptoms, live a more positive life because of their hopeful outlooks. This leads me to believe that the recovery model has worked and the mental health system has moved forward.

Mr. Perry has published several e-books of poetry and essays, including, A Peer on Peer Perspectives in Psychiatric Health (In Prose and Poetry) by Jeffrey V. Perry, from where this original article was taken.

Peer Counseling from page 14

reduce their substance abuse, and improve their employment outcomes. Their social functioning and quality of life improve more when compared to those who only receive professional services (Besio & Mahler, 1993; Solomon & Draine, 2001; Ault, 2006: Kling, Dawes, & Nestor, 2008; Sledge, Lawless, & Sells et al., 2012). In addition, peer support encourages participation in treatment by helping consumers counter loneliness, rejection, discrimination, and/or frustration they may feel when dealing with the mental health care system (Deegan, 1992; Solomon, 2004). Having this unique role can also have a positive impact on the recovery of the peer counselor (Anthony, 2000; Solomon, 2004). Through participation in this work, peer counselors can experience an increased sense of self-efficacy, empowerment, and healing (Akabas & Gates, 2007; Solomon, 2004).

As an employer of one of the largest hospital-based peer programs nationally, KCHC has begun to explore the effectiveness of using peers added to traditional providers in service delivery. This is a challenging process that requires leadership to often revisit ideas about the work of peers and its impact on both perceptions about recovery as well as treatment outcomes. Despite descriptions of the work done by peers, demonstrating their effectiveness is a process that eludes quantification and measurement. Research is limited in terms of linking peer services with treatment outcomes. Many studies are descriptive and reveal great variability of services provided by peers and the programmatic structures within which they operate. In addition, definitions of terms used to describe these services have not been standardized. Categories describing peer services include consumer-operated services, peer support, mutual support, and self-help, to name a few (Campbell, 2005; Solomon, 2004).

Despite the variability in models and terminology, there are some commonalities among peer support models. Most peer-provided mental health services believe that consumers can benefit from interacting with people who have themselves experienced similar difficulties, and who have learned to cope with them and found reasons for hope for the future. Peer services are founded on core values such as empowerment, taking responsibility for one's own recovery, the need to have opportunities for meaningful life choices and the valuation of lives of disabled people as equal to those of people without disabilities (Resnick & Rosenheck, 2008).

In 2012, KCHC presented "Developing Metrics to Measure Effectiveness of Peer Counselors Working in Acute Care Settings: A First Look" at both the American Psychiatric Association (APA) Institute for Psychiatric Services (IPS) in October, and at the Sixth Annual NYC Peer Specialist Conference in July. In addition to providing national and organizational contexts for integrating a recovery model including the use of peers, peer counselors and department leadership discussed the development of KCHC's peer program and highlighted their work; the psychosocial processes that underpin this work; tools created to capture and categorize this work; and metrics established to measure consumer satisfaction as well as knowledge and integration of recovery principles among staff. These preliminary steps helped create operational definitions for such variables as consumer satisfaction, engagement, empathy, and hope.

Core Skills

The uniqueness of the peer role is premised on their willingness to publicly disclose their lived experience using mental health services. Recovery knowledge and experience, empathy, and role modeling are some of the core skills required of peer counselors. Recovery, notwithstanding its myriad definitions, requires change. Peer counselors frequently talk about how stigma has affected them. However, they also talk about setting goals that are meaningful and help them move beyond discrimination that often accompanies the illness experience. Growth requires disavowing the illness paradigm constructed by institutions, family members, and society as a whole. *What could require greater change?* Peers must not only embrace this message, but convey it to others seeking recovery. Peers provide evidence that recovery requires change and that change is possible.

There is an unparalleled therapeutic boundary between peers and consumers with whom they work. When engaging consumers using disclosure of personal recovery experiences, peers must constantly monitor their identification with, and tendency to react to people they are helping. Supervision can be an ideal forum to explore countertransference often experienced by peers who frequently relive or are retraumatized by hearing about or seeing a consumer's experiences. Having insight into one's own recovery is also necessary to understand how this work impacts personal recovery. Helping others requires a rigorous application of self-care.

Empathy is one of the greatest assets any human service worker brings to the table. Peers in particular relate to those they work with by listening attentively and putting themselves in the other person's shoes. Although peers may not have experienced the same situation as someone they are engaged with, they identify with the feelings associated with feeling hopeless, disenfranchised, abandoned, and traumatized. The ability to meet a person where they are and offer conditional regard is a skill associated with peer workers (Rapp & Chamberlain, 1985). Peers role model using recovery-oriented language that helps other staff understand the power language holds. This helps reduce stigma through education about how words impact a person's self-esteem and belief about their ability to set goals, live a meaningful life, and recover in a manner that is self-defined.

"Tools of the Trade"

Paradoxically, peer counselors contribute to consumers' treatment and recovery experience in ways that are both visible and intangible. Hence, leadership within the Division of Wellness, Recovery, & Community Integration created in collaboration with peer counselors tools to capture, describe, and quantify their

see Peer Counseling on page 36

Embracing Agency-Wide Change: Delivering Person-Centered Services at MHA Westchester

**By Doris Schwartz, LCSW,
Chief Operating Officer,
and Barbara Bernstein, PhD, MPH
MHA Westchester**

Doris Schwartz, LCSW

Barbara Bernstein, PhD, MPH

Since its organization shortly after World War II, the Mental Health Association of Westchester County (MHA) has provided services to meet the changing needs of our county. MHA quickly became known as the agency which provided services to those most in need, in an atmosphere of respect and focus on the individuals' goals for their lives.

It is no wonder that in the Spring of 2008 MHA jumped at the chance to join with the Westchester County Department of Community Mental Health (DCMH) to participate in "Care Coordination" an innovative recovery-focused service for individuals with mental health conditions who historically were not well-served by the mental health system. As previously implemented by the Western New York Care Coordination Program (WNYCCP), Care Coordination had achieved astonishing outcomes including improving quality of life while also reducing ER visits and days in the hospital as well as days incarcerated or homeless – all resulting in decreased Medicaid costs. We knew immediately that this initiative was for MHA when we saw Commissioner Mitchell's Power Point slide that asked the key question "Service-resistant Clients OR Client-resistant Services?" This resonated with us. Fundamental elements of Care Coordination are 1) emphasis on person-centered planning and recovery; 2) empower individuals through promotion of choice and partnership with provider; 3) participation of peer mentors; 4) preference for use of evidence-based best practices; 5) coordination of services by multiple providers and 6) availability of self-directed service dollars. Once launched, the staff and individuals enrolled in Care Coordination immediately experienced very high levels of satisfaction working *in partnership* toward goals that were identified and driven by the person receiving the service; and steeped in the values of respect, dignity, choice, self-determination and shared decision making. It was a win-win for everyone.

Heartened by positive outcomes and super-enthusiastic feedback from the individuals enrolled in Care Coordination, it was a no-brainer for MHA to embark on an agency-wide culture change. . .embracing the person-centered approach throughout all of our services. We intended to create revolutionary change, rather than simple re-engineering or restructuring. Using the five key elements of the SAMSHA matrix, Vision, Leadership, Alignment, Culture and Continual Process, we designed a roadmap to guide our five-year strategic plan for the MHA transformation process, which ultimately very much resembled a person-centered treatment or service plan.

Vision

We started by forming a transorganizational Steering Committee to lead the process - comprised of people using different services within MHA, Board members, staff, including direct service staff, human resources, information technology, intake & referral and finance. Our Steering Committee agreed that mental health recovery is a highly personal, individualized journey of healing and self-discovery which includes regaining control of one's life and engaging in meaningful roles in the community - or in the words of Patricia Deegan, "attaining a life worth living." *Our stated vision was that MHA would promote recovery using the principles, values and practices of person-centeredness.* In short order we adopted the principles of a person-centered approach including; individuals identifying their own hopes, dreams, and goals, belief that growth and recovery is possible and expected, all people are treated with respect and dignity using self-determination, choice and an outcome based orientation, people with lived experience must be included in the service system, diversity of language and culture and beliefs are honored, etc.

Leadership

Acknowledging the importance of buy-in of leadership, our Steering Committee included influential Board members and key executive staff. Our transformation initiative kicked off with presentations to MHA leadership by experts in person-centered approach and received with excitement and enthusiasm.

Alignment

We have all learned from experience that meaningful and lasting change requires much more than staff training. It is necessary to align all of an agency's systems, policies, procedures & physical environment to ensure successful culture change. Without systems alignment, organizational change is doomed to failure…and this is where the bulk of the work of organization or culture change lives. The Steering Committee identified the following processes that would need strategic and thoughtful planning and managing; clear definition of a recovery culture, roles & expectations of leadership, program managers, board of directors, direct service staff, all staff, psychiatrists, people using MHA services, training and supervision needs, human resources, referral, billing, documentation/ forms, reception, intake, physical environment, developing performance measures, including self-evaluation and finally communication with stakeholders. Let us offer some examples of what unexpectedly worked very well. Our human resource manager recognized immediately the critical nature of HR processes and procedures. First, *all* the job descriptions were rewritten to reflect the expectations for performance. We wanted to be sure anyone applying for a job at MHA would be clear about the skills and attitudes we value and require. Second, all job postings/ads were re-crafted, using language that would clearly signal our values and expectations in order to attract staff that would be a good fit (e.g.; "patience, flexibility, compassion, deep belief in recovery-oriented values necessary, knowledge of person-centered practice a plus. People with the lived experience of mental health conditions and recovery are encouraged to apply"). Annual performance evaluations were re-designed to reflect the importance of a person-centered orientation. (e.g., "Please describe practitioner's level of understanding & practice of person-centered planning. Describe practitioner's ability to partner with individuals, treat them with respect and dignity, accomplish treatment or service planning collaboratively with the individual, include significant others in the planning process, develop goals that are driven by the client & client consistently receives a copy of the plan"). Additionally, new-staff orientation was re-created to reflect our person-centered approach and now includes a presentation and subsequent discussion regarding the importance of recovery-based language that we all use. Who would predict that a human resource manager would become the greatest champion for a person-centered culture?

Culture

Our new culture had to become part of the fabric of MHA. It wasn't enough that direct service staff adopted a new language and way of working…our finance department and their accounting practices needed to understand and support it. Same with information technology. We all needed a new common language.

Continual Process

Everyone connected with MHA recognized a change in less than 3 years. Even OMH in the *2010-2014 Statewide Comprehensive Plan for Mental Health Services* acknowledged that our efforts paid off! The postscript to this strategic initiative is that we think and talk about our practice frequently, and make shifts as needed. We even administer an annual Recovery Self-Assessment evaluation (Adams & Grieder), which elicits feedback on how we're doing – from; 1) the people we provide serves to; 2) executive staff and 3) direct service staff. It has been a boatload of work, but those of us who are part of MHA are vastly more satisfied with our roles and our work. While we don't ask staff to push aside their years of training and experience, they report it is more effective and more deeply human to partner with someone on their own goals, rather than having to be 'the expert'. And of course the people who we work with experience MHA as *the* go-to service to help them attain lives worth living.

Recovery and Employment Go Hand in Hand at Federation of Organizations

By Barbara Faron, LMSW, CPRP
CEO, Federation of Organizations

Employment and/or volunteer activities provide socially-recognized, valued roles that contribute to community integration and enhance and support the recovery process. Federation of Organizations has been employing consumers to deliver mental health services since 1981. By now 20-30% of our consumers fill jobs throughout the agency, many of which are not designated peer positions. Our latest project is a Transition to Community Residence Program (TCR) on the campus of Pilgrim Psychiatric Center for 75 individuals discharged from the Residential Care Center for Adults (RCCA) at Kings Park. There are fourteen full-time Peer Specialists employed at the TCR. The residents have long-term histories of institutional care and complex chronic health conditions in addition to mental illness and most have lived for many years at the RCCA. In the TCR people who have not lived independently for many years will learn the skills and develop the supports needed to move on to community housing. This is an ideal setting for peer workers who can bring their lived experience of recovery to people who may have lost hope and forgotten their dreams.

Barbara Faron, LMSW, CPRP

Some peer positions were filled by graduates of Federation of Organizations' Personalized Recovery Oriented Services (PROS) Programs in Suffolk County. PROS services are designed to help people overcome barriers related to their mental health condition so they can work, attend school, improve social relationships and achieve their life dreams. The stories and success of the peer specialists are providing living proof to the residents of the TCR, that recovery is possible. Peer specialists at the TCR report that, while it is not always easy, they love their job and attribute their success in working to their participation in the PROS Program. All agreed that the help they received in understanding their strengths, identifying barriers, and developing the confidence and self esteem needed to do the job was essential in their success.

These employees are eager to share their experience. "PROS helped me put it all together" commented John, who once spent time in jail and at drug rehabs before finding PROS. John attributes his success to being able to relate to the people at TCR because, "I see myself in them and I want to help them to move to better place." John believes people should have the same opportunities, "and get the chance to live life like I have." John is in a better place in his recovery from having participated in the PROS program, where he has gone from being a "receiver of services to a provider of services" and for that he is very grateful.

Amy had worked in the past, but described her experience as having some "ups and downs." She believes services offered through PROS better prepared her for employment by helping her identify what was blocking her success and develop her confidence to work. Amy is now considering going back to school.

Dawn received Federation PROS services before her employment at the TCR, acknowledged that PROS staff had more confidence in her than she had in herself. That support encouraged her to recognize and accept her potential. She now sees her own challenging life experiences as preparing her to relate to others and give people hope. She is a very courageous woman who once was "too scared to work" and through the assistance of PROS, now finds comfort in helping others explore their potential.

Denise attributes her success working at TCR to her involvement with Federation of Organizations PROS Program and her experience working as an intern in our Companion Program. The Companion Program is a peer outreach program relying on mutual support. Denise feels her volunteer experience as a Companion prepared her for work and gave her confidence that she would be able to work full-time. Denise commented, "I love my job. I always dreamt about a job like this. I am so proud of myself and I love coming to work everyday."

People who have obtained employment with the help of the PROS Program continue to receive On-going Rehabilitation and Support Services (ORS). ORS services are available for members of PROS

see Employment on page 31

Northern Westchester Recovery Network in Action

By Cindy Peterson-Dana, LMHC,
Director, Northern Westchester
Recovery Network (NWRN) and the
Sterling Community Center (SCC)
MHA of Westchester

The Mental Health Association of Westchester County, Inc. has established an exciting cutting edge service known as the *Northern Westchester Recovery Network* (NWRN) with initial focus on the communities of Peekskill, Ossining, and Mohegan Lake, New York. NWRN is funded by the Office of Mental Health as a Recovery Center. This model was designed by and for people who have lived experience of mental health conditions and recovery with the leadership, vision and inspiration provided by John Allen, Director for the Bureau of Recipient Affairs of the New York State Office of Mental Health.

Community based mental health services were created after people who had endured unnecessary extended stays in State Hospitals were discharged into the community in the 1960s. Westchester County became rich in outpatient, as well as inpatient community hospital services, to achieve the goals of helping people avoid lengthy hospitalizations, decrease occurrence of psychiatric symptoms, and increase individuals' community tenure. Recovery was viewed as linear, that is to say, individuals were expected to demonstrate *compliance* with a higher, or more restrictive level of care, in order to progress to a "step-down" or less restrictive level of service. The prevailing belief was that if individuals experienced symptoms, it was unlikely that they were ready for work, school, or independent living. While the community-based service system may be credited with helping people decrease inpatient hospital stays, it also fostered social exclusion and dependence on the mental health system. As a result, many people were segregated into mental health settings and denied opportunities to create meaningful lives within the community.

Cindy Peterson-Dana LMHC

Today, our prevailing goal is not increased community tenure, but of assisting people as they create relationships and meaningful lives in their own community – in short, a commitment to authentic recovery. The Recovery Center model derives from the accumulated wisdom gathered from decades of efforts to establish true partnerships between service providers and service participants. The establishment of a peer-run Recovery Center in Northern Westchester County provides the truest opportunity yet to avoid fostering unnecessary dependency on professionalized services for people in recovery from mental health conditions, while encouraging them to live rich, self-determined lives in their natural communities.

The Recovery Center model started as part of New York State's Office of Mental Health's intention to move mental health services toward a greater recovery focus Recovery Centers are run by people who have both professional training and their own lived experiences of recovery. The services provided expand on those traditionally provided by peers to include a strong focus on making connections with natural supports, including academic, recreational, and spiritual communities, as well as accessing needed healthcare, housing, education, employment, mutual support, wellness, self-help, and advocacy. The goal of Recovery Centers is to foster robust recovery, full community integration, and a life beyond services.

You may know or work with people who are stuck in services or have been on benefits for years, who seem to have lost hope or do not have a plan going forward in their recoveries. The Northern Westchester Recovery Network brings hope, sparks interests, and supports people as they take steps to move on to robust recovery and complete lives in the community. *Recovery Specialists* and *Assistant Recovery Specialists* engage individuals around the four key components of recovery: 1) Connection and Peer Support; 2) Social and Recreational Activities in the Community; 3) Economic Literacy and Self-Sufficiency; and 4) Health and Wellness.

The Recovery Center is not a physical facility; rather, we meet people where they are through outreach and engagement, supporting each individual on his or her personal journey to recovery. We strive to create an environment of trust and mutual respect, encouraging people to take risks and try new activities, bolstering self-confidence and self-esteem. Whether individuals have become dependent and stalled through prolonged "programming," or have not yet had adequate opportunities, we will engage them and help them to either find or rediscover their passion in life. Perhaps they want a new place to live, a job, better relationships with friends and family, or to take up a new hobby. Our goal is to partner with them and help make this happen.

Peer staff work with individuals to be sure they are aware of and accessing the entitlements and benefits for which they are eligible. Since work and meaningful activity are such a critical aspect of recovery, staff help people find jobs. Initially,

see Network on page 35

Finding the Right Tools for the Job

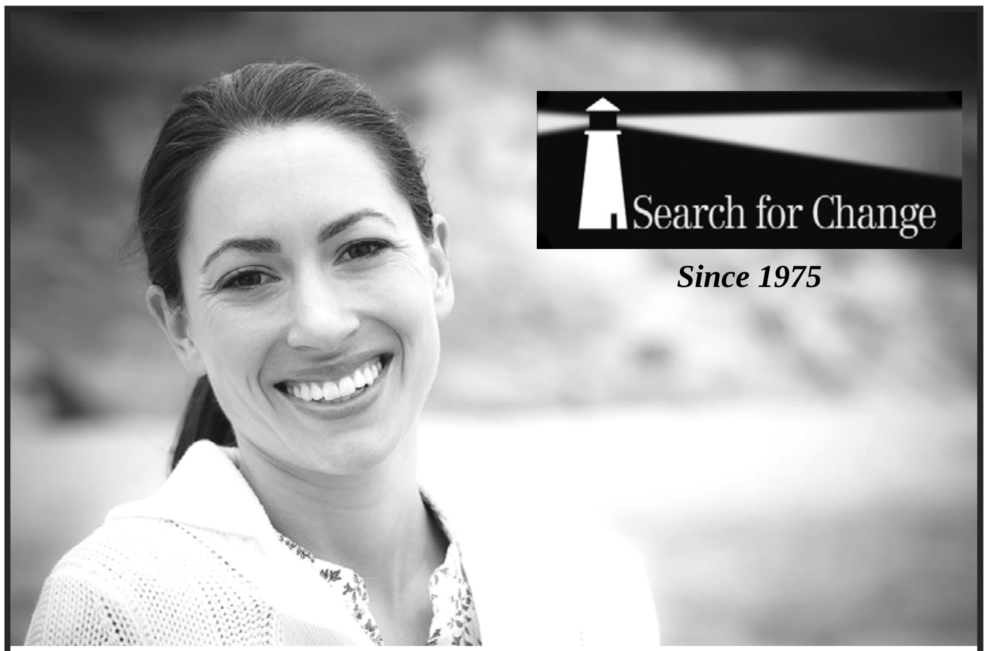
By Peter Marino, MA,
Professional Clinician
Mental Health Association
of Rockland County, Inc.

As a provider of mental health services, offering a person-centered approach to recovery calls clinicians to not only be flexible, but also objective in order to systematically address the needs unique to each individual. Recovery is not always smooth and positive. When a consumer is marked as “high risk” the reasons for instability are particularly vital for selecting which intervention would be best suited for the individual and in the context of his or her circumstances. Methods for personalized recovery planning defend against relapse and decompensation by accessing strengths and controlling for limitations recognized by the consumer.

Since characteristics of recovery typically constitute internal subjective cognitive and emotional states of mental healthcare recipients, it is difficult to define and reliably measure recovery with consistency. According to Fisher et al. 2009, several scales have been created to assess mental health recovery programs, including: Psycho-Social Well-Being Scale (PSWS) (O’Hare et al. 2003); the Camberwell Assessment of Need and Behavior and Symptom Identification Scale (Trauer and Tobias 2004); Satisfaction with Life Scale (Test et al. 2005); Level of Care Utilization System (LOCUS) (Sowers et al. 2005); Milestones of Recovery Scales (MORS) (Pilon et al. 2006), to name a few. The goal of developing these scales were to identify and standardize indicators that represent meaningful changes in people’s lives, such as employment status, frequency of crisis, engagement with the mental health system, and extent of meaningful roles in the community. Traditionally, providers have evaluated consumers according to their level of compliance with treatment and insight into their illness. Pilon & Ragins (2007) assert insight and compliance are poor indicators because both do not predict engagement in treatment. Consumers may be highly engaged utilizing treatment fully, but still not believe that they have a mental illness. Or they may refuse recommended medications, while participating actively in other aspects of treatment (i.e. group or individual sessions, or prevocational training). It is the quality of the relationship between a provider and consumer that may best determine a consumer’s level of engagement. For example, for incidences when treatment is involuntary (thus, absent of a working relationship) long-term changes that would signify recovery, either cognitive, emotional or behavioral, often are not achieved (Pilon & Ragins 2007).

Peter Marino, MA

Person-centered recovery involves progress in quality of life as it is defined by the individual. Being aware of where individuals are in their recovery can highlight challenges interfering with moving from higher to lower level care. Each person has the capacity to development their own natural supports; a potential maximized by recognizing when to use the right tools for the right person.



Recovering the *Person* in Treatment

By Richard Beauvais, PhD
Director
The Wellspring Institute

Person-centered recovery could well be reframed as *recovering the person*; for isn't that what treatment is ultimately about? At Wellspring, a multi-service mental health agency in Bethlehem, Connecticut, we base our *relational* approach to treatment and education on a multi-dimensional concept of the *person*. We also organize our multi-modal residential programs for children, adolescents and young adults to address precisely that.

In many treatment settings, an individual is provided with a psychiatric diagnosis and objectified as a particular disorder. While useful for clinical practice, a diagnosis with its symptoms easily becomes a label, defining the individual as an "it" or object, rather than a "thou" or subject. (Buber, 1957) I can't tell you how many clinical summaries I've read that are devoid of any sense of a *person*.

The cornerstone of Wellspring's relational approach is that inherent in each individual is a *wellspring* of personal being that is unique, unrepeatable and imbued with spirit. Respect for the sacredness and dignity of each individual proceeds from this belief. As the foundation of our relational approach, *personal being* is understood as a particular expression of all Being, which implicitly connects us with one another and all other creatures. We emphasize this as a core treatment value, because there are forces within our culture and society that would blur this awareness.

Richard Beauvais, PhD

The word *person* originated with the Greek term, *phersu*, which depicted the mask used in ceremonies of the cult of Persephone, a goddess who symbolized the seasonal aspect of fertility, because she spent half the year above ground in the light and the other half below ground in the Underworld. Thus, the nature of *person* was thought to be *partly manifest and partly hidden – both apparent and mysterious*.

In Roman times, the word evolved to designate the mask through which an actor spoke his lines – hence, *dramatis personae*. *Persona* stood for the character represented by the mask, as well as the voice speaking through it, *per-sonare,* i.e. through sound. *Person* in this sense is *a quality of being communicable through expression*. The late Fritz Perls, originator of Gestalt Therapy, agreed saying that the truth of the *person* – the authenticity of communication as *personal* – is in the sound of the voice, not the content of the words. This ring of truth – of the truly *personal* – is what we listen for in our Emotional Expressive Groups.

Historically, the concept of *person* evolved from religious and theatrical contexts into civic life. Here, its meaning was altered to convey a special *dignity* associated with social stature and civic rights. Women, children and slaves, for example, were not considered *persons*. However, with Cicero, the great Roman poet and orator, the meaning of *person* was transferred from the exterior social sphere to an interior and metaphysical meaning, which pertained to all individuals regardless of status or function. *Person* was used to denote *that which is essential and distinctive in each individual*, in contrast to the humanity shared by all. As a quality of being inherent and intrinsic to the individual, *person* was no longer reducible to utility or number. (Schmitz, 1997)

Finally, another Greek term, *prosopon,* was also incorporated into the meaning of *person*. It emphasized the human face and *the experience of intimacy with self and other* through face-to-face encounter and exchange; hence, the source of the familiar phrase "up close and personal." (Schmitz, 1997)

Each of these five lines flows into the meaning of *person*, and each informs how we engage our clients in a process of *person recovery*:

- Both apparent and mysterious;
- Communicable through expression;
- Of dignity and deserving of respect;
- Essential and inherent to each and every individual;
- A quality of intimacy shared between individuals.

What we need to become aware of is that a fundamental shift of emphasis occurred historically, which tended to

see Recovering on page 37

Mental Health and Addiction Recovery: A Comparison

By Naomi Weinstein, MPH, Director,
Center for Rehabilitation and Recovery,
Coalition of Behavioral Health Agencies

Three months ago, I accepted a new position as Director of the Center for Rehabilitation and Recovery at the Coalition of Behavioral Health Agencies. During the interview process, I was asked about my understanding of mental health recovery as it related to addiction recovery (an appropriate question, since I was then working for a large drug treatment organization). I was very interested in the job, and wanted to show my interviewers that I had a strong recovery orientation, and that my knowledge of substance abuse would be applicable to the mental health world. So I talked about the many similarities between these two kinds of recoveries.

I must have demonstrated an appropriate understanding because I landed the job. And since I've started, I've been asked this same question many more times. How is mental health recovery different from addiction recovery? Are they the same thing? Now my answer is a little different. Now I say, "it's complicated."

A good place to start looking at this issue is to focus on the problems themselves. Both addiction and mental illness are brain diseases that affect behavior, attitudes, moods, and cognition alike. Both are profoundly stigmatized and those who struggle with these issues too often deal simultaneously with social isolation, poverty, family estrangement, unemployment, and a loss of social status both at home and in the community. Many end up treated more like children than adults – people unable to make their own decisions or have control of their fate. Recovery represents a stark contrast to this reality.

Recovery is a multi-purpose word. There is economic recovery, post-disaster recovery, and of course, recovery from illness. When we talk about recovery in a health context, we are referring to an acute condition – a bout of pneumonia or a broken leg. In these cases, we are talking about a return to a state of good health following illness or injury. When we want to apply this same idea to a chronic condition, we opt for words like "remission" or just "has it under control."

To recover can also be a verb, and it is in this sense that it may be more applicable to behavioral health situations. To recover can mean to get something back that was lost – such as when we recover stolen property. So from the perspective of mental illness or addiction, recovery can refer to getting your life back, living a post-diagnosis life beyond the narrow confines of the illness.

There are many overlapping features in mental health and addiction recovery - SAMHSA actually lays out 10. Leading the charge is hope – the idea that tomorrow may bring something better. And there is empowerment – feeling like you have the agency to make your own decisions, to be in control of where you are headed, and to take a stand when you don't like where things are going.

Recovery recognizes that people are multi-faceted. The symptoms of the illness are only one part of the picture. There are strengths, interests, and priorities. So the person with schizophrenia may also be a first-rate writer or a music lover, have a close relationship with family, or be a valued employee. And the person who has struggled with alcohol in the past may now be a drug treatment counselor, church member, or community advocate. The symptoms and the illness are a part of the person, but not the entirety.

Treatment can be a starting point for recovery, but it is not the end. The behavioral health system has developed a sophisticated continuum of care that includes intense episodic residential services at one end, and ongoing community based recovery services at the other. In the addiction world, there are 12-step programs,

see Comparison on page 37

The Importance of Public Policy Advocacy for People in Recovery

By David Sanders, Board Member
United States Psychiatric
Rehabilitation Association

There is a quote I often think of when considering the importance of being at the table where decisions are made. Senator Tom Harkin from Iowa once said "If you are not at the table, you are on the menu." I believe this is especially true for decisions made in regard to policies affecting people in recovery from mental health and addiction issues. As a person in recovery myself, I make it a priority to be more knowledgeable about public policy and how that will affect my life, and also the lives of my peers.

I got involved in public policy advocacy eleven years ago, and it has been a passion of mine ever since. I was fortunate enough to have some great mentors that had years of experience doing grassroots public policy advocacy. I came to the realization that many times policy makers really are looking for information on behavioral health, because that is not their expertise. Most of them are very open to suggestions regarding mental health and addiction policy. They also like to align themselves with grassroots advocacy which helps their image in the community.

Strategy is important when conducting public policy advocacy. Knowing when and where to deliver your message, and how to craft that message is crucial. Over the years I have picked up some "habits" from my mentors and from experience that I practice when considering tacking a public policy issue. A good foundation for your advocacy will be to familiarize yourself with the legislative process, and with any allies and decision makers at your local level. The "habits" as I call them are listed below.

1. Investigate. Look into what the policy makers are considering, what do your peers and allies think are the issues, and look for issues being considered that fit into your priorities.

2. Evaluate. Evaluate the advantages and disadvantages of being proactive or reactive on every issue. An example of a proactive strategy is taking action when a piece of legislation is introduced or advocate for introduction of the legislation. A reactive approach is monitoring legislation and taking action if the legislation is taken up by the decision making body. Remember, you may choose to be proactive on some issues and reactive on others.

3. Defend Your Position. Gather materials that you will need to back up your position. Consider factors such as who might challenge it and why, and who will support the issue and why. Consult with your allies when forming a position, and make sure they stay involved throughout the process.

4. Educate Yourself. Familiarize yourself with the structure and policy making process of your local decision making body. Know which representative on that body is responsible for representing you and your local community. Listen for what the elected officials care about, and who the key players are. Know what your role as an advocate is in the process, and where you fit in. Keep in mind factors such as who is running for re-election in the near future and relationships between various decision makers.

5. Develop a Plan. Identify issues that are important to you and your allies. Identify Individuals who will support your position, and know who will oppose it and why. Identify coalitions and groups that will support your position, and consider what their priorities are. Work together with your allies to develop a position and

see Public Policy on page 33

Recovery from Mental Illness: Consumer Readiness as a Driving Force

By Peter D. Beitchman, DSW, LMSW
Chief Executive Officer
The Bridge

Peter D. Beitchman, DSW, LMSW

In this account, I'm sharing our experience at The Bridge, the New York City non-profit mental health rehabilitation agency, to illustrate the key role that consumers play in moving service providers to a recovery/rehabilitation orientation.

The Bridge was created in 1954 by a group of seriously mentally ill men and women who had been in the hospital together and who were among the first group of "patients" to be given prescriptions for the brand new "miracle drug" Thorazine and summarily discharged from the hospital. The group found that there was little waiting for them back in the community, other than the follow-up appointments they were given at the time of their discharge which directed them to a local hospital to have their prescriptions refilled. They did something unexpected, although perfectly logical given the lack of supportive services; they created their own supportive program, The Bridge.

For 15 years, from 1954 to 1969, The Bridge operated as a kind of psychosocial club, with an emphasis on the "social." Once a space was leased thanks to the fundraising efforts of some dedicated volunteers, the "members" had a place to socialize together, sharing meals, celebrating holidays and birthdays, playing cards, having invited guest speakers recount their foreign travel adventures. During this time, there were no mental health professionals involved; just the members and supportive fundraisers.

This changed dramatically in 1969 when the group decided to accept its first government contract to provide services to the flood of people being discharged from State psychiatric centers. Located on the Upper West Side, The Bridge was in a neighborhood that was heavily impacted by the deinstitutionalization because it contained many welfare hotels and SROs. By the late 1960s, more than 3,000 people discharged from state psychiatric centers filled the SROs or were homeless in the streets. Little wonder then that the State Office of Mental Health reached out to The Bridge with its offer of government funding to respond to the overwhelming need for services and supports.

With its first contract, a royal sum of $17,500, The Bridge hired its first mental health professionals, including: an Executive Director, Social Worker, Group Psychotherapist and a Psychoanalyst. For the next 20 years the agency was focused on two major activities. From his psychoanalytic background, the Director brought the theory of the day: that mental illness was caused by impaired family relationships (blaming mothers most specifically). Following this theory the Director developed the idea of the "second chance family," in which Bridge staff would provide a corrective experience to consumers by being "good parents." This idea was expressed in a paternalistic way in which staff members were parents and consumers were the loved and cared for children.

The second idea that the Director brought was from social work: the need to focus on and address the consumers' basic needs: for food, clothing, a safe and supportive place to be, for entitlements, benefits and, beginning in 1979, for quality housing.

This paradigm, in which the consumers were viewed as the children, the staff as parents and the relationship between them consisted of staff nurturing and taking care of consumers lasted for almost 20 years until the late 1980s. The paradigm shift that occurred then was led, not by the staff, but by the agency's consumers.

In 1987, a group of consumers presented themselves to express a problem: they were bored. According to them, they were benefiting from all that the agency had offered them: securing their entitlements, providing a 365-day-a-year program with a variety of groups and activities that they had participated in, and providing quality housing. While they were certainly appreciative they were also *bored*. They asked what else the agency might have for them. When asked what they might want, they became quiet. Finally a member of the group said "how about work?"

While the concept of work had always been on the radar, the agency had an attitude toward work that reflected

see Readiness on page 34

Making Recovery More Than Just a Word

By Connie Williams Neils,
Magaly Polo, and Josephine Wong
New York City Department of Health
and Mental Hygiene (DOHMH)

Over the past 50 years, the mental health system in New York City has evolved from a system of dependent care to a more person-centered system. But there is still much work to be done. Employment rates for people living with mental illness are still abysmally low….unemployment for people with mental illness is three to five times higher than those without mental illness and one third to one half live below the poverty level.

How do we make recovery more than just a word? The New York City Department of Health and Mental Hygiene (DOHMH) struggles with this every day. We've created committees, hosted trainings, built consumer advisory boards, and funded peer services, yet building a recovery-oriented system of care remains an enormous challenge. We are faced with deconstructing many norms and boundaries that have been built over decades. Funding streams have been created to support service silos rather than integrated care and we have major deficits to overcome in equal access to opportunity, integration and self-sufficiency in the forms of unemployment, homelessness, incarceration, poverty, and stigma.

SAMHSA's definition of recovery is a "process of change whereby individuals work to improve their own health and wellness and to live a meaningful life in a community of their choice while striving to achieve their full potential." Many of the programs we fund and oversee throughout the City ranging from supportive housing to Assertive Community Treatment (ACT) and psychosocial clubs are making dramatic improvements in becoming more recovery-oriented; but this requires, for many, a paradigm shift. DOHMH has begun including recovery language in every program that we fund requiring that programs "increase the individuals' capacity to manage their health & wellness, live a self-directed life, and reach their fullest potential by providing consumer directed, recovery oriented services." Now we have to measure our progress through increased employment rates, increased income levels, housing stability and independence, community integration and improvements in health and wellness.

The Department has committed to achieving these outcomes by supporting programs through that paradigm shift. We are beginning to help programs assess their own recovery-orientation using an adapted tool by Dr. Mark Ragins. Our intent is to get a better picture of recovery "on the ground"... how programs are implementing recovery-oriented practices in concrete and measurable ways. This includes domains such as: A welcome and inclusive environment; Service treatment choice; Participation in program management; Focus on education and employment; Focus on housing; Involvement in the community; Growth orientation; and Quality of life.

This tool encourages the transformation of a program by focusing on relationships rather than traditional treatments. The tool is intended to be low burden, is interview based and completed over time. In selecting this tool, the Department conducted extensive research, consulted experts, and identified many instruments. We looked for those with sensitivity to change that would provide valid, reliable measures, longitudinally track improvements in recovery practices within agencies (e.g. at baseline and again in 5 years), identify areas where agencies need technical assistance, and compare scores across different program types or agencies. We've now piloted this tool at several programs and are hosting training in February conducted by Dr. Ragins. As a benefit of this research, DOHMH has a compendium of instruments that will support agencies, providers and individuals.

As a public health department, we seek out and identify best and promising practices worldwide. We engage experts from around the globe to better learn and understand what is working in other places and to import, adapt, implement and evaluate them here in New York City. We recently did so by identifying Intentional Peer Support (IPS) and the Need Adapted Treatment Model (NATM) to incorporate into Parachute NYC, a continuum of crisis services that DOHMH is building.

IPS was developed originally in New Hampshire through the work of Shery Mead and NATM began in Finland. Both models have expanded significantly since their inceptions. Parachute NYC will practice these models together for the first time and will use a mixed staffing pattern of clinicians and peers. Both models embrace recovery. "IPS is a way of thinking about and intentionally inviting powerfully transformative relationships among peers. Participants learn to use relationships to see things from new angles, develop greater awareness of personal and relational patterns, and to support and challenge each other as we try new things" (www.intentionalpeersupport.org/whatisips.htm).

NATM is a non-hierarchical approach to working with people experiencing psychosis that emphasizes communication, relationship, tolerance of uncertainty and reliance on an individual's "family" network rather than service providers. Additionally, Dr. Peggy Swarbrick is designing a new curriculum to train peers as Health Navigators in order to help link Parachute participants with primary and preventive care and promote wellness.

see Word on page 34

The Family Role in Recovery: Understanding the Illness and Embracing the Process

By Wendy Brennan, MS
Executive Director
National Alliance on Mental Illness
of New York City (NAMI-NYC Metro)

The fear and distress are unimaginable when serious mental illness strikes families. They become confused when their loved one acts in an erratic or unfamiliar way and may feel helpless when a child or adult refuses treatment. New concerning behaviors emerge, and aspects of their loved one's personality may seem lost.

Families often feel anxious and bear feelings of guilt that they are the cause of the problem. Denial of the illness is a natural response at first. Grief and recognition follow with the reality that this is an illness that is here to stay. Families are an extremely important component of the recovery process, and their roles are complex. Families need to learn how to meaningfully participate in recovery and realize that their acceptance will positively impact how a loved one responds.

Wendy Brennan, MS

Understanding Consumer-Defined Recovery

"The common clinical definition of recovery often implies something akin to a cure," states Lisa Dixon, Director of the Center for Practice Innovations at the New York State Psychiatric Institute. The prevailing, if unspoken, view is that this type of recovery is rarely possible for people with serious mental illness. The consumer-focused recovery involves a state of hope, empowerment, and personhood, resembling more of a process than an end-state or an outcome. Dixon explains that "the research world has just started to connect with the challenges posed by the consumer perspective on recovery." According to Dixon, shared decision-making models, clinical partnerships, and peer-based programs may provide a solid framework to promote recovery in clinical care.

Managing Expectations and Stress

Eric Leventhal, a senior social worker at the outpatient clinic at Bellevue Hospital, a private practice psychotherapist, and Board member of the National Alliance on Mental Illness of New York City (NAMI-NYC Metro), explains that "families need to be educated about the illness and learn how to communicate effectively with their loved one in order to foster better results." According to Leventhal, just being involved is not enough, unless it's the right kind of involvement. Effective involvement is not always easy to achieve, especially when families place high expectations on their loved ones.

"There needs to be an understanding among families that individuals who are mentally ill may not want the same things that healthier people want and may be happy living a simple life," he states. Certain behaviors are often difficult for families to understand, however, families must try to accept that individuals struggling with mental illness may not be connected to their environment the way healthier people are and may live life differently. It also does not mean that the family or the family member with mental illness is a failure," explains Leventhal.

Besides managing expectations, families must learn how to minimize stress. "It can often be stressful for a family living with an individual who is mentally ill, which brings a lot of emotions to play in the household. If you keep the emotional temperature in the house low and remain calm, the individual who is ill will usually respond much better," says Leventhal.

Michael Andersson, a NAMI-NYC Metro Peer-to-Peer course facilitator and an adult consumer with a dual diagnosis of bipolar disorder and PTSD, recalls his days of living with his family: "It just brings out all the bad habits and with the illness on top of that, it is just a nightmare." Fortunately for Andersson, his family eventually enrolled in NAMI's Family-to-Family course. "It was a huge transition for them once they completed the course. They finally had an understanding of my illness and stopped blaming me. It was a huge relief," Andersson explains.

Acceptance Through Education and Support

It's true that those families who recognize the importance of educating themselves will eventually learn that mental illnesses are biologically-based brain disorders, and just like any physical illness, there are signs to look for. Until the biological basis is understood, however, feelings of anger, guilt, and denial will prevail and acceptance of the illness will remain difficult.

Acceptance certainly took some time for Deniece Chi-David, NAMI Basics coordinator, whose daughter was diagnosed with bipolar disorder as a child. "Within the Latina culture, the stigma within my family was so strong. It took

see Family on page 33

Employment from page 26

who want additional support while working. It gives people an opportunity to meet with their counselor twice a month to discuss any issues they are having, which may possibly compromise their recovery and employment.

Peers employed by Federation emphasize the role that employment plays in their recovery. Some have reported it gives them a reason to keep moving forward and gives their life meaning. For others becoming self-sufficient provides feelings of pride they never felt before. The importance of helping others is a key for many peers in their perception of job satisfaction and recovery. Peers believe that their experience in the mental health system has helped them develop their practice as professionals. Their experience varies. Some people now working have experienced long term psychiatric hospitalizations and resided in state run housing programs. They know what worked for them and what hindered in their recovery. This knowledge shapes their interactions with residents and creates a trusting relationship. Peer workers offer a dynamic presence in staff and treatment team meetings. Peer specialists share experiences with the non peer staff. This helps all staff understand another perspective and informs their practice. Through their own struggles in the mental health system peer workers truly strive to enrich the lives of the people with whom they work as they enrich their own experience of recovery.

For more information regarding Federation programs consult our website: www.fedoforg.org or call Tracy Falkner, Director of Community Services at (631) 447-6460 or TFalkner@fedoforg.org

Recovery 101 from page 21

our clients the best-case scenario was a niche in our insular community—having good friends here, a daily structure, and some responsibility. Even when clients had been "thrown away" by society or by their families, they were valued in our program. We had a warm community, and many clients stayed in it for years.

What PROS offers is the opening of a window to the life beyond our community, beyond serious mental illness and lifelong treatment settings. And that makes a huge difference. For many people, the light and air coming through that window has been transformative. There is a new feeling that someone can get back to or create a normal life in spite of lifelong illness.

Many of our participants, however, are not on board with recovery. When asked about their goals for the future, they may only parrot the old, politically-correct-at-the-time message, "My goal is to stay out of the hospital, take my medication, and come to program every day." All efforts to encourage something more are rebuffed and may even feel—to both parties—like staff is harassing the person.

There is no easy answer to the conundrum of motivation, especially for people who have been in the old mental health system for many years. The recovery model offers some guidelines, and we have developed some on our own.

One subset of apparently unmotivated PROS participants are those who are severely withdrawn, almost uncommunicative, ensconced in their own world. They are not able to clearly state a life goal in PROS and may not be able to communicate much at all. We have a four times weekly group called Developing Focus, which creates a safe space within the larger program for these participants to begin to look outside themselves, to learn basic communication skills, to start seeing themselves as able to direct their own lives. Perhaps that may begin by choosing the activity of the group for the day, or the destination of a walk in the community.

Another initiative in the PROS program that has helped to throw open the window is the vocational program, which requires us to help people find jobs, using the Individualized Placement and Support (IPS) approach, an evidence-based practice, something the previous CDT and IPRT weren't authorized to do. The effect on the community of seeing peers getting jobs has been inspiring, and we expect this influence to grow as more participants go out to work.

Finally, we have hired a worker who has peer specialist training and life experience of mental illness, and we expect that this will also contribute to an atmosphere of hope and potential. This worker can not only be a role model, but can provide specific information about recovery from the perspective of one who's been there.

Neither staff nor participants are sure that we fully trust the larger world outside our small community. Will there be jobs for "our" people—the Bronx has the highest unemployment rate in the state (11.8%, according to the November 2012 report from the state Department of Labor)? Will the world out there tolerate our people's sometimes severe idiosyncrasies and understand that they are not evidence of dangerousness? Will our people be stigmatized and treated poorly out there?

The recovery model tells us that these challenges are the price of freedom, and that people with mental illness, like all of us, can take the risks and survive and thrive, perhaps with some help from programs like PROS.

For more information on JBFCS' Bronx REAL PROS program, contact Intake Coordinator Laura Salamone: 718-931-4045, x247.

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See also http://www.dsgonline.com/rtp/resources.html for past newsletters and other recovery resources from the Recovery to Practice initiative of SAMHSA.

Advocacy from page 12

More generally, let's not forget that fear generates a willingness to erode civil liberties. Democracy can only be preserved if we tolerate the hazards of freedom.

Third, saying that the American mental health system is terribly inadequate ignores all the progress that has been made. Those of us who have been mental health advocates over the past 30-50 years have contributed to vast improvements in the mental health system. Everyone should read *Better But Not Well*, a wonderful book by Richard Frank and Sherry Glied (who is now Assistant Secretary of HHW), which documents the fact that more people are getting more effective mental health treatment now than ever before.[2] Of course, as the book's title implies, more improvements are needed, but when we overstate the flaws of the current system, we discourage any rational policy maker from putting more money into the system. If increased spending has not resulted in a better mental health system, why spend even more?

Fourth, headlines—and the fears they generate—fade quickly. Determination to improve the mental health system turns to disinterest in the blink of the next political scandal, fiscal cliff, or threat of terrorism. Effective advocacy over time takes persistence and needs reasons for change that go far beyond fear of rare heinous acts.

Fifth, these are dangerous times for health and human services in the United States. Conservatives are determined to force cuts in federal discretionary spending and entitlements. That means cuts to Medicaid—the major source of public funding for mental health—and to Medicare, which will become a more important source of funding as America ages. Is threatening the American public with murders by people with severe mental illness the way to fend off these cuts? I don't think so.

For all these reasons, I personally am opposed to playing on irrational fear to gain ground for mental health services. Of course, as I've said, sometimes it works. So, I could be wrong, and over the years I've become a bit less moralistic about going this way. But I still hope that community mental health advocates will ask seriously whether occasional, horrible acts by people with serious mental illness should be seen as an opportunity to trumpet the need for more and better mental health services or as a temptation to be resisted.

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Footnotes

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Transition from page 18

Other questions to ask will be:

· Does the state's proposal fairly require that providers at each level of care will only be held accountable for outcomes which lie clearly within their span of control? That is, will the MMCOs be allowed or denied the opportunity to shift responsibility without acting as partners in clinical problem solving?

· Does the proposal recognize that the current criteria being utilized by Medicaid MCOs are ill suited for making care determinations when addressing the needs of the SPMI population, as they are meant to evaluate acute care situations appropriate to the oversight of patients utilizing only limited behavioral services?

· Do the state's contracts incorporate safeguards which would protect persons with SPMI if MCO services are completely carved in and do the contract metrics required of MCOs make improved clinical and financial outcomes more likely? For example, will the state require that any savings, if there are any, in the behavioral premium be reallocated to consumers with these problems or will these dollars be reallocated to the general health system as has happened in other states? Will the state track how often SPMI patients end up in jails or prisons as a result of inadequate treatment or poor coordination?

· Do the service deliverables include the essential services considered necessary to improved outcomes for persons with SPMI? At a minimum, the array of services should be no less than those currently available to persons with SPMI.

· Does the state describe a mechanism by which MCO coordination with all of the social service agencies and entities, like school systems, corrections, juvenile services, housing agencies, etc., is assured? Most general Medicaid MCOs are not familiar with the broad array of support services that are provided to many seriously ill patient with behavioral problems.

· Does the state require that the MCOs hire MHSUD clinical and administrative staffs that have proven expertise in managing the SPMI population?

If the proposed system is to serve persons with SPMI well, advocates should only be satisfied if these and other targeted questions are asked and affirmatively answered. Some of these questions can be answered now before rolling the dice and transferring all patients if the state would require the MMCPS to produce clinical and financial data on how well their current population of patients with these problems are being handled.

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Family from page 31

me a long time before getting my daughter proper services and treatment because my family didn't believe in it and blamed my daughter's condition on me not disciplining her enough," she recalls.

According to Chi-David, families need to understand that support systems are important, but it doesn't mean that they have to be limited to immediate families. "There's this mentality that families need to rally around each other when a loved one is physically ill. But, if the stigma surrounding mental illness exists within families, it is OK to reach out to friends, church groups, even total strangers as support systems," says Chi-David.

"I don't know how families get through without the support and the knowledge base," states Jennie Megibow, a social worker and NAMI Family-to-Family graduate whose adult son has schizophrenia. For Megibow, the most valuable information she gained was learning to communicate in a way that her son understood her. "You have to be non-threatening, encouraging, and have a sense of humor. If I didn't have a good sense of humor, I would be lost," she states.

The Crucial Role of the Family in the Hospital Setting

Support systems can be particularly helpful when families experience the hospitalization of a loved one. During this time, families need to recognize that they contain valuable information about their loved ones and are able to separate them from their illness. "The hospital stay is a critical time for families to get involved and to provide information to the treatment teams, such as history of behaviors or what types of responses they may have to certain medications," explains Leventhal. Hospitals are busy, high-stress places, and families need to remain assertive. It's difficult to continually follow-up and ask questions or take the time out of a workday to come and meet with treatment teams, but it's a vital part of the recovery process and learning how to effectively advocate for a loved one will go a long way.

"Families can serve as valuable contributors after an initial history is taken," states Patti Sacher, a NAMI Family-to-Family course facilitator and the mother of an adult consumer who has been hospitalized eight times since 1989. "Families must be attentive and aware of the fact that during the hospitalization of a loved one, an exact diagnosis is often difficult, and effective medications can take time to find, often change, and can have strong side effects," she explains. Families need to know that some people with serious mental illness are unable to accept their illness, which is actually a symptom of the illness itself. "No one with lack of insight suddenly gains insight during a three, six, or even eight week hospitalization," explains Sacher. Many times, this 'lack of insight' will lead to non-adherence to treatment, which many families find extremely challenging. "Once families do gain better understanding, hospitalizations can provide vital stabilization and an opportunity to begin the process of recovery, but it takes time," she says.

Time Matters

The element of time plays an important role during the recovery process for families. It is not uncommon when loved ones are first diagnosed that family members believe that once they are given the medication they will be OK and be able to continue on with their daily lives. Often families need to rethink expectations of a quick recovery and understand that there may be permanent changes in some treasured aspects of personality and motivation, but that does not mean that recovery is not possible. Families need to be patient. With effective outpatient treatment, therapy, time, and, of course, knowledge, families will see their loved ones begin to heal.

Sibling Involvement

Families can learn to integrate their loved ones' mental illness into their lives without having it take over, and siblings can play an important role. "The sibling relationship is unique because it's the longest relationship a patient will have. It's comforting for people with mental illness to know that someone else is going to be involved in their care when their parents are no longer around," states Leventhal. While some siblings choose not to be involved at all, many families have found ways to assign roles to each member of the family so that one person does not take the entire burden.

While siblings play an important role, the parents of multiple children must recognize that different treatment is needed for those with mental illness and those without.

"As a parent, you work within your family to accommodate the needs of your child, which is very difficult if you have other children. It took me five years of living with my daughter to realize that I couldn't parent her the same way that I did with my older daughter," explains Karen Jacoby, NAMI Basics facilitator and mother of a child with bipolar 1.

The Bottom Line

There is strong evidence that shows family participation in the care of individuals with mental illness contributes to improved consumer and family outcomes. Unfortunately, family participation does not occur in the majority of cases of adult consumers. When mental illness strikes a family, the absence of knowledge drives unreasonable expectations regarding recovery and acclimation. This undermines the sufferers' very fragile sense of self and hinders the treatment process. Effective engagement will only come once families educate themselves and learn ways to meaningfully integrate the illness into their everyday lives.

On Behalf of the Board and Staff of Mental Health News
We Wish to Send Our Thoughts and Prayers
To the Residents of the Communities
Ravaged by Hurricane Sandy

Stay Strong During These Enormously Difficult Times
We Are All Behind Your Incredible Efforts

Ira H. Minot, Executive Director
David H. Minot, Associate Director

Public Policy from page 29

create a plan that is specific, and assigns activities and roles to team members. Activate your alliance through consistent and frequent communication. Make sure everyone understands their responsibilities in the plan, and be certain everyone is on board to implement the plan on schedule. As part of consistent communication always follow-up, monitor and report progress to the group.

6. Take Action. This is where all you're planning comes into practice. Implement the actions you identified in your plan such as making appointments for face to face meetings with members of the decision making body. You may also decide to write letters or e-mails, make phone calls and distribute any materials such as position statements that you have developed. Whatever the plan is, implement it fully and keep to timelines and other details in the plan. It is also helpful to remain flexible, because the plan may need to be changed at a moment's notice when your issue begins to take shape. Your plan also may include strategies such as organizing a community meeting, and asking allies to assist with a phone tree or letter writing campaign. If you have met with a policy maker and you committed to sending additional information to anyone do so immediately.

7. Follow Up. This is one of the most important habits. Many times we all get so busy with the action part of the plan that we forget to follow up with descion makers and allies on what the final outcome of all the planning and activity was. Sending thank you letters to policy makers regardless of the outcome may pave the way for a future collaborative relationship. Always inform your allies of the outcomes of your activity, and celebrate successes.

I believe that we will see many proposed changes to behavioral health policy at both the state and federal level within the next year. This is due to several factors including further implementation of the Affordable Care Act (ACA), and reactions by lawmakers to recent acts of violence around the nation. With society and the media inaccurately linking acts of violence to mental health issues, the stigma is worse than ever. Research tells us that people with mental health issues are more likely to be victims of violence, not perpetrators. The general public has such a misunderstanding and lack of knowledge around mental health issues that fear is the ultimate response. Both of these issues are critical for individuals in recovery to take action on. We must support behavioral health parity to improve access to mental health and addiction services. We must ensure that policies that govern involuntary civil commitment provide a full measure of due process, and protect the human and civil rights of people experiencing mental health issues. We must also include community based alternatives to civil commitment such as peer ran respite centers to address the issue of mental health crisis.

Anytime loss of liberty such as civil commitment is at stake we must make sure there is due process, and that the assessment of the need for involuntary treatment is based on imminent risk of harm to self or others. Such standards for civil commitment should not include criteria that are based on a prediction that an individual may become violent at an indefinite time in the future; a supposed "lack of insight" on the part of the individual, which is often no more than disagreement with the treating professional; assumption that there is a potential for deterioration in the individual's condition or mental status without treatment; or an assessment that the individual is "gravely disabled" or "not able to care for one's self."

People in recovery must unite and initiate conversations with policy makers that lead to action for improving their quality of life, protecting their human and civil rights, and build strong communities. Policy makers must value and seek input from the recovery community on policies that impact our lives. Together we can create and implement public policy that builds and strengthens communities that are recovery informed and oriented.

SAMHSA from page 1

Community: Relationships and social networks that provide support, friendship, love, and hope.

Guiding Principles of Recovery

Recovery emerges from hope: The belief that recovery is real provides the essential and motivating message of a better future – that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them.

Recovery is person-driven: Self-determination and self-direction are the-foundations for recovery as individuals define their own life goals and design their unique path(s).

Recovery occurs via many pathways: Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds (including trauma experiences) that affect and determine their pathway(s) to recovery. Abstinence is the safest approach for those with substance use disorders.

Recovery is holistic: Recovery encompasses an individual's whole life, including mind, body, spirit, and community. The array of services and supports available should be integrated and coordinated.

Recovery is supported by peers and allies: Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery.

Recovery is supported through relationship and social networks: An important factor in the recovery process is the presence and involvement of people who believe in the person's ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change.

Recovery is culturally-based and influenced: Culture and cultural background in all of its diverse representations (including values, traditions, and beliefs) are keys in determining a person's journey and unique pathway to recovery.

Recovery is supported by addressing trauma: Services and supports should be trauma-informed to foster safety (physical and emotional) and trust, as well as promote choice, empowerment, and collaboration.

Recovery involves individual, family, and community strengths and responsibility: Individuals, families, and communities have strengths and resources that serve as a foundation for recovery.

Recovery is based on respect: Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems – including protecting their rights and eliminating discrimination – are crucial in achieving recovery.

The Patient Protection and Affordable Care Act (ACA)—often referred to as health reform—is changing how Americans access health care. In the coming years, these changes will affect many people with substance use and mental health conditions. Health reform presents significant opportunities to make a positive impact on health and behavioral health systems, services, and payer sources. By defining recovery, SAMHSA hopes to position recovery at the center of efforts to design, deliver, and finance services for those with mental health conditions and addiction problems. In this way, SAMHSA is helping to ensure that person-centered, recovery-oriented supports and services are available for all who need and want them.

For further information about the SAMHSA working recovery definition, the four recovery dimensions, and the 10 guiding principles of recovery please visit: http://www.samhsa.gov/recovery/

Several States have already adopted SAMHSA's working definition in their efforts to implement recovery-oriented service systems. SAMHSA continues to promote the adoption of recovery-oriented behavioral health services through programs such as the following:

Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS): BRSS TACS helps states, providers, including peer providers, systems and program administrators, policy-makers, and others adopt and implement policies and practices to support the adoption and implementation of recovery support services and systems. BRSS TACS provides training, technical assistance, and resources tailored to specific needs. For further information, contact BRSS TACS@center4si.com.

Recovery To Practice (RTP): RTP answers two questions: What is "recovery" in relation to mental disorders and substance use disorders? And, what implications does recovery have for transforming behavioral health practice to become "recovery-oriented"? RTP is developing curricula on recovery for peer specialists, psychiatrists, psychologists, nurses, social workers, and addictions counselors. For further information: www.samhsa.gov/recoverytopractice/

National Recovery Month: Recovery Month promotes the societal benefits of prevention, treatment, and recovery for substance use and mental disorders, celebrates people in recovery, and lauds the contributions of treatment and service providers, and promotes the message that recovery in all its forms is possible. For further information go to: www.recoverymonth.gov/

Partners for Recovery (PFR): PFR seeks to improve services, systems of care, and supports; and provides technical assistance to those who provide services to prevent and treat substance use and mental health conditions. PFR's "focus area" on recovery contains a wide array of resources and materials. (www.partnersforrecovery.samhsa.gov/recovery.html)

SAMHSA is also including the definition, dimensions, and principles of recovery in some of its Requests for Applications (RFAs) for grants and contracts, and is taking a variety of additional steps to promote adoption and implementation of recovery-oriented supports and services.

When You're Feeling Down - Don't Ever Give Up Hope
There is a Caring Mental Health Community Out There to Help You

Word from page 30

Parachute NYC will create a system of community-based services for individuals experiencing psychiatric crisis. These services include four enhanced mobile crisis teams that will respond within 24 hours to crisis calls and work with people for up to one year, four crisis respite centers that will offer people a safe, and home-like place to stay for up to fourteen days as an alternative to hospitalization for people experiencing or anticipating a psychiatric crisis, and a citywide peer operated support line for anyone to call for someone to talk to in times of distress. The first Need Adapted Mobile Crisis Team (NA-MCT) and Crisis Respite Center (CRC) opened in Manhattan on January 10, 2013 and can be accessed via 1-800-LIFENET. The Support Line will launch in February and the Brooklyn, Bronx and Queens NA-MCTs and CRCs will open over the next 14 months. Services in Brooklyn will focus exclusively on young adults (16-25) experiencing a first episode of psychosis (first-break).

This project is funded through a 3 year $17.6M grant from the Federal Centers for Medicaid and Medicare Services with the goal of improving care, improving health and reducing costs. It will create 185 new jobs, 165 of which are designated for people with a lived experience of mental illness.

In order to help people recover from mental illness, this recovery orientation must be pervasive throughout all our systems of care. We begin here, within the four walls of the New York City Department of Health and Mental Hygiene by educating ourselves, our colleagues, funders, oversights, and partners. The Department strives to view all of our work through a recovery lens—whether it involves developing new hospital diversion programs, creating alternatives to incarceration, or changing how we serve people with co-occurring mental health and substance use issues. In everything we do, we need to ask ourselves: is this helping people recover? Is this the service system I want to build for my friends, my family and myself? How do I know what we're doing is working? How do we measure this change? We are challenging ourselves every day to approach our work – whether contracts and audits, training, oversight, new program development, funding decisions, data gathering, research and evaluation, policy development, and planning—with a recovery framework. Many of you are partnering with us in these efforts already and we look forward to hearing feedback from all of you in the future.

Readiness from page 30

its paternalism: we believed that our consumers could be good citizens and worthwhile human beings and not work. After all, the consumers were our children to be taken care of, not even young adults being prepared to go out into the world.

But their request resonated with senior management. It was clear that the consumers, whose basic needs were met during the era of paternalism, were now ready to focus on their next level of needs: to seek integration into the community through work or the achievement of other personally defined goals.

With the consumers taking the lead as champions, management obtained funding from the State Office of Mental Health to develop a vocational program. When a Program Director was hired we introduced him to the agency community and looked forward to a new, important program initiative.

But nothing happened. Over the first 6 weeks of his tenure, not a single staff member referred a client to the vocational program. It was then that we realized that the consumers were in the lead, more ready than the staff was to move the agency into the next phase of its development. It took many months, in truth years, for some staff to make the shift toward the recovery paradigm.

In making the shift, now happily in full fruition, roles and values at the agency changed dramatically. Instead of paternalism, the core agency value is the self-actualization of our consumers. Instead of being "parents" the staff are now facilitators or teachers and the clients are no longer passive children, they are individuals striving to achieve their own life goals.

Today we are in what I call The *Golden Era of Psychosocial Rehabilitation*. With the proven evidence-based practices highlighted in the PORT Study (*Schizophrenia Bulletin* vol. 36 No. 1, 2010, pp. 48-70), and the full blossoming of the consumer and recovery movements exemplified by leaders such as Patricia Deegan ("Recovery and Empowerment for People with Psychiatric Disabilities," in *Social Work in Health Care*, vol. 25, No. 3, 1997, pp. 11-24), people with serious mental illness are able to fulfill their dreams and goals. At The Bridge, our consumers clearly led the way; the joy of the work is in sharing and supporting them in their journey of recovery.

Reform from page 1

United States since 1950, health care reform will effectively end the "exceptionalism" that has undermined mental health practice since de-institutionalization. The separate but presumably equal system of mental health care that has since grown up on a parallel track to medical care has never been funded adequately and has confined many persons with serious mental illnesses to a shadow existence physically in but not socially or emotionally of their communities. It also has contributed to their dying, on average, 25 years younger than persons who do not have serious mental illnesses. At the same time, a majority of persons with mental illnesses receive care for their mental health conditions from primary care providers who have little training in the provision of mental health care, with only about one out of three receiving specialty mental health services.

Health care reform addresses these issues in a recovery-oriented way by conceptualizing mental health conditions as health conditions and insisting that care for mental health conditions be funded on a par with care for other conditions. In recognizing that a majority of care for persons with mental illnesses is delivered in primary care settings, health care reform also calls on primary care settings to expand their traditional focus and scope to incorporate mental health professionals and expertise so that the mental health care provided in these settings will be of high quality. There still will be a need for specialty mental health care for persons with the most serious and disabling disorders, but this will be funded on a par with other rehabilitative services and supports and provided in less stigmatizing settings. Persons with private health insurance who develop serious mental illnesses will no longer have to forfeit their insurance and become destitute, and parents of children who develop such conditions will no longer have to give up their legal guardianship, in order to qualify for the only long-term psychiatric services and rehabilitative supports available in most communities, which have been those funded by public dollars. Ending exceptionalism in mental health care, and integrating mental health and primary care, will do away with these largely discriminatory practices and promise to make quality, non-stigmatizing, care more accessible to more people.

2. Person-centered health homes. The other major change being introduced into primary care, which is the use of health homes, is equally resonant with recovery-oriented practice and provides the needed impetus for mental health practitioners, along with all other health care providers, to offer person-centered care in a collaborative fashion.

One of the few substantive advances made thus far in transforming mental health care to a recovery orientation has been the shift from practitioner-driven treatment planning to collaborative recovery planning. Treatment plans have traditionally been deficit and problem-focused, concerned solely with what mental health practitioners need to do to treat an illness or remediate its associated deficits, driven by practitioners' needs to document their care for reimbursement and accreditation purposes, and stipulated what pre-existing programs or services a person is to participate in or receive.

Individualized recovery plans are very different, and in a way that is highly consistent with the person-centered care plans that will be required by health homes. They are focused on the person's own life goals and what he or she needs to pursue those goals and are thus driven by the person rather than by the practitioner. While they include a focus on illness and impairments, they reframe these issues as barriers to goal attainment and pay equal, if not more, attention to the strengths and resources (both internal and external) that the person has to drawn on in overcoming or compensating for the barriers he or she faces in pursuit of the life of his or her own choosing. Finally, while recovery plans include the interventions and services to be provided by mental health, and other, practitioners in support of the person's recovery, they also stipulate what action steps the person is committing to on his or her own behalf and the supports that will be provided to the person by others who may not be service providers (e.g., family members, friends, tutors, employers, etc.).

In moving from fragmented, uncoordinated, and practitioner-driven treatment planning to collaborative person-centered care planning within the context of the health home model mandated by health care reform, primary care providers may very well end up learning from, and adapting, the person-centered recovery planning approach of their recovery-oriented mental health practitioner colleagues.

3. Patient navigators. Another prominent component of the health home model of direct relevance to this discussion is the inclusion of "patient navigators." Based on experiences with community health workers, the role of patient navigator has been developed as an essential component of the health home model to assist individuals in connecting to needed care, help them overcome barriers to receiving care, and assist them in various other ways to maximize their effective and efficient use of appropriate services and supports. Tasks may include scheduling appointments, reminding people of appointments, providing or arranging for transportation to and/or accompanying people to appointments, and offering information, education, and support. When also trained in behavioral activation, navigators can help people prepare for health care visits and to ask questions, identify and set health-related goals, and plan specific action steps to achieve goals, as well as encourage exercise and good nutrition and assist in other daily management tasks. Especially for persons who have become demoralized by repeated failures and who feel controlled by their illnesses—such as many adults with serious mental illnesses—navigators also can be instrumental in activating self-care by instilling hope and helping people regain a sense of efficacy in relation to their health.

As a valuable addition to health homes, the patient navigation role represents an exciting opportunity, and stable source of funding, for the tens of thousands of peer staff who have been trained and hired within mental health systems over the last two decades as a core component of mental health transformation. Bringing the invaluable dimension of first-hand experiences of recovery to their work, mental health peer supporters can provide a ready role model for patient navigators within primary care, at the same time expanding the scope of their own work to include the kind of holistic health focus needed to effectively decrease the morbidity and premature mortality experienced by persons with serious mental illnesses.

Conclusion

The three examples provided above suggest that there can be synergy between mental health and primary care as they become integrated through the vehicle of health care reform. Mental health practitioners will be encouraged to view mental illnesses as health conditions that can be managed effectively, when not entirely overcome, while primary care providers will be encouraged to adopt a collaborative, person-centered approach to care planning that allows a prominent role for persons with first-hand experiences of self-care and recovery in activating and supporting people in learning about, living with, and recovering from whatever health conditions may happen to befall them.

Larry Davidson, PhD, is a Professor of Psychiatry and Director of the Program for Recovery and Community Health at the School of Medicine and Institution for Social and Policy Studies of Yale University. He also directs the Recovery to Practice Initiative for the federal Substance Abuse and Mental Health Services Administration. His work has focused on processes of recovery from and in serious mental illnesses and addictions, evaluation of innovative recovery-oriented practices, including peer-delivered services, and designing and evaluating policies to promote the transformation of systems to the provision of recovery-oriented care. In addition to being a recipient of psychiatric care, Dr. Davidson has produced over 275 publications, including a 2009 book entitled "A Practical Guide to Recovery-Oriented Practice: Tools for Transforming Mental Health Care" and a 2010 volume entitled "The Roots of the Recovery Movement in Psychiatry: Lessons Learned." His work has been influential both national and internationally in shaping the recovery agenda and in translating its implications for transforming behavioral health practice.

Network from page 26

some of the positions may be part-time, enabling individuals to regain their benefits. As self-confidence grows, full-time employment, and independence from entitlements may follow. Naturally, incentives such as Medicaid Buy-In for Working People with Disabilities, PASS Plans, and others are encouraged. Recovery Specialists also encourage people to develop plans for budgeting, saving, building personal assets, increasing income, and creating economic self-sufficiency.

One participant in NWRN learned how to travel by bus in her community by working with an Assistant Recovery Specialist. NWRN staff also helped her apply for a half-fare card. She reports that her newfound independence makes it possible for her to use her mental health program as she chooses rather than being limited by her program's transportation schedule. She has more confidence and independence than ever, improving her quality of life.

Health and Wellness are addressed for participants by making connections to Health Homes when needed, but also by focusing on self-help services in the community. For example, Recovery Specialists may accompany people to 12-Step groups, yoga, exercise, nutrition and cooking classes or help create and connect people to community based, trauma informed self-help alternatives, such as Dr. Mary Ellen Copeland's *Wellness Recovery Action Plan* (WRAP) Groups.

One NWRN Recovery Specialist who had lived experience of both homelessness and recovery from a mental health condition worked with a participant living in a shelter and feeling very hopeless and depressed about his future. As a peer, empathic and experienced, the Recovery Specialist was able to quickly gain this young man's trust, inspire hope, and help him take steps toward his goal of working as a culinary chef. This participant is now enrolled in Job Corps, which is providing him with housing, education, and training in the culinary arts. He is working towards his dream of becoming a culinary chef. In the process of making this step forward, his mental health condition is also much improved and he has gained hope for his future.

Another compelling aspect of NWRN is our data collection and service evaluation. We complete outcome surveys with all participants when they join the Network and every 4 to 6 months thereafter. We intend to demonstrate that our peer services are effective and that the people we serve truly move forward with their goals for mental health recovery and full lives in their communities.

We are all peers and hope to inspire others with mental health conditions to build rich lives in their communities. Our motto is, *If we can do it, you can do it too.*

For more information or to make a referral for services, please contact NWRN's Coordinator, Linda Carroll at CarrollL@mhawestchester.org. or (914) 345-5900 ext. 7594.

Wellness from page 22

development plans. Managers also consider team members' strengths when planning collaborative team projects. StrengthsFinder promotes an environment in which employees "have the opportunity to do what you do best every day."

3. Catalytic Coaching is a management technique by which, on an annual basis, managers engage their team members in an iterative three-step process of identifying achievements and setting goals for personal and professional development. Through this process the team member and the supervisor bring their respective perspectives into the conversation and work together to assign roles and responsibilities that will be both engaging for the team ember and optimally beneficial to the organization. The Mental Health Center of Denver has pioneered the practice of using StrengthsFinder to inform and enhance the Catalytic Coaching process to develop plans that play to employees' strengths.

4. Employee Recognition is an important means of facilitating staff members' appreciation for each other's extraordinary contributions. A "Way to go!" is a paper certificate that any employee can award to a colleague at any time. The RIISE Awards are bestowed quarterly and annually on the basis of nominations by staff members who wish to Recognize Innovation, Inspiration [and] Service Excellence.

5. Wellness-promoting activities and trainings are advanced in many ways. A Health and Wellness Initiatives Committee meets monthly to plan and implement activities to educate and activate staff members to take care of themselves in every respect – physically, emotionally and financially. For example, the HWIC conducts an annual Wellness Challenge that provides employees an opportunity to score points by doing such things as enrolling in a health club, purchasing fresh fruits and vegetable, participating in an athletic event and getting a physical checkup. Participants achieving the point target receive a cash prize and are entered in a drawing for an even larger cash prize. Among other activities, HWIC also organizes a virtual "Walk Across America" using pedometers to measure progress along a route plotted on a map of the United States and sponsors a lecture series on such topics as nutrition, meditation, inflammation, detoxification, credit score protection and spiritual wellness.

In addition to conducting the Pathways to Leadership training program with Verus Global, the Wellness Culture CREW organizes activities including an AIDS Walk, All Staff Picnic/Olympics, Dragon Boat Races, chili cook-offs, barbeques, and on and on. The Mental Health Center of Denver's employee assistance program and internal training department also provide extensive training in such areas as work/life balance, stress management, time management, self-care, trauma recovery, compassion fatigue and smoking cessation. The Mental Health Center of Denver promotes a smoke-free workplace, provides discounted membership to health clubs, and maintains well-appointed fitness centers at its two largest locations.

We also support environmental wellbeing and strive to be the greenest community mental health center in the country. Our Together Green Team arranges for reduced price passes for Denver's public transportation system, incentivizes carpooling and use of public transportation for off-site organization-wide meetings, coordinates the annual Earth Day observance (with activities including a clothing exchange and recycled clothing fashion show) and Bike to Work Day. The Together Green Team continuously seeks to promote resource efficiency, informing the purchase of Energy Star-rated appliances, compact fluorescent bulbs, and water filters for faucets and fountains in place of bottled water or coolers. Our dedication to being green strongly influenced the choices we made in rehabilitating a 60-year-old structure as the home of our new Recovery Center, a building that is on track to earn a LEED Platinum certification.

Just as we have developed measures of recovery for our consumer services, we are committed to measuring the engagement of our employees and the wellness culture. We have recently partnered with a company, New Measures, to assess our employee engagement. In addition to providing us with comparison data to other companies, they are working with us to identify the critical drivers of engagement specific to our organization. This enables each team to develop a plan for improving engagement scores in the same way our recovery measures enable them to develop plans to increase their success in promoting recovery.

We strongly believe that wellness culture we have created and are sustaining for our staff improves recovery outcomes for our consumers. We are currently in the process of collecting data from our staff engagement measures and our consumer recovery measures to test this hypothesis.

Peer Counseling from page 24

work: *Activity logs* document service provision in four areas including individual and group engagement, treatment planning, and other activities that support consumer care; *Weekly orientation tracking reports* capture the detailed process conducted with newly admitted consumers consisting of eight domains ranging from understanding the milieu to learning about advance directives; *Patient Assessment and Goals (PAG)* forms foster empowerment by helping consumers identify goals and concerns prior to attending treatment team meetings; *Peer-run groups* address such topics as advocacy, goal setting, ambivalence, conflict resolution, and crisis and aftercare planning; *Counseling and collaboration* with other team members optimizes aftercare planning and identifies appropriate community resources, as well as exemplifies "out-of-the-box" thinking rather than pathologizing when it comes to addressing consumers' concerns and discomforts.

Observations

Consistent with the literature on peer engagement, trends commonly identified are that peer counselors help consumers recover by providing hope, showing empathy and conditional regard, and fostering identification. They help change organizational culture by promoting recovery in attitude and practice. Peer Counselors support their personal recovery by helping others. They provide evidence that recovery is real. They are the evidence.

Outcomes

In response to nine statements relating to the impact peer counselors made on consumers' level of engagement, sense of empowerment, and presence of hope, consumers reported during a six-month period that peer counselors often made a positive impact on their hospital stay in numerous ways *(N=290; 85-90%)*. The vast majority of non-peer staff agreed with eleven statements relating to visibility, integration, and perceived effectiveness of peer counselors working on six adult inpatient units *(N=120; >90%)*.

Next Steps

As we continue to move forward we look for ways in which to expand, professionalize, and refine the role of the peer counselor at KCHC. The peers on the inpatient units have recently begun documenting in the electronic medical record, giving them an additional venue to communicate their work with consumers to the other members of the treatment team; solidifying their role as an interdisciplinary team member.

Performance metrics are vital in healthcare. All disciplines work closely with quality management to create and track competency and performance from both a quantitative and qualitative perspective. We have recently created a supervisory review that allows us work closely with the peer counselors on areas at which they excel, and to identify and guide supervision around areas of struggle. As the peers move forward with documenting their work, we will move toward a peer chart review, where they can continue to support and learn from each other.

Leadership is also looking for new avenues in which to incorporate the role of peer counselor. At KCHC there are 6 adult inpatient units. One of the most important times in a consumer's care continuum is immediately following discharge. The transition from an inpatient setting back to the community is often quite difficult. KCHC is looking to utilize the role of the peer counselor during this transition. The linkage of consumers with a peer is a normalizing intervention that can help ease the transition from the highly structured inpatient setting, providing supportive bridging that is accepting and empowering.

It is the responsibility of leadership to create opportunities for peer counselors to grow both in the role as a peer (creating a supervisory structure), as well as in other areas of services within the hospital setting. Many of the peer counselors have moved into other roles, specifically within the social work department at KCHC. Education is also encouraged with all staff, and many peer counselors are enrolled in college as well.

Summary

Peer counselors have a positive impact on consumers in various settings throughout the hospital, helping them recover by letting then know that they have been there. They are "ambassadors of empathy" and agents of change, by helping change the culture of the institution. They do this by promoting recovery in attitude and practice. Peer counselors provide evidence that recovery is real, because they are the evidence. Most importantly, they maintain their own recovery by helping others.

We wish to acknowledge Joyce B. Wale, Sr. Assistant Vice-President, HHC Central Office of Behavioral Health for her vision and support of integrating peers in HHC's Behavioral Health workforce; Dr. Joseph P. Merlino, Deputy Executive Director, Behavioral Health Services, KCHC; and Behavioral Health Services overall, with whom we collaborate to further advance a Wellness and Recovery model benefitting both consumers of care and staff.

Surviving from page 8

conversation about my own recovery.

There are no rules in art, no judgment, and in the end, a drawing is just a piece of paper, a clay vessel, a hollow mound of hardened earth. Yet, art has had the capacity to alter and influence entire civilizations, starting with the cave dwellers. It is what is left when man isn't.

The power of art to heal is equally just as revolutionary. Creativity is the foundation from which all art springs. Like the seed of resilience in each of us, creativity is something we are all born with and have the capacity to develop and express. Unfortunately, in most instances, creativity is not nurtured. Not only is it squelched in our society at a young age, it is often times seen as a hopeless endeavor, bringing hardship and the lack of prosperity to the individual who pursues its path. Yet creativity is necessary for human life and without it, we would all live in a horrific state of boredom.

What then can make the difference between growth or stagnation, illness or recovery? Again, I come back to this question. Creativity alone is not enough. If I remained in my studio my entire life trying to recreate and define the most exquisite piece of art possible, and that's all I did, I would probably end up under a tree like Van Gogh. A life cut short.

But art is not complete without an audience and neither is a struggling soul complete without the continual presence of another human being. However, it takes a unique and compassionate healer, ideally an entire community, who is able to stand present to support, nurture and connect, with honesty and self awareness. It is in this continuous place where we hold each other, that the healing of our hearts and minds take root. It requires a risk for both parties and the benefit to both is indisputable. Trust ensues and recovery is now possible. Call it Love, Empathy, or Hope. For those of us who suffer, by striving to connect with others, we find the strength we need to overcome anything. For those of us who are the healers, our gift is the breath that we receive in exchange.

For more information about Susan Weinreich please visit: www.susanweinreich.com and www.aepnetwork.com.

Recovering from page 28

disconnect the meaning of *person* in each of these five senses from its depth.

This shift was first expressed by Descartes' philosophical cornerstone – "I think; therefore I am." The statement signified an increasing introversion, which circumscribed the meaning of *person* in terms of subjective self-consciousness, while disconnecting that meaning from participation in the larger mystery of Being. Our own field of Psychology reflects this orientation: Psychoanalysis is a case in point. Subsequently, the sense of *person* and of *personality* has become increasingly elaborated and made more and more complex. However, complexity *is not the same as depth or authenticity with respect to human being.*

Along with this increase in subjective complexification was a corresponding tendency toward depersonalization. Whether defined in terms of ethnic stereotyping or social utility, the individual has tended to become more and more emptied of *personhood* and reduced to mere matter or number, to which the visible carnage of bodies on the movie screen attests. The same tendency is mirrored in our clinical reporting.

The challenge for us at Wellspring, and for anyone serving in mental health, is to consciously extend our caring and healing mission against this increasingly pervasive *I-It* orientation. If only because, as Martin Buber points out, any time our consciousness reduces the other to an *it*, we diminish our own sense of *I*. It's what, I believe, this issue is attempting to address.

At Wellspring, we think of the work of *person recovery* as having two complementary thrusts. One is to change unhealthy patterns of relationship to self and others that distort or block *who this person in essence actually is*. The second is to reveal and affirm this core *personal* self, so the individual can align with it and build on it as the basis of a *personal* identity.

What our multi-modal and holistic treatment programs provide are different windows for seeing, mirroring, affirming and supporting the emergence of the *person* in the context of clinical work. Because *persons* are many faceted and differently gifted, no single treatment modality or approach can serve all, but each modality contributes to the work of *person recovery* in its own particular way.

What staff bring to the process of *person recovery* is an alertness and receptivity to individual differences and the uniqueness of individual gifts. Because individuals cannot see their own nature, they take for granted what they do and how they do it. What they need is to be seen, acknowledged and affirmed within an interpersonal framework that focuses itself on *person recovery*, so that they can begin to align with a sense of who they are.

A *person* thus emerges only in the context of relationship: The two are inseparable. Individual therapy provides face-to-face intimacy and exchange, which is amplified in turn by relationships with staff in the milieu. Interactive group therapies provide a context for the individual to see and be seen as a *person* among peers, exploring individual differences and commonality with others through engagement. Family therapy can work through problems in primary relationships that open ways to *person recovery.* A child or adolescent may have been oppressed by the parents' vision of who he should be, or he may have been unseen altogether. In the treatment of addiction, parents can recognize the re-emergence of the essential *person* in their child that they had lost sight of but had known long before.

Emotional Expressive Group is another important context for *person recovery*. By working through blocked emotions of anger, sadness, grief and joy, the individual can stand clear of defenses and be more vulnerable and real. With creative-expressive modalities that encourage self-expression – art therapy, puppetry, dance and sand-tray work, for instance – the creative products stand as signposts of the *personal.*

At Wellspring, we maintain the presence and care of animals in all of our residential programs, because relationship with an animal simply makes us more human. It is why the non-verbal, land-based, experiential therapies of work, animal care, horticulture, and adventure program receive special emphasis, because nowhere is the essential nature of an individual more clearly revealed than in the instinctual responsiveness of body activity. Sally's process of *person recovery* began with discovering a deep love for animals that opened a career path as a veterinary assistant and possibly as a vet.

The same *personal* approach holds true in education, where different learning disabilities and learning styles must be approached individually. This is truly the art and the heart of "special education." Debbie, for example, was motivated to learn only when she was able to adapt her entire curriculum to the needs of cooking, after we discovered how passionate she was about food, and had been so, her mother assured us, since she was 4 years old.

Finally, the disorder itself can provide a window for *person recovery*. Symptoms, simplistically, can be understood as substitute ways to meet previously unmet needs – for attention, affection, appreciation and acceptance. But the *personal* can also be expressed through the symptom, whether in the artfulness of a defense or the style of a manipulation, the ways in which an individual strives to be special or to disappear. When Sara, a twelve year-old, hacked into our computer system to read her chart, some were outraged at her behavior as symptomatic of a budding character disorder. Others noted her audacity and technical aptitude, and lauded her innate drive to uncover secrets as a born detective. The "disordered" act became the basis for her emergence into health.

To the degree that we as a therapeutic community direct our efforts toward the process of *person* recovery, we provide an environment where treatment, education, and the healing of the *person* are enhanced.

Comparison from page 28

faith-based groups, recovery coaches, and recovery centers. In mental health, there are clubhouses, advocacy programs, supported employment and housing options.

This carries its own problems. Some professionals think that true recovery means that you fully integrate with the general population, and leave that community behind. But we know that recovery communities are vital resources - most people in recovery find it comforting to be with others at least periodically who share similar experiences and concerns.

Recovery is clearly an evolving process, often lifelong. It is not a straight line, but like life, has its ups and downs. And it is individualized – no one person shares the same recovery story as another.

So are mental health and addiction recovery the same thing? No – there are still some very clear differences.

Probably the most obvious distinction between the two is that in the addiction world, "recovery" is used as a synonym for abstinence, almost like saying "I'm on the wagon." Some people even start using this word as soon as their immediate withdrawal symptoms begin to wane – "early recovery," they state, alluding to the fact they are trying to stay clean but their head may still be a little cloudy, their decision making poor, and their relapse vulnerability high.

The connection between recovery and abstinence has become more complicated as the drug treatment world has increasingly acknowledged the vital role of medications to support treatment. So people might say they are "in recovery" when they are taking methadone or suboxone as treatment options. Or they may use psychotropic medications to manage co-occurring disorders.

While the general public might substitute "recovery" for sobriety, drug treatment professionals are more expansive in their definition. They recognize that sobriety is far from permanent, and it doesn't embody the true spirit of recovery. For most addiction professionals, the goal is a recovery that incorporates personal values, attitudes, and behaviors that leave no room for drug or alcohol use. A person who embraces honesty and healthy problem solving, for example, is not likely to turn to substances when the going gets tough.

While addiction recovery is not synonymous with abstinence, it is inclusive of it. Traditionally, people cannot be considered "in recovery" if they continue to drink or use drugs.

So unlike those in mental health recovery, people transitioning to addiction recovery have to make a conscious decision to stop using in order to regain control over their own lives (even those who are court-mandated to treatment). The very first step of recovery is itself an act of recovery.

Finally, it is important to note that we expect a person in addiction recovery to no longer show any signs of that illness, although internally they may remain vigilant against possible relapse. Our recovery role models tend to be those who have reintegrated into society fully, and are indistinguishable from the rest of the population. In fact, if we were told that the person used to have a drug problem, we would be surprised. After all, they would show no outward signs of those past behaviors or ways of thinking.

When we talk about mental health recovery, we are looking at a whole other kettle of fish. In mental health recovery, we are not looking so much at a remission of symptoms, as an equation that reads "past life" + "diagnosis" = "new, improved, fulfilling life." (That said, it is important to acknowledge that there has been extensive longitudinal research documenting that for somewhere between one-quarter to two-thirds of people, there is a total remission or substantial improvement of symptoms.)

In mental health recovery, it is about a person moving forward with his or her life despite the diagnosis and the illness. People who are in mental health recovery have found ways to regain control of their lives. They work and have hobbies. They participate in their communities. They have family and friends. They have their own priorities.

Some of the underlying thinking about mental health recovery is borrowed from the disability movement. We know that someone who has become a paraplegic as a result of an auto accident is not expected to recover the use of his legs before he is able to move forward with his life. Instead, we expect that person to integrate the new disability reality into his approach to life, and go on. People in wheelchairs work, get married, travel, volunteer, exercise, and in all other ways contribute to society. Their disabilities are woven into the fiber of their beings. But we do not expect, nor wait, for a remission of symptoms. Similarly, those in mental health recovery do not need to wait for their symptoms to magically disappear. There is no reason they cannot move forward in life.

Another difference between mental health and addiction recovery is advocacy. Unlike addiction recovery, the mental health recovery community has included a well-developed advocacy movement, formed by both individuals in recovery and their loved ones. They routinely demand their place at the table, speak out for their rights, and insist that their experiences be recognized. And in so doing, they are ensuring that their needs and concerns are respected. (The addiction system is starting now to develop its own advocacy moment). So the next time I am asked that question about mental health and addiction recovery, I'm going to answer as before. "It's complicated."

Parachute from page 16

on prevention, wellness, and quality health care and linking participants to a medical provider who will be integrated into the treatment team.

A fourth new element will be the establishment of New York City's first peer-operated support line. To be operated by peers hired by Community Access, it will provide a contact point for New Yorkers experiencing emotional distress, an opportunity to connect with individuals who have had similar experiences.

A fifth component will be the establishment of four new crisis respite centers that will have a capacity of seven to ten guests at a time, serving as an alternative to hospitalization for those participants who need this level of support.

Finally, all Parachute services will focus on engaging an individual's entire support system—family, friends, colleagues—however that system is defined by the person being helped.

The primary entry point for Parachute NYC will be MHA's 1-800-LIFENET hotline, which will screen calls and make referrals to borough-based Need Adapted Mobile Crisis Teams. In Manhattan, the first Parachute service to open, VNSNY operates the Need Adapted Mobile Crisis team. Referrals from mental health providers, family members, and self-referrals will first go to VNSNY. The teams will respond with an in-person visit within 24 hours and will provide ongoing services for up to one year for interested participants.

The first crisis respite center, operated by Community Access, opened in January 2013. Located in Manhattan on Second Avenue, the site was formerly an OMH-licensed community residence that has been renovated and downsized from 14 to seven beds. We have created a respite center that will be a hopeful place where people will be encouraged to think differently about the crises they are experiencing and through support to make connections with others who have had similar struggles. Guests will have an opportunity to learn about and develop self-help and mutual support strategies.

Three additional crisis respite centers will be established in Brooklyn, the Bronx, and Queens – to be opened by Services for the Underserved in the spring of 2013, Riverdale Mental Health Association in the summer of 2013, and Transitional Services of New York, Inc., in the winter of 2014, respectively.

The Need Adapted Treatment Model (NATM), one of the approaches that will be integral to Parachute NYC, ensures that open and transparent communication guides the treatment process. Individuals experiencing crisis identify members of their support network, which may include family, friends, and treatment providers. In Parachute NYC the enhanced mobile crisis team will use NATM principles to engage individuals in their homes and communities and will work with people for up to a year to help sustain them in the community. In the NATM approach all voices, those of the individuals in crisis and those of the support network members, are valued and given the space to be heard.

An equally valuable component of Parachute NYC is Intentional Peer Support (IPS), an approach developed by Shery Mead, a peer professional. Among the values of IPS are learning versus helping, focusing on the relationship versus the individual, mutuality, hope and connection. It is an approach that seeks to diminish the power differential between service providers and recipients.

Parachute NYC will bring together the values and practices of these two approaches in a new environment. Both emphasize the value of relationships, hope, transparency, honesty and acknowledging not having all the answers.

By establishing these new contexts in which peers can help others to recover, Parachute NYC offers both more rewarding futures for individuals experiencing psychiatric crises and illuminates a path for other providers of human services to follow.

In closing, here is the perspective of Jamie Neckles, Project Manager of Parachute NYC at the Department of Health and Mental Hygiene: "This exciting new initiative is a clear demonstration of our belief in the value of peer involvement. It will create 185 new jobs, 165 of which will be for peers. It will connect many people, build many new relationships, create space to think about things differently, and invite some new people into the conversation." In every respect, the launch of Parachute NYC is certainly a cause for celebration.

The Rockland Living Museum: Using Art Therapy To Aid in the Recovery Process

By Eric Bender

At the Rockland Living Museum the members are creating art that tells about their recovery from mental illness. It is a process I have been privileged to record on video. What I observed at the Rockland Living Museum was that over time and with much experimentation, members developed a personal style and craft that served to express their artistic ideas. The Rockland Living Museum is an art studio that serves residents and out patients of Rockland Psychiatric Center in Orangeburg, New York. It is a space that reflects the vision, creativity and pure energy of the studio's director, Christine Randolph. She has created a place where members are free to create art in a range of media including paint, clay, plaster, cardboard and found materials. The result of this freedom is evident everywhere you look, from the red footprints marking the way to a set of decorated rings painted on the gray concrete floor to the paintings and drawings crowding the walls, and up to the ceiling where strings of colorful prayer flags hang from the rafters. The music that is always playing and the laughter and cheerful talk at the tables where art is being made, give the room a relaxed tone that reflects Christine's success in making the Museum a place where members can use art materials to express themselves in many creative ways.

My video is about how art therapy helps people recover from mental illness by showing how the process of therapy works. When I first started recording members making art they often asked me what I thought about their work. At first, my impulse was to say something positive. I eventually learned that given the therapeutic context in which I was working, the more appropriate response was to ask what the artist thought, or felt, about the work. I taught members of RLM how to use my video cameras and with Christine's enthusiastic support, allowed them to shoot their own videos around and outside the studio. When I later looked at their work I saw that the recordings documented the members' explorations in ways that presented the RLM as a nurturing, dynamic arts environment. I made DVDs of the videos and gave them to the videographers, so they would have their work to watch again, or share as the inspiration for some other art project.

Under Christine Randolph's expert direction, the RLM has become an incubator for new and effective approaches to art therapy. The Museum's program of activities, including workshops in print and mask making, trips to museums such as the Metropolitan Museum of Art in Manhattan and shows featuring the work of RLM artists, enhance members' confidence and self esteem and promote their recovery from mental illness.

Working with Christine, her staff of college interns and the members of the Museum helped me understand the process of art therapy and find my place in it as a videographer. As I understand it now, my role is to go on framing my subjects' art as expressions of their evolving life stories. Eventually, I will use my video files to make a film about the RLM. I believe the story of how Christine Randolph created and continues to lead the work of the Rockland Living Museum is something that will inspire all those who help people working towards recovery from mental illness.

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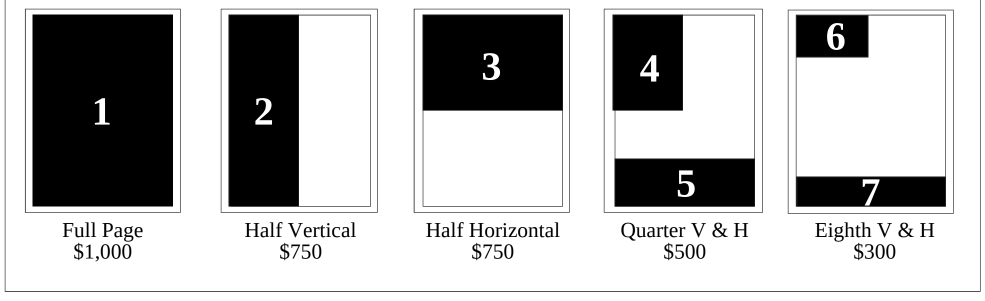

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