Project GREAT Recovery Based Training Procedures Manual

A guide to teaching professionals the recovery model of mental health care

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August 2008
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Introduction:

Though the recovery movement in mental health service delivery has deep historical roots (Peebles, Mabe, Davidson, Fricks, Buckley, & Fenley, 2007), it has truly ascended as a major influence in transformation of delivery systems in the past two decades (Anthony, 1993). In fact, the impact of the recovery movement has been so influential and far-reaching that the President’s New Freedom Commission on Mental Health (2003) determined that recovery must be the guiding vision in restructuring the national mental health service delivery system. Enthusiasm regarding the impact of Recovery based service systems centers on innovations that previously developed models did not offer: (1) broader treatment goals and aims (beyond symptom-reduction and different measures of success (i.e. hope, empowerment, life satisfaction), (2) a truly collaborative relationship between provider and consumer of services, and (3) the inclusion of individuals with mental illness, their family members, and advocacy groups as members of treatment team (Peebles, et al., 2007). The ascendance of the recovery movement in mental health care has led to the development and implementation of several educational curricula for mental health providers to assist in mental health care system transformation efforts. However, to date, few have focused on the training of doctoral-level professionals in knowledge, attitudes, and skills that center on transformation to recovery based service systems. Moreover, to our knowledge, there have been no guidelines proposed regarding the transformation of an academic department of psychiatry into a recovery based system of care. The Medical College of Georgia (MCG) partnered with the Georgia State Department of Human Resources (DHR) to develop, implement, and evaluate such an educational curriculum for providers within an academic medical institution and to disseminate the transforming principles among the state’s mental health providers with a special emphasis on doctorally-trained mental health providers. This three year effort, entitled Project GREAT (Georgia Recovery based Educational Approach to Treatment), led to the creation of a curriculum based on the SAMHSA-defined (2006) critical components of recovery. And it is from Project GREAT’s efforts that this guide for teaching professionals the recovery model of mental health care has developed.

Defining Recovery

Reisner (2005, p. 231) has asserted that “the Recovery Model is more an overarching philosophy of treatment than an empirically validated treatment in and of itself.” However, empirical support for components or aspects of the recovery perspective has been building over time (Peebles, et al., 2007). In their present stage of development, definitions of the recovery construct continue to be more philosophical than data-based, though at least one group of researchers has attempted to support some key aspects of recovery with empirical data (see Resnick, Fontana, Lehman, & Rosenheck, 2005). Davidson, O’Connell, Tondora, Lawless, and Evans (2005) view recovery as (1) consumer acceptance of mental illness and its effects/ consequences, (2) development of a sense of hope and ability to cope, and (3) a shift in personal sense of self. In addition, Davidson and colleagues (2005) indicated that recovery-oriented services are those that: (1) renew hope and commitment, (2) help redefine consumers’ sense of self, (3) incorporate illness into life as a whole, (4) help involve consumers in meaningful activities, (5) battle stigma, (6) assist consumers in assuming
control, (7) assist consumers in becoming empowered and taking initiative, (8) help consumers manage complex systems, and (9) help consumers find social support.

In an attempt to obtain consensus regarding recovery and its defining characteristics, SAMHSA (2006) convened a panel of 110 practitioners, researchers, consumers, consumer family members, mental health policy experts, and others. This panel developed a list of ten “Fundamental Components of Recovery,” which were listed as the following:

1. Consumer self-direction
2. Individualized and Person-Centered Treatment
3. Empowerment
4. Holistic treatment focus
5. A Non-linear Change Perspective
6. Strengths-Based Treatment
7. Inclusion of Peer Support
8. Respect
9. Consumer Acceptance of Personal Responsibility
10. Hope

Though this list of key components is not parsimonious (nor is it empirically-based), it represents a significant effort forward in providing a comprehensive conceptualization of the recovery perspective. Project GREAT adopted this SAMHSA (2006) definition of recovery as the basis of its educational curriculum but made some minor modifications in its core components in order to simply what appeared to be overlapping constructs. Therefore, this project endeavored to transform professionals’ knowledge, attitudes, and skills to be congruent with the following key principles of recovery:*  

1. Empowerment
2. Person-Centered Care
3. Whole Person Care (Holistic)
4. Focus on Strengths
5. Support (Systemic Treatment Orientation)
6. Recovery as a Journey (Non-linear Process)
7. Hope

*Each principle will subsequently be defined along with their associated knowledge, attitude, and skill components.

**Obstacles to Transforming Professionals’ Approach to Mental Health Care**

Recovery-oriented care requires a fundamentally shift in how providers and consumers address mental health care. It transcends the exclusive focus on symptom reduction that marks the traditional medical model and encourages the perspective that individuals with mental illness may or may not recover from the symptoms and demands of mental illness but they can always recovery in the context of mental illness a life of purpose and meaning. Consequently, recovery sees that the course of life with mental illness can be an empowered one filled with hope, while at the same time being a non-linear process or journey that includes setbacks and challenges. People living with mental illness have strengths, goals, and
dreams to be honored with holistic care that provides for well-being of the total person. In recovery-oriented care, it is neither that “the doctor” is the sole expert nor is it solely consumer self-help. Rather the recovery model advocates a collaborative model of care in which consumers participate in the development of goals, engage in joint decision making regarding health care interventions, and pursue wellness activities in order to contribute to their own health and well-being. Recovery-oriented care is what health care practitioners can offer in support of the person’s own efforts to enter into and pursue recovery. While such perspectives of mental health care appear to hold self-evident benefits for providers and consumers alike there are key obstacles that will likely hinder the transformation of mental health care to a recovery based one.

“Doctor Beliefs.” We propose that in the context of training and practice in traditional psychiatric care, key attitudes and beliefs are formed that can easily become hindrances for the adoption of recovery based approaches to mental health care. One set of beliefs that could be a hindrance for the adoption of the recovery model of care relates to the conceptualization of “the focus of healing.” From the traditional model of psychiatric care, healing is derived from an understanding of illness and their associated symptoms. Thus the focus on intervention begins with an accurate diagnosis formed by an assessment of symptoms and concludes with interventions designed to cure or ameliorate symptoms associated with the underlying illness. The elimination/reduction of symptoms becomes the sole target for successful intervention, and when symptom elimination/reduction is not achieved then traditional psychiatric care has failed. Such a myopic view of mental illness neglects, however, to consider that healing can entail more than the elimination/reduction of symptoms and can touch on such profound issues as finding purpose and meaning even while experiencing the demands/stresses of mental illness. Similarly, traditional psychiatric care has maintained that the “nature of healing” lies in accurate diagnosis by the “doctor” and scientifically derived interventions designed to address the underlying etiology of psychiatric illness. With its “recovery from” lens traditional psychiatric care maintains the focus of care on what the “doctor” can diagnosis and prescribed. Collaboration with the consumer is directed toward the “patient” providing the “doctor” with accurate information regarding symptoms and with the “patient” complying with doctor-prescribed interventions. Again with this view of healing, the professional will have difficulty connecting with other realities such as the importance of “relationship”, consumer self-efficacy, determination/hope to get better/to be better, strengths, and social support in the “healing process” and the recovery of a life with meaning and purpose. Doctors have been socialized to take responsibility for their “patients”’ health and in a positive sense there is instilled in professionals a commitment to provide the best of care on behalf of their “patients.” It is suggested, however, that this perspective regarding the “responsibility for healing” places too much emphasis on what the “doctor” is going to do versus what the consumer can and should be doing on their own behalf. Sharing responsibility for healing may be made more difficult for the professional who fundamentally believes that the “patient” is not competent to collaboratively participate in his/her care. Unfortunately, attitudinal surveys continue to suggest that mental health care providers maintain similar “stigmatizing beliefs” as those held by the lay public that individuals with mental illness are not competent, are potentially dangerous, are “weak in character” and thus responsible for their problems, and are undesirable people to be avoided (Corrigan, 2004; Mann & Himelein, 2004; Schulze, 2007). Consequently, there is little
wonder why some mental health professionals are reluctant to elicit the perspectives and opinions of their consumers when making and implementing treatment decisions. Pervasive in the attitudes, language-jargon, and practice habits with traditional care is a “them versus us” perspective in which the professional readily identifies his/her own desire for autonomy and empowerment when the matter pertains to their own well-being but has difficulty empathizing with the individual with mental illness who desires autonomy and empowerment in their mental health care. Within the largely consumer driven movement of recovery the term “patient” itself conjures up a pejorative sense that the “doctor” views the consumer from a perspective of superiority and control. Professionals, like the lay public, often do not appreciate the reality that in their lifetime as many as 50 percent of all us will have a diagnosable mental illness (Kessler, et al., 2005). And with this perceived lack of similarity with their consumers, professionals often have difficulty with empathic understanding and a collaborative sense with those whom they serve. The traditional model of mental health care has been founded on the professionals’ sense of duty to “reduce risks” for their patients. The Hippocratic Oath compels doctors to avoid doing harm to their patients, and medical risk management strategists advise against any practice that might risk an increase in symptoms or risk for relapse. “Playing safe” and avoiding risks are routinely taught and practiced in traditional models of care. Yet, the recovery model of care often encourages consumers to take risks that might offer opportunities for a life with greater purpose and meaning- even though making such efforts might result in an increase in stress and symptoms. Finally, the impetus for change to a recovery based model is likely impeded by the professionals’ general satisfaction in the traditional model of care. In the past 25 years there has been notable progress in evidence-based practice involving both psychotropic medications and psychotherapy interventions for a variety of mental illnesses. This progress has been derived from clinical science applied to traditional psychiatric models of care. Thus it is not surprising that relatively few psychiatrists and psychologists are ready to abandon an approach to mental health that seemly holds much promise for better outcomes. In contrast, the recovery model of mental health care has been primarily a consumer “civil rights” movement that has at times seemed to distance itself from the science of mental health care. Trained to respect and rely upon science for progress in their respective fields, professionals are thus not naturally drawn away from the traditional model of care that has increasingly embraced the value of scientific evidence to support a recovery model that in some circles eschews scientific evidence as irrelevant. It should be pointed out that though limited in number effectiveness studies has shown that many of evidence-based practices of traditional psychiatric care have not fared particularly well in field studies with relatively modest effect sizes being reported for both psychotropic medications as well as various behavioral intervention strategies (e.g., DeRubeis et al., 2005; Kazdin, 2008; Mitte, 2005a; 2005b; Mitte, Noack, Steil, & Hautzinger, 2005). Also, utilization findings have noted that many consumers have not found traditional psychiatric care “user friendly” or helpful (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.,1999). Thus professionals’ general satisfaction with the traditional model of care is not matched by field studies of its effectiveness nor by consumer satisfaction - perhaps data that is not widely known by practitioners in the field. Encouragingly within the recovery movement there has been increasing acceptance of the merit of and consideration of the evidence that supports the
benefits of recovery based principles and practices (Torrey, Rapp, Tosh, McNabb, & Ralph (2005).

**Consumer Beliefs.** Consumers cared for in traditional models of mental health care likely come to form very similar beliefs about their illness and their lives as those held by their providers. Mirroring the attitudes of those providing the services, consumers may readily adopt positions that “healing comes from the doctor” and not from other sources of strength or reliance. Similarly, consumers socialized within traditional models of care may readily accept that “Doctors treat illnesses” and nothing more should be expected from them as the consumer of the “doctor’s” diagnosis and traditional treatment of illnesses and their associated symptoms. While many consumers want to be actively involved in the decisions made about their health care, some consumers may feel overwhelmed by the complex information presented and the sometimes difficult decisions that have to be made about their care. Consequently, some consumers may readily embrace the perspective that “Doctors are responsible for my health and well being” and prefer to take a passive role in their mental health. During periods of deteriorating mental health, consumers may come to recognize that they are not capable of making good decisions and acting effectively on those decisions. In this state of acute crisis, they come to the conclusion that “I am too sick to make decisions,” and even when the crisis subsides they may continue to hold to the belief that they are not capable of actively participating in their own care. Suffering from the stresses of mental illness and experiencing multiple disappointments and failures in their life experiences some consumers likely struggle with ‘low self efficacy.” While such consumers may readily acknowledge that active participation in their own health care may prove to be quite beneficial in achieving positive outcomes, they do not view themselves as capable of engaging in such health promoting activities. The prospects of having to be responsible for decisions about their own care or having to engage in certain wellness activities are likely to be viewed as burdensome and overwhelming for those consumers with a low opinion about their capabilities. Finally, based on the dramatic increase in psychotropic medication use in the past 20 years, it appears that many consumers in the United States have bought into marketing messages that would seem to offer the prospects that there is a “magic pill that can fix my problems.” Given the choice of diligently pursuing information about their health care, making careful and reasoned decisions regarding treatment options, and engaging in sometimes difficult and risky efforts that might offer improved health versus taking “the magic pill” that promises to fix everything lures some consumers into a passive and complacent position of over reliance on medication and their doctors for addressing mental health problems. While the recovery model of mental health care promotes consumer choice and self-determination, it is proposed that for the system to change the following issues must be addressed:

- **“Taking an active role in treatment” may be a new idea for the consumer that is not so readily adopted.** Observational studies have shown that even for consumers wanting to take active roles in their medical care there is a tendency to be quite passive in their care (Adams & Drake, 2006).

- **Providers are likely to have difficulty identifying and incorporating consumers’ opinions or ideas when they do not coincide with their own views of best treatments** (Adams & Drake, 2006).
Being “active” in the face of feeling overwhelmed by symptoms/problems may be difficult for consumers.

In high risk situations, consumers may want information but not the responsibility to make decisions.

Being active in one’s treatment is not easy for consumers – requiring increased knowledge, increased wellness efforts, and increased willingness to take risks.

While most consumers want information about their health and want a trusting relationship with their health care provider, they vary in their preferred role of making medical decisions (Adams & Drake, 2006).

Obstacles within the Mental Health Care System. Within the mental health care system there are common issues that also are likely to make adoption of the recovery model of mental health care difficult. “Time with the Doctor is limited” and has been steadily decreasing over the past ten to twenty years across all of medicine and specifically in psychiatric care (Olfson, Marcus, & Pincus, 1999). For the most part there is an insufficient workforce to provide the mental health care that is needed for our society today, and thus caseloads of existing mental health workers are quite high limiting the time to provide quality care for consumers. Therefore, it is not surprising that psychiatric practice appears to be drifting toward primarily psychopharmacological management with precious little time available to address such recovery matters as identifying life goals relevant for treatment or identification and utilization of consumer strengths and supports to achieve life goals. If the psychiatric workforce is going to embrace the recovery model of mental health care, the implementation of recovery principles and practices must be time efficient. “Health care comes at a price” that also has been increasing over the past ten to twenty years (Zuvekas, 2001). Financially, the price for mental health care has been increasing and the financial burden being placed on the consumer for their own mental health care has been growing rapidly in the past ten years. Though mental health care is more than just a commodity that responds predictably to market pressures, the reality is that the financial price tag for recovery based care must be addressed. Systems adopting the recovery model of care have to consider how to get reimbursement for what at the present does not fall into the traditional forms of psychiatric care (e.g., peer specialist services and training in wellness activities versus traditional services that are reimbursed - diagnostic assessments, medication management, and psychotherapy). “The stress of chronic illness” represents a pervasive problem in mental health care given the enduring and recurring nature of many mental illnesses. The stresses of chronic illness increase the burden of effort on the part of the consumer, require more sustained resources to address ongoing needs, and lower consumer expectations/hope and satisfaction with mental health care (Twemlow, Bradshaw, Coyne, & Lerma, 1997). In the context of chronic illness, positive outcomes resulting from a system change to a recovery model of care are likely to be slow and more difficult to achieve thus not so readily adopted. In changing a traditional psychiatric model of care into a recovery based one it comes readily apparent that “what is in the psychiatric tool box” are not recovery principles and tools. As previously proposed, the prevailing attitudes and opinions of the traditionally trained practitioner of psychiatry are often at odds with a recovery model perspective. In addition, the skill set of the traditionally trained psychiatrist has focused almost exclusively on the fundamentals of diagnosis and psychiatric treatment with little to no attention to matters related to such recovery based skills as how to operationalize life goals, how to effectively
engage in shared decision making, or how to enhance hope. Many psychiatric training programs place a heavy emphasis on the biological aspects of psychiatric assessment and treatment such that training in basic psychosocial assessment and treatment tools that might be adapted in recovery based care are not emphasized. “Drugs treat Psychosis, they don’t provide recovery.” Traditionally available in the psychiatric toolbox are drugs and therapies focused on symptom relief – proximal outcomes – but not on long term goals of a meaningful and purposeful life. Consequently, the transformation of the traditionally trained mental health professional will require the addition of a whole new set of tools and not just an adaptation of existing tools. The pharmaceutical industry influence with its emphasis on psychotropic medications as the key element of effective psychiatric care could also have a dampening effect on the transformation to recovery. Certainly from an historical perspective, the pharmaceutical industry has played a significant role in the kind of information and educational opportunities that are made available to traditionally trained psychiatrists – predominantly funding materials, speakers, and educational events in support of medication use. And in more recent years direct marketing to consumers has placed a heavy emphasis on medication use to address problems associated with mental illness rather than the more psychosocial strategies emphasized in the recovery model of mental health care. Also in recent years the mental health care system has been persistently “underfunded and undermanned” (Appelbaum, 2002), and as a result it is suggested that the mental health system has by and large become focused on crisis stabilization and does not aspire to longer term goals that are the focus of “recovery.” Unfortunately, this crisis stabilization focus likely perpetuates and at times exacerbates the deteriorating patterns of more frequent and more severe relapses further driving the focus of care toward symptom reduction rather than the development of sustain efforts to develop and build upon the broader goals of developing a life of meaning and purpose. Organizational, traditional psychiatric systems of care may have difficulty determining “where the Certified Peer Specialist fits in.” Defining the role of the Certified Peer Specialist (CPS) in the health care team may be difficult in the context of a health care system that has only recently begun to value “Patient/Family Centered Care” in which the consumer plays an important role in the health care system. Numerous organizational/ administrative issues will have to be addressed for the CPS to become an effective member of mental health care team. Prompts and feedback to the providers are important tools in guiding practice habits and implementing system change. Yet relevant for transformation to recovery based care there are “limited or no provider prompts/ feedback regarding care” beyond audits of health care documentation and simple consumer satisfaction surveys. For recovery transformation to occur, providers must be provided prompts, reminders, and incentives to encourage the adoption of recovery based principles and tools.

In conclusion, the recovery model of mental health care demands that new competencies be developed for providers and consumers alike:

- **For people with mental illness**, they must learn how to live with, manage and have a whole life despite the illness.
- **For practitioners**, they must learn how to enhance people’s access to opportunities to “live, work, learn, and participate fully in the community” and offering the supports needed for them to take advantage of these opportunities.
To succeed in the endeavor to help providers and consumers develop these competencies, however, new attitudes regarding mental illness and mental health care must be fostered, new tools must be put in the psychiatric tool bag, and new organizational strategies must be developed in order transform the system into a recovery based model. At the same time, we propose that many components of traditional psychiatric care and the science that has supported it should not be discarded but rather should be integrated into new forms of collaborative mental health care.

**Mission and Values:**

The primary mission of Project GREAT and this training procedures manual is to assist the Georgia Department of Human Resources (Division of Mental Health, Developmental Diseases, and Addictive Diseases) in its efforts to transform the mental health care system of the state into a recovery based one that ushers in an empowering and hope-inspiring collaboration with providers and consumers. This manual focuses in particular on the development of psychiatrists, psychologists, and other doctorally trained mental health professionals as full and active participants in the recovery based transformation. It is acknowledged that many recovery training materials and programs are currently available entailing well-designed educational curricula and highly skilled presenters with years of experience in the development and dissemination of recovery principles and practices. Nevertheless, in our review of the field of recovery training we concluded that currently available materials and programs were not tailored to address the unique educational needs of the doctorally trained mental health professional. Thus Project GREAT and materials presented in this manual were designed specifically for this level of providers because of their unique perspectives on mental health care, their unique areas of expertise and skills, and the unique contributions that they could have in moving the recovery efforts forward in our mental health care system. Inherent in our approach to recovery training for the doctorally trained provider was an overarching aspiration to build “bridges” between what appear to be two disparate perspectives of how mental health care should be provided. And in so doing, (1) the positive attributes of the traditional model of mental health care would not be lost in the effort to transform the current system of care into a recovery based one, and (2) doctorally trained providers would be more willing to assimilate recovery principles and practices in their practice habits. To have successful and sustained efforts in this approach to bring doctorally trained professionals into the transformation to recovery initiative the following assumptions/ beliefs and values have guided Project GREAT:

**Assumption/Belief:** The current system of mental health care is broken and in need of change.

There is accumulating evidence that the current system of mental health care is broken. Prevalence rates of mental illness are trending upward. The burden associated with mental illness continues to be distressingly high. While financial restraints to obtain mental health care vary by region, many consumers continue to be reluctant to access and/or maintain their participation in mental health services that they perceive to be disempowering and not relevant to their needs. There continues to be a gap between the need for and availability of high quality mental health care. Stigma and its impact on society continue to be a major
source of suffering, prejudice, discrimination, and inadequate treatment for those experiencing mental illness. Unfortunately, some of the traditional care providers’ beliefs, attitudes, and practice habits are likely contributing to the failures of the current system of mental health care.

1. **Value:** Consumers desire mental services that are empowering, relevant to their needs, available, and free of stigma.

   **Assumption/Belief:** “Recovery” can be legitimately construed and pursued as: (1) Recovery from mental illness in which the goals focus on the reduction or elimination of symptoms and the amelioration of the deficits caused by mental illness; and (2) Recovery in mental illness in which the goals focus on learning how to live a safe, dignified, full, and self-determined life in the face of the enduring disability which may, at times, be associated with mental illnesses.

   The traditional model of mental health care has focused on recovery from mental illness and thus has pursued and incorporated empirically derived practices of diagnosis and treatment. This emphasis on clinical diagnosis and treatment has resulted in advances in the field in regard to how to better understand and treat mental illness. Therefore, this aspect of traditional care has merit and should be a continued aspect of effective mental health care. The recovery movement has legitimately pointed out the narrowness of this traditional perspective on mental illness and captured another important prospect of the human experience that elevates and empowers individuals to pursue a life of purpose and meaning that can be defined and achieved even while experiencing the adverse effects of a mental illness. The recovery perspective offers new hope in its definition of recovery.

2. **Value:** Consumers will benefit from a mental health care system that values the benefits that can be derived from traditional diagnostic and treatment procedures as well as the benefits that can be derived from a recovery based emphasis on individual choice, empowerment, and resilience.

   **Assumption/Belief:** For an effective and sustainable transformation of the current mental health care system to take place, recovery should be a joint provider and consumer effort.

   For providers to embrace and actively engage in recovery based mental health care, they will have to develop new knowledge and skills pertaining to their conceptualization of mental illness, treatment, and recovery. At its core, the recovery model will direct providers to be more collaborative with treatment decisions and activities, to be more versed on strengths and resilience based strategies, to broaden definitions of the “treatment team” to include peer specialists, and to be more aware of the critical nature of hope in the face of enduring symptoms and the disability sometimes associated with mental illness. Likewise, consumers participating in recovery based mental health care will have to develop complementary knowledge and skills in order to be able to work collaboratively with their providers. In the recovery model, at the least consumers are directed to be better informed about their illness and treatment choices, to be better able to identify their own desires and goals regarding treatment outcomes, to be active in pursuing wellness and other growth enhancing efforts, to
be more informed regarding supports systems and how to access and use them, and to be better able to find the strengths and hope within themselves and support systems. Recovery based mental health care requires vital knowledge and skills that have not be emphasized and have not been readily available in traditional mental health care.

3. Value: Consumers will benefit from a mental health care system that emphasizes a collaborative partnership between the consumer and providers in which they share common goals, are able to identify relevant tasks, and enjoy mutual trust, respect, and acceptance of the other’s unique contributions to the pursuit of wellness.

Assumption/Belief: Effective transformation of the mental health care system to a recovery based one is more likely to be achieved by the combined forces of science and the “voice” of people who have personally experienced mental illness.

A scientific approach to mental health care practice has and could move the mental health system forward in regard to providing access to care that is demonstratively proven, relevant, and effective in regard to achieving outcomes that are desired by consumers. The recovery literature cogently points out, however, that the lessons learned from those who have lived with mental illness can and should direct improvements in the mental health system as well. Torry et al. (2005) point out that both evidence-based practices and recovery movements “…warn of the iatrogenic potential of the service system, promote consumer-centeredness in the delivery of services, and stress the importance of equitable and timely access to effective practices. Together, the movements provide hope and guidance for improvement in the field.” (p. 96). We would emphasize that both movements can inform the other. Evidence-based strategies can provide useful tools for refining ways recovery principles can be implemented in clinical practice. Likewise, evidence-based strategies can inform educators/trainers and administrators as to effective ways of fostering the adoption of recovery based principles in the mental health care system. Similarly, the consumer’s voice is essential in directing science to the study of relevant processes and outcomes that are founded on recovery principles. The consumers’ individual desires and goals, their sense of what processes facilitate progress in their lives, and finally their sense of their societal rights and a culture that foster choice, respect, healing rights all represent invaluable insights in regard to the direction that scientific study and the development of evidence-based practices should be headed.

4. Value: Consumers will benefit from a mental health care system that is shaped by the knowledge gained by science and by the knowledge gained through the perceptions and insights of those who have personally experienced mental illness.

Assumption/Belief: At its core, the recovery model of mental health care emphasises the value of the consumer’s voice in understanding and effectively responding to the challenges of mental illness.
The recovery movement champions the importance of the lived experience in regard to understanding and responding to the challenges of mental illness. Moreover, the individuality of the lived experience with mental illness should necessitate inquiry of the unique experiences and perceptions of the consumer as an integral component of the process of shared decision making. Yet, too often consumers’ perceptions and opinions regarding their lived experience have not been routinely elicited or incorporated in the traditional model of mental health care. Perhaps it also fair to say that mental health consumers have not always been skillful in communicating and advocating for their own needs and desires. For the mental health system to truly embrace provider-consumer collaborative care in which consumer perspectives are routinely elicited and used to guide treatment then the consumer must become skilled at voicing opinions and likewise the providers must learn to listen. Sabin and Daniels (2002) suggested that one effective strategy in getting an organization to listen to the consumers is to bring consumers onto the staff and to give them a voice in organizational policy and practices. In Georgia, CPSs have become the fulcrum for such a consumer driven strategy to change the system (Sabin & Daniels, 2003). These CPSs must have had experience with mental illness and evidence of demonstrated efforts in self-directed recovery which along with training in advocacy and support skills enables them to provide direct supportive services for consumers and also to serve as change agents in the mental health system. Specific to the latter agenda, CPSs have the unique combination of experience and training that could add much needed consumer perspectives and insights in guiding the development and implementation of mental health services both at an individual consumer level and at an organizational level. Specific to the focus of our mission of developing psychiatrists, psychologists, and other doctorally trained mental health professionals into full and active participants in the recovery based transformation, it is proposed that the CPS should play a major role in giving voice to the consumer and teaching providers to be better listeners.

5. Value: Pivotal to system transformation to a recovery model of mental health care is the inclusion of the certified peer specialist not only as one of the direct service providers but also as a key educator and system change agent.

**Personnel:**

Decisions regarding personnel needed for recovery based training are intimately linked to the intended targets for the training as well as the nature of the material being presented. The targets for training can be conceptualized in three key ways: (1) who is being trained; (2) what is the content to be learned; and (3) what type of outcome or change is desired.

**Provider-Driven Training:** As previously stated, the primary focus for the “Who is to be Trained” in this project has been on doctorally trained mental health professionals – psychiatrists, psychologists, and other doctorally-trained mental health care professionals. The implications of focusing on this level of mental health provider are important in regard to what type of personnel is needed to effectively train this population of learners. First, it would be beneficial to include in the teaching team trainers who have similar educational and clinical experiences as those of the learners in order to maximize the relevance of the
instruction being provided. Provider-Trainers with doctoral training in the mental health field and practical experience in the provision of mental health care have the advantage of greater familiarity with the existing knowledge, beliefs, attitudes, and practices of the learners targeted. With this knowledge of the learners, the content can be presented in a more effective manner that moves learners forward from their current level of knowledge and understanding - educational research supports the benefits of beginning with the learner at their current level of knowledge and life experience (Irby & Papadakis, 2001; Stuart, Tondora, & Hoge, 2004).

Second, it would be beneficial to include in the teaching team trainers who have or have acquired talents in delivering instruction in a dynamic, pragmatic, amicable, and intellectually competent manner. In regard to the “Content to be Learned” issue, one of the great challenges of teaching recovery principles and practices is the complexity of the information that must be taught. As previously noted, the SAMHSA (2006) conceptualization of recovery entails ten different domains of recovery, and a careful examination of these domains makes it clear that each one of these components of recovery has its own subset of complex and at times vague concepts and less than clear application principles. Teaching recovery is not analogous to teaching proper hand washing techniques to medical personnel, and thus the instructional skills required to effectively teach recovery are considerable. Furthermore, in regard to the “Type of Outcome or Change Desired”, the message of the recovery model of mental health is significantly more than a transfer of knowledge of how mental health care should be provided. Intertwoven among the concepts of recovery are the emotions and attitudes that are the compelling force behind the recovery movement. Therefore to train others in the recovery model of mental health care, the instructor must possess a strong conviction of its worth and have the ability to stimulate serious contemplation of the fallibilities of traditional psychiatric practice while inspiring a heart felt desire to “do more” for those facing the challenges of mental illness. Clinical teaching in general is demanding, and those who do it well have passion for their work as well as a high level of technical skill (Bussema & Nema, 2006; Irby & Papadakis, 2001; Stuart, Tondora, & Hoge, 2004). This manual will hopefully provide a useful guide as to instructional approaches that could be effective in teaching recovery principles and practices. The outcome of the instruction provided on the basis of this manual, however, will rely heavily on the ability of the instructor to gain rapport with the learning participants, to passionately convey the message, and to share inspiring stories that move providers toward knowledge and attitudes that are embedded in the recovery model of mental health care. Finally, it would be beneficial to include in the teaching team trainers who have personally experienced the process of transformation from a traditional model of mental health care to a recovery based on. With this personal experience of professional practice change, the trainer would have the advantage of having a greater appreciation for the challenges involved in system/practice change and thus could better direct the learner in addressing these challenges. Moreover, a “coping model” of a provider who has actively engaged in and succeeded in transforming their practice into a recovery model is a valuable change agent tool. In summary, it is proposed that recovery education will benefit from a training team that includes provider-instructors who:

1. Have doctoral training and clinical experience relevant for the practice of mental health care.
2. Have talents in delivering instruction in a dynamic, pragmatic, amicable, and intellectually competent manner.
Project GREAT Recovery-Based Training Procedures Manual

3. Have personal experience of changing their professional practice from a traditional model of mental health care to a recovery model of care and are able to demonstrate a passion for the recovery movement.

**Consumer-Driven Training:** The recovery model of mental health care champions the individuality of the lived experience and the ownership of recovery process (Oades, Deane, Crowe, & Gordon, 2005). Increasingly the consumer has been found to be a valuable part of the recovery education efforts (Jacobson & Curtis, 2000; Young et al., 2005), and research has suggested that by involving consumers in mental health education both positive knowledge and attitude change can be enhanced (Wood & Wahl, 2006). In addressing diverse problems with stigma/prejudice/ discrimination, there is accumulating evidence that exposure to the “stigmatized” group can reduced adverse attitudinal/social responding problems (Wood & Wahl, 2006). Returning to the targets of training, it proposed that there is likely a “Who” by “Outcome” interaction, such that consumers can certainly be helpful in teaching providers recovery principles and practices, but they are absolutely essential in addressing matters of attitude. It is proposed that by presenting competent consumers articulately telling their recovery stories, providers will begin to form more positive impressions of consumers and their ability to collaborate in their care (Corrigan, et al., 2001). Moreover, by encouraging consumer participants to contrast their traditional psychiatric care experiences with recovery care experiences, providers would have “real examples” of the potential value of the recovery model. Therefore, it would be beneficial to include in the teaching team trainers who are CPSs with the following qualifications in addition to their training in providing consumer support services: (1) meaningful lived experiences with mental illness so that insights regarding the impact of mental illness and associated interventions can be shared with providers; (2) recovery successes such that the message can be effectively communicated that recovery is possible and insights can be gained from consumers regarding how wellness, purpose, and meaning can be achieved through the strengths and resources of the consumer; (3) complementary attitudes and a social style such that the consumer(s) can facilitate a sense of true partnership with the consumers and providers in implementing a recovery model of mental health care. As emphasized with the provider trainers, the effectiveness of the CPS(s) in teaching and achieving the desired outcomes will rely heavily on their skills in gaining rapport with the learning participants, passionately conveying the message, and articulately sharing recovery stories.

While the primary focus for the “Who is to be Trained” in this project has been on doctorally trained mental health professionals, the consumer must be a target of recovery instruction as well. Inherent in the recovery model of mental health care is the shift in consumers’ roles to be more active in their own care. This will require, of course, instruction of the consumer, and in our project we conceptualized the training of the consumer as achieving two important instructional outcomes: (1) the consumers develop knowledge, attitudes, and wellness skills that facilitate recovery; and (2) the consumers learn to better inform (instruct) their providers regarding what they need, what they want, and what they can contribute in pursuing life and treatment goals. In light of the later instructional outcome it is proposed that recovery instruction should facilitate the development of a reciprocal instructional style in which consumers and providers inform one another as they learn to partner in recovery based mental health care. The CPS is viewed to be instrumental when targeting the consumer. As a “coping model” that has lived experience with mental illness as
well as knowledge of and success in using recovery principles, the CPS is considered essential in consumer instruction.

**Administrative Support:** Finally, when considering the “Type of Outcome or Change Desired” the instructional goals must be considered in the broader context of program development. For a mental health care system to transform to a recovery based one, the instruction in recovery must be supported by an administration that: (1) encourages providers to participate in recovery educational events; (2) hires and supports CPSs; (3) provides administrative support for the provision of recovery educational materials, recovery based health care documentation, and recovery based health care prompts (e.g., newsletters, documentation audits, consumer satisfaction surveys, etc.); and (4) facilitates the participation of consumers in providing ongoing consumer advocacy and program development advisement. Thus an essential member of the teaching team must be a program administrator that can provide support to the recovery educational efforts and can facilitate system responsiveness to the changes proposed by the recovery model of mental health care.

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**Training Program:**

System transformation entails multiple levels of intervention that would be beyond the scope of this training manual. Therefore, this manual will direct its attention to recovery instruction in service of the knowledge, attitude, and clinical practice changes that would be required elements in transforming a mental health care system into a recovery based one. Similar to the selection of and qualifications of needed personnel, the curriculum/design of the proposed recovery training in based on considerations of the targets for training.

**“Who is being Trained.”** With the focus on doctorally trained providers of mental health care – psychiatrists, psychologists, and other doctoral level providers, the curriculum/design must take under consideration that the instruction is for adult learners and practitioners in traditional models of mental health care. Based on educational theory and research (e.g., Bowen, 2006; Bussema & Nema, 2006; Geoffrey, 2006; Irby & Papadakis, 2001) the following instructional strategies were emphasized in addressing the nature of who is being trained:

1. **Instruction should attempt to connect learning to the participants’ preexisting data bank, and draw out their experiences that were relevant to the topic.** By making this connection to past knowledge and current experience, the adaptability and relevance of the new material are enhanced. Furthermore, this connection emphasizes that current psychiatric/psychological knowledge and reasoning are relevant and valuable for recovery based care – reinforcing an underlying theme that the providers were welcome participants in the recovery movement. Throughout Project GREAT workshop presentation materials, new principles and practices are compared and contrasted to existing knowledge and perspectives.

2. **Instruction should attempt to include materials in the form of clinical situations or consumer problems/treatment stories to help the participants see that learning the recovery material at hand could help them achieve their goals.** Our targeted participants are likely to be highly goal directed and relevancy oriented. Therefore,
Project GREAT Instructional Materials Needed to Emphasize Clinically Relevant Situations, Problems, and Goals.

3. **Instruction should attempt to enhance a sense of challenge and active learning through Socratic questions, clinical vignettes with group discussion, and role-play (skill practice).** Didactic instruction that puts participants in passive learning roles tends to be ineffective with adult learners. Instructional effectiveness can be enhanced when participants are challenged by the material but also given a sense that they have within their informational and reasoning capacity the ability to successfully master the new material. Therefore, interwoven among Project GREAT lecturing materials were active-participatory learning techniques.

4. **Instruction should attempt to validate and/or illustrate recovery principles and practices from a scientific/evidence-based practice basis.** Trained in the traditions of medical/social science, our targeted participants are more likely to accept and assimilate recovery principles and practices when they are “legitimized” by scientific evidence. Though not exhaustive, Project GREAT materials routinely included research findings to support the materials being presented.

5. **Instructional materials should include practice prompts to be used as tools in a recovery based practice.** Research has indicated that prompts to engage in recommended practice habits can be effective in implementing consumer care changes (Grol & Grimshaw, 2003). Also, doctoral level providers must be efficient and goal-oriented in their work due to the heavy demands on their time and skills. Therefore, it is important to translate the more abstract recovery principles into concrete action in order for recovery to be “put into practice.”

6. **Instructional materials should include pre and post presentation measures of recovery knowledge and recovery related attitudes.** By challenging participants in their current state of knowledge and attitudes in the pre-instructional assessment “deficits” or “problems” can be identified and used to motivate learning. By providing post presentation assessment, participants can enjoy the satisfaction of progress in their recovery knowledge and attitudes. The **Project GREAT Recovery Knowledge Measure** we used was developed by the Project GREAT team and was based directly upon the curriculum presented in the initial recovery principles and practices workshop. The 26-item multiple choice measure focuses on knowledge of the key recovery components presented with many of the questions requiring participants to apply their knowledge of recovery principles to clinical situations. Reliability estimates have ranged from an alpha of .68 to .74 (Peebles, Mabe, Fenley, Buckley, et al., 2008). The **Recovery Attitudinal Pre-Post Survey** was used to assess recovery related attitudes (See Cook, Jonikas, & Razzano, 1995). This instrument was developed and employed in a study by Cook, Jonikas, and Razzano (1995) that examined consumer vs. non-consumer training of mental health practitioners in the Recovery model. The survey contains 30 items that are intended to assess practitioner attitudes related to recovery (“the likelihood that mental health consumers could live a normal life, return to work, and become productive citizens,”) Stigma (questions regarding provider attitudes about consumer “potential for violence,” “personal appearance,” and provider satisfaction with their work in severe mental illness) and Consumers as Practitioners of mental health services (provider opinions regarding the abilities of consumers to deliver service, train others, and to be dependable). Participants are asked to rate their
level of agreement (6 = strongly agree to 1 = strongly disagree) with each item. Approximately half of the items are reverse scored. A higher score on the survey indicates a more positive attitude toward a Recovery perspective, reduced belief in attitudes associated with stigma, and greater belief in Consumers as Practitioners. Alpha levels for the total scale measured in this study were as follows: .55, .54, and .68.

“Content to be Learned.” As previously noted, one of the great challenges of teaching recovery principles and practices is the complexity of the information that must be taught. Upon review of the ten principles proposed by SAMHSA (2006), it was concluded that some of the principles readily could be incorporated into other recovery principles allowing for a more parsimonious model of recovery. Thus Project GREAT attempted to reduce the complexity of the recovery model by condensing the SAMHSA (2006) ten principle model of recovery to seven key principles. The resulting seven principles adapted from the SAMSHA model and emphasized in Project GREAT are the following:

1. Empowerment
2. Person-Centered Care
3. Whole Person Care (Holistic)
4. Focus on Strengths
5. Support (Systemic Treatment Orientation)
6. Recovery as a Journey (Non-linear Process)
7. Hope

To further simplify the recovery instruction, four principles of recovery were emphasized in the materials presented as well as the practice tools provided by Project GREAT. These four recovery principles were conceptualized as representing areas of needed practice change that would be feasible within the time constraints of traditional mental health practice and readily learned and adopted by providers schooled in traditional models of mental health care. The learners were challenged to change their practice by incorporating the following critical aspects of recovery:

1. Hope = A hope inspiring strategy.
2. Self-Determination = Person-Centered goal setting and shared decision making.
3. Self-Efficacy = Assessment of individual strengths as related to personal goals.
4. Support = Identifying key resources.

For each of these four aspects of recovery deemed to be critical to recovery based care, providers prompts were provided that could be readily incorporated into mental health practice. Listed below are these practices prompts along with a brief description of their form and implementation (See APPENDIX A):

1. Hope – The State Hope Scale (Snyder et al., 1996) - This is a brief six-item assessment of the consumer’s current level of hope. The even-numbered items are agency (belief in one’s ability to engage in actions that could bring about positive change), and the odd-numbered items are pathways (belief that there are actions
available that can lead to positive change). The State Hope Scale is a tool to be given to consumers at the time of any contacts with providers – to be completed before seeing the provider and given by the consumer to the provider as a prompt for the provider to consider the consumer’s current level of hope as part of their assessment and treatment efforts.

2. **Self-Determination -Behavioral Health Planning Form (Project GREAT)** – This is a one-page form that prompts the consumer to identify one to two life goals that would be used as part of treatment planning. The consumer is given the Behavioral Health Planning Form to be completed before the initial intake evaluation and once completed given to the provider as a prompt for determination of treatment goals relevant for the consumer’s life goals. This form would be updated periodically dependent upon the progress of the treatment and changes in life goals.

3. **Self-Determination - Shared Decision Making Checklist (Project GREAT)** – This is a one-page form that prompts the provider to conduct assessment of the quality of shared decision making care provided on behalf of the consumer. For example, the provider is asked to rate to what extent, “Provided information about treatment options (including options of doing nothing).” The provider and/or the provider’s supervisor would complete this form following a provider contact or as part of the routine case management supervision conducted for a provider in training.

4. **Self-Efficacy – Strengths Assessment Form (Project GREAT)** - This is a one-page form that prompts the consumer to identify strengths that might be useful in working toward achieving life goals. The consumer is given the Strengths Assessment Form to be completed before evaluation and treatment provider contacts (frequency based on evaluation/treatment plan) and once completed given to the provider as a prompt for determining/updating an action plan toward working on life/treatment goals.

5. **Support - Project GREAT Recovery Assessment Form** – This is a consumer encounter documentation template that prompts the provider to record consumer life goals and associated consumer/family and provider tasks relevant for achieving these goals, assessment of consumer strengths, assessment of support systems that might be helpful in addressing life/treatment goals (including referral for CPS services), and assessment of the consumer’s current state of hope. Use of this template is recommended for all consumer encounters.

“What type of outcome or change is desired.” Project GREAT training seeks to teach recovery principles in a manner in which the providers will be enabled to not only possess knowledge of its key principles but also endeavor to implement them in their practice. Educational research has indicated to achieve this practice-based outcome passive non-interactive teaching strategies that include lecture, a single workshop, handouts, and audio-visual materials are insufficient (Stuart, Tondora, & Hoge, 2004). Based on reviews of educational strategies that have exhibited some positive impact on provider practice habits, the following strategies are proposed and were incorporated at varying levels in Project GREAT training efforts (For review of strategies to achieve clinical practice change see Bowen, 2006; Bussema & Nema, 2006; Geoffrey, 2006; Grol & Grimshaw, 2003; Irby & Papadakis, 2001; Stuart, Tondora, & Hoge, 2004; Van Der Vleuten, Dolmans, & Scherpbier, 2000):
1. **Lectures/Workshops should be conducted using an interactive style.** As previously noted, all Project GREAT training presentations integrated the use of Socratic questions, clinical vignettes with group discussion, and role-play (skill practice). Through these active teaching strategies learners are encouraged to explore their own beliefs about recovery, determine clinical implications of recovery principles, and discover ways to apply recovery principles in their practice.

2. **Training should include teaching in “real life settings” as much as possible.** As part of the introductory recovery training workshop, a role play of a “15-minute medication check” contact was provided in order to enhance the opportunity to relate recovery principles to a “real” consumer encounter. Likewise, case vignettes were constructed in a manner that enhanced their association with “real” consumer encounter issues/problems. It is proposed that after the introductory workshop that the training should progress to include outreach visits/academic detailing in which the trainers meet with providers in their workplace to observe clinical practice and provide supervisory feedback regarding the implementation of recovery principles. The CPS’s role in providing on-going teaching and supervision in the implementation of recovery principles is critical to “real-life” context training. Consequently, the CPS must be routinely involved in clinical care team meetings and “given a voice” in providing feedback about the implementation of recovery principles in the care being provided. Finally, clinical supervisors must be incorporated into the recovery training team – becoming not only knowledgeable about recovery principles but also skilled in supervising trainees in the development of recovery based skills. Thus training efforts must target clinical supervisors as invaluable in the development of a mental health workforce that skillfully uses recovery principles.

3. **Training should include follow-up reminders.** Project GREAT training included reminders in the form of the practice prompts described above that engaged the consumers in providing recovery relevant information to their providers, a self-assessment and/or supervisor assessment of shared decision making practice, and documentation prompts for recovery based information. Moreover, on-going audits of consumer mental health care documentation can provide additional reminders to providers to not only engage in recovery based practice but to systematically document their efforts. Project GREAT also implemented a monthly newsletter that provided recovery based information and news as well as ongoing teaching of recovery principles. (See Appendix B for samples of the “Taking Flight” newsletter).

4. **Training should include recruitment of “opinion leaders.”** Project GREAT training efforts included the identification of providers within the system that have influence both in regard to clinical training and clinical service organization. Periodic contacts with these “opinion leaders” have been and can be useful in regard to continued efforts to “market” recovery principles and practices within the system as well as to elicit feedback and recommendations regarding recovery training efforts.

5. **Training should include on-going consumer mediated feedback and education efforts.** Recovery based mental services must entail ample opportunities for consumers to give input as to the services being provided by the system and by individual providers. The impact of this consumer mediated feedback can result in enduring practice changes favorable for recovery based care. Project GREAT efforts to incorporate the “consumer voice” in shaping recovery transformation of the system
and practice changes in its providers have included the development of a Behavioral Advisory Council. This council consists of consumers that are encouraged to examine the form and quality of the mental health care being provided in the system and to make recommendations of changes that might make the system more “consumer friendly” and consistent with the principles of recovery. Unfortunately, “patient satisfaction surveys” that are in use in many, if not most, traditional mental health care systems are too broad or just irrelevant to the task of determining whether or not providers are adhering to the key principles of recovery. Project GREAT proposes that by revising “patient satisfaction surveys” to include assessment of adherence to recovery principles and practices, the consumer can help to effectively change the system. Moreover, with the provision of consumer satisfaction data to individual providers more enduring practice change can be made possible.

As previously noted an important outcome of recovery training should be attitudinal changes in the providers. Specifically targeted in this regard are the following desired attitude changes: (a) The “them versus us” attitudes often held by providers should be replaced with a “we” perspective in which providers have a greater appreciation for the similarities shared with consumers regarding interests, strengths, values, and life goals; (b) The stigmatizing attitudes held by the lay public, providers, and consumers alike should be replaced by attitudes of respect and empowerment in which consumers are viewed as morally equivalent and capable of making decision regarding their own care and as being agents of positive change in their own lives; (c) Paternalistic attitudes regarding the nature of mental health care in which the provider is the primary source of healing should be replaced with a partnership view of the nature of healing/recovery. To achieve these attitude changes, Project GREAT proposes and made use of the following educational strategies:

1. **Routine exposure to recovery stories.** Though the empirical literature has not adequately addressed this matter, Project GREAT has observed that the value of personal recovery stories cannot be underestimated in regard to efforts to shape provider understanding of the key principles of recovery, to inspire consumers and providers to aspire to the practices of recovery, and to achieve genuine appreciation and respect for consumers and their aspirations, hopes, and strengths. Inherent in these recovery stories are lived experiences of those facing the challenges of mental illness. Inherent in their telling is an authenticity that recovery is “real” and not just an aspiration drawn from the more abstract principles of recovery. Moreover, recovery stories convey struggles and emotions that stir up affect in the learner that can more effectively influence beliefs and attitudes than mere presentation of recovery principles. And for consumers and providers alike, recovery stories provide vivid pictures of “coping models” who did not easy master the challenges of mental illness but rather endured hardships and setbacks in order to achieve a life of purpose and meaning. We have found these “coping models” to be both inspiring and highly practical in helping consumers and their providers find the will and the way to achieve recovery. Given their value, Project GREAT advises and has made use of recovery stories as much as possible. In workshop presentations, recovery stories have been integrated through: (a) clinical vignettes provided by the provider presenters; (b) pictures of people of notoriety who have faced the challenges of mental illness (e.g.,
Natalie Cole – depression, Buzz Aldrin – depression, Jane Pauley – Bipolar Disorder, Earl Campbell – panic disorder, John Nash – schizophrenia, etc.), (c) recovery stories by the Project GREAT CPS presenter; and (d) recovery stories by “local” CPSs (CPSs who are working in the area in which the workshop is being presented. We propose that by including “local” CPSs in presentations the impact on attitude change can be enhanced due to the familiarly and contact with the CPSs telling their stories. When using “local” CPSs or other consumers to tell their recovery stories, however, we advise that some coaching be provided in order to maximize their benefits in changing provider attitudes. Specifically, we have offered the following stylistic pointers in the telling of recovery stories: (a) be time efficient in telling the story – recovery stories can be quite lengthy as individuals that have faced the challenges of mental illness can readily attest; (b) while it is quite appropriate to point out disappointments with the mental health care that was received along the journey, it is best not to denigrate the recovery story into merely a “provider bashing” session; (c) emphasize areas of one’s strengths or resources that were instrumental in achieving recovery – providers need to be repeatedly reminded that consumers have strengths and resources that can be valuable in efforts to achieve positive outcomes; and (d) when possible point out positive things that providers did to contribute to recovery efforts – providers need hear that there are actions that they can take beyond the traditional treatment efforts that can be enormously beneficial for consumers and in fact are being carried out by providers in the field.

2. **Routine contact with consumers outside the usual clinical practice context.** At the very least, consumers should play active roles in recovery instruction (Jacobson & Curtis, 2000; Young et al., 2005) and in administrative decision making. When the provider-consumer contacts are not restricted to the “one down position” often observed in the traditional “patient role” then providers have the opportunity to better appreciate the similarities with and positive attributes of the consumers that they serve. In fact, there is accumulating evidence that by integrating education with personal contact with individuals with mental illness, genuine stigma reduction can occur (Wood & Wahl, 2006). Project GREAT recommends and routinely involves CPSs in recovery workshops as trainers – not only to tell their recovery stories but also to actively contribute to the discussion of Socratic questions, clinical vignettes, and role-play. Likewise Project GREAT recommends that CPSs should actively engage in clinical team discussion of consumers and other training activities with providers and doctoral trainees. Additionally, as part of Project GREAT’s efforts providers and administrators are invited to attend the Behavioral Advisory Council monthly meetings to participate in discussion of clinical and administrative issues relevant for consumer friendly/recovery based mental health care. Finally, providers and doctoral trainees should be routinely encouraged to attend mental health support/advocacy group meetings (e.g., NAMI) and advocacy dinners.

3. **Ongoing communications with “opinion leaders.”** The periodic contacts with the “opinion leaders” previously mentioned in the context of “marketing” recovery principles and practices should also endeavor to promote recovery friendly attitudes. These leaders are theoretically in positions of social influence that affect the prevailing attitudes within the system (Corrigan, 1998; Grol & Grimshaw, 2003) and thus should be specifically targeted for attitude change efforts. Communications with these
opinion leaders should include assessment of attitudes toward recovery and recovery training efforts in order to determine possible impediments and possible supportive agents toward change. Furthermore, as much as possible opinion leaders that are supportive of the recovery efforts should be recruited into the ongoing assessment of and planning of recovery educational interventions. By engaging the opinion leaders into the recovery educational process, then it is more likely that a “buy in” to the efforts can be established not only in regard to the opinion leaders but also in regard to those that they influence. The periodic meetings with the opinion leaders must convey a collaborative tone and openness to feedback regarding their views regarding provider and system changes being sought. A noteworthy limitation to the use of opinion leaders, however, can be the difficulty of identifying who the “leaders” are (Grol & Grimshaw, 2003). Project GREAT approached this issue of the identification of opinion leaders within the system by selecting training and program directors that by position had influence on the ongoing education and service provision within the department. Additionally, the Project GREAT personnel worked together to identify individuals within the department that exhibited interests and supportive attitudes regarding the recovery training efforts (these included faculty and trainees). By combining positional leaders alongside with faculty and trainees supportive of recovery educational efforts it was hoped that a receptive tone for attitude change could be established.

Recovery Training Powerpoint Presentation:

The attached Powerpoint Presentation is designed to be a 3-4 hour introductory training session on the basic principles of recovery and proposed practice applications for using recovery principles in the provision of mental health care by doctorally trained providers. The presentation is comprised of three primary sections that focus on: (1) an examination of the traditional model of mental health care with an emphasis on its problems and limitations; (2) an introduction to the definition/meaning of “recovery” from various points of view; and (3) an overview of the key principles of recovery and their potential clinical applications. The presentation includes multimedia components that entail carefully selected pictures/images/videos that are intended to elicit cognitive and affective responses, and a team teaching style that combines the efforts of provider trainers and CPS trainer(s) that hopefully portray competent and articulate presenters who understand and believe in the virtues of the recovery model of mental health care. Moreover, it is important that the provider and CPS trainer(s) model a collaborative and complementary style of relating. The workshop materials must be complemented by a rich array of provider and CPSs recovery stories that illustrate the reality and affective/attitudinal importance of the content being taught. Pre and post presentation assessment of recovery knowledge and attitudes is also recommended in order to facilitate trainees examination of pre-presentation knowledge and attitudes and in contrast to what hopefully is learned across the course of the presentation (See Appendix C for knowledge and attitude assessment instruments).
Recovery Training Strategic Plan:

The process of transforming the practices of mental health providers into a recovery based ones is not a simple or rapid one. Moreover, while elements have been proposed in this process relatively little is known regarding how to strategically implement the various components of recovery training and system transformation. Nevertheless, Corrigan (1998) provides some data and theoretical perspectives on training and development strategies in psychiatric rehabilitation work that could be helpful and were incorporated in Project GREAT’s efforts. Below is the recovery strategic plan that Project GREAT that has been following with a brief rationale for elements and strategic timing of the elements in the plan:

**Step 1:** Elicit administrative support and commitment to recovery training.

**Rationale:** Recovery training requires organizational resources and cultural changes that require active participation by administrative leaders in the mental health care system. The virtues of the recovery model of mental health care must be clearly communicated to these administrative stakeholders, and their perception of need of and capacity for change must be targeted in order to begin to establish the foundation for change. To this end, administrative input throughout the planning and development of recovery training is essential.

**Step 2:** Training personnel need to be identified and prepared for the educational presentations and on-going implementation of training activities.

**Rationale:** As previously stated, the recruitment of a CPS trainer(s) is absolutely essential for effective recovery training. Furthermore, providers committed to the recovery model of mental health care need to be identified and recruited into the recovery training team. This manual hopefully provides the start-up materials needed to prepare for the initial educational interventions, but on-going training events and supervision will also going to be needed.

**Step 3:** Identify “opinion leaders” and engage them in participative decision making regarding the strategies to follow in the recovery training.

**Rationale:** “Opinion leaders” within a mental health care system are more likely to facilitate effective training and system change if they have been a part of the design and implementation of the program. After providing an overview of the nature and intent of recovery based mental health care and the proposed recovery training, “opinion leaders” are then guided in an ongoing dialogue of how best to train providers in the recovery model and what steps are needed to actively engage the providers in the process.

**Step 4:** Launch “classroom” training events as depicted in the Recovery Training Powerpoint Presentation provided in this manual.
**Rationale:** “Classroom” training should not be consider a one-time event but rather a series of presentations that begin with an overview of the recovery model and increasingly focus on practice aspects of the recovery model of mental health care.

**Step 5:** Bring the “consumer voice” into the provider’s practice, starting with joint diagnostic/treatment meetings involving providers and the CPS(s) and eventually adding a Behavioral Advisory Council entailing consumers providing regular feedback and advice regarding how the system can implement/enhance recovery based care. And last but not least, periodic information should be distributed to providers and consumers regarding recovery principles and practices along with recovery stories (e.g., “Taking Flight” monthly newsletter).

**Rationale:** Practice changes are more likely to occur when providers are given regular feedback about how their style of practice impacts consumers. Thus the “consumer voice” must be heard early in the training effort and must be on-going.

**Step 6:** Introduce, train providers in their use, and implement recovery practice prompts. As presented in this manual, the following practice prompts are proposed in this suggested order of introduction:

a. Project GREAT Recovery Assessment Form – provides a recovery information documentation template.
b. Behavioral Health Planning Form – provides a form to elicit information about life goals relevant for treatment as well as interest in working with a CPS.
c. Strengths Assessment Form – provides a form to elicit information about the consumer’s strengths that could be useful in achieving important life goals.
d. Goals Scale (State Hope Scale) – provides a form to elicit information about current state of hope in consumers.
e. Shared Decision Making Checklist – provides a provider and/or provider supervisor assessment form for determining to what extent provider-consumer collaborative care is being provided.

**Rationale:** Practice prompts are an essential part of changing provider and consumer behaviors. Prompts for the documentation of recovery related information should begin immediately after the initial recovery workshop has been launched to be followed by practice prompts to be used as part of provider-consumer contacts. We are proposing that prompts not be implemented simultaneously due to the nature of behavior change – that is, transforming to recovery based care will entail knowledge, attitude, and skill changes that are complex relative to other common practice changes (e.g., getting the provider staff to routinely check on the accuracy of current medications being taken). Therefore the changes to be incorporated have to be built slowly, and efforts to insure that each prompt is being used properly and is having its intended effect needs to be established before introducing the next prompt.

**Step 7:** Develop consumer satisfaction measures that provide recovery relevant information regarding the nature and quality of care being provided by providers. Once developed provide routine feedback to providers concern the quality of the recovery based care that is being provided.
Rationale: This step is suggested as the last one in this sequence of training efforts because it is best not to evaluate provider efforts until key elements of recovery knowledge, attitudes, and skills have been developed. Otherwise, providers will potentially be “punished” for not providing services that they are not prepared to implement, and consumers will be set up to have negative expectations of mental health services that they are receiving.

References:


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inclusive approach to user participation in higher education. *Journal of Advanced Nursing, 58*, 246-255.


Wilson, K. G., & Groom, J. (2002). *The Valued Living Questionnaire*. (Available from K. G. Wilson, Department of Psychology, 205 Peabody Building, University of Mississippi, University, MS 38677)


Appendix A

Recovery Prompts

Hope – The State Hope Scale………………………………………………. Pages 34-35

Self-Determination -Behavioral Health Planning Form ……………….. Page 36
(Project GREAT)

Self-Determination - Shared Decision Making Checklist………………. Page 37
(Project GREAT)

Self-Efficacy – Strengths Assessment Form (Project GREAT)………. Page 38

Support - Project GREAT Recovery Assessment Form…………………. Pages 39
The State Hope Scale

Directions: Read each item carefully. Using the scale shown below, please select the number that best describes *how you think about yourself right now* and put that number in the blank provided. Please take a few moments to focus on yourself and what is going on in your life at this moment. Once you have this "here and now" set, go ahead and answer each item according to the following scale: 1 = Definitely False; 2 = Mostly False; 3 = Somewhat False; 4 = Slightly False; 5 = Slightly True; 6 = Somewhat True; 7 = Mostly True; and 8 = Definitely True.

1. If I should find myself in a jam, I could think of many ways to get out of it.
2. At the present time, I am energetically pursuing my goals.
3. There are lots of ways around any problem that I am facing now.
4. Right now I see myself as being pretty successful.
5. I can think of many ways to reach my current goals.
6. At this time, I am meeting the goals that I have set for myself.

*Note.* When administering the measure, it is labeled the Goals Scale. The even-numbered items are agency, and the odd-numbered items are pathways. Subscale scores for agency or pathways are derived by adding the three even- and odd-numbered items, and the total State Hope Scale score is the sum of all six items.

Goals Scale
Medical College of Georgia
“Putting Patient/Family Centered Care and Recovery into Practice”

Name: ___________________________     Date: _______________

Welcome to our clinic.

This form can help you take an active role in your care with us. Please take a few minutes to fill it out and give it to your doctor or therapist as a part of your visit today.

Using the scale shown below, please select the number that best describes how you think about yourself right now and put that number in the blank provided. Please take a few moments to focus on yourself and what is going on in your life at this moment. Once you have this "here and now" set, go ahead and answer each item according to the following scale:

<table>
<thead>
<tr>
<th>Definitely False</th>
<th>Mostly False</th>
<th>Slightly False</th>
<th>Slightly True</th>
<th>Somewhat True</th>
<th>Mostly True</th>
<th>Definitely True</th>
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___ 1. If I should find myself in a jam, I could think of many ways to get out of it.

___ 2. At the present time, I am energetically pursuing my goals.

___ 3. There are lots of ways around any problem that I am facing now.

___ 4. Right now I see myself as being pretty successful.

___ 5. I can think of many ways to reach my current goals.

___ 6. At this time, I am meeting the goals that I have set for myself.
Welcome to our clinic.

This form can help you take an active role in your care with us. Please take a few minutes to fill it out and give it to your doctor or therapist as a part of your visit today.

Tell us what your goals are:
Help us make your life goals the focus of your care. Please write down one or two ways that you want your life to be better.

Be specific.

Think of something that you would enjoy or something that would give you a sense of meaning and purpose.

Examples: “I want a job.” “I would like to be able to go out with friends.” “I want to enjoy doing things with my child.” "I want to have more meaningful and fulfilling relationships."

Goal 1:

________________________________________________________________
________________________________________________________________

Goal 2:

________________________________________________________________
________________________________________________________________

Would you have an interest in also meeting with a Peer Specialist?

Yes___ No ____

A peer specialist is a person who has lived with mental health problems and learned skills to live well. The peer specialist can work with you one on one or in a support group.
Shared Decision Making Checklist
Medical College of Georgia
“Putting Patient/Family Centered Care and Recovery into Practice

1. Provided information about the health issue at hand in a manner that was understandable to the consumer.
   strongly disagree  disagree  undecided  agree  strongly agree

2. Provided information about treatment options (including options of doing nothing).
   strongly disagree  disagree  undecided  agree  strongly agree

3. Identified values relevant to the decision.
   a) Described options so that the consumer could understand and could imagine what it is like to experience their physical, emotional, social effects.
   strongly disagree  disagree  undecided  agree  strongly agree
   b) Asked the consumer to consider which positive and negative features matter most.
   strongly disagree  disagree  undecided  agree  strongly agree

4. Identified mutually endorsed and valued outcomes that are the target of intervention.
   strongly disagree  disagree  undecided  agree  strongly agree

5. Identified tasks that were agreed upon, seen as relevant, and in which there is a responsibility to act.
   strongly disagree  disagree  undecided  agree  strongly agree

6. Have established a relationship built on trust, acceptance, and confidence.
   a) Technical competence.
      1. Thorough evaluation of the problem.
      2. Provision of effective treatment options
   strongly disagree  disagree  undecided  agree  strongly agree
   b) Interpersonal Factors
      1. Communication of understanding.
      2. Expressions of caring.
      3. Communications that are clear and complete.
      4. Emphasis on partnership.
      5. Demonstrations of honesty and respect.
   strongly disagree  disagree  undecided  agree  strongly agree
Name: ___________________________     Date: _______________

Welcome to our clinic.

This form can help you take an active role in your care with us. Please take a few minutes to fill it out and give it to your doctor or therapist as a part of your visit today.

Tell us what you believe are your strengths:
Because your strengths can play such an important role in your success working with us, we want to know what you do well. Please answer the questions below.

1. What about you makes you strong and has helped you through difficult times? (e.g., positive attitudes, personal traits such as patience/sense of humor/strong work ethic, or spiritual faith, etc.)

2. What special skills do you have?

3. What do you do for fun?

4. Which people in your life have been helpful to you?

5. Who helps you keep physically healthy?

6. What’s good about the home and neighborhood you live in?

7. What gives your life purpose and meaning?
Project GREAT Recovery Assessment Form

I. Person-Centered Treatment Plan (Life Goals and Objectives)
   Goal 1:
  ______________________________________________________________________________
  ______________________________________________________________________________
   New Consumer/Family Tasks____________________________________________________
  ______________________________________________________________________________
   New Provider Tasks/Responsibility_______________________________________________
  ___________________________________________________________________________
   Goal 2:
  ______________________________________________________________________________
  ______________________________________________________________________________
   New Consumer/Family Tasks____________________________________________________
  ______________________________________________________________________________
   New Provider Tasks/Responsibility_______________________________________________
  ___________________________________________________________________________

II. List Personal Strengths for Consumer related to personal life goals:
   1.____________________________________________________________________________
   2.____________________________________________________________________________
   3. ____________________________________________________________________________

III. Systems-based Treatment Plan:
     Is this individual/family appropriate for referral for Peer Support Services? (e.g., Peer Support Specialist, AA, NA, NAMI, Parent-to-Parent, Bereaved Parents of America)?
     YES     NO

     Would the consumer like to participate in Peer Support Services here in our agency?
     YES     NO

     Would any of the following community support areas be appropriate for consideration in your treatment planning (Please circle appropriate services):

     Activities/Hobbies   Child Care   Financial support   Health Care
     Housing             Physical fitness Occupational/job support
     School/Educational Support Spiritual/religious support
     Substance Abuse Program Transportation Other_______________

IV. Hope Assessment: Person’s beliefs that they are capable of doing things to make things better: High    Medium    Low

     Person’s beliefs that there are pathways toward making things better: High    Medium    Low
Appendix B

Taking Flight Newsletters
Taking Flight
A Briefing from Project GREAT
Georgia Recovery based Educational Approach to Treatment

ANNOUNCEMENTS

MCG Hiring Second Peer Specialist
Some time fairly soon this spring, a new MCG peer specialist will join Gareth Fenley to spend more time on the 3 South inpatient unit and in other settings with residents, students, patients, faculty and staff.

Project GREAT Hits the Road
Both psychiatry and psychology residents are signing up for day trips to help deliver Recovery based trainings to Georgia community service providers. Interested? Contact Dr. Alex Mabe.

A RECOVERY STORY
“For months I sat and smoked cigarettes until it was time to collapse back into a drugged and dreamless sleep. But one day something changed… A tiny, fragile spark of hope appeared… I rode in the car, I shopped on Wednesdays, and I talked to a friend for a few minutes… I took responsibility for my medications, took a part-time job, and had my own money… I went to school to become a psychologist so I could work with disabled people.”

--Patricia Deegan, PhD

LEARNING POINTS
Hope is about having the “Will” and the “Way.” The “will” is about conveying the message that people with mental illness can recover and can have meaningful lives.

Q: What is the “Georgia definition of recovery”? A: “Recovery is the process of gaining control over one’s life – and the direction that one wants that life to go – on the other side of a psychiatric diagnosis and all of the losses that are usually associated with that diagnosis.”

(Appalachian Consulting Group.)
ANNOUNCEMENTS

MCG Recovery Initiatives Featured in Magazine Article

Reporters from MCG Today interviewed members of the Project GREAT team (including Dr. Peter Buckley, Dr. Alex Mabe, and Gareth Fenley) for a feature article in the winter issue. Watch for it to show up soon on MCG’s Web site.

New Peer Support “Warm Line” at 1-888-945-1414

A new state-funded, consumer-directed peer wellness and respite center in Georgia is offering a free alternative for anyone struggling with mental health issues, 24 hours a day. This new service complements the Georgia Crisis and Access Line, which continues in operation at 1-800-715-4225.

LEARNING POINTS

Hope is critical in the recovery of a meaningful life in the face of mental health crises. Often it is the “The Relationship” and not just technical skills that affirms personal worth and conveys belief in a positive future. Providers should work to foster an affirming and hopeful connection with their consumers.

A RECOVERY STORY

“My feelings and thoughts are a kaleidoscope when I’m at a peak or a pit in my illness. I was once elated when I thought I was in Heaven, but when I began to realize that I had been locked up in a mental hospital, I was very angry. I expected to have to fight to get respect. The kindness and patience of the staff and my family then surrounded me with positive messages. Instead of writing off my future in despair, I left the hospital and went back to work.”

- Gareth Fenley

Department of Psychiatry and Health Behavior, Medical College of Georgia
997 St. Sebastian Way, Augusta, GA 30912, (706) 721-0162
In Partnership with Georgia Department of Human Resources, Division of Mental Health, Developmental Disabilities, and Addictive Diseases
Taking Flight

A Briefing from Project GREAT
Georgia Recovery based Educational Approach to Treatment

ANNOUNCEMENTS

New Peer Support “Warm Line” at 1-888-945-1414
Trained peer specialists answer this line 24 hours a day for anyone wanting to talk.

A RECOVERY STORY
David was diagnosed with schizophrenia in 1989. He says it took him years to make progress slowly after that. What helped him most, he says, were a supportive family, exercise, prayer, music, writing, and “being willing to believe that it could be different.”

In 1998, David started listening to personal development tapes while he took five-mile walks. He stopped eating junk food and drinking sodas. As time passed, David got involved in a peer support group called Schizophrenics Anonymous, and even went to a national conference. He says it was hard to take risks and try new things like this, but he says he put things in perspective by thinking, “If I’ve been contemplating suicide, then I can take some big risks to say alive. Now this is my life’s purpose, to recover from this. It is an adventure.” David keeps busy today with writing plays and romantic dating.

LEARNING POINTS
People are more than their illness. Yet it is easy for people with mental illness and their providers to fall into the trap of focusing on “the symptoms” to the exclusion of other important facets of a person’s life. As David’s story demonstrates, when we consider the whole person – physically, emotionally, socially, and spiritually, then new pathways of recovery can be discovered. Of course, like David’s story, pursing new pathways of wellness is not always easy and does involve taking risks – as do most things in life that offer the promise of great reward.
Taking Flight

A Briefing from Project GREAT
Georgia Recovery based Educational Approach to Treatment

ANNOUNCEMENTS
NAMI (the National Alliance on Mental Illness) has educational meetings and support groups ongoing in Augusta, Aiken, and Thomson. For information call (706) 733-8838.

A RECOVERY STORY
My name is Jacqueline Wolfgang. I’m a wife and a mother and a peer advocate. I was in five different foster homes but was adopted at 2 years of age. I lived with developmental delays and ADHD and lived through childhood molestation.

I began my Recovery path when I was educated through NAMI. I realized I have been living with depression most of my young adult life. Notice, I said that I live with depression. Depression is not WHO I AM. I’m a person first!

Faith was the number one reason why I could move on my Recovery path. Scripture and my church are a big part of who I am today. The people in the church are there when I need them in more ways than I can express.

At one time my family, friends and yes, even my doctor told me, “If you take your meds you MAY live a normal life.” Well, let’s say I allowed the negative messages to limit me from achieving the life I wanted. To go forward I had to believe in myself, my strengths and abilities.

NAMI is another community support that I became a part of. I started going to the family support group for my son. I learned a lot about how to help my son and get support at the same time. I also learned about depression and learned how go about treatment for it.

I am the evidence that you can move past the mental illness and create a life full of meaning and purpose. I’m a walking miracle.

LEARNING POINTS
Inspiring hope in individuals with mental illness is an important component of effective treatment. Negative messages by a provider about the consumer’s future life with mental illness can interfere with a collaborative and active therapeutic relationship and result in poor treatment outcomes. Whereas hopeful messages by a provider can increase therapy efforts and increase tolerance of the inevitable stresses of mental illness. One key component of Jacqueline’s story is that she had to get past the negative messages from her doctor. Sadly, the doctor’s words were a big part of the problem and not the beginning of solutions. Providers need to maintain and communicate the beliefs that obtainable goals can always be realized and working together “we can do this.” Hope is the start point for...
effective treatment and the pursuit of a life with purpose and meaning.
Taking Flight

A Briefing from Project GREAT
Georgia Recovery based Educational Approach to Treatment

ANNOUNCEMENTS

Residents Rise in MCG New Year
Medical College of Georgia has entered a new academic year. This means many consumers in the clinic and hospital are seeing new doctors because the residents are assigned to new roles.

Find Support and Get Involved
MCG offers more ways to be involved with your own behavioral health care. If you’re interested, ask your psychiatrist or psychologist about our FREE support groups and advisory council.

A RECOVERY STORY

By Sarah Ho, Kona, Hawaii

We had a support group meeting tonight. One of the women there was feeling shaky and vulnerable when I picked her up. But the love, validation, support, and gentle reminders the group gave her helped her pull up and out. There was laughter before we were done. She had moved from suffering into aliveness.

I watched my friend’s face change tonight. She was feeling paranoid and very sad at first. But we kept encouraging her to see her problems in a different way. She opened up as she heard understanding and loving suggestions. She listened and let them in, and soon she was smiling.

Be your bravest self. Dare to look at your own thoughts. Step off your mental not-so-merry-go-round and watch the spinning, the wasted time. You have a choice. Redirect and transform. Become alive and aware.

Reprinted with permission from Prosumer News, San Antonio, Texas.

LEARNING POINTS

Often traditional psychiatric care has maintained that the “nature of healing” lies primarily in accurate diagnosis and medical interventions by the “doctor.” Consequently there has been a focus on what the “doctor” can do to bring about healing. Based on many recovery stories such as the story told by Sarah Ho as well as accumulating scientific evidence, however, we are beginning to understand that healing can come from many other sources including a supportive relationship with the doctor, consumer strengths, hope, determination, and social support. In particular, opportunities to talk with other individuals who have faced similar challenges in dealing with mental illness can be enormously helpful in providing understanding and emotional support, sharing recovery efforts, and providing advice on wellness strategies that have been found to be helpful to others. Consequently, more and more mental health programs are adding certified peer specialists to offer this kind of support from someone who has
successfully faced the challenges of mental illness.

Appendix C

Recovery Knowledge and Attitude Measure
Project GREAT: Knowledge of the Recovery Model Assessment

1. James, an individual with Schizophrenia that you’ve been following for over a year, presents for his session stating that he’s “having a bad day.” Further exploration with James reveals that his “bad day” entails increasing severity of his auditory hallucinations, despite what appears to be good medication compliance. From a Recovery perspective, an appropriate response to James would be:

   a. “I am sorry you are having a bad day with your symptoms. Let’s think through this together to see what we can do to overcome this setback.”
   b. “Since your hallucinations have increased in severity, we will need to adjust your medication dose to deal with the worsening of your condition.”
   c. “You shouldn’t be too concerned. I can either adjust the dose on your current treatment regimen or if necessary switch you over to another medication.”
   d. “I know that this is disappointing for you, but you need to understand that it is common for consumers with Schizophrenia to have such relapses in the first year of treatment.”

2. In the Recovery Model treatment decisions are made by:

   a. The provider and consumer in full partnership with one another.
   b. The provider that carefully follows an evidence-based approach.
   c. The provider that leads and involves an interdisciplinary team of care.
   d. The consumer according to his/her needs, wants, and personal preferences.

3. Which of the following statements is most consistent with the Recovery based perspective of mental illness?

   a. Having a mental illness can be both debilitating and lifelong.
   b. Mental illnesses are medical conditions that often disrupt one’s life across physical and social domains.
   c. Mental illness is only part (and possibly a small one) of one’s identity.
   d. Mental illness impacts all functioning and can be central to one’s identity.

4. According to the Recovery Model, assessment and treatment planning should focus on:

   a. Establishing a clear diagnosis that will help to guide the course of treatment.
   b. Establishing a hierarchy of symptoms that are most troublesome for the consumer to determine treatment priorities.
   c. Evaluating consumer’s vulnerabilities that might interfere with effective implementation of the treatment.
   d. Identifying consumer assets that will help the consumer meet treatment goals.

5. Which of the following consumer goals would more likely lead to the desired Recovery based outcome of increasing hope?

   a. “I would like to keep employment so that I can pay my own bills.”
   b. “I would like to feel less depressed.”
   c. “I would like to be able to live independently.”
   d. “I would like to do my best to get off of my medications someday.”
6. Certified Peer Specialists' are invaluable in the provision of Recovery based mental health care treatment because of:
   a. Their unique training in the provision of skills training.
   b. Their extensive knowledge of peer support services.
   c. Their ability to serve as a liaison between consumers and their providers.
   d. Their unique life experiences.

7. According to the Recovery model, which of the following approaches to treatment planning is a priority?
   a. The provider should elicit the consumer’s perspectives regarding goals and methods of treatment.
   b. The provider should use empirically based approaches to problem assessment.
   c. The provider should be careful to fully explain the proposed course of treatment.
   d. The provider should use a biopsychosocial perspective on understanding consumer problems.

8. In working with individuals diagnosed with severe mental illness, the recovery model advocates that the provider should:
   a. Encourage an outlook on the course of mental illness that is optimistic.
   b. Help the consumer make relapses predictable and thus preventable as much as possible.
   c. Limit discussion of relapses and setbacks in order to reduce feelings of hopelessness.
   d. Inoculate consumers against the feelings of hopeless and failure should relapses occur.

9. The Recovery model emphasizes which of the following treatment perspectives:
   a. The consumer must be personally involved and take responsibility for determining treatment goals and devising treatment methods.
   b. The provider must take the primary role in determining treatment goals and devising effective treatment methods.
   c. An interdisciplinary team must work together to determine treatment goals and devise effective treatment methods.
   d. Evidence-based practices should be guiding the determination of treatment goals and development of effective treatment methods.

10. Studies of the experience in recovery indicate that:
    a. For individuals with serious mental illness relapses are common and without aggressive treatment will lead to poor mental health outcomes.
    b. For individuals with serious mental illness full to partial recovery (in symptom-reduction terms) is common.
    c. For individuals with serious mental illness relapses are uncommon but have serious implications when they do occur.
    d. For individuals with serious mental illness full to partial recovery (in symptom-reduction terms) is uncommon.

11. A prominent businessman is in treatment for Bipolar II Disorder. He reports concerns regarding the effects of his newly-prescribed medication regimen. This individual states that he is less effective and productive at work since he began taking the medications, which “take away” his “energy and drive.” From a Recovery based treatment perspective, how should the provider respond to this concern?
a. Make no changes to the prescribed regimen – advise the consumer that he must learn to
live with this change in order to allow the medications to stabilize his mood.
b. Adjust the regimen to reduce the unwanted side-effects while accepting the risk of less
optimal control of the consumer’s hypomania.
c. Discuss with the consumer the importance of his work and his need to be effective.
d. Provide the consumer with psychoeducation regarding the medication and its effects.

12. Which of the following statements best reflects attitudes consistent with the Recovery
Model?
a. “A significant number of the mentally ill must be carefully supervised to maintain
adherence to their medication regimen.”
b. “Schizophrenics can establish a functional life with assertive community treatment.”
c. “Borderlines often have a great deal of interpersonal instability that can interfere with an
effective provider-consumer relationship.
d. “Most consumers with serious mental illness are capable of making informed decisions
regarding the best choice for medication treatment.”

13. Which of the following listed treatment goals was most likely developed through
consideration of the Recovery Model?
a. Consumer will be compliant with her medication regimen.
b. Consumer will visit the local Social Security office to apply for Disability benefits.
c. Consumer will seek employment by networking at an upcoming professional conference.
d. Consumer will become less irritable in interpersonal relationships.

14. Effective treatment from a Recovery Model perspective must include:
a. Positive encouragement of the consumer’s efforts to comply with treatment
recommendations.
b. Efforts to provide choices and encourage the consumer to make his/her own decisions
regarding the course of treatment.
c. Contacts with family members for corroborative data.
d. Emphasis that with sustained efforts cure is possible.

15. Samantha is a 22-year-old, White, single female referred for outpatient treatment. She was
recently discharged from inpatient care following her first psychotic break (which involved
command hallucinations with suicidal ideation). From a Recovery perspective, which of the
following statements would establish the best treatment stance?
a. “Symptom relapses are relatively rare and usually avoidable.”
b. “Even with our best efforts, symptom relapses are always possible. But they aren’t the
end of the world.”
c. “Symptom relapses can be significantly limited with good compliance on my
medications.”
d. “Since symptom relapses are unpredictable it is best not to worry too much about them.”
16. Which of the following provider-to-consumer communications would be most consistent with Recovery Model guidelines?
   a. “You’re depression does not seem to be getting better, so I am going to be changing you over to a newer antidepressant medication.”
   b. “To monitor your progress, I will need to regularly contact your wife to get her observations of how you are doing.”
   c. “You seem to be having difficulty taking the medication that I have prescribed for you, let’s review what you hope the medication could do for you.”
   d. “I believe that attending college is not an option for you until we can stabilize your mood.”

17. From a Recovery perspective, treatment for a consumer experiencing auditory hallucinations and paranoid ideation would place primary emphasis on:
   a. Reducing hallucinations and improving concentration.
   b. Reducing paranoid thoughts and the cognitive distortions that may contribute to them.
   c. Establishing positive interactions with friends, family, and care providers.
   d. Establishing a safety plan with the consumer and his/her family.

18. Which of the following treatment methods best exemplify a Recovery Model approach?
   a. The provider prescribes medication dosing that best fits that consumer’s work schedule
   b. The provider carefully titrates medication dosing to reduce side-effects problems.
   c. The provider routinely performs mood checks at each appointment to monitor the effectiveness of the medication regimen.
   d. The provider routinely elicits feedback from the consumer’s family regarding effectiveness or ineffectiveness of medication regimen in symptom relief.

19. Which of the following is the best description of the assessment process from a Recovery perspective?
   a. Collaborative discussion with the consumer to obtain an accurate diagnosis.
   b. An efficient, time-limited, process that leads to a symptom-relieving treatment plan.
   c. An ongoing process that centers on individual goals and tools that help reach them.
   d. A discussion of consumer supports that will help the consumer in reducing the effects of symptoms.

20. Which of the following professional activities would most exemplify the Recovery Model of mental health care?
   a. The provider actively participates in his/her own professional organization.
   b. The provider takes a primary role in advocating for the consumer’s rights in regard to health care.
   c. The provider supports local charities that provide services for those with mental health needs.
   d. The provider encourages consumers to join consumer advocacy groups.
21. Which of the following is the most appropriate characterization of the Certified Peer Specialist’s role in treatment?
   a. CPS’s are adjunct care providers who help providers and their consumers identify peer support community-based resources.
   b. CPS’s are adjunct care providers who assist consumers with mental illness by providing modeling, social/emotional support, and skills training.
   c. CPS’s are paraprofessionals who provide supportive counseling through the sharing of their personal experiences with mental illness and the mental health care system.
   d. CPS’s are adjunct care providers who provide instrumental assistance for consumers attempting carry out prescribed community-based activity directives.

22. A Recovery based perspective to the consumer’s role in treatment would be:
   a. From the initiation of treatment, consumers should be encouraged to believe that they are capable of working toward resolution of their problems.
   b. While initially mental illness often limits the extent to which consumers can actively participate in treatment, however, with proper treatment many consumers can become much more active.
   c. Active participation in treatment may not be possible when the consumer is seriously mentally ill.
   d. The level of consumer participation in treatment is directly linked to the degree to which symptom relief can be achieved.

23. Which of the following consumer behaviors best reflects response to treatment from a Recovery perspective?
   a. Excellent medication regimen compliance
   b. Provides an accurate report of adverse side effects
   c. Identification of own effective coping strategies.
   d. A high show rate for mental health care appointments.

24. Providers would best demonstrate Recovery principles in their practice when doing which of the following:
   a. Providing a thorough initial evaluation so that a clear diagnosis can be established and a persuasive discussion of the diagnosis can be made.
   b. Giving the consumer an effective rationale for treatment recommendations by reviewing the empirical data in terms that the consumer can understand.
   c. Emphasis of wellness over illness in treatment with consumers
d. Use of an empathic and supportive communication style.

25. A Recovery based assessment:
   a. Encourages a systematic and structured approach.
   b. Emphasizes that an accurate diagnosis is key to an effective treatment regimen.
   c. Is routinely revised as consumer strengths/accomplishments are noted.
   d. Attempts to establish the diagnosis and treatment regimen in a timely manner.
26. From the Recovery perspective, the consumer’s presenting problems are best understood as:
   a. Problems that arise from the interaction of individual and environmental influences.
   b. Primarily a reflection of the consumer’s subjective experience of their symptoms.
   c. Problems primarily emanating from biological and/or psychological predispositions
      within the consumer.
   d. Symptoms of an insufficiency in the consumer’s coping resources.

Answer Key:

1. a - Recovery as a Journey (Non-linear Process)
2. a – Empowerment/Person-Centered Care
3. c - Whole Person Care (Holistic)
4. d - Focus on Strengths
5. a – Hope
6. d - Support (Systemic Treatment Orientation)
7. a - Person-Centered Care
8. d – Hope
9. a – Empowerment/Person-Centered Care
10. b - Recovery as a Journey (Non-linear Process)
11. c - Whole Person Care (Holistic)
12. d - Empowerment
13. c - Person-Centered Care
14. b – Empowerment/Person-Centered Care
15. b - Recovery as a Journey (Non-linear Process)
16. c - Person-Centered Care
17. c - Whole Person Care (Holistic)
18. a - Person-Centered Care
19. c – Empowerment/Person-Centered Care
20. d - Empowerment
21. b - Support (Systemic Treatment Orientation)
22. a - Empowerment
23. c - Focus on Strengths
24. c – Hope
25. c - Focus on Strengths
26. a - Support (Systemic Treatment Orientation)
Attitudinal Pre-/Post Survey

Please read each statement and decide how much you agree or disagree with it, using the scale below. Then put the number corresponding to your level of agreement or disagreement on the line in front of the statement. A “6” means you strongly agree and a “1” means you strongly disagree with the statement. While you may choose any number from “1” to “6”, keep in mind that the higher the number the more you agree with the statement.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
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___ a. Most people with serious mental illness can, with treatment, get well and return to productive lives.

___ b. I feel I have a good understanding of different consumer perspectives about assertive community care management.

___ c. The mentally ill are far less of a danger than most people believe.

___ d. Consumer service deliverers may have greater problems with stress than professional service deliverers.

___ e. Will power alone will not cure mental disorders.

___ f. Mental health consumers are effective in providing training to other staff.

___ g. Some clients do not want to receive services from another person who has been a mental health consumer.

___ h. It is easy to recognize someone who once had a serious mental illness.

___ i. Mental health consumers have much to teach us about how to work with mentally ill clients.

___ j. Consumer service deliverers may misunderstand the humor professionals sometimes use when discussing clients with each other.

___ k. I don’t believe mental illness can ever really be cured.

___ l. Although I believe in empowerment for consumers, I am uncomfortable with the idea of them carrying a caseload.

___ m. Helping the mentally ill person with his financial and social problems often improves his condition.
<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

n. Understanding mental illness from the consumer perspective makes one a better professional.

o. Many of the people who go to mental hospitals are able to return to work in society again.

p. I would feel uncomfortable “venting” my feelings about situations I encounter in my case work if there was a consumer service deliverer present.

q. In most cases, keeping up a normal life in the community will help a person with mental illness get better.

r. I am afraid that if a consumer co-worker can not handle the stress of serving people with severe psychiatric disabilities, I’ll end up having to do more work.

s. Having a mental illness is not different from having any other kind of illness.

t. Consumer service deliverers may have difficulty separating their own experiences from those of their mentally ill clients.

u. People with chronic mental illnesses are, by far, more dangerous than the general population.

v. Using mental health consumers to provide services to persons with severe mental health illness is not a proven approach.

w. Mental health professionals often misunderstand the families of persons with severe mental illness.

x. You can tell a person who is mentally ill from his appearance.

y. You have to be careful what you say around a service deliverer who has been a mental health consumer.

z. Even if they seem OK, people with chronic mental illness always have the potential to commit violent acts.

aa. Mental Health is largely a matter of trying hard to control the emotions.
Stron gly            Stron gly
Disagree           Agree

|       |            |        |      |  |
|1      | 2           | 3              | 4     | 5            | 6 |

bb. Working with a mentally ill person’s family, when appropriate, is an important part of serving the client.

cc. Using mental health consumers to provide training to professionals is a good idea.

dd. I get quite a bit of personal satisfaction from delivering services to persons who have severe mental illness.

Item Recoding & Subscale Computation Procedures

1. Item Recoding

Several of the items included in this attitudinal scale must be recoded before they are used to compute a total scale score or to compute the three subscale scores. Recoding the items will result in item responses that flow in the same direction, i.e., with positive attitudes reflected by higher scores.

The following 14 items must be recoded:

Items d, g, h, j, k, l, p, r, s, t, u, y, z, and aa.

Recode these items so that:
(1=6) (2=5) (3=4) (4=3) (5=2) (6=1)

2. Subscale Computations

Three subscales were statistically derived from this group of items. These scales represent factors to “Recovery,” “Stigma,” and “Consumers as Providers.”

The following items, once recoded, are group together to create the three individual subscales:

Recovery = Sum items (a + c + e + h + m + n + o + q)
Stigma = Sum items (b + g + k + u + x + dd)
ConsumerProviders = Sum items (f + i + j + l + p + r + t + v + y + z + aa + cc)

Please note: Items d, s, w, and bb are not used to compute these subscales. They are used in computation of the total scale score only.

Cook, Jonikas, & Razzano (1995)