

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

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The Louis de la Parte Florida Mental Health Institute at the University of South Florida has a mission to strengthen mental health services throughout the state. The Institute provides research, training, education, technical assistance, and support services to mental health professionals and agencies as well as consumers, consumer organizations, and behavioral health advocates statewide. At the state level, the Institute works closely with the Departments of Children and Families (DCF), Corrections (DOC), Elder Affairs (DOEA), Education (DOE), and the Agency for Health Care Administration (AHCA), as well as with members and staff of the State Legislature and providers of mental health services throughout Florida.

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

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

Background

In October 2004, Florida's Medicaid Authority--the Agency for Health Care Administration (AHCA), developed and implemented new Medicaid services intended to promote the recovery and rehabilitation of adults with severe mental illnesses. These services are described in the Community Behavioral Health Services Coverage and Limitations Handbook (AHCA Handbook) and are designed to replace other less rehabilitative approaches (Agency for Health Care Administration, 2004). The Louis de La Parte Florida Mental Health Institute (FMHI) at the University of South Florida conducted a two-part study of these services under contract to AHCA entitled Recovery-Oriented Services for Adults with Severe Mental Illness – Parts I and II (Winarski, Thomas & Ort, 2006 and Winarski, Thomas & DeLuca, 2007).

The first phase of the study examined the delivery of these services from the perspective of both staff and consumers. The study examined the transition from traditional day treatment programming, with a focus on consumer monitoring and management, to rehabilitative/recovery-oriented services that focus more on consumer self-direction and community functioning. The second phase of this study 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.

These studies describe a period of transition for programs in mental service provider agencies (referred to herein as agencies), where consumers and staff are both defining new roles and responsibilities for delivering recovery-oriented services. The studies also identified a lack of guidelines and service implementation tools that are essential to supporting this transition. In addition, the studies identified the need for a systematic way to ensure that the services described in the AHCA Handbook are being delivered in a manner consistent with recovery principles. Other key findings include:

- Consumers in the study often did not experience program activities as relevant to achieving their life goals.
- Consumers often experienced treatment planning as a bureaucratic rather than as an interpersonal process.
- Staff perspectives on recovery principles and practices varied considerably across individuals. Some staff were well informed and enthusiastically supportive, while others expressed little belief in the potential for recovery and the value of recovery-oriented services.
- There is a range of disparate service activities throughout the state that are recovery-oriented, but there is currently no framework to coordinate these efforts.

- Funding agencies should coordinate resources to support recovery-oriented services as part of a strategic plan.
- Fee-for-service finance mechanisms limit flexibility in providing holistic, recovery-oriented services. Managed care plans can offer the flexibility to better support these types of services.
- The AHCA Handbook can only provide general parameters for guiding service delivery. It cannot be expected to support consistent levels of implementation across individual clinicians and programs.

Based on findings from these studies, AHCA supported the development of the Self-Assessment/Planning Tool for Implementing Recovery-Oriented Mental Health Services (SAPT). AHCA also supported a pilot study of the tool at select agencies throughout the state during the period Fall 2008–Spring 2009. The SAPT was designed to assist agencies with establishing a baseline of performance for delivering recovery-oriented mental health services and guidance for enhancing program capability. The tool also provides support to agencies in achieving outcomes described by the Recovery Oriented Systems Indicator (ROSI) (Onken, Dumont, Ridgway, Dornan & Ralph, 2004; Dumont, Ridgway, Onken, Dornan & Ralph, 2006).

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

The development of the SAPT was inspired by the charge of President Bush's New Freedom Commission to transform mental health systems, programs, and services to actively facilitate the process of recovery (New Freedom Commission on Mental Health, 2003). The strategies recommended in the SAPT are based on the following assumptions about the nature/course of mental illnesses and approaches that facilitate the process of recovery:

- Recovery is possible for people with serious mental illnesses (Harding, Zubin & Strauss, 1987, Harding, Brooks, Ashikaga, Struass & Breier, 1987a, DeSisto, Harding, McCormick, Ashikaga & Brooks, 1995a, and DeSisto, Harding, McCormick, Ashkaga & Brooks, 1995b).
- Recovery should be the primary goal of agency services (New Freedom Commission, 2003 and Hogan, 2003).
- A recovery-orientation is not limited to a sub-set of agency programs, but should be reflected in all administrative and clinical programs/activities (New Freedom Commission, 2003).
- Leadership is critical to successful implementation of recovery-oriented services (NASMHPD/NTAC, 2004).
- A focus on recovery should be an integral part of the agency's process of continuous quality improvement and strategic planning (Delman, 2007).
- Strategic plans should focus on developing strengths as well as ameliorating weaknesses.
- Person-centered planning provides the lynchpin for implementing recovery-oriented services (Adams & Grieder, 2005).

Moving from more traditional and limiting views of mental illness to a recovery vision requires clear articulation of supportive policies and practices. The SAPT is designed to:

- Operationalize the recovery vision.
- Assist service provider agencies with establishing a baseline of performance in recovery-oriented services implementation.
- Suggest options for enhancing service delivery.

Organization of Document

- Section I: SAPT Pilot Study

This section provides a summary of a pilot study of the SAPT that included seven Florida mental health service provider agencies. The pilot examined the efficacy of the tool for supporting the planning and implementation of recovery-oriented services in mental health service provider agencies. This section describes how the pilot study findings informed the revision of the tool.

- Section II: SAPT Survey

This section describes the SAPT survey as well as instructions for administering and interpreting findings from the survey. The survey includes 54 items organized under the domains of Administration (12 items), Treatment (23 items), and Community Integration (19 items) to help determine levels of capability in areas critical to implementing recovery-oriented services.

- Section III: SAPT Planning and Implementation Guide

The Planning and Implementation Guide provides guidance to agencies in 14 key categories that correspond to the 3 domains in the SAPT survey. It defines the essential characteristics of recovery-oriented services, describes common barriers and remedies for overcoming barriers, and lists resources that support service implementation.

SAPT and ROSI

The SAPT domains correspond to outcomes described in the Recovery Oriented System Indicators (ROSI; Dumont, et al., 2006). The SAPT helps agencies establish policies and practices that result in positive recovery-oriented services and outcomes. The ROSI informs agencies about the degree to which they have achieved those outcomes. Applied together, the SAPT and ROSI may be used to support processes for policy development, program planning, staff development, and outcome evaluation.

Section I: Pilot Study of the Self-Assessment/Planning Tool for Implementing Recovery-Oriented Mental Health Services (SAPT)

Purpose

The purpose of the SAPT pilot study is to determine the efficacy of the SAPT for supporting the implementation of recovery-oriented services in mental health service provider agencies. We specifically explored the degree to which the tool supported administrative, treatment and community support services that are critical to recovery for persons with serious mental illnesses. We also examined how the tool assisted service provider agencies in determining program/service priorities and developing agency plans.

Development of SAPT

Recovery Oriented System Indicator (ROSI)

The SAPT was designed to assist agencies in achieving outcomes described in the ROSI, and thus, the ROSI provided the framework for SAPT development. The ROSI was developed as part of a collaborative effort among a number of State Mental Health Authorities, national organizations, consumer 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 (Onken, et al., 2004 and Dumont, et al., 2006). The ROSI includes a 42-item self-report questionnaire for consumers of mental health services, as well as an administrative profile that includes 19 administrative indicators (Dumont, et al., 2006).

The ROSI was selected based on several factors: (1) the significant participation of mental health consumers at every step of its development; (2) its reliance on objective, rather than subjective data; (3) its inclusion of administrative-level indicators (rather than purely consumer-level data) that can serve as a management tool to monitor performance and improvement in key areas; (4) its congruence with existing program evaluation processes, i.e., some Florida mental health service providers have already used the ROSI to assess their programming, and the ROSI is receiving interest nationally as a useful measure of recovery orientation at both consumer and agency/system levels (Campbell-Orde, Chamberlin, Carpenter, Leff, 2005).

Development Team

The Florida Mental Health Institute (FMHI) assembled a team of faculty and a consumer of mental health services to develop the SAPT. A clinical supervisor from a Florida agency served as an external reviewer.

Framework and Process

The development team identified 14 major domains from the ROSI that served as the framework for developing survey items. The domains correspond to the eight components that emerged from the factor analysis of the ROSI self-report questions and to additional performance indicators in the ROSI administrative data profile (Dumont, et al., 2006). The team conducted a process for brainstorming survey items based on a review of the literature listed in the reference section of this document and in the reference section of two previous AHCA studies (Winarski, Thomas & Ort, 2006 and Winarski, Thomas & DeLuca, 2007). Each item was designed to describe capable performance of recovery-oriented services for each of the domains. After a process of review and revision, the team developed 89 items that were used for the pilot study. The 89 items were organized under three broad categories of Administration, Treatment, and Support.

Pilot of SAPT

Pilot Demonstration Agencies

Seven agencies from throughout the state of Florida were selected to participate in the pilot study, based on their interest in implementing recovery-oriented services, as demonstrated by participation in previous AHCA studies of recovery-oriented services and community based systems transformation activities. By focusing on agencies demonstrating the strongest commitment to the recovery approach, we increase the likelihood that the tool's users will be engaged in the process of implementing the SAPT and using the SAPT as designed. The participants were approved by AHCA and include the following agencies:

1. Apalachee Center – Tallahassee (AHCA Area 2)
2. Bridgeway Center – Ft. Walton Beach (AHCA Area 1)
3. COPE Center, Inc. – Defuniak Springs (AHCA Area 1)
4. Lakeside Behavioral Healthcare – Orlando (AHCA Area 7)
5. Lakeview Center, Inc. – Pensacola (AHCA Area 1)
6. Meridian Behavioral Healthcare – Gainesville (AHCA Area 3)
7. Suncoast Center for Community Mental Health – St. Petersburg (AHCA Area 5)

FMHI provided staff from each agency with an orientation to the principles and practices of recovery-oriented services and the SAPT, prior to implementing the survey. We also provided technical assistance with implementing the SAPT survey and with applying findings as part of agency strategic planning.

In addition to the seven agencies, FMHI made the SAPT pilot study survey available to all mental health service provider agencies throughout Florida. Five agencies participated, but their findings were not used as part of this pilot demonstration.

SAPT Survey

The SAPT survey was loaded onto a web-based platform using Qualtrics web-survey software. The web-based application allowed respondents to easily access the survey questionnaire through computer terminals at agency program sites. The questionnaire was tailored specifically to each of the seven agencies. Staff were asked

what program they worked in, their primary role in the agency, whether the section they work in has a strong recovery orientation (1=strongly disagree to 4=strongly agree), their gender, and whether they have at least a basic understanding (1=yes, 2=no) of the agency’s recovery-oriented policies and practices in each of three areas: administration, treatment, and support. After they completed these questions, they completed the 89 SAPT survey items describing recovery-oriented policies and practices—28 questions regarding administration, 36 questions regarding treatment, and 25 questions regarding supports. For each of the 89 items, staff were asked to rate their agency (1=strongly disagree, 2=mostly disagree, 3=mostly agree, 4=strongly agree) and then they were asked to rate how important the question was to assessing a recovery orientation (1=not important, 2= somewhat important, 3=important).

SAPT Data Collection.

Using the Qualtrics web survey software application, each of the seven agencies was provided their own questionnaire link to disseminate to staff via email with instructions (see sample in Appendix 3). The agency contact person was asked how many individuals were asked to complete the survey in order to estimate return rate. Estimates are shown below. The software application automatically times how long it took the individual to complete the survey. Although multi-tasking or keeping the application open to finish later easily explains a long duration, a very short duration is a strong indication of invalidity. After pilot testing the software, we concluded that any response duration of 10 minutes or less was suspect and would be dropped from the dataset. (That would be about 3 seconds per response.) The number of staff asked to take the survey, the number of usable surveys, and estimated return rate are listed for each agency in the chart below.

Agency	Number of staff asked to complete the survey	Number of usable surveys	Estimated return rate
1. Apalachee Center	250	86	34.4%
2. Bridgeway Center	50	24	48.0%
3 COPE Center, Inc.	10	8	80.0%
4. Lakeside Behavioral Healthcare	500	282	56.4%
5. Lakeview Center, Inc	37	26	70.2%
6. Meridian Behavioral Healthcare	360	159	44.1%
7. Suncoast Center for Community Mental Health	235	98	41.7%
Total	1442	683	47.4%

SAPT Data Analysis.

Deletion of observations with a large amount of missing data. The number of omitted items (out of 89) on the survey ranged from 3 people who omitted all 89 items, to 265 people who omitted 0 items. The mean number of omitted items was 10.04, with a *SD* of 18.63 items. We suspected that people with a relatively large amount of missing data were either not knowledgeable about the agency policies and procedures or may not have taken the survey seriously. Correlations between the number of items missing and the sum of the respondent's initial judgments of whether they had at least a basic understanding of recovery-oriented policies and practices in the three areas confirmed this impression, $r=.29, p=.0001$. Moreover, the relationship held for each of the three areas: $r = .085, p = .044$ for administration, $r = .34, p = .0001$ for treatment, and $r=.19, p = .0001$ for supports. In each area, people who had said they were not knowledgeable had more missing data. Therefore, we constructed a one-tailed confidence interval ($p < .05$) to identify and delete those observations with a significantly large amount of missing data. Thus, 56 observations (8.20%) that each had 41 or more items missing were deleted. We were left with 627 observations, with an average of 5.22 items missing.

Deletion of relatively unimportant items. Two methods were used to characterize an item as relatively unimportant—those items which were rated as significantly lower in importance than the mean importance rating, and those items that had a *significantly* large amount of missing data. Interestingly, the correlation between average importance rating and average number of completed responses (across the 89 items) was $r=.65, p=.001$. The mean importance rating was 2.77 with a *SD* of 0.098. A one-tailed confidence interval ($p < .05$) suggested that five items were relatively unimportant (rated below 2.61). The mean number of observations available per item was 590.25 with a *SD* of 25.0. A one-tailed confidence interval ($p < .05$) found that 6 items with fewer than 550 observations had a significant amount of missing data. Two of those items also met the earlier criterion; so 9 items were deleted from the survey at this point, leaving 80 items.

Deletion of items with ceiling effects. A “ceiling effect” is found when an item has a relatively high mean and a relatively low standard deviation. Items with ceiling effects are not effective at differentiating varying levels of recovery orientation. Thus, confidence intervals ($p < .05$) were established that identified 4 items with relatively high means (above 3.56) and 5 items with a relatively low *SD* (below .606). Three items met both criteria and were therefore deleted. For example, the item with the highest mean and the lowest *SD* was, “Agency staff receive approval of the person receiving services before involving significant others.” Although this is an important and necessary practice, it is legally mandated and clearly known to be the standard of care in behavioral healthcare whether or not a recovery orientation is utilized.

Examination of item-subscale correlations. The scale was designed to assess administrative, treatment, and support policies and procedures. Prior to conducting item analyses on these three subscales, we wanted to confirm that each item was on the most appropriate subscale. Thus, each item was correlated with the sum of all of the other items on their respective subscale (item-remainder correlation) and each item was correlated with the two other subscale totals. Out of 77 items (which means 144 comparisons), we found that one Administration, two Treatment, and two Supports items correlated slightly higher with one of the other subscales than the

item-remainder correlation, although the largest raw difference between correlations was extremely small--.027, so we allowed the item analyses to continue below without additional adjustments. It seemed reasonable to maintain the original theoretical placement on these scales. At this point there were 23 items on the Administration subscale with a coefficient alpha of .952, there were 30 items on the Treatment subscale with a coefficient alpha of .956, and there were 24 items on the Supports subscale with a coefficient alpha of .963.

Item analyses. Each subscale was analyzed sequentially, dropping the item with the lowest item-remainder correlation as long as coefficient alpha did not decrease by .01 or more at that step and as long as there was at least one item retained from each of the original domains. The Administration subscale was reduced to 12 items, with at least one item retained on each of the five original administrative domains, and the final coefficient alpha for the subscale was .934. The Treatment subscale was reduced to 24 items, with at least one item retained on each of the five original treatment domains, and the final coefficient alpha was .954. The Supports subscale was reduced to 19 items, with at least one item retained on each of the four original domains, and the final coefficient alpha was .954. Thus, there were 55 items on the final scale, reduced from the original 89 items. Coefficient alpha for the 55 item total scale was .978.

In preparation for collecting new data for the fiscal year 2009-10 report to AHCA, we made minor changes to the wording of 10 items. In addition, we integrated two items in the treatment domain that related to validation of the person, which seemed very similar and correlated, $r = .80$. Thus, the final Version 1.0 of the SAPT Survey includes 54 items.

The SAPT pilot study survey with the original 14 domains and 89 items is listed in Appendix 1.

Technical Assistance to SAPT Pilot Agencies

FMHI provided technical assistance to each of the pilot study agencies in interpreting survey findings and applying them to agency plans. Lessons learned from this process were integrated into the instructions for the SAPT Planning and Implementation Guide.

Summary of Interviews with Federal System Transformation State Grantees

In 2005, the Substance Abuse and Mental Health Services Administration (SAMHSA) announced the Mental Health Transformation State Incentive Grant program to assist states with developing infrastructure and service delivery improvements, as described in President Bush's New Freedom Commission report "Achieving the Promise" (New Freedom Commission on Mental Health, 2003). Seven states were awarded the first round of grants to support planning and development activities that foster recovery-oriented systems of care, including Connecticut, Maryland, New Mexico, Ohio, Oklahoma, Texas, and Washington.

FMHI interviewed representatives from six of the grantee states (all but New Mexico) to determine if instruments to track the implementation of recovery services/transformation had been implemented. Our goal was to determine if tools similar to the SAPT had been developed in other states, and to identify similarities and differences in approach.

None of the six states indicated that they had developed any assessment/planning tools that were designed to track progress in transforming services or agencies to a recovery orientation over time. One state had administered a one-time assessment that was developed to measure clinicians' personal views about recovery, but did not assess other domains. The other states reported completing information that was required by their contracts with SAMHSA, but had not used any other tools. However, a few of the states reported that they were interested in such a tool and were hoping to develop something in collaboration with consumers in their own states. One of the states hoped to pilot an instrument in the fall of 2009 and another state reported using an instrument called the Recovery Self Assessment (RSA) developed by Yale University.

None of the six states have developed or implemented a tool similar to the SAPT. However, all six states expressed considerable interest in learning more about the SAPT after it is published.

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

Instructions for Using the SAPT Survey

The SAPT Survey includes 54 items organized under the domains of Administration (12 items), Treatment (23 items), and Community Integration (19 items) to help determine the agency's level of capability in critical areas. The instrument uses a four-point rating scale for each item.

To complete the SAPT Survey, the agency should select staff from among senior administrative staff, clinical supervisors, and clinical staff. Staff selected should include individuals who are most knowledgeable about how mental health services are delivered at the agency and 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 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 2.)
- *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, as described in the SAPT Pilot Study. (See sample instructions in Appendix 3.)

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 independently in each agency program.
- Prepare a score for each of the 3 domains by taking an average of the scores for the items under each domain.
- Compile a score for each program by taking an average of the 3 domain scores.
- Establish an agency wide score by computing an average of the 3 domain scores and overall scores from all the programs.
- Record comments or observations made by participants as part of the assessment process in each agency.

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. This will enable agencies to easily organize results by staff roles, program, or other important designations.

Interpreting SAPT Survey Findings

The self-assessment includes a list of operational definitions 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, from which we can compare impressions from senior administrative and clinical staff, consumers with findings from objective reviews.

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

Agencies may use the SAPT and the ROSI 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 ROSI to gather information from consumers 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 consumers. Taken together, this information can empower agencies to chart a course for capable implementation of recovery-oriented services.

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

Version 1.0

Self-Assessment Survey (54 Items)

	Strongly Disagree	Mostly Disagree	Mostly Agree	Strongly Agree
<i>Administration</i>	1	2	3	4
1. The agency strategic planning process incorporates diverse viewpoints from consumers. *				
2. The agency has a process in place to ensure that consumers 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 consumers 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 consumers and families.				

<i>Treatment</i>	1	2	3	4
1. Agency staff use person-first language in all verbal and written communication.				
2. Agency staff use language that is encouraging and hopeful in conversation 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 and history of immigration, and the 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 consumers collaborate to develop an individual service plan that identifies needed resources and supports. **				
15. The person receiving services has a choice in selecting staff that will be part of the individual's service plan. **				
16. The person receiving services defines his/her family's level of involvement in the service plan. **				
17. The agency provides wellness education and support to consumers (e.g., Wellness Recovery Action Plan – WRAP).				
18. The agency provides education and support to family members and significant others to help support the person's process of recovery.				
19. Agency staff encourage consumers to build self-care plans based on their strengths and abilities.				
20. Services are available when consumers feel they are needed.				
21. The consumer's right to refuse treatment is respected.				
22. The agency has a process in place for the review of advance directives when consumers experience relapse/incapacitation. *				
23. Agency clinical staff are trained to assess the person's possible history of abuse/trauma.				

<i>Community Integration</i>	1	2	3	4
1. Agency staff return communications from consumers/families at the first opportunity.				
2. The agency provides consumers and families with comprehensive information about community resources, including detailed information about eligibility criteria and processes for making applications.				
3. Agency staff help consumers to develop skills to obtain community resources (e.g., housing, employment, education, collaborating with physicians).				
4. The agency facilitates opportunities for consumers to participate in community activities of their choice.				
5. The agency provides community education designed to decrease stigma and increase early identification of mental illnesses and the recovery process				
6. The agency has a process in place to determine consumers' satisfaction with their housing.				
7. The agency ensures that consumers are provided access to all available independent and supported housing options.				
8. Agency staff use person-centered planning that includes strategies to assist consumers in securing and maintaining employment.				
9. The agency ensures that consumers are provided access to all available employment and training opportunities.				
10. Agency staff ensure that consumers experience support and assistance for their educational choices.				
11. Agency staff utilize person-centered planning that includes strategies to assist consumers in pursuing educational goals.				
12. The agency ensures that consumers have access to all available educational opportunities.				
13. Agency staff ensure that consumers experience support and assistance for their educational choices.				
14. Agency staff assist consumers to develop the interpersonal skills needed to initiate and maintain positive relationships with others.				
15. The agency ensures that consumers have opportunities to initiate and maintain positive interpersonal relationships in the community.				
16. Agency staff utilize person-centered planning that takes into account a person's spiritual needs and interests.				
17. Agency staff view spirituality as an integral part of the person and not merely as an expression of pathology.				
18. The agency provides consumers with information regarding peer run services (e.g. support groups, drop-in centers, respite services and mentoring programs).				
19. The agency utilizes peer specialists for recovery, advocacy services, and support.				

* 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 III: 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 developing plans to address findings from the SAPT Survey and to support enhanced delivery of recovery-oriented mental health services. It provides information to support capable performance in 14 key categories:

Administration

1. Philosophy
2. Continuous Quality Improvement
3. Outcome Assessment
4. Staff Support
5. Consumer 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 is 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 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 answer questions about performance levels in implementing recovery-oriented services. But determining goals for future action also requires analysis of agency needs and resources, and determination of best next steps. The planning and implementation section helps agencies answer the question: “How do we know when we are capably implementing recovery-oriented services?” and assists agencies with developing actionable objectives and plans for improvement.

It is important to note that identifying even one or two goals 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 recovery-oriented services capability as much or more than ameliorating areas of weakness. By combining a focus on strengths and weaknesses, and making the most efficient use of agency resources (e.g., targeting “low hanging fruit” and activities that do not require extra funding or that may be supported by external grant funding), agencies can produce positive results in a relatively short period of time.

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

Most agencies implement a CQI process to focus the energies of the organization to achieve positive outcomes. We recommend that agencies organize a recovery team or sub-group that works as part of the CQI process. The team should take the lead in facilitating data collection, identifying priorities, monitoring progress, and in 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 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 consumers are not at the center of this process the efficacy of all other strategies is significantly diminished (Daniels and Adams, 2006).

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

The SAPT self-assessment 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 Oriented Systems Indicator (ROSI) at the same 12-month intervals, agencies will have performance data from the perspective of both staff and consumers 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 policies 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, 2006). It is important for the agency to fully accept recovery values, such as honoring consumer choice, to ensure that references in the mission statement to recovery 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 consumers 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 consumers 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 consumers 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 consumers of mental health services. Consumers 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 consumers.

- The orientation should provide definitions of basic concepts and principles that are applied in developing the mission statement.
- Staff should be given 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 policies, procedures, and performance outcomes are congruent with the recovery-oriented mission statement.

Resources

Review of Recovery Literature

Ruth Ralph, a consumer 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/general_files/publications/ntac_pubs/reports/ralphreviewweb.pdf

Sample Mission Statements

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

The Main Place, Inc., “Your Recovery Center”, is a consumer-operated mental health recovery center that promotes recovery through peer support, socialization, education, and training. By working together, consumers 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 consumer 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 consumers 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 consumers. The focus is less on quantity (e.g., number of service units delivered) and more on the quality of service reflected in staff-consumer 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 consumers 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 consumers 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 consumers.
- Consumer 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 consumers 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 consumers 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 consumer involvement (e.g., remuneration for participation and funding to cover expenses).

Remedies

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

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

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

The agency should help consumers 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).

Where do I begin? Learning Organizations and Continuous Quality Improvement by Garrison and Dahlin. Available for download at the following web site: www.dcf.state.fl.us/admin/dependency/docs/learningorgcqimanual.pdf

Consumer Quality Initiatives is a mental health consumer operated research, evaluation and quality improvement organization based in Massachusetts. Its web site provide 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 consumers 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 consumer and consumers 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 as essential components:

- **Formal Policies.** A policy that articulates the purpose of outcomes measurement and that stipulates the inclusion of consumers and families throughout the process. Consumers and families play a role, in partnership with staff, in how outcomes measures are developed and implemented.
- **Staff and Consumer 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 consumers may lack understanding of the purpose of outcomes measurement and the involvement of consumers and families in the process.

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

The agency may have difficulty locating consumers 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 consumer 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 consumers should be oriented regarding the purposes of recovery outcomes measurement and the importance of consumer and family engagement in the process.

The agency and consumers should collaborate to identify core sets of data to be collected that is 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 consumers interested in outcomes measurement activities.

The agency should help consumers 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/general_files/publications/ntac_pubs/reports/MHSIPReport.pdf

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, and Leff, 2005):
http://www.tecathsri.org/products_list.asp

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 consumers 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. Consumers and families should 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 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 skill, and support staff in adapting skills 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 consumers 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 in achieving recovery-oriented clinical outcomes, and ultimately in realizing 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 consumer and family needs, 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 being devoted to staff support. In the agency, there may be a lack of in-house expertise, 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, consumers, and family members.
- Agreements with other agencies to share staff support activities (e.g., in-service meetings, training, coaching).
- The inclusion of consumers 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 available for download at this web site:

<http://mhc.casanova.katipo.co.nz/publications/documents/show/37-recovery-competencies-for-new-zealand-mental-health-workers>

Core Competencies of Service Providers: Views of Consumer Stakeholders prepared by Jean Campbell, Ph.D. of the Missouri Mental Health Institute in 1998 is available for download:

<http://mimh200.mimh.edu/PicDb/01683.htm>

Implementation Research: A Synthesis of the Literature: The National Implementation Research Network (NIRN) has prepared a synthesis of the literature on implementing effective programs.

<http://nirn.fmhi.usf.edu/resources/publications/Monograph/>

From Study to Action: A Strategic Plan for Transformation of Mental Health Care includes recommendations for work force development (Daniels and Adams, 2006) and can be download from the internet at:

http://www.psychiatry.uc.edu/hcc/downloads/From_Study_to_Action.pdf

5. Consumer 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 consumers and family members to ensure integration to life in the community and their full participation with the design and delivery of services.

Consumer 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 consumers 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
- 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. Consumers 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 consumers and family members to be productive members of the planning process.

Barriers

Many of the barriers to effective consumer and family support are a function of the culture of the agency. Staff resistance to including consumers 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 consumers 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 consumers 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 consumers and family members, e.g., the Freedom Self-Advocacy Curriculum.
- Provide leadership training for consumers and family, e.g., Florida Peer Network, Inc. leadership training curriculum.
- Realign agency board procedures and agency policies and procedures to include consumers and family members as essential participants in the life of the agency.

- Include consumers and family members in employee trainings.
- Provide staff with concrete examples of recovery through consumer stories, such as *Common Threads: Stories of Survival & Recovery* (Hendry, P., 2007) and the NAMI *In Our Own Voice* program.
- Provide training to clarify issues surrounding confidentiality laws, including HIPPA.

Key Resources

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

Freedom Self-Advocacy Curriculum, available through the National Mental Health Consumers' 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/general_files/publications/ntac_pubs/reports/MHSIPReport.pdf

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

Recovery: The lived experience of recovery. Degan, 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

Florida Peer Network Leadership Training and Beyond, (2008). The Florida Peer Network, Inc. www.floridapeernetwork.org

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 on illness and 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. Consumers 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 is for better or for worse, that consumers 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 consumers 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's 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 lever 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 consumers.

- **Responsive to Culture:** Staff awareness and sensitivity in responding to issues of culture is of critical importance in 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 pneumatic ADDRESSING:

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

Barriers

Lack of financial incentive: Taking time to listen and respond empathically takes more time and is not supported under reimbursement structures.

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 with little background/preparation.

Remedies

Agency leadership must be committed to the principles of recovery, as this sets the tone for policies and practices that shape the agency culture. Leadership staff should provide a model of respectful and empathic behavior toward consumers, families and other staff. Such behavior also needs to be reinforced by supervisors and 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 consumers 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 consumers. Available from the Center for Psychiatric Rehabilitation at Boston University:

<http://www.bu.edu/cpr/products/curricula/technology/readiness.html>

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](http://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://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.chapter.61302>

Motivational Interviewing: Preparing People for Change is the seminal text on the subject, available through Guilford Press (Miller & Rollnick, 2006).

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. 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 be expert in helping people with psychiatric disabilities 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 charts the course for the recovery journey.

Essential Characteristics

The following characteristics are critical to a person centered approach to treatment planning (Adams and 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 rather 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.

Barriers

Service providers often view treatment planning as a mandatory administrative burden (Adams and 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 consumers 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 consumers. Formal policies and procedures should specify the staff roles and responsibilities for this involvement, with 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 consumers' 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 and skills of the approach to successfully make this transition. Training and technical assistance can help agencies with developing staff capability.

Treatment Planning for Person-Centered Care: the Road to Mental Health and Addiction is the seminal textbook in the field (Adams and 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 (Adams and 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:

<http://www.bu.edu/cpr/products/curricula/technology/management.html>

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 consumers in a process of education and support that prepares them to assume personal responsibility. Mary Ellen Copeland, a national leader in helping consumers with self-care/wellness planning, describes its importance to mental health consumers: “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, M. E., 2008 and Mental Health Recovery & WRAP, www.mentalhealthrecovery.com). When consumers begin to both 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 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 consumers 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 consumers 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.

Remedies

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

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 and www.mentalhealthrecovery.com

SAMHSA Self Help Booklet Series,
<http://mentalhealth.samhsa.gov/publications/selfhelp.asp>

Opening Doors to Health Education Questions (2005) Eli Lilly & Co.
Hearts and Minds, NAMI

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 witnessed 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 to do so.

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 principles and practices of recovery.

The agency should provide opportunities to assist consumers 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: http://www.upennrrtc.org/resources/view.php?tool_id=132

Who Should Make Decisions About Your Mental Health Care? You Should!!! Florida Department of Children & Families

Who Should Make Decisions About Your Mental Health Care? You Should!!! Florida Department of Children & Families

How to be a Good Mental Health Surrogate, Florida Department of Children & Families

Mental Health Advance Directives, Florida Department of Children & Families

Mental Health Advance Directives: A Primer for Provider Agencies & Mental Health Professionals, Florida Department of Children & Families.

Personal Safety Plan (for advance crisis planning), Florida Department of Children & Families.

Advance Directive Provider Training, PowerPoint, Florida Dept. of Children & Families.

Advance Directive Individual Training, PowerPoint, Florida Dept. of Children & Families.

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 consumers, 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 both 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 (Sowers, 2005, Blanch & Parrish, 1994). Though the principles of recovery-oriented services focus on ensuring consumer choice and involvement, this does not preclude the need for an agency to develop strategies that address the need for safety and security of consumers 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 consumers who experience diminished decision making capacity:

- The agency states its goal of reducing or eliminating coercive practices.
- Policies 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 consumers 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 consumer 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 consumer's decision making ability are not always based on established medical and legal criteria, but rather 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 consumers. Consumers 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 consumers in developing Wellness Recovery Action Plans (WRAP). WRAPs help consumers 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. (Consumers should lead or play a major role in this presentation).
- Conflict management strategies.
- Jail diversion.
- Legal and medical criteria for involuntary treatment.
- Crisis management skills.

Program Strategies: Munetz and Frese (2001) have proposed two strategies for including consumers in involuntary commitment issues. Neither has yet been tested, but both provide good examples of innovative approaches for partnering with consumers. In the first strategy, a consumer guardian program involves the

development of nonprofit agencies staffed by consumers 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 consumer, 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 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/general_files/publications/ntac_pubs/reports/ManagingConflictCooperativelyADR.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://gainscenter.samhsa.gov/html/>

The TAPA Center for Jail Diversion serves as a national resource for all relevant jail diversion information and research. <http://gainscenter.samhsa.gov/html/tapa/CMHS/overview.asp>

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 entrance into 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 demand and diminishing resources.

Despite the limitations on access that are characteristic of leanly 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 consumers/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.

Consumers 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 consumer and family cultural and ethnic backgrounds, consumers 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 consumers and families.

Barriers

An agency that has facilities located in areas that are not convenient for consumers can create significant obstacles for access. This problem is compounded by poor public transportation, often cited by consumers 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 consumers 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 be 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 consumers receiving services about challenges to access and include consumers 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 consumers and families affected by mental illness, such as NAMI, Recovery and Resiliency Task Forces, the Florida Peer Network, and the local chapter 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 consumers 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

Resources on Mental Health Disparities and Cultural Competency – Reports, Books and Manuscripts is available for download:

www.psych.org/resources/OMNA/disparitiesresources.aspx

A Cultural Competency Toolkit: Ten Grant Sites Share Lesson's Learned. National Consumer Supporter Technical Assistance Center, National Mental Health Association

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 consumers 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 making application.
- 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 consumers 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 consumers 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 consumers in receiving primary health care by making appropriate referrals and assisting consumers 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 consumers' 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 consumers 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 consumer 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/general_files/publications/med_directors_pubs/Technical%20Report%20on%20Morbidity%20and%20Mortality%20-%20Final%2011-06.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 resources to assist agencies with developing stigma reduction activities: <http://www.stopstigma.samhsa.gov/>

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).

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

Essential Characteristics

Meaningful activities include: 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 consumers) may perceive that people with mental illness are not capable of participation in activities and roles because of their illnesses.

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

Staff lacks training and skill-building regarding principles of recovery and community integration.

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

Many people with psychiatric disabilities resist leaving group living environments because they are afraid of becoming lonely and isolated.

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 such as Compeer.

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.

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.

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”, and this includes assuming leadership roles in redefining the public mental health system. As consumers assume leadership roles in system transformation, it is important to provide resources to expand their leadership and advocacy skills and opportunities. Agencies should support consumers in developing those skills and support the provision of peer-run services. This includes providing information to consumers 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 consumers 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 consumers 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 consumers in the provision of services and supports, the need for peer leadership grows. The agency can assist in this process by providing consumers 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 consumers with access to education, ensuring that consumers participate in the delivery of services and 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 consumer of mental health services.

Agencies wishing to provide recovery, advocacy and leadership training for consumers 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 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 consumer and family advisory councils as part of the administration of the agency.

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

Resources

NAMI Provider Education Training: www.nami.org

Steps to Recovery Training available through the Florida Peer Network
<http://www.floridapeernetwork.org/>

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

Leadership & Beyond Training available through the Florida Peer Network
<http://www.floridapeernetwork.org/>

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.

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Appendix 1

Self-Assessment/Planning Tool For Implementing Recovery-Oriented Mental Health Services (SAPT) <i>Pilot Study Version -2008</i> Self-Assessment Survey (89 Items)	Strongly Disagree	Mostly Disagree	Mostly Agree	Strongly Agree
Administration	1	2	3	4
1. Philosophy				
<ul style="list-style-type: none"> ❖ The agency mission statement reflects a recovery-orientation. 				
<ul style="list-style-type: none"> ❖ Agency policies and procedures include principles that support a recovery-orientation. 				
<ul style="list-style-type: none"> ❖ Agency organizational reviews and strategic planning processes incorporate diverse viewpoints from consumers. * 				
<ul style="list-style-type: none"> ❖ Agency staff believe that recovery for persons with mental illness is the rule and not the exception 				
2. Continuous Quality Improvement				
<ul style="list-style-type: none"> ❖ The agency has a process in place to ensure that consumers are included in CQI activities as equal partners with professionals. * 				
<ul style="list-style-type: none"> ❖ The agency budget reflects compensation for consumer involvement in CQI activities. * 				
<ul style="list-style-type: none"> ❖ The agency administers the ROSI or other recovery-oriented surveys to monitor staff effectiveness from a consumer perspective. 				
3. Outcome Assessment				
<ul style="list-style-type: none"> ❖ The agency uses personal outcome indicators related to quality of life and recovery. 				
<ul style="list-style-type: none"> ❖ The agency identifies and uses standardized, quantifiable scales for assessing recovery outcomes (e.g., ROSI). 				
<ul style="list-style-type: none"> ❖ The agency has a process for consumers to participate in developing recovery-oriented outcome indicators. 				
<ul style="list-style-type: none"> ❖ Outcome measurement processes are used by the agency to improve services and programs through the expansion of recovery-oriented care.* 				
4. Support				
<ul style="list-style-type: none"> ❖ Training 				
<ul style="list-style-type: none"> ▪ The agency has a comprehensive program to promote recovery-oriented knowledge, attitudes, and skills in its workforce. 				
<ul style="list-style-type: none"> ▪ The agency provides recovery-oriented educational materials for staff (e.g., articles, manuals, videos, audiotapes). 				

<ul style="list-style-type: none"> ▪ The agency uses consumer and family trainers. 				
<ul style="list-style-type: none"> ▪ Agency staff have opportunities to interact with consumers in non-clinical settings (e.g., living, learning and work settings). 				
❖ Supervision				
<ul style="list-style-type: none"> ▪ The capable delivery of recovery-oriented services is a basis for review/discussion between agency supervisors and clinical staff. 				
<ul style="list-style-type: none"> ▪ There are mentoring processes in place for agency employees in recovery so that they can advance in their own recovery. 				
<ul style="list-style-type: none"> ▪ The agency has a mechanism in place that provides consumer employees the opportunity to discuss job related problems. 				
❖ Staff Evaluation				
<ul style="list-style-type: none"> ▪ The agency assesses capable delivery of recovery-oriented mental health services in staff evaluations. 				
❖ Staff Hiring				
<ul style="list-style-type: none"> ▪ Competencies in delivering recovery-oriented services are part of the agency's hiring criteria. 				
5. Consumer and Family Support				
<ul style="list-style-type: none"> ❖ The agency provides training in self-advocacy for consumers and families. 				
<ul style="list-style-type: none"> ❖ Consumers are oriented to agency grievance procedures. 				
<ul style="list-style-type: none"> ❖ There is an agency dispute resolution process in place that is clearly defined and accessible to consumers. 				
<ul style="list-style-type: none"> ❖ Agency staff make consumers and families aware of advocacy opportunities on local, state, and national levels. 				
<ul style="list-style-type: none"> ❖ Consumers and family members are included in agency planning (e.g., advisory committees, boards, and formal work groups). 				
<ul style="list-style-type: none"> ❖ The agency budget reflects compensation for consumer and family participation in agency activities. 				
<ul style="list-style-type: none"> ❖ The agency offers opportunities for consumers to participate in the hiring, training, and evaluation of staff. 				
<ul style="list-style-type: none"> ❖ Family and consumer involvement will be reflected in the agency's educational, social and advocacy programming. 				
Treatment				
1. Validation of the Person				
❖ Demonstrating Respect				
<ul style="list-style-type: none"> ▪ The agency's consumer satisfaction surveys track the degree to which persons receiving services feel understood by the staff. 				
<ul style="list-style-type: none"> ▪ Agency staff refer to the person by name and not by psychiatric labels (e.g., "schizophrenic male"; "the patient".) 				
<ul style="list-style-type: none"> ▪ Agency staff receive approval of the person receiving services before involving their significant others. 				
<ul style="list-style-type: none"> ▪ Agency staff use person first language in all verbal and written communication. 				
<ul style="list-style-type: none"> ▪ Agency staff use language that is encouraging and hopeful in conversation with persons who are receiving services. 				

<ul style="list-style-type: none"> ▪ The agency does not tolerate derogatory language about persons with mental illnesses. 				
<ul style="list-style-type: none"> ▪ Agency staff recognize and support the person's attributes that contributed to their coping with a mental illness. 				
❖ Cultural Competence				
<ul style="list-style-type: none"> ▪ Agency services are provided in the person's spoken language as often as possible. 				
<ul style="list-style-type: none"> ▪ Agency assessment tools are culturally sensitive. 				
<ul style="list-style-type: none"> ▪ Agency staff are knowledgeable about and sensitive to the impact of culture on the person's experience of mental illness. 				
<ul style="list-style-type: none"> ▪ Agency staff have self-assessed their own cultural competence/biases. 				
<ul style="list-style-type: none"> ▪ Agency staff are sensitive to the person and family's experience and history of immigration, and their country of origin. 				
<ul style="list-style-type: none"> ▪ Agency staff work with the person to implement culturally sensitive service plans. 				
2. Person-Centered Decision Making				
❖ Person Centered Treatment Planning **				
<ul style="list-style-type: none"> ▪ The persons receiving services are encouraged and assisted in identifying their own goal(s). 				
<ul style="list-style-type: none"> ▪ The persons receiving services direct the therapeutic alliance/partnership. 				
<ul style="list-style-type: none"> ▪ The persons receiving the services drive the process of goal setting based on their hopes and preferences. 				
<ul style="list-style-type: none"> ▪ Assessment and intervention activities are integrated as part of a holistic treatment approach. 				
<ul style="list-style-type: none"> ▪ Mutual reciprocity in a trusting, hopeful relationship is considered essential to the therapeutic process. 				
<ul style="list-style-type: none"> ▪ Agency staff work from a strengths/asset based model. 				
<ul style="list-style-type: none"> ▪ Agency staff and consumers collaborate to develop an individual service plan that identifies needed resources and supports. 				
<ul style="list-style-type: none"> ▪ The person receiving services has a choice in selecting staff that will be part of the individual's service plan. 				
<ul style="list-style-type: none"> ▪ The person receiving services defines his/her family's level of involvement in the service plan. 				
3. Self Care – Wellness				
❖ Provide Information and Support				
<ul style="list-style-type: none"> ▪ The agency provides wellness education and support to consumers (e.g., Wellness Recovery Action Plan – WRAP). 				
<ul style="list-style-type: none"> ▪ The agency provides education and support to family members and significant others to help support the person's process of recovery. 				
❖ Person-Centered Focus				
<ul style="list-style-type: none"> ▪ Consumers are encouraged to build their self-care plans around their strengths and abilities. 				
<ul style="list-style-type: none"> ▪ Services are available when consumers feel they are needed. 				
<ul style="list-style-type: none"> ▪ The consumer's right to refuse treatment is respected. 				

4. Advance Directives				
❖ The agency has a process in place for obtaining advance directives from consumers during periods of healthy functioning. *				
❖ The agency has a process in place for the review of advance directives when consumers experience relapse/incapacitation. *				
❖ The agency has a policy in place to support the utilization of advance directives.				
5. Alternatives to Coercive Treatment				
❖ Guardian advocates are obtained to act on behalf of consumers who are unable to provide informed consent.				
❖ The agency demonstrates a reduction in the use of coercive treatment options over defined periods. *				
❖ The agency ensures and documents that involuntary treatment arrangements occur in the least restrictive environment for the shortest period of time. *				
❖ The agency ensures that a person's transfer to voluntary status is facilitated as soon as possible. *				
❖ The agency has a process to review the status of consumers with guardianships and representative payees and to restore their rights as soon as possible. *				
❖ Agency clinical staff are trained to assess the person's possible history of abuse/trauma.				
Supports				
1. Access				
❖ Welcoming Intake				
▪ The agency provides clean, attractive, and comfortable facilities.				
▪ All persons entering agency facilities are promptly acknowledged and welcomed.				
❖ Financial/Insurance Issues				
▪ The agency has effective processes in place to obtain services for persons who are not adequately insured or are otherwise financially unable to access services. *				
❖ Waiting Lists				
▪ If waiting lists for services are in place, the agency offers service alternatives (e.g., peer support).				
▪ Agency staff regularly contact people on waiting lists for services to determine their ongoing needs.				
❖ Follow-Up Time				
▪ Agency staff return communications from consumers/families at the first opportunity.				
2. Basic Life Resources				
❖ Linking to resources				
▪ The agency provides consumers and families with comprehensive information about community resources, including detailed information about eligibility criteria and processes for making application.				
❖ Skill development				
▪ The agency helps consumers develop skills to obtain community resources (e.g., housing, employment, education, collaborating with physicians).				

3. Meaningful Activities and Roles				
❖ Community Integration/Involvement				
<ul style="list-style-type: none"> ▪ The agency facilitates opportunities for consumers to participate in community activities of their choice. ▪ The agency provides community education designed to decrease stigma and increase early identification of mental illnesses and the recovery process 				
❖ Housing				
<ul style="list-style-type: none"> ▪ The agency has a process in place to determine consumers' satisfaction with their housing. ▪ The agency ensures that consumers are provided access to all available independent and supported housing options. ▪ The agency uses person-centered planning that takes into account consumers' housing preferences. 				
❖ Employment				
<ul style="list-style-type: none"> ▪ The agency uses person-centered planning that includes strategies to assist consumers in securing and maintaining employment. 				
<ul style="list-style-type: none"> ▪ The agency ensures that consumers are provided access to all available employment and training opportunities. 				
<ul style="list-style-type: none"> ▪ The agency ensures that consumers experience support and assistance for their educational choices. 				
❖ Education				
<ul style="list-style-type: none"> ▪ The agency utilizes person-centered planning that includes strategies to assist consumers in pursuing educational goals. ▪ The agency ensures that consumers have access to all available educational opportunities. ▪ The agency ensures that consumers experience support and assistance for their educational choices. 				
❖ Relationships				
<ul style="list-style-type: none"> ▪ Agency staff assist consumers to develop the interpersonal skills needed to initiate and maintain positive relationships with others. 				
<ul style="list-style-type: none"> ▪ The agency facilitates opportunities for consumers to initiate and maintain positive interpersonal relationships in the community. 				
❖ Spirituality				
<ul style="list-style-type: none"> ▪ The agency utilizes person centered planning that takes into account a person's spiritual needs and interests. 				
<ul style="list-style-type: none"> ▪ Spirituality is viewed by agency staff as an integral part of the person and not merely as an expression of pathology. 				
4. Peer Leadership				
<ul style="list-style-type: none"> ❖ The agency documents that consumers are provided with information regarding peer run services (e.g. support groups, drop-in centers, respite services and mentoring programs). 				
<ul style="list-style-type: none"> ❖ The agency utilizes peer specialists for recovery, advocacy services, and support. 				

* 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).

Appendix 2

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 for 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 have completed 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 3

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 for 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 have completed 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://#####>