Self-Assessment/Planning Tool for Implementing Recovery-Oriented Mental Health Services (SAPT)

Adapted for Florida's Recovery Oriented System of Care Initiative (ROSC)

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Preface to the Self-Assessment Planning Tool for Implementing Recovery-Oriented Mental Health Services (SAPT): Adapted for Florida's Recovery Oriented System of Care Initiative (ROSC)

The Self-Assessment Planning Tool for Implementing Recovery-Oriented Mental Health Services (SAPT): Version 2.0, was originally developed at the University of South Florida (USF) Louis dl la Parte Florida Mental Health Institute (FMHI) under contract to Florida's Medicaid authority, the Agency for Health Care Administration (AHCA). This adaptation comes five years after the tool was published in 2011 and has been revised to support the Recovery Oriented System of Care (ROSC) Process in the State of Florida. ROSC is a system transformation initiative being led by Florida's Department of Children and Families (DCF) to establish an integrated, values based recovery oriented system of care where recovery is expected and achieved through meaningful partnerships and shared decision making with individuals, communities and systems.

The ROSC framework has been supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) to assist with the transformation of behavioral health service systems to a recovery orientation throughout the United States (SAMHSA, 2010). ROSC is designed for organizing and coordinating multiple services, supports and systems, and supports person centered, self-directed approaches to services.

This version of the SAPT includes the following revisions:

- Updated language to reflect the latest developments in the field of recovery-oriented services. Persons who are recipients or consumers of services are referred to as peers.
- The Recovery Self-Assessment is used in place of the Recovery Oriented System Indicator (ROSI) as the measure of peer outcomes (O'Connell, M., Tondora, J., Croog, G., Evans, A., Davidson, L., 2005).
- Updated resources in the SAPT Planning and Implementation Guide.

The ROSC adaptation of the SAPT was developed under contract to the South Florida Behavioral Health Network, Inc. (SFBNH), with financial support from Magellan Complete Care.

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Background

Florida Medicaid Studies Identified the Need for Tools to Support Recovery-Oriented Mental Health Services

The Self-Assessment/Planning Tool for Implementing Recovery-Oriented Mental Health Services (SAPT) was developed at the University of South Florida (USF) Louis de la Parte Florida Mental Health Institute (FMHI) under contract to Florida's Medicaid authority, the Agency for Health Care Administration (AHCA), in response to a two-part study entitled, *Recovery-Oriented Medicaid Services for Adults with Severe Mental Illness – Parts I and II* (Winarski, Thomas, Dhont, & Ort, 2006; Winarski, Thomas, & DeLuca, 2007). The studies examined the implementation of new Medicaid services intended to promote the recovery and rehabilitation of adults with severe mental illnesses. These services were described in the Community Behavioral Health Services Coverage and Limitations Handbook (AHCA Handbook) and were designed to replace other, less rehabilitative approaches (Agency for Health Care Administration, 2004).

The first phase of the study examined the delivery of these services from the perspective of both staff and persons receiving services. The study examined the transition from traditional day treatment programming with a focus on client monitoring and management, to rehabilitative/recovery-oriented services that focus more on self-direction and community functioning. The second phase examined Florida's system readiness to implement recovery-oriented services in relationship to guidelines, standards and finance structures that are emerging in the mental health field.

The studies included a series of interviews and focus groups with peers, service provider administrators, clinicians, and representatives from managed care organizations.

Five major response themes emerged from an analysis of the data:

Peer Experience

- Peers did not always experience program activities as relevant to achieving life goals.
- Peers had varying levels of participation in agency operations, and there was little evidence of equal working partnerships with staff.
- Peers often experienced treatment planning as a bureaucratic rather than an interpersonal process, in contrast to staff perceptions of treatment planning as highly person-centered.
- Peers generally expressed high levels of satisfaction with agency services but expressed more critical views when asked to provide details about specific experiences.

Recovery-Oriented Service Delivery

- Staff perspectives on recovery principles and practices vary considerably across individuals, with some actively integrating recovery orientation into practice. Others expressed little knowledge/understanding of recovery as it relates to mental health services and viewed recovery as an unrealistic expectation.
- Services placed a greater emphasis on skills teaching in clinical settings and less on application of skills in community settings.

- Both peers and staff identified difficulties with adapting to the emphasis on greater peer self-direction that is central to the implementation of recovery-oriented services.

Community Integration

- Many peers experienced loneliness and isolation. This was expressed even among peers living in group settings (e.g., Assisted Living Facilities, also known as ALFs).
- In addition to accessing treatment, mental health services were described as an important way to maintain social connections.
- The lack of affordable housing and employment opportunities and lack of transportation created significant barriers to achieving full community integration.

Work Force Issues

- Staff turnover was described as a concern by peers in each of the programs that were studied. Program staff also identified lack of staffing as a barrier to effective service delivery.
- Most staff did not express a strong need for technical assistance or training. Only one person identified the need to learn about recovery-oriented services. This lack of interest in training may be indicative of an incomplete awareness of the knowledge and skills required to effectively implement recovery-oriented services.

Finance Mechanisms

- The studies concluded that the shift in some AHCA areas from fee-for-service financing to capitated systems, represented by managed care organizations, has important implications for the delivery of recovery-oriented services. Fee-for-service financing focuses on discrete units of care defined by medical necessity. Capitated financing, on the other hand, can provide more flexibility while also potentially being more compatible with the holistic approach of recovery-oriented services.
- The definition of rehabilitative, recovery-oriented services needs to be described in managed care contracts to ensure that these services are delivered.

In summary, these studies described a period of transition in programs implemented by mental health service provider agencies, with both peers and staff engaged in a process of defining new roles and responsibilities in the delivery of recovery-oriented services. The studies also identified a lack of program guidelines and service implementation tools needed to support this transition, with no systematic way to ensure that the services described in the AHCA Handbook were delivered at an acceptable level.

Pilot Studies of the Self-Assessment/Planning Tool for Implementing Recovery-Oriented Mental Health Services (SAPT)

In response to these findings, AHCA approved a project to support the development of a tool to assist Florida agencies with the planning and implementation of recovery-oriented services (Winarski, Dow, Hendry, Robinson, & Peters, 2009). The Self-Assessment/Planning Tool for Implementing Recovery-Oriented Mental Health Services (SAPT) was tested as part of a two part pilot study in which Florida mental health service provider agencies completed the SAPT self-assessment survey to determine the degree

to which policies and practices reflected a recovery orientation. The structure of the SAPT was designed to provide support to agencies in achieving outcomes described by the Recovery Oriented Systems Indicator (ROSI) (Dumont, Ridgway, Onken, Dornan & Ralph, 2006; Onken, Dumont, Ridgway, Dornan & Ralph, 2004). Processes and procedures were also developed to implement the SAPT survey on the internet with a software program. In addition, the findings informed revisions made to the survey and planning/implementation guide (Winarski & Dow, 2010).

The second phase of the pilot implemented both the SAPT and ROSI surveys at five Florida mental health service provider agencies to determine the relationship between the two instruments. We applied statistical analysis to findings and determined a strong linear relationship between the SAPT and the ROSI; agencies with a high SAPT score tended to have a high ROSI score. We further tested the web-based process completing both the SAPT and ROSI surveys and found it to be a viable method for data collection (Winarski & Dow, 2010).

The pilot studies provided information from an agency and peer perspective that demonstrated the efficacy of the SAPT and ROSI for supporting recovery-oriented policy development, program planning, staff development, and outcome evaluation activities. The findings informed revisions in developing the SAPT Version 2.0.

Introduction to the Self-Assessment/Planning Tool for Implementing Recovery-Oriented Mental Health Services (SAPT)

Recovery is Now the Lynchpin of Federal Mental Health Policy

The development of the Self-Assessment/Planning Tool for Implementing Recovery Oriented Services (SAPT) was inspired by President Bush's New Freedom Commission, a landmark federal mental health policy initiative. The Commission assessed the nation's mental health system as "fragmented and in disarray leading to unnecessary and costly disability, homelessness, school failures and incarceration" and recommended fundamentally transforming service delivery based on a vision of recovery. The Commission's report, *Achieving the Promise: Transforming Mental Health Care in America*, and the documents of its subcommittees, provided the charge to translate the vision of recovery into effective policies and practices (New Freedom Commission on Mental Health, 2003).

The Recovery Vision is Critical to Delivering Effective Mental Health Services

The vision of recovery for people living with serious mental illnesses is fundamentally one of hope: hope that disturbing symptoms can be overcome; hope to become a meaningful participant in community; and hope in the possibility of a life fully lived. In the recovery vision, the integrity of the person is paramount; mental illnesses and the symptoms associated with them pose challenges to the person but they do not define the person (Anthony, 1991; Deegan, 1988; New Freedom Commission on Mental Health, 2003).

The hopeful and empowering vision of recovery is contrary to assumptions that have shaped mental health policy and practice for the past half century. Traditional beliefs viewed mental illnesses as following a course of long-term deterioration in symptoms and functioning that inevitably limit meaningful participation in community life. Mental health systems and programs offered little hope that persons with mental illness could ever achieve a vital and satisfying life. Recipients of mental health services often felt diminished and demoralized by the very system designed to help them (Chamberlin, 1978; Clay, 2005; Deegan, 1988).

The vision of recovery is important because it provides a deeper understanding about the nature and course of mental illnesses, based on scientific and anecdotal data gathered from individuals over a lifetime. Therefore, a recovery orientation allows us to develop policies and practices that truly respond to the lived experience of these disorders (Deegan, 1988; Harding, Zubin, & Strauss, 1987; Harding et. al., 1987a). The recovery vision is realized when peers participate fully at all levels of the mental health system, working as partners, and sharing both power and responsibility (Jacobson and Curtis, 2000; Mercer, 2006; Onken, Dumont, Ridgway, Dornan, & Ralph, 2002).

The SAPT Helps Translate the Vision of Recovery into Effective Policies and Practices

The purpose of the SAPT is to help mental health systems and programs move from more traditional and limiting views of mental illness to practices that reflect a recovery vision. This shift requires fundamental changes in roles and responsibilities of mental

health professionals and peers. Judgments about who may or may not recover must be relinquished in favor of creating “communities of hope” which surround all people with psychiatric disabilities (Deegan, 1996). The SAPT helps define the policies and practices as well as new roles and responsibilities of recovery-oriented mental health services. It includes a 50-item survey to track performance in key areas of recovery-oriented services implementation, in addition to a planning/implementation guide to support quality improvement strategies.

SAPT Development

Development Team

The SAPT was developed by a team of faculty and peers at the University of South Florida (USF) Louis de la Parte Florida Mental Health Institute (FMHI). A clinical supervisor from a Florida mental health service provider agency served as an external reviewer. Input was solicited from peers and staff at mental health service provider agencies as part of a two part pilot study; findings informed the revision of the survey and planning/implementation guide (Winarski & Dow, 2010; Winarski, Dow, Hendry, Robinson, & Peters, 2009). The ROSC leadership team provided input on revisions to support the development of SAPT adapted for Florida’s Recovery Oriented System of Care (ROSC).

Development Process and Linkage to Peer Outcomes

To ensure a direct connection to the experiences of peers, the SAPT was designed to support outcomes described in the Recovery Oriented System Indicator (ROSI) (Dumont et al., 2006). The ROSI was developed as part of a collaborative effort among a number of state mental health authorities, national organizations, peer survivor leaders, and mental health recovery researchers entitled, *Mental Health Recovery: What Helps and What Hinders? A National Research Project for the Development of Recovery Facilitating System Performance Indicators*. It provides a core set of system-level indicators that measure the critical elements and processes of recovery-oriented services in mental health programs and delivery systems (Dumont et al., 2006; Onken et al., 2004).

ROSC Application of Recovery Self-Assessment to Track Outcomes

The ROSC leadership team identified that some peers in Florida have experienced difficulties with completing ROSI surveys. The team recommended the inclusion of a measure that addresses the major domains identified in the ROSI, but with a more user-friendly survey. The Recovery Self-Assessment (RSA-R), developed by the Yale University Program for Recovery and Community Health, was selected (O'Connell, M., Tondora, J., Croog, G., Evans, A., Davidson, L., 2005). Specifically, the RSA-R Person in Recovery Version and Family Member/Significant Other Version, include survey items related to values, policies, and practices that closely correspond to the domains of the SAPT and ROSI (O'Connell, Tondora, Kidd, G, Hawkins, and Davidson, 2007). The structure of the RSA-R provides a clear and simple process for survey implementation.

The SAPT includes three domains with 14 sub-categories that provide the structure for the SAPT Survey items and the SAPT Planning and Implementation Guide. The domains are based on the eight components that emerged from the factor analysis of

the ROSI self-report questions and on additional performance indicators described in the ROSI administrative data profile (Dumont et al., 2006).

Administration

1. Philosophy
2. Continuous Quality Improvement
3. Outcome Assessment
4. Staff Support
5. Peer and Family Support

Treatment

1. Validation of the Person
2. Person-Centered Decision Making
3. Self Care – Wellness
4. Advance Directives
5. Alternatives to Coercive Treatment

Community Integration

1. Access
2. Basic Life Resources
3. Meaningful Activities and Roles
4. Peer Leadership

The SAPT development team developed survey items for each domain based on a review of the literature. The documents reviewed are listed in the reference section of this document and in the reference sections of two previous AHCA studies (Winarski, Thomas & DeLuca, 2007; Winarski, Thomas & Ort, 2006). Each item was designed to describe key recovery-oriented service activities for each of the domains. The team then developed the Planning and Implementation Guide based on this same framework.

The SAPT is designed to be used independently or together with the RSA-R. The SAPT helps agencies establish policies and practices that result in positive, recovery-oriented services outcomes. The RSA-R informs agencies about the degree to which they have achieved those outcomes. Applied together, the SAPT and RSA-R may be used to support processes for policy development, program planning, staff development, and outcome evaluation.

Section 1: Self-Assessment/Planning Tool for Implementing Recovery-Oriented Mental Health Services (SAPT) Survey

Instructions for Using the SAPT Survey

The SAPT survey includes 50 items organized under the domains of Administration (12 items), Treatment (21 items), and Community Integration (17 items). The instrument uses a four-point rating scale to rate the degree of agreement or disagreement with each item.

To complete the SAPT survey, the agency should select staff from senior administrative positions, clinical supervisors, and direct clinical positions. Staff selected should include individuals who are most knowledgeable about how mental health services are delivered at the agency in specific programs. It is important to collect survey information from staff in each program within the agency. A person should be designated to take the lead in collecting, scoring, and interpreting the results and in applying findings as part of a recovery-oriented services implementation plan.

Agencies may collect information by the following methods:

- *Manual Collection*: The survey and instructions may be distributed to staff members in hard copy to complete using a pen. Data from each survey may be entered into a spreadsheet application, such as Excel (see sample instructions in Appendix 1).

- *Web-based*: The survey may be loaded onto a web-based platform using survey software applications such as Qualtrics or Survey Monkey. The survey and instructions may then be forwarded to staff members via e-mail and accessed through a link in the e-mail message (see sample instructions in Appendix 2).

In addition to the SAPT Survey, agencies may conduct staff focus groups to gather more detailed information about how services are implemented. The focus groups may discuss specific areas identified in the SAPT survey and target specific programs and staff. The discussion can help provide a deeper understanding of staff perspectives and issues that affect implementation. The discussion can also help foster collaboration among staff and assist them in developing strategies for program improvement.

Scoring the SAPT Survey

All of the items are scored on a four-point Likert Scale: 1 = Strongly Disagree, 2 = Mostly Disagree, 3 = Mostly Agree, and 4 = Strongly Agree. The following steps for compiling/scoring survey data should be considered:

- Administer and score the survey from key staff in each agency program.
- *Program Means*: Average all of the responses for all items within each program.
- *Program Domain Scores*: Prepare a score for each of the 3 domains (Administration, Treatment, and Community Support) by taking an average of the scores for the items under each domain.
- *Agency Means*: Average all of the responses for all items within each program.
- *Agency Domain Score*s: Prepare a score for each of the 3 domains (Administration, Treatment, and Community Support) by taking an average of the program domain scores.
- Record comments or observations made by participants as part of the assessment process in each agency.

Survey software applications can be set up to compile and report the above information automatically. Agencies that use a web-based software application to administer the survey may have to download item means into Excel or another application to compute scale subscores.

Interpreting SAPT Survey Findings

The SAPT survey items describe key recovery-oriented service activities for each of the 3 domains to help agency staff determine, on a four-point scale, the degree to which agency performance is reflected by each statement. An individual item score of 1 or 2 is an area of weakness needing improvement, and an individual item score of 3 or 4 is an area of strength.

Agencies should examine the scores for each domain, program, and the combined scores of programs to establish a baseline of strengths and weaknesses for implementing recovery-oriented services. It is important to note that the SAPT is a self-report instrument, and provides only staff impressions about each item; it does not provide an objective analysis of performance. Staff perceptions provide an important starting point to compare peer impressions or the results of other objective reviews.

The results should be used to establish priorities and develop plans for program or agency wide improvement. Findings should also be compared to objective evidence such as policy statements and clinical records, in addition to observations of agency practices.

SAPT and RSA

Agencies may use the SAPT and the RSA during the same 12-month interval to provide complementary outcome information. The SAPT can be used independently to help shape agency policy and practice. However, by administering the RSA to gather information from peers on recovery-oriented services outcomes, agencies can determine if these policies and practices are making a difference in the lives of service recipients. By administering both assessments during the same 12-month interval, agencies will have performance data from the perspective of both staff and persons served . Identifying areas where there are discrepancies between the perspectives of staff and persons served is especially helpful in establishing priorities for quality improvement.

Self-Assessment/Planning Tool For Implementing Recovery-Oriented Mental Health Services (SAPT) Version 2.0 Self-Assessment Survey (50 Items)	**Strongly Disagree**	**Mostly Disagree**	**Mostly Agree**	**Strongly Agree**
	1	2	3	4
Administration (12 Items)				
1. The agency strategic planning process incorporates diverse viewpoints from peers.				
2. The agency has a process in place to ensure that peers are included in quality improvement activities as equal partners with professionals.				
3. The agency administers the ROSI or other recovery-oriented surveys as part of the quality improvement process.				
4. The agency uses outcome indicators that track quality of life.				
5. The agency uses standardized, quantifiable scales for assessing recovery outcomes.				
6. The agency has a process for peers to participate in developing recovery-oriented outcome indicators (e.g., ROSI).				
7. The agency uses outcome measurement processes to improve recovery-oriented services.				
8. The agency has a comprehensive program to promote recovery-oriented knowledge, attitudes, and skills in its workforce.				
9. Clinical supervision focuses on the capable delivery of recovery-oriented services.				
10. Clinical staff evaluations assess the capable delivery of recovery-oriented services.				
11. The agency hiring criteria include competencies in delivering recovery-oriented services.				
12. The agency provides training in self-advocacy for peers and families.				
	1	2	3	4
Treatment (21 Items)				
1. Agency staff use person-first language in all verbal and written communication.				
2. Agency staff use language that is encouraging and hopeful in conversations with persons who are receiving services.				
3. Agency services are provided in the person's spoken language as often as possible.				
4. Agency assessment tools are culturally sensitive.				
5. Agency staff implement culturally sensitive service plans that consider the impact of culture on the person's experience of mental illness.				
6. Agency staff have assessed and are aware of their own cultural competence/biases.				
7. Agency staff are sensitive to the person and family's experience, history of immigration, and country of origin.				

8. The persons receiving services are encouraged and assisted in identifying their own goal(s).				
9. The persons receiving services direct the therapeutic alliance/partnership.				
10. The persons receiving services drive the process of goal setting based on their hopes and preferences. **				
11. Assessment and intervention activities are integrated as part of a holistic treatment approach. **				
12. Treatment is provided in the context of a trusting and hopeful relationship.				
13. Agency staff work from a strengths/asset-based model. **				
14. Agency staff and peers collaborate to develop an individual service plan that identifies needed resources and supports. **				
15. The person receiving services defines his/her family's level of involvement in the service plan. **				
16. The agency provides wellness education and support to peers (e.g., Wellness Recovery Action Plan – WRAP).				
17. The agency provides education and support to family members and significant others to help support the person's process of recovery.				
18. Agency staff encourage peers to build self-care plans based on their strengths and abilities.				
19. Services are available when peers feel they are needed.				
20. The agency has a process in place for the review of advance directives when peers experience relapse/incapacitation. *				
21. Agency clinical staff are trained to assess the person's possible history of abuse/trauma.				
	1	2	3	4
Community Integration (17 Items)				
1. Agency staff return communications from peers/families at the first opportunity.				
2. The agency provides peers and families with comprehensive information about community resources, including detailed information about eligibility criteria and processes for making applications.				
3. The agency facilitates opportunities for peers to participate in community activities of their choice.				
4. The agency provides community education designed to decrease stigma and increase early identification of mental illnesses and the recovery process.				
5. The agency has a process in place to determine peers' satisfaction with their housing.				
6. The agency ensures that peers are provided access to all available independent and supported housing options.				
7. Agency staff use person-centered planning that includes strategies to assist peers in securing and maintaining employment.				
8. The agency ensures that peers are provided access to all available employment and training opportunities.				
9. Agency staff ensure that peers experience support and assistance for their employment choices.				
10. Agency staff utilize person-centered planning that includes strategies to assist peers in pursuing educational goals.				
11. The agency ensures that peers have access to all available educational opportunities.				

12. Agency staff ensure that peers experience support and assistance for their educational choices.				
13. Agency staff assist peers to develop the interpersonal skills needed to initiate and maintain positive relationships with others.				
14. The agency ensures that peers have opportunities to initiate and maintain positive interpersonal relationships in the community.				
15. Agency staff utilize person-centered planning that takes into account a person's spiritual needs and interests.				
16. Agency staff view spirituality as an integral part of the person and not merely as an expression of pathology.				
17. The agency provides peers with information regarding peer run services (e.g., support groups, drop-in centers, respite services and mentoring programs).				

* Adapted from *The American Association of Community Psychiatrist Guidelines for Recovery Oriented Services* (Sowers, 2005).

** Adapted from *Treatment Planning for Person-Centered Care: The Road to Mental Health and Addiction Recovery* (Adams & Grieder, 2005).

Section II: Self-Assessment/Planning Tool for Implementing Recovery-Oriented Mental Health Services (SAPT) Planning and Implementation Guide

Introduction

The SAPT Planning and Implementation Guide is designed to assist agencies with developing plans to address findings from the SAPT Survey and to support effective delivery of recovery-oriented mental health services. It provides information to guide program planning and development in 14 key categories:

Administration

1. Philosophy
2. Continuous Quality Improvement
3. Outcome Assessment
4. Staff Support
5. Peer and Family Support

Treatment

1. Validation of the Person
2. Person-Centered Decision Making
3. Self Care – Wellness
4. Advance Directives
5. Alternatives to Coercive Treatment

Community Integration

1. Access
2. Basic Life Resources
3. Meaningful Activities and Roles
4. Peer Leadership

The guide includes the following information for each of the 14 categories:

Description: Provides a clear definition of the domain and explains why it important for implementing recovery-oriented services.

Essential Characteristics: Provides a brief summary of the most important service components, including a description of activities needed for capable implementation.

Barriers: Describes some of the most common barriers for each domain that mental health agencies encounter in implementing services.

Remedies: Suggests strategies for overcoming barriers to effective implementation.

Resources: Provides reference to key resources, such as articles, manuals, and web sites that can assist agencies with program planning and service implementation.

Instructions for Using the SAPT Planning and Implementation Guide

The information included in the SAPT Planning and Implementation Guide is intended to be used as a reference for agency staff in developing program plans and implementation strategies. It clarifies terms and practices that define a recovery-orientation, provides practical guidance for service implementation, and presents select resource references.

The SAPT Survey and Planning and Implementation Guide are designed as tools. The successful implementation of recovery-oriented services requires a commitment by the agency to provide administrative support, training, supervision, and technical support over the long term. In addition, these core components need to be linked to a process of program monitoring, evaluation, and development.

The following strategies for planning and implementation should be considered:

1. Identify agency priorities and establish a manageable number of goals:

   The SAPT survey helps agencies rate performance in specific activities that translate to a recovery-orientation. There may be a broad range of areas that require attention. Survey results should be examined in relation to the agency's overall strategic plan, within the context of needs and available resources. Identifying even one or two goals with corresponding action plans provides a valuable starting point to move the agency toward a recovery-orientation. It is most important that the course of action selected is manageable, measurable, and fully supported by the agency.

2. Focus on areas of strength as well as weakness:

   When establishing priorities for agency/program improvement, it is important to recognize that building upon areas of strength can often enhance the agency's ability to implement recovery-oriented services as much or more than ameliorating areas of weakness. By emphasizing strengths as well as addressing weaknesses and efficiently targeting resources (e.g., conducting activities that do not require extra funding or that may be supported by external grant funding), agencies can begin to see improvement within a short period of time.

3. Integrate recovery-oriented services planning with Continuous Quality Improvement (CQI) activities:

   Most agencies implement a standard process of Continuous Quality Improvement (CQI) to monitor and support positive program outcomes. We recommend that agencies organize a recovery team or sub-group that works as part of the CQI system. The team should take the lead in facilitating data collection, identifying priorities, monitoring progress, and developing the agency's recovery-oriented services plan. The team's activities and findings should be integrated with agency-wide CQI processes.

   Findings from the CQI recovery team and the plan for implementing recovery-oriented services should also inform the agency's strategic plan.

4. Establish person-centered decision making as a high priority:

   Among the SAPT items, those related to person centered decision making are among the most critical to implementing recovery-oriented programs and services. The treatment plan is the primary mechanism through which the person receiving services decides upon goals, objectives, and key activities that will define the course of treatment. If peers are not at the center of this process, then the efficacy of all other strategies is significantly diminished (Daniels & Adams, 2006).

5. Repeat the SAPT Survey and modify plans every 12 months:

   The SAPT survey should be administered every 12 months as part of the agency's standard process of continuous quality improvement. Modify goals, objectives, and action plans based on the results. By also administering the Recovery Self-Assessment (RSA-R) at the same 12-month intervals, agencies will have performance data from the perspective of both staff and peers that can help guide planning and implementation efforts.

Self-Assessment/Planning Tool for Implementing Recovery-Oriented Mental Health Services (SAPT)

Planning and Implementation Guide

Administration

1. Philosophy

"Having a clearly articulated mission statement gives one a template of purpose that can be used to initiate, evaluate, and refine all of one's activities." (Laurie Beth Jones, 1998)

Description

Mission statements are the primary mechanism through which the philosophy of organizations is communicated. Mission statements express the overall purpose of mental health service provider agencies and can be a powerful tool for supporting the implementation of recovery-oriented services. It is important for agencies to include recovery from mental illness in mission statements because they reflect the field's most current understanding about the nature and course of mental illness and because they support the development of polices and practices that are most responsive to the needs of service recipients (Harding et al., 1987; Harding et al., 1987a). Mission statements help organizations make decisions that align with their values and goals.

Essential Characteristics

The agency should include an explicit statement about recovery in the mission statement to help ensure a clear, recovery-oriented focus and congruence among program policies, practices, and outcomes. The agency should also fully embrace the core principles of recovery such as those articulated by the Substance Abuse Mental Health Services Administration National Consensus Statement on Mental Health Recovery (SAMHSA, 2011). It is important for the agency to fully accept recovery values, such as honoring peer choice, to ensure that references to recovery in the mission statement are more than just rhetoric and reflect an authentic commitment to realizing the recovery vision.

The mission statement should serve as the frame of reference in program development and implementation activities. Agencies should consider the following action steps:

- Include peers in the process of developing mission statements and ensure that they play a key role in the development of policies and procedures.
- Periodically compare current policies and procedures as part of an agency work group to ensure that they are consistent with the mission statement.
- Explore innovative ways to translate the recovery philosophy into practice that moves beyond current policies and practices.
- Monitor the degree to which staff interactions with peers are consistent with the recovery philosophy and mission. It is important to note that making the transition

to a recovery-oriented culture is best realized through changes in performance at every level of the organization, but especially in areas where peers directly interact with agency staff.

Barriers

A large agency that provides a broad range of services may feel hard pressed to include recovery as part of the mission statement because of concern about creating a "laundry list" of services that would dilute the purpose of the mission statement.

A lack of agreement among the agency's leadership about the importance of recovery and other key issues can present obstacles to developing a clear mission statement. After the mission statement is created, an agency may not always use it to guide decision-making or the implementation of policies and procedures.

An agency seeking to develop a recovery orientation to services sometimes establishes separate recovery programs as a sub-set of the array of mental health services they provide. This creates the impression that the experience of recovery is program specific, when it should be the focus of all agency services.

Some agency staff may not "buy-in" to a recovery mission.

Remedies

Developing a compelling recovery-oriented mission statement is best achieved when agency leadership works in collaboration with peers of mental health services. Peers with a broad range of backgrounds should play key roles on agency boards, committees, and workgroups.

Agencies should recognize that a recovery-oriented mission should be applied to all mental health programs. Traditional psychiatric services such as prescribing/managing medications and counseling can all be implemented with a recovery-orientation. There are also services such as person centered planning and skills training in which recovery is a special focus. All of these services share in realizing the mission of promoting recovery for individuals with mental illnesses.

It is important to provide an orientation to the principles and practices of recovery-oriented mental health services for all agency staff and peers.

- The orientation should provide definitions of basic concepts and principles that are applied in developing the mission statement.
- Staff should be given the opportunity to openly express diverse viewpoints about recovery as part of the orientation process to help establish buy-in.

Agencies should recognize that culture change is achieved primarily through changes in performance.

- Agency staff should be required to meet recovery-oriented performance requirements regardless of their degree of buy-in to the mission.

- The agency should designate a work group to monitor the degree to which agency polices, procedures, and performance outcomes are congruent with the recovery-oriented mission statement.

Resources

Review of Recovery Literature

Ruth Ralph, a peer researcher, prepared a review of recovery literature for the National Association for State Mental Health Program Directors (NASMHPD) that provides agencies a valuable orientation to the principles and practices of recovery (Ralph, 2000). http://www.nasmhpd.org/sites/default/files/ralphrecovweb.pdf

Sample Mission Statements

The following samples provide examples of integrating recovery into mission statements:

The Main Place, Inc., "Your Recovery Center," is a peer-operated mental health recovery center that promotes recovery through peer support, socialization, education, and training. By working together, peers build better lives for themselves, gain employment, maintain independence and earn acceptance within their communities.

The Mental Health and Recovery Services Board of Lucas County exists to enhance the well being of our residents by promoting mental health, preventing substance abuse and facilitating a process of recovery for persons experiencing mental illness and/or alcohol and other drug disorders.

2. Continuous Quality Improvement

"It is essential that services keep improving care by continually striving for optimal quality." (World Health Organization, 2003)

Description

"In mental health care, quality is a measure of whether services increase the likelihood of desired mental health outcomes and are consistent with current evidence-based practice" (World Health Organization, 2003). For people with mental health disorders who seek services, the receipt of quality care is critical to their recovery and improvements in their quality of life. Quality care can be a vehicle for imparting hope and empowerment to individuals who strive to manage their illness. The process of "continually striving for optimal quality" is the essence of continuous quality improvement (CQI) activities. It is an "inbuilt mechanism for identifying and addressing problems" (WHO, 2003).

Agencies that invest time and resources into CQI seek to improve services by continuously reviewing the agency's activities, programs, and policies. An important aspect of CQI processes is the solicitation of feedback from customers and using that feedback to make system changes. Recovery-oriented CQI processes not only

incorporate peer feedback regarding their satisfaction and appraisal of recovery oriented services through the use of such tools as the Recovery Oriented Systems Indicators (ROSI), but they also involve peers in CQI related activities, such as service reviews, monitoring, and outcomes measurement.

Essential Characteristics

Recovery-oriented CQI provides a structure and process to monitor agency policies, procedures, trainings, and other activities that influence interactions between staff and peers. The focus is less on quantity (e.g., number of service units delivered) and more on the quality of service reflected in staff-peer relationships. The essential features of a recovery-oriented continuous quality improvement process include:

- An established agency policy that outlines the purpose of CQI and its foundation in the principles of recovery.
- A process for educating staff and peers about the importance of the recovery-oriented CQI process to foster a common understanding of its value and intent.
- Activities that are designed to solicit feedback from peers and families regarding the services they receive and mechanisms for incorporating that feedback into agency operations.
- Activities (e.g., monitoring, case reviews, audits) that are designed to assess services on an ongoing basis, especially those that involve interactions between clinicians, staff, and peers.
- Peer and family involvement in CQI activities at all levels.

Barriers

Staff may lack understanding of the purpose and function of continuous quality improvement activities and not appreciate the need to involve peers and families in the process.

Collecting information required for recovery-focused CQI may add to the administrative burden that the agency already faces in providing information required by funders, accreditation agencies, auditors, etc.

The agency may have difficulty locating peers with the skills, time, and interest to participate as equal members of a CQI team.

The agency may have difficulty providing the necessary financial resources to support peer involvement (e.g., remuneration for participation and funding to cover expenses).

Remedies

Agency staff and peers should be educated about recovery-oriented CQI processes and the importance of peer and family engagement in the process.

The agency, its funders, and researchers should collaborate to identify core data sets, eliminate requirements for data that are duplicative or less important, and suggest efficient ways of gathering the information.

The agency and other advocates should advertise openings for peers interested in CQI activities as widely as possible.

The agency should help peers participate in CQI activities by providing training and identifying resources (e.g., money for time and expenses) to facilitate their involvement.

Resources

Quality Improvement for Mental Health published by the World Health Organization (2003).

Peer Quality Initiatives is a mental health peer operated research, evaluation and quality improvement organization based in Massachusetts. Its web site provides useful CQI information with a recovery-orientation: http://www.cqi-mass.org/default.aspx CQI utilizes a Community-Based Participatory Action Research framework, with an emphasis on protocols that are designed to impact policy and practice.

3. Outcome Assessment

"The recovery vision expands our concept of service outcome to include such dimensions as self-esteem…empowerment, and self-determination."
(William Anthony, 1993)

Description

A core principle of the recovery model is that services should help people achieve personally valued goals that help them live meaningful, rewarding lives that are more fully integrated into the community. Assessment of outcomes is the process by which providers work with peers to determine progress in achieving these goals. Outcomes demonstrate to funders that services are effective and worthy of the investment of resources and most importantly, that services yield "…real life outcomes for people who are striving to attain and sustain recovery; build resilience; and work, learn, live, and participate fully in their communities" (SAMHSA, 2008). Outcomes assessment is an essential part of the feedback loop needed to insure that services remain recovery focused.

Essential Characteristics

A recovery-oriented outcomes assessment process should be grounded in recovery principles, i.e., it should focus on the outcomes that are of value to the peer, and peers and families should participate in the assessment process at all levels. An agency that

seeks to establish a recovery-oriented outcomes assessment process should consider the following essential components:

- ***Formal Policies***: A policy that articulates the purpose of outcomes measurement and that stipulates the inclusion of peers and families throughout the process. Peers and families play a role, in partnership with staff, in how outcomes measures are developed and implemented.

- ***Staff and Peer Orientation***: An orientation to outcomes measurement that fosters a common understanding of the process and its importance.

- ***Assessment Tools***: Outcomes assessment tools that have been proven to be valid and reliable and yet not overly burdensome to administer.

- ***Data Collection***: Established principles and procedures for the use of data collected in the outcomes measurement process.

Barriers

Staff and peers may lack understanding of the purpose of outcomes measurement and the involvement of peers and families in the process.

The collection of outcome data may add to the administrative burden that the agency already has to provide data to funders, accreditation agencies, auditors, etc.

The agency may have difficulty locating peers and families who have the skills, time, and interest to participate in the outcomes assessment process.

The agency may have difficulty providing the necessary financial resources to support peer and family involvement (e.g., remuneration for participation and funding to cover expenses).

It may be difficult for the agency to reconcile recovery-oriented outcomes measurement with the outcomes measurement requirements of funders, accreditation agencies, monitors and auditors.

Remedies

Staff and peers should be oriented regarding the purposes of recovery outcomes measurement and the importance of peer and family engagement in the process.

The agency and peers should collaborate to identify core sets of data to be collected that are not duplicative of other data reporting requirements and identify efficient ways of gathering the information. The agency should continue to advocate for the elimination of data reporting requirements that are duplicative, non-essential, and are counter-productive to the principles of recovery.

The agency should assertively advertise for peers interested in outcomes measurement activities.

The agency should help peers participate in outcome measurement activities by providing training and identifying resources (e.g., money for time and expenses) to facilitate their involvement.

Resources:

Mental Health Recovery: What Helps and What Hinders? A National Research Project for the Development of Recovery Facilitating System Performance Indicators is available for download from the NASMHPD web site: http://www.nasmhpd.org/content/mental-health-recovery-what-helps-and-what-hinders-national-research-project-development

Personal Outcome Measures in Consumer-Directed Behavioral Health, The Council on Quality and Leadership, www.thecouncil.org

***Principles for Assessment of Patient Outcomes in Mental Health Care*:** This article in Psychiatric Services provides a solid foundation for developing and implementing outcome measures (Smith, Manderscheid, Flynn & Steinwachs, 1997).

A Compendium of Recovery Measures Volume II is available from the Evaluation Center at HSRI (Campbell-Orde, Chamerlain, Carpenter, & Leff, 2005): http://www.hsri.org/publication/measuring-the-promise-a-compendium-of-recovery-measures-volume-ii/

4. Staff Support

"It is not our job to pass judgment on who will and who will not recover from mental illness... Rather, it is our job to form a community of hope which surrounds people with psychiatric disabilities. It is our job to nurture our staff in their special vocations of hope."
(Pat Deegan, 1996)

Description

Implementing recovery-oriented programs requires competent staff who have the attitudes, knowledge, and skills to meaningfully engage peers in the recovery process. Mental health service provider agencies should provide administrative and supervisory support to staff in implementing recovery-oriented services to ensure capable performance and support positive outcomes for recipients of services.

Essential Characteristics

An agency committed to focusing on recovery should develop a staff support plan that addresses each of the core components of effective program implementation: staff selection, pre-service and in-service training, ongoing coaching and supervision, staff and program evaluation, administrative support, and systems interventions (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). These components are critical to the support of all mental health services. Peers and families should a play a role in all these critical components. Agency plans for managing and supervising staff should include strategies for supporting a recovery orientation for all programs and services. Plans

should align with the agency mission and support positive, recovery-oriented outcomes for service recipients.

Staff Selection: The agency's hiring criteria should include attitudes, knowledge and skills that are conducive to supporting the process of recovery for service recipients.

- Candidates should buy in to the concept of recovery for individuals with severe mental illnesses and demonstrate optimism and hope about the potential for improvement.
- Candidates should be comfortable in establishing partnerships with service recipients and in serving as a guide/facilitator/coach in their process of recovery. They should also respect individual differences, especially cultural or ethnic differences, in that process.
- Key skill areas include engagement, person centered goal setting and planning, service coordination, skill development/application, and the ability to establish linkages to the community.

Training: Training is critical in helping staff acquire and sustain the core competencies required to implement recovery-oriented services. The agency should develop a training plan for addressing recovery services that accounts for the level of knowledge and skill among staff. The subject areas addressed in training should provide support to staff in achieving strategic, agency-wide objectives for implementing recovery-oriented programming. Training trainers in core competencies can be an effective method to ensure skill development over time. Training initiatives need to be developed as part of an overall plan for service implementation (Fixsen et al., 2005).

Ongoing Coaching and Supervision: Coaching and supervision reinforce the development of recovery-oriented knowledge and skills and support staff in adapting the lessons they learn to real life situations. Supervisors are responsible for supporting staff in achieving objectives for job performance. Supervisors should also support staff with the application of recovery-oriented skills that are acquired in training sessions. In addition, there should be mentoring processes in place to support employees who are mental health service recipients with their own process of recovery.

Staff Evaluation: Assessments of staff performance in providing recovery-oriented services should be integrated with the process of training, coaching and supervision. Staff need clear expectations for implementing recovery-oriented services in order to gauge levels of progress/achievement. Effective staff evaluation supports the continued improvement of individuals and programs within the agency.

Program Evaluation: Recovery-oriented evaluation tools such as the Recovery Oriented System Indicator (ROSI) should be integrated into the agency's evaluation plans. The agency should not only ask peers and families for feedback, but also encourage their participation in training and evaluation activities.

Administrative Support: Senior management is responsible for providing leadership and organizational structures to assist staff to achieve recovery-oriented clinical outcomes and ultimately realize the mission of the agency. Administrative support is critical to creating conditions within the agency that allow staff and service recipients to thrive.

Systems Interventions: The state of Florida has taken steps to transform its system of care consistent with the vision of recovery described by President Bush's New Freedom Commission (New Freedom Commission on Mental Health, 2003). These steps have included a variety of planning and implementation activities at the state and local levels. The agency will derive important benefits by participating in systems level initiatives, such as a greater awareness of peer and family needs, the opportunity to learn from and collaborate with other service provider agencies, opportunities to inform state-level policy development, and access to an important forum to address community concerns.

Barriers

The primary barrier to supporting staff in implementing recovery-oriented services is the lack of a staff support plan. Planning is especially important in environments where budget reductions have contributed to a lack of resources specifically devoted to staff support. In the agency, there may be a lack of in-house expertise, thereby creating a greater need for external resources. In addition, the public mental health system may not provide programmatic guidelines for implementing recovery-oriented services.

Recovery-oriented approaches for providing mental health care are not part of most college and university programs. Staff enter the field at different levels of readiness to deliver recovery-oriented services. Consequently, agency staff typically develop recovery-oriented knowledge and skills as part of their career practice. This places a greater burden on service provider agencies to prepare and support staff to implement these services.

Remedies

The agency should develop a plan for staff support that includes the following components:

- Defined staff support roles and responsibilities for each core component of program implementation.
- Performance goals in staff evaluations that are consistent with the items in the Self-Assessment and Program Planning Tool for implementing Recovery-Oriented Mental Health Services (SAPT).
- An inventory of recovery-oriented educational resources (e.g., books, manuals, articles, and websites) should be made available to staff, peers, and family members.
- Agreements with other agencies to share staff support activities (e.g., in-service meetings, training, coaching).
- The inclusion of peers and family members as leaders and participants in training/educational activities.
- Participation in system-wide planning activities that target the most efficient use of community resources for staff development across agencies.

Resources

Recovery Competencies for New Zealand Mental Health Workers is available for download at the following web site:
http://www.maryohagan.com/resources/Text_Files/Recovery%20Cometencies%20O'Hagan.pdf

Core Competencies of Service Providers: Views of Peer Stakeholders prepared by Jean Campbell, Ph.D. of the Missouri Mental Health Institute in 1998 is available for download from the following web site:
https://www.dhs.wisconsin.gov/sites/default/files/legacy/ccs/docs/CCSManualPartDCoreComp.pdf

Implementation Research: A Synthesis of the Literature: The National Implementation Research Network (NIRN) prepared a synthesis of the literature on implementing effective programs.
http://ctndisseminationlibrary.org/PDF/nirnmonograph.pdf

An Action Plan for Behavioral Workforce Development: A Framework for Discussion
This report was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by The Annapolis Coalition on the Behavioral Health Workforce (Cincinnati, Ohio) under Contract Number 280-02-0302 with SAMHSA, U.S. Department of Health and Human Services (DHHS). Ronald W. Manderscheid, Ph.D., and Frances L. Randolph, Dr.P.H., M.P.H., served as the Government Project Officers. Senior authors of the report by the Annapolis Coalition were Michael A. Hoge, John A. Morris, Allen S. Daniels, Gail W. Stuart, Leighton Y. Huey, and Neal Adams.
http://www.mentalhealthconnection.org/pdfs/annapolis-report.pdf

5. Peer and Family Support

"When we talk about independent living, we're not talking about leaving people alone to suffer with no help. We're talking about having freedom to make choices; to choose whom and what to be interdependent with; to choose when we need help, how it is to be provided, and by whom…in short we are talking about empowerment. We're talking about independent living with supports and services that enable us crazy folks to make a success of independent living." (Howie the Harp, in Carling, P.J. 1993)

Description

Mental health service provider agencies that implement recovery-oriented services provide education and other types of support to peers and family members to ensure integration to life in the community and their full participation in the design and delivery of services.

Peer and family supports should address both the personal and social dimensions of recovery. Individuals with mental illnesses have described “the internal sense of self, inner striving and their whole being (physical, emotional, mental, and spiritual) as affected by and affecting the recovery process” (Onken et al., 2002). The social dimension includes a core of active, interdependent social relationships – being connected through families, friends, peers, neighbors and colleagues in mutually supportive and beneficial ways” (Onken et al., 2002).

Essential Characteristics

Agency support for peers and families should include the following core components:

- Education;
- Access to a well defined dispute resolution process;
- Knowledge of advocacy opportunities;
- Inclusion on boards, advisory committees and work groups; and
- Opportunities to participate in hiring, staff training, program planning and staff evaluation.

Individuals and families, like other members of the service team, need specialized education and training to fulfill their role to its maximum potential. Peers and families need to be fully informed about how to play an active role in the mental health system.

Agencies should provide access to self-advocacy training such as the Freedom Self-Advocacy Course published by the National Mental Health Consumer’s Self-Help Clearinghouse. Specialized training in meeting management, leadership skills, and board and committee involvement will greatly assist peers and family members to be productive members of the planning process.

Barriers

Many of the barriers to effective peer and family support are a function of the culture of the agency. Staff resistance to including peers and family members in the design and provision of services is still common, due in part to a lack of sufficient training on recovery principles and a lack of knowledge of the most current research findings. Some agencies have policies that restrict peers and family members from participating on boards. Many agencies are not aware of peer developed trainings in advocacy and recovery that are designed to support peers and families in their efforts to be included.

Concerns about confidentiality of the person receiving services can create barriers to families in playing a supportive role. Confidentiality laws need to be upheld, but provisions of the law are frequently misunderstood and misapplied in practice.

Remedies

- Provide training to staff in the principles and practices of recovery to support culture change, e.g., National Alliance for the Mentally Ill (NAMI) Provider Education Course.
- Provide self-advocacy training for peers and family members, e.g., the Freedom Self-Advocacy Curriculum.

- Provide leadership training for peers and family, e.g., Peer Support Coalition of Florida, Inc. leadership training curriculum.
- Realign agency board procedures and agency policies and procedures to include peers and family members as essential participants in the life of the agency.
- Include peers and family members in employee trainings.
- Provide staff with concrete examples of recovery through peer stories, such as *Common Threads: Stories of Survival & Recovery* (Hendry, 2007) and the NAMI *In Our Own Voice* program.
- Provide training to clarify issues surrounding confidentiality laws, including HIPAA.

Resources

Wellness Recovery Action Plan (WRAP), Mary Ellen Copeland, www.copelandcenter.com

Freedom Self-Advocacy Curriculum, available through the National Mental Health Peers' Self-Help Clearinghouse web site: http://www.mhselfhelp.org/

Personal Outcome Measures in Consumer-Directed Behavioral Health, available from the Council on Quality and Leadership, www.thecouncil.org

In Our Own Voice, NAMI National: http://nami.org/

Mental Health Recovery: What helps and What Hinders? Onken, S. J, Dumont J. M., Ridgway, P., Dornan, D. H., & Ralph, R. O. (2002). National Technical Assistance Center for State Mental Health Planning: http://www.nasmhpd.org/content/mental-health-recovery-what-helps-and-what-hinders-national-research-project-development

Return to Community: Building Support Systems for People with Psychiatric Disabilities. Carling, P. J. (1995). New York: The Guilford Press.

Recovery: The lived experience of recovery. Deegan, P. (1988) Psychiatric Rehabilitation Journal, 11.

On Our Own, Together: Peer Programs for People with Mental Illness. Clay, S., Schell, B., Corrigan, P. & Ralph, R. (Eds). (2005). Nashville, TN: Vanderbilt University Press.

Common Threads: Stories of Survival & Recovery from Mental Illness. Hendry, P. (Ed). (2007). The Florida Peer Network, Inc. & The University of South Florida, Tampa. http://www.floridatac.com/files/document/Common%20Threads%2012.18.07%20Final.pdf

Treatment

1. Validation of the Person

"It is not suffering as such that is most deeply feared but suffering that degrades."
(Susan Sontag, 1991)

Description

Recovery-oriented services, first and foremost, are based on a person-centered orientation where the focus is on the individual's strengths and abilities rather than their illness or disability. Many mental health service programs have operated under the assumption that persons with serious mental illnesses follow a course of long-term deterioration in symptoms and functioning. Little hope has been offered that the person could ever achieve a vital and satisfying life (Deegan, 1993). In this view, the person is defined by the illness and required to reduce expectations about the potential for future success. Peers of mental health services have often felt diminished and demoralized, and indeed invalidated, by the very system designed to help them (Clay et al., 2005; Deegan, 1988).

Validating the person is best achieved by demonstrating respect for each individual's character and cultural background. It requires listening, acknowledging strengths, providing support for areas of challenge, and responding empathically in every interaction (Asay & Lambert, 2006). It also requires that service provider agencies recognize that every interaction, for better or for worse, reflects how peers are either lifted up or diminished by every encounter (Carkhuff, 1969). Mental health service provider agencies act to either facilitate or obstruct the process of recovery by how they respond.

Essential Characteristics

Validating the person through interactions that are respectful to each individual and sensitive to cultural identity is at the heart of recovery-oriented services. Programs that claim a recovery orientation without respectful communications between staff and peers do so in name only. Ensuring respectful and culturally sensitive communication should be considered a top priority in the agency's recovery-oriented services plan. The following are important characteristics of programs that validate the person:

- ***Hopeful Orientation***: It is important to note that a hopeful orientation about the future prospects of individuals with severe and long term mental health disorders does not mean that the seriousness of these conditions are ignored or that unrealistic expectations for improvement have been established. Rather, it is acknowledged that improvement is possible and that the course of improvement is different for each individual. Staff work as partners with each individual to establish goals that foster hope and inspire committed action.

- ***Empathic Communication***: Staff need to demonstrate the capacity to respond meaningfully to the content, feeling, and meaning in communication with persons receiving services. This level of responding should be apparent not only as part of clinical interactions, but in every part of the agency's operations. For example,

administrative, clerical, and physical operations staff should demonstrate respect in every interaction with peers.

- ***Responsive to Culture***: Staff awareness and sensitivity in responding to issues of culture is critically important to the delivery of behavioral health services. This includes not only matters of race and ethnicity, but also the many ways that individuals identify themselves. Adams and Grieder (2005) provide a framework for considering human diversity using the pneumonic ADDRESSING:

    - Age and generational influences
    - Developmental and acquired disabilities
    - Religion and spiritual orientation
    - Ethnicity
    - Socioeconomic status
    - Sexual orientation
    - Indigenous heritage
    - National origin
    - Gender

Barriers

There is a perception among staff persons that mental health agency concerns about financial survival and increased demand for paperwork limits their ability to spend the time is required to establish empathic relationships with peers (Winarski, Thomas, & DeLuca, 2007; Winarski, Thomas, Dhont, & Ort, 2006).

Difficult to quantify: Because validating the person involves interpersonal processes, it is difficult to define, measure, and support.

Deficiencies in education: Most academic and internship programs place little emphasis on the development of communication skills. Consequently, individuals enter the field without formal training in accepted techniques.

Remedies

Agency leadership must be committed to the principles of recovery, as this sets the tone for polices and practices that shape the agency culture. Leadership staff should provide a model of respectful and empathic behavior toward peers, families and other staff. Such behavior also needs to be reinforced by supervisors through employee evaluations. In addition, the agency should provide training and technical assistance for staff who need support in applying interpersonal skills.

Resources:

The following interpersonal skills programs can assist agencies with validating peers and facilitating a process of recovery:

Rehabilitation Readiness: This program teaches practitioners how to help people to actively assess and develop their own readiness to engage in rehabilitation and includes a section on connecting that focuses on establishing positive helping relationships with peers. Available from the Center for Psychiatric Rehabilitation at Boston University:

https://cpr.bu.edu/resources/newsletter/assessing-developing-readiness-rehabilitation

Motivational Interviewing: Motivational interviewing is a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence. The following materials are available free of charge.

WWW.MotivationalInterviewing.org includes general information about the approach, as well as links, training resources, and information on reprints and recent research.

TIP 35: Enhancing Motivation for Change in Substance Abuse Treatment
http://store.samhsa.gov/product/TIP-35-Enhancing-Motivation-for-Change-in-Substance-Abuse-Treatment/SMA13-4212

Motivational Interviewing: Preparing People for Change is the seminal text on the subject, available through Guilford Press (Miller & Rollnick, 2013).

2. Person Centered Decision Making

"Professionals who learn to collaborate with the active, resilient, adaptive self of the client will find themselves collaborating in new rewarding ways with people who may have been viewed as hopeless..." (Pat Deegan, 2001).

Description

The process of recovery for persons experiencing severe mental illnesses is closely linked to the process of decision making. Decision making is an integral part of human growth and development, and the kinds of decisions that are made have a profound effect on the direction and quality of life. Persons with mental illnesses can face special challenges with decision making because of the signs and symptoms of psychiatric disorders. Programs that provide services need to have expertise in helping people with psychiatric disabilities to make informed decisions, not only about the course of mental health care, but about all areas of life that are important to the person.

In mental health service provider agencies, the development of the treatment plan provides the mechanism through which persons receiving services decide upon the goals, objectives, and key activities that will define the course of treatment. To support the experience of recovery, individuals and family members need to be at the center of the process. Effective treatment planning is more than a paper exercise; it is fundamentally an interpersonal process based on mutual partnerships that chart the course for the recovery journey.

Essential Characteristics

The following characteristics are critical to a person-centered approach to treatment planning (Adams & Grieder, 2005).

- ***Self Determination***: The individual receiving services needs to be the driving force of the plan.
- ***Equal Partnerships***: Professionals provide expert information, but act more as coaches and facilitators than as caretakers who assume they know what is in the best interest of the person. Persons receiving services are active participants in the planning and delivery of their care.
- ***Respect for Individuals and Family Members***: Respect is demonstrated by responding to the needs and preferences of peers, by sensitively responding to the individual's age, gender, culture, ethnicity and tradition, and by focusing on the unique attributes of each person.
- ***Effective Communication***: Individuals receiving services need to be fully informed about all matters related to their care, including diagnoses, prognoses, and alternatives for services and supports, along with potential benefits and risks. Language should be "person first" rather than focused on diagnostic labels.
- ***Family Participation***: Family members are often vital sources of information and provide support that is critical to the process of recovery. However, peers should always approve the level of family involvement.
- ***Functional Plan***: The plan should be practical and understandable to provide a map for the process of recovery. It should be the focal point of all therapeutic interactions. It should provide a mechanism for acknowledging the hopes and dreams as well as the strengths and resources of each individual and family.

Barriers

Service providers often view treatment planning as a mandatory administrative burden (Adams & Grieder, 2005). In addition, persons receiving services in Florida's mental health system often experienced treatment planning as bureaucratic rather than as an interpersonal process (Winarski et al., 2006).

Some staff may feel that establishing equal partnerships with peers diminishes their role as professionals. Some staff may also hold the belief that people with mental illnesses do not have the capability to make informed decisions. Staff may lack the knowledge and skill for implementing person-centered approaches to assessment, planning, and service delivery.

Remedies

All agencies provide treatment planning, and some identify the process as person-centered. However, planning that is recovery-oriented needs to be more than a bureaucratic process and should fully involve peers. Formal policies and procedures should specify the staff roles and responsibilities for this involvement, with a particular focus on the key characteristics of self-determination, equal partnerships, respect for individual and family, effective communication, family participation, and a functional plan.

Strategies to implement person-centered decision-making should include determination of the beliefs, knowledge, and skill level of staff that are responsible for treatment planning. Assumptions or beliefs held by staff about the nature and course of mental illnesses and peers' capacity for meaningful participation often go unstated, yet they can have a profound effect on the effectiveness of services. Staff who have not received formal education or training in person-centered approaches may not be aware of the

importance of fully engaging the person in the planning process. Person-centered planning often represents a significant shift in roles and responsibilities for staff. They need to have the basic knowledge of the approach and the skills to successfully make this transition. Training and technical assistance can help agencies with developing staff capability.

Resources

Treatment Planning for Person-Centered Care: the Road to Mental Health and Addiction is the seminal textbook in the field (Adams & Grieder, 2005).

The Role of Person-Centered Service/Care Planning in Mental Health Recovery is a white paper and literature review prepared for the Center for Mental Health Services and is available for download at the following link (Adams & Grieder, 2005): http://www.psych.uic.edu/uicnrtc/cmhs/pcprecovery.adams-grieder.doc

Boston University's Center for Psychiatric Rehabilitation Case Management Training Package provides workbooks and curricula for training in a person-centered approach to providing case management services: https://cpr.bu.edu/resources/curricula/training-technology/case-management

3. Self Care – Wellness

"*Every aspect of your life – the place you live, the people you live with, your friends and acquaintances, the things you do or don't do, the things you own, your work, even things like pets, music and color affect how you feel." (Developing a Recovery and Wellness Lifestyle: A Self-Help Guide, SAMHSA, 2002).*

Description

Self care – wellness describes the process through which people with mental illnesses learn how to feel better through all of the ups and downs that are part of life's journey. It involves the complex interaction of all of the critical dimensions of an individual's life, including mind, body, and spirit and how each person integrates them to achieve not only recovery from mental illness, but also a vital and satisfying life. Regaining good mental health is inextricably linked to each of these elements.

Essential Characteristics

To create an environment that supports self-care/wellness, agencies need to partner with peers in a process of education and support that prepares them to assume personal responsibility. Mary Ellen Copeland, a national leader in helping peers with self–care/wellness planning, describes its importance to mental health peers: "It is up to you, with the assistance of others, to take action and do what needs to be done to keep yourself well. Learn all you can about what you are experiencing so you can make good decisions about all aspects of your life" (Copeland, 2008 and Mental Health Recovery & WRAP, www.mentalhealthrecovery.com/). When peers begin to give and receive

support from others, they regain an experience of control over their lives that is central to a feeling of well-being.

Agencies can play an important role in helping individuals take control of their self-care as part of a plan for wellness. Key activities should include the implementation of peer-based interventions such as Whole Health Action Management (WHAM), Wellness and Recovery Action Planning (WRAP), physical health management and alternative wellness management tools. Services should also focus on developing strengths and abilities rather than just ameliorating deficits. In addition, agencies should provide support and education for family members and significant others to help support the individual's process of recovery. The person's right to refuse treatment must also be respected, even when professional staff disagrees with the decision.

Barriers

Barriers to fostering an environment of self-care and wellness in an agency can be traced to a focus on the signs and symptoms of mental illness to the exclusion of the preferences and needs of the whole person. Holistic approaches are sometimes regarded as frivolous or of secondary importance. Case managers are usually assigned to peers to help coordinate multiple services. However, disparate treatment components, even if well coordinated, do not substitute for the need to respond to the whole person.

There is often a lack of wellness planning educational materials available to peers that address the needs of the whole person. The lack of available physical health care and community supports also hinders wellness for those seeking recovery.

Primary health care agencies may lack the staff competencies and resources required to address the needs of patients who present with co-occurring primary and behavioral health care needs.

Remedies

Increase the use of WRAP training for peers, family members and providers to learn the fundamentals of building a comprehensive wellness plan.

Implement peer support strategies to support health and wellness in mental health agencies, such as the Whole Health Action Management (WHAM) program, developed by the Center for Integrated Health Solutions.

Co-location of mental health and physical health services is a best practice for persons with mental illnesses. Federally Qualified Health Centers (FQHC) are an example of integrating community mental health services at local medical clinics to address the needs of persons with co-occurring primary and behavioral health problems.

Distribution of self-help materials such as the SAMHSA booklet series:

Action Planning for Prevention and Recovery
Dealing with the Effects of Trauma
Speaking Out for Yourself
Developing a Recovery and Wellness Lifestyle
Building Self Esteem

Making and Keeping Friends

Increase the use of recovery training for staff members.

Distribute wellness materials developed by NAMI and pharmaceutical companies.

Support activities that increase physical health in developing treatment plans.

Resources

Wellness Recovery Action Plan (WRAP), Mary Ellen Copeland,
www.copelandcenter.com
www.mentalhealthrecovery.com
http://mentalhealthrecovery.com/info-center/

Whole Health Action Management (WHAM) is a training program and peer support group model developed by SAMHSA's Center for Integrated Health Solutions (CIHS) to encourage increased resiliency, wellness, and self-management of health and behavioral health among people with mental illnesses and substance use disorders.
http://www.integration.samhsa.gov/health-wellness/wham

Wellness for Life: is a multidisciplinary intervention designed to increase health-promoting behaviors and reduce the negative effects of metabolic syndrome disorders among persons with serious mental illnesses. Exercise, nutritional counseling, health literacy education, and peer wellness coaching are provided by allied health professionals and students. Gill, Kenneth J.; Zechner, Michelle; Zambo Anderson, Ellen; Swarbrick, Margaret; Murphy, Ann (2016). Wellness for life: A pilot of an interprofessional intervention to address metabolic syndrome in adults with serious mental illnesses. *Psychiatric Rehabilitation Journal*, Vol 39(2), Jun 2016, 147-153.

How to Integrate Physical and Mental Health Care for People with Serious Mental Disorders – Executive summary of a report by the Bazelon Center for Mental Health Law (June 2004).
http://www.bazelon.org/LinkClick.aspx?fileticket=FamA0HBvilA%3d&tabid=104

SAMHSA Self Help Booklet Series,
http://store.samhsa.gov/home

Action Planning for Prevention and Recovery
http://store.samhsa.gov/shin/content/SMA-3720/SMA-3720.pdf

SAMHSA-HRSA Center for Integrated Health Solutions:
http://www.integration.samhsa.gov/

The U.S. Department of Health and Human Services- Healthfinder.gov:
https://healthfinder.gov/

4. Advance Directives

"Who Should Make Decisions about your Mental Health Care? You Should!"
(Florida Department of Children & Families)

Description

Advance Directives offer a powerful method by which people can exercise control over important health care decisions prior to the emergence of a crisis situation. The Florida Legislature enacted a landmark statute, Chapter 765, the Florida Health Care Advance Directive law that states:

> "The Legislature finds that every competent adult has the fundamental right of self-determination regarding decisions pertaining to his or her own health, including the right to choose or refuse medical treatment."
>
> "To ensure that such right is not lost or diminished by virtue of later physical or mental incapacity, the Legislature intends that a procedure be established to allow a person to plan for incapacity by executing a document….to direct the course of his or her medical treatment upon his or her incapacity. *Mental Health Advance Directives: Executive Summary,* Florida.

Advance directives allow an individual the opportunity to plan his/her treatment options in a way that is most supportive to recovery. It provides an important mechanism to ensure self-determination during periods when individuals are most vulnerable and are essential to implementing recovery-oriented services.

Essential Characteristics

"An advance directive is a written document or oral statement designating a surrogate in which instructions are given by a person concerning any aspect of the person's health care. The advance directive must be signed by the person in the presence of two adult witnesses (a person unable to sign may direct another person to sign his or her name). A person named as a surrogate cannot act as one of the witnesses, and one of the witnesses must not be either the person's spouse or blood relative." *Mental Health Advance Directive: Executive Summary.*

A copy of the directive should be given to the surrogate. The person issuing the directive can appoint an alternate surrogate in case the primary surrogate is unable or unwilling to perform his or her duties.

An individual is presumed by law to be competent to make his or her health care decisions unless they have been determined to be incapacitated. In that sense, incapacity or incompetency means that a person is physically or mentally unable to communicate a willing or knowing decision about their health care.

A surrogate is any competent person designated by the individual to make health care decisions on their behalf. If a person has not designated a surrogate or executed an advance directive, a proxy may be appointed on their behalf or chosen by the person if they are competent.

It is particularly important that these documents are retained and respected by the mental health service provider agency that the individual will be counting on in a crisis. The agency should make a proactive effort to assist people in creating advance directives and should maintain up-to-date copies as agreed upon with the individual.

Barriers

People receiving services are often unaware of the availability of advance directives.

Staff members are sometimes unaware of the availability of advance directives.

The necessary forms for advance directives are often not distributed widely in the agency.

Advocates and staff members need to be trained to implement the advance directive procedures.

If the agency does not retain copies of advance directives, they are often unaware of their existence.

Remedies

The agency should provide staff training on the principles and practices of recovery.

The agency should provide opportunities to assist peers in filling out advance directives.

The agency should develop policies to support the creation and ongoing use of advance directives.

Resources

Psychiatric Advance Directives: Pros, Cons, and Next Steps: The purpose of this Community Integration Tool is to offer some of the major pros and cons associated with psychiatric advance directives. It also offers tips, next steps and a list of tools, resources, and references to guide discussion around optimal implementation. Available for download from the UPenn Collaborative on Community Integration at the following link: http://tucollaborative.org/pdfs/Toolkits_Monographs_Guidebooks/self_determination_psychiatric_advanced_directives_self_directed_care/Psychiatric_Advance_Directives.pdf

The National Resource Center on Psychiatric Advance Directives*:* The Center's web site provides a central resource of information on psychiatric advance directives: http://www.nrc-pad.org/component/option,com_frontpage/Itemid,1/

Power in Planning: Self-Determination Through Psychiatric Advance Directives includes the Bazelon Center's model to create an advance directive to specify preferences for mental health care in the event that an individual is not able to grant or withhold consent. Contents also include an analysis of state laws governing the use of

psychiatric advance directives (PADs), a discussion of lessons learned through the use of PADs and a discussion of peers' and providers' views of PADs:

http://www.bazelon.org/News-Publications/Publications/List/1/CategoryID/14/Level/a/ProductID/28.aspx?SortField=ProductNumber,ProductNumber

5. Alternatives to Coercive Treatment

"By speaking directly about who has the power to do what, and what that means in a collaborative relationship, we can establish guidelines and strategies for handling difficult situations and working through potential conflict without coercion."
(Sherry Mead and Mary Ellen Copeland, 2004)

Description

Coercive treatment includes those activities that take decision making authority away from peers, including overt actions such as involuntary inpatient and outpatient treatment, seclusion, and restraint, and more subtle forms of coercion, such as providing limited treatment options and withholding information needed to make informed choices. Agencies should seek to reduce the need for the use of coercive measures and ensure respectful treatment that preserves the civil rights and fundamental dignity of each person, if such measures become necessary (Blanch & Parrish, 1994; Sowers, 2005). Though the principles of recovery-oriented services focus on ensuring peer choice and involvement, this does not preclude the need for an agency to develop strategies that address the need for the safety and security of peers and the community during periods of incapacitation. However, these strategies should always be implemented in a way that respects the fundamental integrity of the person.

Essential Characteristics

Recovery-oriented service strategies should be developed to help prevent the need for coercive measures and to maximize participation of the person receiving services in every phase of treatment, including phases of care that address the needs of persons with diminished decision making capacity. The following actions characterize a recovery-oriented approach to preparing for and responding to peers who experience diminished decision making capacity:

- The agency states its goal of reducing or eliminating coercive practices.
- Polices and procedures are consistent with mental health law and standards for psychiatric practice.
- The agency has a process for examining constellations of interpersonal violence and control, including staff/staff, patient/patient, patient/staff, staff/patient, as well as unnecessary punitive administrative procedures (Blanch & Prescott, 2002; Curtis and Diamond, 1977).
- Persons receiving services have a contingency plan to guide decision making in the event of diminished capacity, e.g., advance directives and Wellness Recovery Action Plan (WRAP).

- Conflict Management Strategies: Agency staff have the capability to respond from a continuum of possible actions, beginning at the point when a potential difference is identified and extending through a period of agreement/resolution. Staff demonstrate effective communication skills and creative approaches for dealing with differences. The goal is not to reach a settlement as much as it is to promote self-determination, choice, and autonomy (Blanch & Prescott, 2002).
- Involuntary treatment arrangements should occur in the least restrictive environment for the shortest time possible (Sowers, 2005).
- Transfer to voluntary status should be facilitated as soon as possible (Sowers, 2005).
- A process exists to review the status of peers with guardianships and representative payees and to restore their rights as soon as possible.
- Agencies should work in partnership with the person receiving services to help manage risk by exploring the benefits and risks associated with peer choices and identifying strategies to help mitigate risk (Langan & Lindow, 2004).

Barriers

Agencies may assume that providing care to persons with diminished decision making capacity necessarily precludes the use of recovery-oriented approaches. In addition, clinical perceptions about a peer's decision making ability are not always based on established medical and legal criteria, but on inaccurate assumptions about the abilities of all persons with serious mental illnesses.

Some persons with mental illnesses may have difficulty expressing their needs and intentions to doctors, judges and other figures of authority, but are not necessarily lacking in decision making capacity. In addition, staff may lack awareness of the traumatizing effects of coercive treatment and also lack the mediation and negotiation skills that could help mitigate the need for such treatment.

Mental health systems that primarily provide programming to address acute care/emergency issues and that do not have access to the full continuum of community supports, limit options for care for both clinicians and peers. Peers requiring less intensive services often must choose between intensive and potentially coercive services or no service at all.

Remedies

Planning Activities: The agency should support peers in developing Wellness Recovery Action Plans (WRAP). WRAPs help peers to plan for periods of diminished decision-making capacity and articulate strategies that help the person to maintain optimal health. Person-centered treatment plans developed in partnership with agency staff and the person receiving services should complement strategies described in the WRAP.

Education/Training: Key areas include:

- Traumatizing effects of coercive treatment (peers should lead or play a major role in this presentation);
- Conflict management strategies;
- Jail diversion;

- Legal and medical criteria for involuntary treatment; and
- Crisis management skills.
- Developing peer-support services

Program Strategies: Munetz and Frese (2001) have proposed two strategies for including peers in involuntary commitment issues. Neither has yet been tested, but both provide good examples of innovative approaches for partnering with peers. In the first strategy, a peer guardian program involves the development of nonprofit agencies staffed by peers who can serve as court appointed guardians. Agencies may wish to collaborate with local, regional, and state level coalitions to explore the potential of such an organization. Munetz and Frese (2001) have also proposed the development of a Capacity Review Panel that would not have legal standing, but serve as an advocate and consultant for individuals facing involuntary treatment issues. It would include three individuals not directly involved with the person and include peer, family member and mental health professional representation. The panel would be designed to review all instances for which ongoing mandatory treatment was being requested and offer an advisory opinion to the treating psychiatrist.

Resources

Managing Conflict Cooperatively: Making a Commitment to Nonviolence and recovery in Mental Health Settings (Blanch & Prescott, 2002) describes principles of conflict management and dispute resolution, describes the application of these principles in the mental health field, describes how conflict management can provide tools for changing institutional culture, and provides recommendations for system improvement. It is available for download from the NASMHPD web site: http://www.nasmhpd.org/sites/default/files/ManagingConflictCooperativelyADR%281%29.pdf

Transforming Florida's Mental Health System - Constructing a Comprehensive and Competent Criminal Justice/Mental Health/Substance Abuse Treatment System: Strategies for Planning, Leadership, Financing, and Service Development provides an analysis of Florida's mental health system and describes strategies for developing and implementing services that provide alternatives to coercive forms of treatment (Supreme Court of the State of Florida, 2007): http://www.floridasupremecourt.org/pub_info/documents/11-14-2007_Mental_Health_Report.pdf

The Gains Center provides state-of-the-art information and technical assistance to support services for persons with co-occurring mental health and substance abuse disorders in the justice system http://www.samhsa.gov/gains-center

Community Integration

1. Access to Services

"We envision a future…when everyone with a mental illness at any stage of life has access to effective treatment and supports"
(The President's New Freedom Commission on Mental Health, 2003)

Description

Access is the ability to obtain and enter needed services, programs, and systems. Unimpeded access is the first essential condition or prerequisite for individuals who seek assistance with their recovery. Unfortunately, in an environment of cost containment and reductions, access to services is often constrained as service providers struggle to keep pace with growing demands and diminishing resources.

Despite the limitations on access that are characteristic of lean funded systems, agencies can create an environment for those who enter services that is welcoming, respectful, and responsive to their needs. These attributes are grounded in an organizational culture of respect for the person and a belief in their ability to recover.

Essential Characteristics

The mental health service provider agency should consider the following characteristics of access when developing plans for recovery-oriented services:

Geographical access
Geographical access means that services are located in areas that are easily reached. An agency that provides good access to services has attractive facilities located in safe areas near public transportation. Their facilities should be reachable within 30 minutes for most individuals they serve. When peers/families enter facilities, they are made to feel welcome and are treated respectfully. Waiting rooms are comfortable and accommodating.

Temporal access
Temporal access means that individuals can access the services they need in a timeframe that is appropriate to the urgency of their needs. Depending upon the person's need, the agency has either open intake, e.g., walk-in appointments, or is able to see individuals within 24-48 hours. Emergencies are handled immediately. Peers and families also have their calls returned as promptly as possible. If waiting lists for services are in place, the agency is able to offer appropriate service alternatives, such as peer run programs, and maintains contact with those waiting for services to determine their ongoing needs.

Cultural access

Cultural access refers to the acceptability of services to individuals and families of different cultural and ethnic backgrounds, beliefs and preferences. Regardless of an agency's success in ensuring adequate geographical and temporal access to services, if the environment and services of an agency are not sensitive and responsive to peer and family cultural and ethnic backgrounds, then peers and families will either fail to seek services or drop out.

An agency that has an environment of respect seeks to employ culturally and ethnically diverse staff who speak the language of persons seeking services. Agency signage, forms, and informational materials are available in the languages spoken by the people that they most often serve. Throughout the therapeutic relationship, clinical staff understand and are responsive to the cultural and ethnic backgrounds of the peers and families.

Barriers

An agency that has facilities located in areas that are not convenient for peers can create significant obstacles for access. This problem is compounded by poor public transportation, often cited by peers and families in Florida as a major barrier to service access, especially in more rural areas (Winarski et al., 2006). In addition, an agency that is experiencing budget reductions may lack the resources usually allocated for maintaining functional and welcoming facilities.

Lack of funding may also restrict the agency's staffing and service capacity, making it more difficult to meet the level of service needs of peers and families in a timely fashion and to provide culturally competent services. A lack of staff awareness and training on issues critical to access also has a significant impact.

Governmental or agency imposed policies and procedures can also create barriers to access. Complicated intake processes, financial requirements for co-pays or imposed fees, and complex eligibility criteria are examples of such barriers that can restrict access. Also, increased administrative responsibilities often require agencies to divert staff time away from clinical/direct services to administration.

Remedies

Agencies cannot always control the complex social and economic factors that effect service access in Florida. For example, affordable space may not be available in the most desirable areas and public transportation is limited in many parts of Florida. However, the agency should develop a strategy to enhance service access as a critical part of recovery-oriented services planning. Many strategies require little or no funds to implement. For example, the agency can:

- Take an inventory of peers receiving services to assess challenges to access, and include peers in discussions about strategies to address these challenges.
- Revise internal policies and procedures that restrict access, including those that influence the four key items identified in the SAPT self-assessment section -- welcoming intake, financial/insurance issues, waiting lists, and follow-up time.

- Establish a partnership with community organizations that support the interests of peers and families affected by mental illness, such as NAMI, supportive housing coalitions, Faces and Voices of Recovery, Youth Move, Federation of Families, Family Café, the Peer Support Coalition of Florida, and local chapters of Mental Health America. These groups can help determine community need and collaborate on community action strategies. They can also help in advocating for changes in policies and procedures that are imposed by external agencies.
- Determine the feasibility of developing transportation resources within the agency (e.g., van service for peers most in need and/or providing vouchers for public transportation).
- Explore additional sources of funding or re-direct current resources to address issues related to access, including re-locating facilities to safer, more reachable locations and providing services in locations other than agency offices on a more flexible time schedule.
- Provide staff training and supervision regarding cultural competency and principles of recovery.

Resources

***A Cultural Competency Toolkit: Ten Grant Sites Share Lesson's Learned*.** National Consumer Supporter Technical Assistance Center, Mental Health America: http://eric.ed.gov/?id=ED463466

Cultural Competence in Psychiatric Mental Health Nursing. A Conceptual Model. This article in the Nursing Clinics of North America presents a conceptual model for enhancing cultural competence in psychiatric nursing. The model, The Culturally Competent Model of Care, views cultural awareness, cultural knowledge, cultural skill, and cultural encounter as critical components of cultural competence. The Culturally Competent Model of Care encourages psychiatric nurses to see themselves as always in the process of becoming culturally competent, rather than being culturally competent (Campinha-Bacote, 1994)

Cultural Competency*: *A Practical Guide for Mental Health Service Providers was published through the Hogg Foundation for Mental Health at University of Texas at Austin (Saldana, 2001).

2. Basic Life Resources

"Adequate standards of living and employment are associated with better clinical outcomes and quality of life."
(United States Public Health Services Office of the Surgeon General, 1999)

Description

Basic life resources include products, information, and services that are critical for survival, including food, housing, and a source of income. Recovery-oriented mental health services should include a focus on basic life resources because individuals with serious mental illnesses are more likely to live in poverty and are more vulnerable to its coercive influences (United States Public Health Services Office of the Surgeon General,

1999). The process of recovery is significantly compromised if the person does not first address basic life resource needs.

Rates of unemployment for people with mental illnesses are significantly higher than among the general population. Social Security Disability (SSDI) is not adequate to cover basic living costs for food, housing, and utilities in many communities. Without support, many individuals do not survive. People with serious mental illnesses served by the public health system die, on average, at least 25 years earlier than the general population (NASMHPD, 2006).

Essential Characteristics

Recovery-oriented services should assist peers with basic life resources by linking them to resources in the community and by helping them to develop and apply the skills required to fully benefit from these resources. Service should reflect the following characteristics:

- The agency should include strategies in a person-centered plan for ensuring that the person's survival needs are being met, including access to adequate income, housing, food/nutrition, primary health care, education, and employment.
- The agency should make available comprehensive information about community resources, including detailed information about eligibility criteria and processes for applying for these resources.
- The agency should establish working relationships with community agencies that address basic life resource issues, such as Social Security, Medicaid, county/community welfare offices, community education offices, local housing authorities, and vocational rehabilitation offices.
- Case management services should support peers in gaining access to and utilizing services that address basic life resource needs. In addition to the initial referral, case managers should provide support to ensure follow-up.
- The agency should assist peers with developing skills needed to obtain community resources (e.g., self-advocacy, staying calm in a crowded environment with long waiting times, understanding acceptance criteria, completing applications, etc.).
- The agency should support peers in receiving primary health care by making appropriate referrals and assisting peers in communicating with physicians regarding health care concerns.

Barriers

In many communities, basic resources are not adequate to meet the needs of individuals living in poverty. In addition, waiting lists and restrictive acceptance criteria can create barriers to access. Agencies also face the challenge of keeping up to date on community services operated by an array of government, not-for-profit, and faith-based organizations.

Some agencies may assume that addressing peers' needs for basic life resources are not the responsibility of mental health services programs. Services that address these needs may not always be reimbursable.

Remedies

Agencies need to acknowledge the critical role they play in helping peers establish basic life resources. Meeting basic needs is fundamental to create the experience of safety and security that is necessary for people to recover.

Case management services should be person-centered and provide follow-up, support, and the development of skills needed to access critical resources.

Agencies should develop an inventory of community resources and solicit peer participation in this activity.

Agencies should promote education and anti-stigma initiatives to educate the community about the connections among issues of poverty, mortality rates, and mental illness.

Resources

Morbidity and Mortality in People with serious Mental Illness was prepared by the Medical Directors Council of the National Association of State Mental Health Program Directors (NASMHPD) (2006) and presents a roadmap for strategic approaches to reduce excess illness and premature death among persons with mental illnesses (NASMHPD). The document is available for download at the NASMHPD web site: http://www.nasmhpd.org/sites/default/files/Mortality%20and%20Morbidity%20Final%20Report%208.18.08.pdf

Transforming Florida's Mental Health System - Constructing a Comprehensive and Competent Criminal Justice/Mental Health/Substance Abuse Treatment System: Strategies for Planning, Leadership, Financing, and Service Development provides an analysis of Florida's mental health system and describes strategies for developing and implementing comprehensive and coordinated service systems (Supreme Court of the State of Florida, 2007): http://www.floridasupremecourt.org/pub_info/documents/11-14-2007_Mental_Health_Report.pdf

SAMHSA's Resource Center to Promote Acceptance, Dignity and Social Inclusion Associated with Mental Health (ADS Center) provides archived conference materials to assist agencies with developing stigma reduction activities: http://www.nasuad.org/hcbs-typestools/archived-conference-materials-presentations

SAMHSA's Projects for Assistance in Transition from Homelessness (PATH) funds services for people with serious mental illness (SMI) and co-occurring substance abuse disorders experiencing homelessness: http://www.samhsa.gov/homelessness-programs-resources/grant-programs-services/path

The National Center for Cultural competence at Georgetown University: http://nccc.georgetown.edu/

The Depression and Bi-Polar Support Alliance:
http://www.dbsalliance.org/site/PageServer?pagename=home

Alcoholics Anonymous; http://www.aa.org/

3. Meaningful Activities and Roles

"…individuals with severe mental illnesses now spend more of their time in the community rather than in institutions, but are all too often only physically in the community, but not of the community, in the sense of psychologically or socially belonging." (UPenn Collaboration on Community Integration, 2008).

Description

"Community integration (or, the opportunity to live like everyone else) should result in community presence and participation of people with psychiatric disabilities similar to that of others without a disability" (Salzer, 2006). It is fundamental to the recovery process as individuals seek to normalize their lives.

"To promote social integration, it makes sense to direct the efforts of formal services toward maximizing contact between people with psychiatric disabilities and potential friends or other supporters. The simplest strategy is to ensure that virtually all such efforts take place in regular work, housing, and educational settings, in ways that lessen or remove any distinction between persons with or without a label of 'mental illness'" (Carling, 1995).

Peer engagement in meaningful activities and having important social roles are at the core of community integration. They connect people to others in meaningful ways and help create a sense of belonging, personal well being, and validation. They are the antidote for having only a physical presence in the community.

Essential Characteristics

Meaningful activities include such things as employment, volunteerism, education, advocacy and civic participation, recreational/leisure pursuits, as well as engagement in spiritual and religious endeavors. Individuals' aspirations for engaging in these activities should be recognized and valued. People should be able to choose the activities that are most meaningful to them and to their recovery goals. They should be afforded opportunities to become involved in those activities at the level they choose to participate and be encouraged and supported in their efforts.

For most people, meaningful roles in life often include being a parent, a spouse or a romantic partner, a family member, a neighbor, a confidante and a friend. All of these roles connect individuals to their larger community in important ways. People with mental illnesses may have lost some of their important life roles while dealing with their illnesses, while others may have never acquired them. In either case, individuals who have expressed a desire to gain or regain the roles that are most important to them should be encouraged and supported. They should be assisted with developing the

necessary skills that will enable them to assume the roles they choose and with regular support to help overcome obstacles.

Barriers

Professionals (and peers) may perceive that people with mental illness are not capable of participation in activities and roles because of their illnesses.

Stigma and discrimination associated with mental illnesses are still pervasive in most communities.

Staff who are not sufficiently trained may lack the knowledge and skills in practices that support community integration.

Funding is not available to support programs such as supported employment, supported education, or housing.

Some people with psychiatric disabilities are reluctant to explore options for a more independent living role in the community because they have adapted to living in institutional settings and are not confident that they can be successful in less restrictive environments.

Remedies

Staff training, coaching and supervision regarding the principles and practice of recovery-oriented services.

Community education focused on improving the understanding of mental illnesses and recovery.

Advocacy for additional funding sources to support programs for supported employment, education, and housing.

Implementation of friend/mentor programs.

Resources

Return to Community: Building Support Systems for People with Psychiatric Disabilities by Carling, Paul J. is available through Guilford Press, 1995. It provides workable solutions to overcoming many of the barriers to successful community integration (Carling, 1995).

Compeer Inc, www.compeer.org is an international non-profit organization that helps adults and children overcome the devastating effects of mental illness, such as loneliness, isolation and low self-esteem – through the power of friendship. Currently implemented in Sarasota, FL.

Simply To Be Let In: Inclusion as a Basis for Recovery describes a program to promote friendships among persons with serious mental illnesses, published in the Journal of Psychiatric Rehabilitation (Davidson et al., 2001).

4. Peer Leadership

"Change agents are most helpful when they have a strong personal commitment to change, whether because they have been directly affected by how people with disabilities are treated, or because of their own experience of social marginalization, empowerment, healing, and recovery." (Carling, P.J., 1995)

Description

Peer leadership encompasses a number of specific categories, including self-advocacy, system advocacy, and peer-run services. The President's New Freedom Commission on Mental Health report (2003) states that "Consumers of mental health services must stand at the center of the system of care"(page 27), and this includes assuming leadership roles in redefining the public mental health system. As peers assume leadership roles in system transformation, it is important to provide resources to expand their leadership and advocacy skills and opportunities. Agencies should support peers in developing those skills and support the provision of peer-run services. This includes providing information to peers about the availability of these services (e.g., support groups, drop-in centers, respite services and mentoring programs).

The growth of the certified peer specialist program in Florida provides an important opportunity for mental health service provider agencies to expand the role of peers in leadership positions. By employing more peers in a wide range of roles, an agency can significantly influence the change of its culture to a recovery orientation.

Essential Characteristics

The concepts of self-help and peer support are integral to peer leadership. The act of providing support to others benefits the helper as well the person being helped (Clay, Schell-, Corrigan, & Ralph, 2005). Competent peer leaders can provide advocacy and peer mentoring, and can operate peer-run services. They offer other peers the benefits of shared experience and the knowledge gained through the process of recovery by people who have lived with psychiatric illnesses. As mental health systems continue to open up to participation by peers in the provision of services and supports, the need for peer leadership grows. The agency can assist in this process by providing peers access to education in leadership and advocacy skills.

Leaders in the peer movement should exhibit the same qualities as leaders in other fields; they need to be motivators, critical thinkers and have the ability to communicate clearly. Leadership qualities are developed through training, work experience, and administrative support. A service provider agency can support this development by providing peers with access to education, ensuring that peers participate in the delivery of services, and maintaining that peers have membership on boards and committees.

Barriers

The primary barriers to developing competent peer leadership are cultures within mental health service provider agencies that do not embrace recovery. Many agencies cling to traditional concepts of the roles of staff and clients. Agencies are often reluctant to hire individuals who receive services within their system. If such individuals are hired,

agencies frequently discourage self-disclosure about being a peer of mental health services.

Agencies wishing to provide recovery, advocacy, and leadership training for peers often find a lack of funding as a significant obstacle. Some administrators believe that freeing up funds for peer run trainings and services will divert resources from crisis services and traditional treatment services. However, recovery-oriented services actually reduce the need for costly "front-end" intensive services (Supreme Court of the State of Florida, 2008). A recipient of services in Florida's mental health system provided the following insight: "deep-end services like crisis support, long-term hospitalization and residential programs tied to services would be needed less [often] because we would support people in their wellness and prevention needs" (Common Threads: Stories of Survival & Recovery from Mental Illness, 2007).

The agency may not have capable personnel to provide training in the key areas of leadership and advocacy, and may need to access outside training resources.

Remedies

The agency should utilize peer specialists for recovery and advocacy services and support programs.

The agency should seek resources to provide comprehensive training in recovery and culture change.

The agency should provide training in advocacy and leadership skills.

The agency should seek additional funding (e.g., grants) or redirect current funding to support peer-run services, such as self-help groups and mentoring programs.

The agency should support the creation of peer and family advisory councils as part of the administration of the agency.

Resources

NAMI *Provider Education* Training: http://www.nami.org/Find-Support/NAMI-Programs/NAMI-Provider-Education
http://www.nami.org/Find-Support/NAMI-Programs
Depression and Bipolar Support Alliance DBSA Peer Leadership Center:
https://www.peerleadershipcenter.org/plc/Peer_Provider_Roles.asp

Freedom Self-Help Advocacy Curriculum is available at the National Mental Health Self-Help Clearinghouse: http://www.mhselfhelp.org/

Fresh Start of Miami-Dade, Inc. Florida Statewide Consumer Network:
http://freshstartflorida.socpartners.info/

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Appendix 1

Sample Instructions for Manual Completion of SAPT Survey

Dear (Insert Agency) Staff Member,

The following note provides instructions for completing a survey regarding the implementation of recovery-oriented mental health services at (Insert Agency). We request that each staff member who receives this note complete this survey.

(Insert Agency) is implementing a tool to support the planning and implementation of recovery-oriented mental health services developed by the Florida Mental Health Institute at the University of South Florida under contract to the Agency for Health Care Administration (AHCA). The Self-Assessment/Planning Tool for Implementing Recovery-Oriented Mental Health Services (SAPT) was developed to help mental health service provider agencies improve performance in delivering recovery-oriented services.

The survey takes about 20 minutes to complete. We will not ask for identifying information or release the answers of individual surveys. Respondents will remain anonymous.

We request that you submit your completed survey to (insert contact person) no later than close of business on (Insert Date).

To complete the survey, please follow the steps listed below:

1. Answer each question on the survey. If you are unsure about the answer, you can leave it blank.
2. When you complete the survey, please forward it to (insert contact person).
3. Complete the survey only once.
4. Please contact (insert contact person) if you have any questions.

Thank you for your assistance with this important project.

Appendix 2

Sample E-Mail Instructions for Web-Based SAPT Survey

Dear (Insert Agency) Staff Member,

The following note provides instructions for completing a survey regarding the implementation of recovery-oriented mental health services at (Insert Agency). We request that each staff receiving this e-mail complete this survey.

(Insert Agency) is implementing a tool to support the planning and implementation of recovery-oriented mental health services developed by the Florida Mental Health Institute at the University of South Florida under contract to the Agency for Health Care Administration (AHCA). The Self-Assessment/Planning Tool for Implementing Recovery-Oriented Mental Health Services (SAPT) was developed to help mental health service provider agencies improve performance in delivering recovery-oriented services.

The survey is on the Internet and takes about 20 minutes to complete. We will not ask for identifying information or release the answers of individual surveys. Respondents will remain anonymous.

We request that you submit your completed survey no later than the close of business on (Insert Date).

To complete the survey, please follow the steps listed below:

1. Click on the link at the bottom of this note to enter the web based survey.
2. Answer each question on the survey. If you are unsure about the answer, you can leave it blank.
3. When you complete the survey, click on the button at the bottom to submit your answers.
4. Complete the survey only once.
5. Please contact (insert contact person) if you have any questions.

Thank you for your assistance with this important project.

CLICK ON LINK BELOW TO ENTER SURVEY:

[http://#########]