

# **“Following the Lead Towards Recovery System Transformation”**

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May, 2006

## **Introduction**

Important changes are underway in the mental health systems of Connecticut, South Carolina, Vermont, Georgia, Ohio, Wisconsin, Kansas and New Zealand (among others). The recovery model is being implemented as part of a restructuring or ‘transformation’ of the areas’ community mental health systems. The recovery reforms that are underway are exciting, potentially revolutionary and point the way forward to a more progressive, caring and rewarding approach to mental health service delivery. Recovery is being implemented in variable fashion, but the common factors among the experiments are innovation, commitment and positive outcomes. Here in Ontario and Canada we need increased awareness and interest in the recovery reforms underway in other national jurisdictions.

Recovery was nearly, or briefly, the focus of Ontario’s mental health reform process, but instead that process has now been subsumed within a health restructuring plan (‘transformation’) that is mainly about integrated networks, system efficiencies, coordination and access. The mental health component of this plan has not been articulated as yet but there is no indication that it will be explicitly recovery-oriented. This is unfortunate and disappointing. Ontario is previously known for its innovative community mental health policies, such as initiating survivor/peer-run services and supporting community economic development businesses, but this progressive work dates back fifteen years ago. Currently, we are definitely under-performing where recovery-oriented innovation is concerned. The current government may be presently making an economic transfusion to its community mental health system, but instead of seizing the opportunity to make recovery-oriented reform it is mainly flowing new dollars to the traditional service domains, i.e. case management, ACT teams, forensics and ‘early intervention.’ Recovery education, training and capacity building are not on the priority list. And, peer (and family) support groups have not seen a significant increase in funding or in the number of support programs since their inception as the Consumer/Survivor Development Initiative in 1991.

Ontario’s mental health system is adequate, but not how it likes to be known, as world-class. And it was never truly ‘broken,’ just under-funded and neglected. At this time we need better. We need a new vision and the drive to make it real. What will it take to move toward a climate of innovation here in Ontario and Canada, and what will it take to get the recovery model recognized by government and policy makers? Within this paper we will provide some information for how that transformation could occur, relative to the

innovative recovery reform underway in the States and New Zealand. We will explore the role of survivor advocacy in recovery implementation. We will consider wellness and empowerment as the distinct but interrelated approaches to recovery. We will briefly address key examples where recovery implementation became the primary goal of state-wide mental health reform. Finally, we will provide general recommendations relating to a policy path for recovery system transformation in Ontario and Canada.

## **Definition**

First, we should define what we mean by recovery.

“Recovery is defined very broadly as the ability to live well in the presence or absence of one's mental illness.” (*New Zealand Mental Health Commission, 1998*)

This is simple and straightforward, but we should add a little more because recovery itself is not simple. Recovery is frequently described as a ‘journey,’ but it is actually more of a great struggle, one that is not exactly supported by society. In a recovery-oriented system there would be more support for this struggle, people would be less isolated. Throughout the province there would be more community supports and opportunities for personal growth and healing. People could undertake their own ‘journey’ to recovery through peer support, fitness, creativity, therapy, education, employment, social activism, voluntarism and spirituality. Whatever people choose as their path to wellness, what counts is that they have increased choices. Recovery is about an individual making key life changes, and having the support of friends, family and community to help make those changes.

Recovery can be a process or an outcome, as well as an extraordinary achievement, but we need to examine recovery more broadly, as a service/support model in the context of system transformation. For the purposes of this paper:

“Recovery can be construed as a paradigm, and an organizing construct that can guide the planning and implementation of services and supports with people with severe mental health problems. The outlines of a new paradigm recovery-enhancing system are emerging. Such a system is person-oriented, and respects peoples’ lived experience and expertise. It promotes decision-making and self-responsibility. It addresses peoples’ needs holistically and addresses more than their symptoms. Such a system meets needs and addresses problems in living. It empowers people to move toward self-management of their condition. The orientation is one of hope with an emphasis on positive mental health and wellness. A recovery-oriented system assists people to connect through mutual self help. It focuses on positive functioning in a variety of roles and building or rebuilding positive relationships.” (Onken et al.2002)

It is this systemic application of recovery that interests us here, and it is exciting and encouraging that certain mental health systems are making these changes and provisions. Whether recovery system transformation can be delivered more broadly, or even whether

it will be sustained, is a pressing question and challenge. Still, recovery stands as the ideal to work towards, and is already being addressed as an ‘evidence-based best practice.’ (Fisher, D. & Ahern, L. 2002; U.S. Surgeon General’s Report, 1999) We are at a probable point in time that it is not a matter of ‘if’ recovery, but when. That said how do we move the clock forward here in Ontario and Canada? We need to look at what has led to the changes in the areas where recovery system transformation is underway.

## **Survivor Leadership in Recovery System Transformation**

Perhaps what is most helpful in terms of predicting traction and sustainability for recovery implementation is the extent to which an area’s psychiatric survivor network has taken up recovery as the *cause celebre*. Here in Ontario and Canada the survivor community is active and influential on many fronts, but at this time, and for a variety of reasons, seems relatively quiet on recovery as policy. Arguably, recovery system transformation is the direct result of sustained survivor advocacy; so it follows that recovery will be likely implemented in those areas where people advocate for it.

To get a better idea of what is involved in this challenge, consider the advocacy work and actual achievements of the survivor networks and leaders in America and New Zealand. As a prominent example of a strong and effective American survivor advocacy group the National Empowerment Commission (NEC) called for the:

“Transformation from the institutionally-based mental health system to a recovery-based system through consumer/survivor leadership, and through consumer led development of a National Recovery Initiative.” (Fisher & Chamberlin, 2004)

Survivor activist and New Zealand Mental Health Commissioner Mary O’Hagan described how the recovery system transformation underway in her country was initiated and informed by survivor values and their own experience of recovery.

“We believed that user/survivor movement values should drive recovery more strongly than any other movement, such as psychiatric rehabilitation. Indeed, we have described recovery as the approach that service users have been asking for all along. So we put the spotlight on human rights, advocacy and on service user partnerships with professionals at all levels and phases of service planning, delivery and evaluation.” (O’Hagan, 2004)

In using recovery as a system reform principle, survivors also assert their own primacy as the recovery experts. They are the messengers (or the message itself), as well as the architects of change. McLean (2002) says:

“Through the continued labors of consumer/ survivor activists and their advocates, the ideals of recovery, self-reliance and empowerment -- as opposed to chronicity, dependence and disenfranchisement -- appeared accessible. Consumers have been partnering productively with mental health professionals

and researchers for two decades to promote their own understandings about the kinds of approaches and services they find most beneficial. The Surgeon General sanctioned the “new recovery approach” as being “supported by evidence on rehabilitation and treatment as well as by the personal experiences of consumers.”

Clearly, the recovery model did not just suddenly emerge as a good idea whose time had come. Survivor leadership was key in making it happen. Survivors were the only ones who could articulate the experience of their own ‘recovery’. They applied their own personal lessons to help others. They did the important ground work creating grassroots services at the same time as they advocated for systemic change. They created the peer support programs, wrote books, articles and magazines supporting hope and personal resilience, created art, and promoted empowerment as key to wellness. Over time the survivor-driven community supports and services showed that recovery was realistic, achievable and evidence-based.

The survivor leaders and their allies then held forums, conferences, think-tanks and drafted recovery policy implementation recommendations. They pushed for their recommendations to be discussed by policy-makers and academics, and now the entire mental health care delivery system is undergoing a radical re-think. In America, Campbell and Leaver (2003) say that peer support and “the proliferation of offices of consumer affairs brought the vision of recovery and the recognition of the important role of peer support to state mental health agencies.”

The survivor movement generally laid the foundation for the recovery movement, but it was the work of key individuals that galvanized others to work for systemic change. Some of the well-known survivor leaders who are pushing for recovery system transformation, or who are leading the way as wellness visionaries are Mary O’Hagan, Mary Ellen Copeland, Dr. Dan Fisher, Dr. Patricia Deegan, Jay Mahler, Laurie Ahern, Larry Fricks and Shery Mead. They and others are in great demand to speak at conferences and workshops throughout North America and Europe. They inspire fellow survivors, and most who hear them. They are finally having a profoundly positive impact on the way that mental health workers, health bureaucrats and policy-makers approach their work, and on what policy and funding decisions are made.

To demonstrate their efficacy as policy advocates, consider that the President’s New Freedom Commission (2003) made sweeping recommendations based on recovery and the promise of transformation. In terms very similar to that of recovery advocates the Freedom Commission called for a recovery-driven transformation of the national mental health system, and stated: “We envision a future when everyone with a mental illness will recover.” The report also states that “care must focus on ....facilitating recovery, and on building resilience, not just on managing symptoms.”

These are encouraging developments, but we should maintain a degree of skepticism, especially with this administration’s record. It has to be kept in perspective that the Freedom Commission also called for repressive measures such as mandatory mental

health tests for school age children. (*N.B. this testing program is already underway in some states and is being litigated by outraged parents.*) Nonetheless, American psychiatric survivors and their allies have been very effective at getting their recovery message taken up by the government. It is a great ideological victory especially after national survivor advocacy groups endured funding threats, and the smear campaign by hard-right psychiatrists E. Fuller Torrey and Sally Satel, as well as by NAMI and Big Pharma. (McLean, 2003)

## **Survivor Recovery Models**

To get a better understanding of the models and practices that have been particularly influential in advancing recovery system transformation we will briefly consider these two distinct recovery models, WRAP (*Wellness Recovery Action Plan*) and PACE (*Personal Assistance through Community Existence*).

Mary Ellen Copeland developed the WRAP model with its blend of positivity, personal wellness, and cognitive-behavioural therapy as part of her own recovery process. She then adapted her personal methodology so that it could be shared with others who would benefit. She became a recovery/wellness educator, subsequently starting a ‘train the trainer’ program which became hugely successful, leading to trained WRAP facilitators in all 50 states. The next step was bigger, implementing WRAP at a state-wide level. In Minnesota and Vermont WRAP services were funded and delivered by the government. In Arizona and Kansas WRAP/recovery delivery systems and ‘train the trainer’ programs were funded by the governments. Mary Ellen Copeland is now working in concert with a federal agency to develop a full certification program for every state in the nation, and is involved in research demonstrating that WRAP is an emerging best practice.

The National Empowerment Center (NEC) developed the PACE model for recovery. It is very influential for different reasons, mainly because its orientation is more political and focused on empowerment. The NEC’s roots are anti-psychiatry, protest and social justice. Their approach is now less oppositional, but from its late seventies inception in Massachusetts the NEC have been forceful and effective advocates for choice, justice, citizenship, anti-oppression, with the main emphasis on empowerment. Fisher (1994) states that:

The empowerment model of recovery .....includes the recognition that the major barriers to recovery from disabilities are in the attitudinal and physical environment rather than within the individual, an emphasis on choice in and control of services by the people who are receiving them, and an assertion that it is possible to be a whole, self-determining person and still have a disability.”

Dr. Dan Fisher, Judy Chamberlin and Laurie Ahern are key figures in the development of the PACE model. Patricia Deegan was also a forceful spokesperson for the PACE model, with her poignant and heartfelt message of choice, ‘personal medicine’ and community. The work of these outstanding activists is not as widely known as that of Mary Ellen

Copeland, but it is likely because of the extensive and long-term efforts of this national advocacy group that the recovery message is now being taken up by so many states.

### **Recovery System Caveat**

Following survivor advocacy and leadership, the recovery vision has been embraced by many services and state authorities, and some more enthusiastically and authentically than others. On that basis, a caveat needs to be stated. Simply naming a mental health system as ‘recovery-oriented’ does not make it so. Some American states include the word ‘recovery’ in their mission statements or in descriptions of treatment programs, as a way of ‘branding’ their old service models while using the new recovery language. Jacobson & Curtis, (2000) describe a common pitfall once a state declares its recovery vision statement:

“With vision statements in hand, some states simply rename their existing programs: Community support services, vocational rehabilitation or housing supports are now described as recovery-oriented services. This renaming process demonstrates a lack of understanding of recovery; in particular, a failure to acknowledge the necessity for a fundamental shift toward sharing both power and responsibility.”

In other words, the recovery paradigm requires a lot more of a human investment than changing our rhetorical approach. Human relations and the power imbalance between the policy-makers, service providers and the psychiatric survivors have to undergo a radical shift that goes well beyond good intentions and tokenism to a place where psychiatric survivors are respected and included as full partners in a substantive change process. Fisher and Chamberlin (2004) say:

“For recovery to take place, the culture of mental health care must shift to a culture that is based on self-determination, empowering relationships, and full participation of mental health consumers in the work and community life of society. To build a recovery-based system, the mental health community must draw upon the resources of people with mental illness in their community.”

Further, Anthony (2000) says that a mental health system guided by a recovery vision must have policies and procedures in place to increase the possibility of recovery outcomes, and that we need system level standards. He says:

“the vision of recovery must be present in most of the leadership’s written and public statements. Recovery is such a paradigm shifting notion that its fundamental assumptions and principles must constantly be reinforced. Recovery is a vision incompatible with the mission of the mental health system of the past century. The leadership must demonstrate through their words and actions that they ...buy into this dramatically new direction.”

## **Recovery System Transformation In Key States**

We offer some focused examples of state recovery initiatives that have moved the recovery model out of the realm of good intentions and into systemic implementation. These examples provide a general picture of leadership and progress. Readers are encouraged to pursue these ‘leads’ for a better appreciation of who is leading the way in recovery system transformation.

**Connecticut** has taken the first steps to overhaul the entire system so that it is calibrated to deliver recovery outcomes. In a speech delivered at the 2005 U.S. Alternatives conference, A. Kathryn Power, said:

“Connecticut is undergoing a social, cultural, organizational and attitudinal change around the way in which mental health services are planned and delivered. In other words, it is experiencing transformation. Connecticut has launched a statewide recovery initiative. It has created a recovery institute to provide information and training in a recovery model of care. In this model, mental health care builds upon each consumer’s assets, strengths, and areas of health and competence. Consumers are empowered to make choices that will build their hope in a self-directed and fulfilling life.”

This process was initially set in motion by Connecticut’s Department of Mental Health and Addiction Services consulting with survivor advocacy groups to define “core values” and plan for a recovery-oriented system of care. Connecticut then responded with the following policy statement: “We shall firmly embed the language, spirit, and culture of recovery throughout the system of services, in our interactions with one another and with those persons and families who trust us with their care.” (Connecticut Policy Statement; 2002)

Commissioner Thomas A. Kirk of the Department of Mental Health and Addiction Services (DHMHA) went further and deeper by stating these practical goals:

“We realized that to transform Connecticut’s behavioural health system into one that is truly recovery oriented, we would need to make changes in many aspects of our work. This systemic approach would encompass (1) development of recovery core values and principles, (2) establishment of a conceptual and policy framework to guide our efforts, (3) new competencies and skills for our workforce, (4) changes in programs in the service structure to promote certain program models such as peer-run programs and programs operated by Recovery Communities, (5) realignment of fiscal resources, and (6) review of administrative policies to ensure that recovery concepts and program models were being supported.”

## **Georgia's 'Peer Support Specialist' program**

Georgia survivor leader Larry Fricks worked with other survivors, health planners, and an unlikely ally, Medicaid, to develop an innovative state-wide program that has trained and gained employment for over 300 consumer/survivors to work in mental health services as 'certified peer support specialists'. The peer specialists "help other consumers through employment, natural supports, and by helping them take charge of their wellness through self-directed recovery" (press release, 2006).

The Certified Peer Specialist Program was created as a result of Managed Care funding fiascos which provided an opening for peer support/recovery advocates to assert that peer support was effective and more cost-effective than traditional mental health care. Somewhat surprisingly that message was heard. McLean (2003) says:

"Since 1999 the Georgia Division of Mental Health under a managed care reconfiguration has promoted peer support and recovery in its public behavioral health care provisions. It developed the certified consumer peer specialist (CPS) role as a core rehabilitation service billable under Medicaid. Georgia placed muscle behind this approach by requiring this service as a prerequisite for reimbursing other community treatments. Peer specialists serve as deliberate change agents to help alter how clinicians and administrators think about mental illness and recovery and help them 'buy in' to a consumer-centric philosophy."

Georgia was the first state to implement Medicaid reimbursable peer support services. At this time, seven states are receiving federal funding to replicate the Certified Peer Specialist Program. Even beyond that there are signs that this model is going to be widely developed. Larry Fricks says "the combination of both good recovery and fiscal outcomes has resulted in the feds putting their full support behind the promotion of peer support nationwide".

## **Vermont**

The Vermont Recovery Education Project is a statewide program to teach recovery skills and practices to citizens with mental health problems, their family members, and professional support providers. The program was designed by Mary Ellen Copeland with other consumer/survivors as well as health care professionals. It has provided a general focus on hope, personal responsibility, self-advocacy, education and support. The educational program has two main objectives:

"To teach individuals who experience psychiatric symptoms, their family members, supporters and health care professionals how to reduce or eliminate psychiatric symptoms safely, simply, and effectively on a daily basis; and, how to get well and stay well." ([www.mentalhealthrecovery.com](http://www.mentalhealthrecovery.com))

## **South Carolina**

The following are some of the recovery-specific goals in the official plan of South Carolina's Department of Mental Health (2004) These goals are offered as examples of how a recovery-oriented official plan would be worded when the planners and the authorities finally 'get it.'

Goal 1.3 Continue to develop Recovery-Based services for adults

1.3(A): Promote Consumer Leadership.

1.3 (B) Increased Peer Support Services.

2.2 Increase capacity of system to ensure client options.

2.3 Provide Training to DMH staff and all providers on recovery, best practices and latest research.

2.1(A) Implement methods to include clients and to ensure all services are Recovery Oriented, including staff/provider training on the implementation of Mary Ellen Copeland's Wellness Recovery Action Plan (WRAP).

2.3 Train staff in Recovery Orientation, Best Practices, and Cultural Competence

## **Worthy Mentions**

There are interesting recovery implementation developments in other parts of the States, but there is inadequate space within this paper to do justice to all of them. To mention just a few more:

- In **Ohio** state and regional authorities are providing workshops that show how to translate the recovery philosophy into practice.
- In **Wisconsin** the Recovery Implementation Task Force and the Wisconsin Coalition for Advocacy are using the Guided Reflection process to help organizations that are implementing recovery. First, they review what the organizations are doing well and where they could improve, and then, they help them develop a plan to continue implementing recovery concepts.
- In **New Hampshire**, some Department of Behavioral Health funding is planned to be shifted to a 'recovery bundle.' (Fisher & Chamberlin, 2004)

And, at the Federal level, the Substance Abuse and Mental Health Services Agency (SAMHSA) recently announced \$92.5 million as 'Mental Health Transformation Incentive Grants' for seven states to move forward with recovery system transformation. As stated these grants "will provide funds to transform state mental health service delivery systems - from systems dictated by outmoded bureaucratic and financial incentives to systems driven by consumer and family needs that focus on building resilience and facilitating recovery." (SAMHSA website)

## **Service Model Innovations**

The state needs to take the lead role in a recovery system transformation, but not necessarily. Sometimes the lead comes from other sources, as in the Georgia example. Recovery programs have also been successfully implemented on a broad scale through a university initiative in Kansas and by a lead agency in Arizona, where both organized unique and extensive recovery service delivery/training systems.

The University of Kansas School of Social Welfare developed the Mental Health Wellness Recovery Empowerment Project. They describe their program:

The Wellness Recovery Empowerment Project empowers consumers to do their own wellness planning and maintenance. In addition, it trains and supports consumer-educators to facilitate recovery workshops and support groups at community support programs and consumer run organizations around the state of Kansas. It also trains case managers and other supporters on how to encourage and facilitate consumers with their wellness and recovery planning. (www.recoverytools.org)

The University of Kansas School of Social Welfare also has an innovative program called Consumer as Provider (CAP) that provides:

“a training opportunity for persons in recovery from severe psychiatric disabilities to develop knowledge and skills to be employed as human service providers, to prepare individuals for considering and pursuing post- secondary education and to create supports and mechanisms that assist Community Support Programs to hire and recruit consumer providers.” (recoverytools.org)

The University of Kansas is also exploring recovery as an evidence-based best practice, and is committed to “measuring recovery at the individual, program and system level.” (recoverytools.org)

Arizona’s Meta-Services, Inc. is another example of how recovery can be implemented on a broad scale through the aegis of a lead agency. Meta-Services, Inc. is described by Hennessey (2005) “as a state-funded vendor of services which has immersed itself in recovery by literally transforming part of its service system into a licensed, post-secondary educational institution for consumers.” As a result, says Hennessey, “consumers become students, and as students they learn how to recover.” Called META’s Recovery Education Center, it offers classes on a range of topics including wellness, community living, dealing with anxiety, voices and trauma. Hennessey says:

“as an example of the scope of this educational effort, for just one of META's classes, a WRAP-based, self-help class, the 2003 attendance was 18,600 students, with more than 200 ongoing classes per month in 20 locations. In addition, most of the classes are taught by META-trained peer specialists, approximately half of the vendor's staff is made up of consumer/providers, almost 170 people, many of them trained within META's own Peer Specialist training program.”

## **Recommendations for Recovery System Transformation**

It is encouraging to observe the progress in other quarters, but also frustrating because of the relative slow pace of progress in our own jurisdiction. Still, the Ontario mental health community seems seriously engaged by the recovery topic and its possibilities. Interest is definitely piqued, as recovery has been the focus of numerous successful conferences throughout the province over the last few years. And, considerable progress has been demonstrated at the local or agency level.

To offer some examples of recovery implementation underway in southern Ontario, the Self Help Alliance in the Guelph area has developed a PACE-based curriculum and recovery program. The Krasman Centre in Richmond Hill is utilizing the WRAP model within their structured program. The Family Outreach and Response Program in Toronto demonstrate leadership and innovation with its integration of recovery in its family support and education programs. Houselink of Toronto has completed an intensive process to implement recovery throughout the agency. Small agencies like Alternatives and the Toronto East Counselling Support Service are implementing WRAP and creating innovative programs that emphasize peer support and employment. The Psychiatric Patient Advocates Office has made strong statements in respect of survivor leadership and recovery system transformation. And before recovery was on the radar in most of North America, the Ontario Council of Alternative Businesses had laid a foundation for recovery by establishing a network of community economic development programs and businesses that are still (unfortunately) unique throughout the world. In relation to that achievement there is the Ontario Peer Development Initiative as the umbrella organization for 55 far-flung survivor-run programs and agencies. Ontario is already on the map; it just needs to get back into the game. Its future potential is on the line.

In respect of Ontario's potential for recovery implementation some recommendations, goals and requirements follow. Some of the recommendations are stated as long-term policy goals, and others relate to what can be done now in your community settings.

### **Housing and Income**

Obviously, recovery is contingent on people having the essentials of life. A CMHA Ontario paper (Everett et al, 2003) emphasized safety in the form of housing and adequate income as the bedrock of recovery:

“Housing and income supports: these basic determinants of health are ‘first among equals,’ because without them life itself is threatened. People who are homeless, living in shelters, and in and out of institutions, or without adequate food and clothing cannot focus their energy on recovery.”

### **Employment Supports**

Recovery outcomes are directly related to employment opportunities. (Warner, 1994) Employment initiatives are Ontario's strong card, and we need to play it more widely. The Ontario Council of Alternative Businesses has shown the direct links between employment and wellness. They also showed that employment was not just an opportunity but a human right, and as the basis for personal growth and social reward (see documentary film "Working Like Crazy," 1999).

Onken et al. (2002) made a strong case for complete employment integration within mainstream mental health agencies. They said, "(M)ore consumer/survivors should be employed as workers. A recovery-oriented system would employ consumer/survivors at all levels". The work of Larry Fricks and the Georgia Peer Specialist Program has shown that this is sound policy in terms of social and fiscal outcomes.

We need to move to the most direct and expedient step to recovery. We need to invest in employment programs and opportunities so that people are able to work their way back to wellness. As Pat Deegan said, "(G)oing to work is powerful medicine."

### Empowerment & Inclusion

The Ontario Ministry of Health and its transfer payment agencies should move with the times by implementing recovery, but direct survivor participation and leadership are critical, as is increased funding for peer support programs.

"Recovery is contingent on people having the power and the support to take charge of their own lives. On that basis, recovery is primarily a survivor-driven phenomenon; hence, survivor initiatives should be more widely developed and appropriately funded throughout the country." (Fisher & Chamberlin, 2005)

Onken et al. (2002) say that a recovery-oriented system cannot be built without the direct involvement of consumers/survivors:

"To build a recovery-based system, the mental health community must draw upon the resources of people with mental health problems in their communities... It is widely recognized that changing the mental health system to be more responsive to consumer needs requires the participation of consumers at all levels of policy planning and program development, implementation, and evaluation."

Fisher and Chamberlin echo that assertion and twist it just enough to show that survivors have to be included if people are going to get an exit out of the system. They say, "(M)eaningful involvement of consumers in the mental health system can ensure they lead a self-determined life in the community, rather than remaining dependent on the mental health system for a lifetime."

### Choices

On a day-to-day level, a recovery-oriented system would provide consumer/survivors with more choices and a wider range of options. Onken et al. (2002) say:

“One of the options is to be able to stop the program or drug that is clearly not working and try something else. There should be more tolerance for diversity and unusual behaviour. The system should also provide support in taking risks rather than avoiding risks and allow people the freedom to take on things and fail”

And, Patricia Deegan and others state that consumers/survivors should have the “purchasing power to purchase their own recovery supports.” They look to the day when consumers can literally act on the meaning of the term ‘consumer’, when they are able to make their own choices about what health care options they wish to purchase. She says, “(S)elf-directed care represents one method for achieving the goals of self-determination and ultimately of a recovery-oriented system through changes in financing and the elimination of third parties in the health care system”.

### Anti-Stigma

In New Zealand, they are implementing recovery with the emphasis on social justice and confronting stigma. The New Zealand Mental Health Commission released a policy document, “The Map of the Journeys towards Equality, Rights and Respect.” (1998) They say “recovery cannot proceed unless the deeply ingrained discriminatory attitudes and misconceptions concerning people with mental health problems are challenged and repudiated at every level of society.”

### Diversity Issues

Race, class, and language barriers are factors in how or whether people experience recovery. Genuine system transformation would proceed in respect of those critical factors, and would make deliberate efforts to reduce the burdens of discrimination and exclusion. There would be increased funding and recovery resource development in the communities that are experiencing marginalization and racism. Community development and recovery are, and always have been well-matched for positive outcomes. Leadership roles and opportunities need to be created. Recovery education and training groups should be established within peer support contexts in challenged communities.

Diverse voices need to be heard and respected throughout community mental health, particularly in respect of what we can learn from each other about recovery, and especially as a matter of equity and inclusion. We have to expand the framework of recovery to include one’s cultural identity, alternate approaches to healing and anti-racism as important components. Survivors from diverse cultures need to be represented with their peers at all levels of planning and consultation. There has to be enhanced diversity hiring practices in all mental health settings, including the Ministry of Health. And the survivor movement itself “has to assess its effectiveness in providing access and inclusion to populations of colour.” (Schlosser, 2000)

## Training & Competencies

In New Zealand they place great emphasis on ‘recovery competencies.’ They say that the “recovery-based competencies should not just be treated as an add-on to current curricula or training standards. They signal a fundamental change to all aspects of the education of the mental health workers. They require that some new material be taught. But they also require that some existing material be taught differently.” And, they are clear that recovery training is not reserved for new, or for front-line workers. They say that “recovery competencies have to be developed at every level or echelon of the system, all the way up to and including psychiatry.” (O’Hagan, 2001)

In the USA, the Freedom Commission’s Subcommittee on Consumer Issues made similar recommendations in its report (2003). It reads:

“The Sub-committee encourages state mental health authorities to include recovery competencies as part of their licensing and professional certification programs for mental health professionals. The inclusion of recovery competencies and consumer participation in the design and implementation of professional training programs is also urged.”

As is clear in the above quotes, recovery education and training should be available and apply to everyone involved with community mental health, whether consumer/survivor, worker, board director, planner, psychiatrist etc. Most important, intensive recovery education and training should be made available by and for consumer/survivors.

## Agency Culture Change

Community mental health agencies have to commit to a ‘culture change.’ Dorman et al (2002) say, “(T)his begins with the acknowledgement that formal mental health services often hinder recovery through bureaucratic program guidelines, poor quality services, negative messages, lack of ‘best practice’ program elements, and a narrow focus on a bio-psychiatric orientation that can actually serve to discount the person’s humanity.”

A shift to a recovery orientation will require attention to wellness and health promotion. It will require closer attention to fundamental rights, and a shift away from coercive responses. It will require more client involvement in planning and evaluation, as well as equity hiring of survivors. It will require creating peer services, such as client-run peer support and wellness groups. And, just as the client is to be viewed as a whole person so should the mental health professional conduct his or herself in the same fashion, not as detached and neutral.

These changes are, of course, already underway in many mental health agencies, and are undoubtedly helping everyone, client and staff alike, feel better about the service. As Dan Fisher said at a recent workshop, “(W)e’re talking about the recovery of the system as well as the individual.”

A recovery culture change is also underway within the confines of the institution as well. Power (2005), a mental health director with SAMHSA, says, “(T)he elimination of seclusion and restraint is possible. Two state hospitals in Pennsylvania have not used restraints, and two others have not used seclusion, in more than two years.” This relates to SAMHSA’s call for a reduction and the eventual elimination of seclusion and restraints. Charles Currie, SAMHSA’s administrator calls their use ‘a treatment failure and not a treatment practice.’ Clearly, the system is beginning to recover its humanity.

### Funding issues

The Georgia model which involves training and employing survivors to work as peer support specialists has demonstrated that funding peer support pays off. Medicaid and the state of Georgia are very impressed with the positive fiscal outcome, as well as with the positive social benefits. That said what has to be done to demonstrate that an investment in recovery peer supports is going to have similar outcomes and rewards here in Ontario and Canada? After all, the investment of time and money would be substantial. Fisher and Chamberlin (2005) say:

“It is clear that a massive shift in philosophy, accompanied by changes in funding mechanisms, will be necessary to implement successful self-determination approaches that maximize the ability of people with psychiatric disabilities to gain control of their lives.”

One wonders or worries if this is possible in a pro-business, conservative political climate. Is there the vision and the political will for such bold action? Will our political leaders act in such an enlightened and inventive fashion? It is encouraging at least that the recent Canadian Senate Report on Mental Health (“Out of the Shadows At Last;” 2006) acknowledges the value of peer support in mental health recovery and contains recommendations that these programs receive appropriate support and funding. It reads:

“The rise of the self help movement in mental health and addiction heralds a significant change in the traditional power relations in our systems of care. With sufficient and regular funding, combined with ongoing government commitment and protection, its full benefits will be realized.”

### Conclusion

Recovery – will it realize its transformative potential and have seismic systemic impact? As was mentioned at the top, it largely depends on the survivor community. As ORC member Robert MacKay puts it: “If not us, who? If not now, when?” Survivors are the only ones who can speak to the subject of recovery with any degree of credibility and conviction.

Still, we have to acknowledge that many survivors are skeptical about the recovery model as the ‘next big thing.’ Some are inclined to view it as more of the ‘same old.’ Will Ontario survivors and allies take a bigger leadership role in the recovery agenda, or will

they take a pass on yet another quixotic reform venture? At any rate, the Ministry of Health has not yet distinguished itself with any particular interest in the recovery model, so it is not altogether promising there either. It is too early to say, but a positive trajectory should be evident (or not) within the relatively short time frame of five years.

In the meantime, people who are convinced of recovery's validity should act to make important community-level changes irrespective of governmental buy-in, and we should persist in our efforts to show the efficacy and the profound human value of this approach. Fifteen years have brought us remarkable and unforeseen changes in the mental health field. Imagine how different the mental health system would be in another fifteen years if we were able to convince the government and its health ministry to implement the recovery model throughout the system. Deegan (1996) sums it up in terms of what we have to do to make that happen:

“So it is not our job to pass judgment on who will and will not recover from mental illness and the spirit-breaking effects of poverty, stigma, dehumanization, degradation and learned helplessness. Rather, our job is to participate in a conspiracy of hope. It is our job to form a community of hope which surrounds people with psychiatric disabilities. It is our job to create rehabilitation environments that are charged with opportunities for self-improvement. It is our job to nurture our staff in their special vocations of hope. It is our job to ask people with psychiatric disabilities what it is they want and need in order to grow and then to provide them with good soil in which a new life can secure its roots and grow. And then finally, it is our job to wait patiently, to sit with, to watch with wonder, and to witness with reverence the unfolding of another person's life.”

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