Recovery Culture Readiness Inventory
by Mark Ragins 3/28/04

Recovery is gaining serious momentum and being pushed on generally ambivalent systems, programs, and people to implement by outside forces like congressional committees, presidential reports, and us. Efforts to this point have focused on promoting belief in recovery as a possibility by sharing first person accounts of recovery, research data about its existence, and some efforts to describe the paths to recovery (My "4 stages" is one of a number of well regarded examples.) The next stage is also underway defining and training in practices that promote recovery (e.g. illness management, consumer staffing, supportive employment, WRAP, rehabilitative goal setting, self help, psychoeducation, community integration, ACT, medication collaboration, supportive housing, etc.). Unfortunately, the culture that these practices are being disseminated through is increasingly the "evidenced based culture", another version of the medical culture recovery is seeking to change. It is unlikely that the results of putting a few recovery based practices within a medical culture to satisfy outside pressures will be the creation of successful recovery based programs. Increasingly, we are seeing the need to work directly with defining and training recovery oriented cultures and leadership in order to create a fertile soil for the seeds of recovery to grow in.

Defining a recovery culture at this point of our development depends a lot on who you're talking to. One of the reasons for recovery's present momentum is that multiple forces are coming together under the same banner, but they have different perspectives. In brief, there are 4 major forces:

(1) consumers – They value consumer participation personally, programmatically, and politically ("nothing about us without us"). Empowerment, wide spread consumer staff, focusing on people instead of illnesses, choice, consumer satisfaction, breaking down barriers between staff and consumers, quality of life opportunities (housing, employment, education, etc.), and respect as and anti-stigma tool ("stigma can be more disabling than symptoms") are their focus.

(2) rehabilitation services – They value increasing people's functioning and participating in our community in meaningful roles even if there are still symptoms. Training programs, rehabilitative goal setting, supported quality of life services, role creation, coaching, and consumer motivation are their focus.

(3) psychiatrists and the professional community – They are often seen as obstacles to recovery implementation, but a subset have been energetic in promoting an illness management model. Understanding illnesses, triggers, and medications, stress management, coping skills, building protective social networks, family and consumer psychoeducation, intensive staff supervision and support (ACT), crisis alternatives to hospitalizations, implementing "best practices", reimbursement parity, and reducing symptoms and their impact are their focus.

(4) Social and political systems – They want to impact the social and political costs of people with mental illnesses. Reducing dangerousness, homelessness, incarceration, hospitalizations and other social costs, integrating substance abuse consumers, reaching out to unserved people, and collecting quality of life data to assess accountability and efficiency are their values.

While these perspectives are clearly not contradictory of each other - in fact they are highly synergistic - it is rare for them to be integrated. Generally, people are only seeing their own priorities. A common result is less effective, fragments of recovery (e.g.

a supportive employment program using an outside unsupportive psychiatrist, a consumer program that excludes crisis or hospital interventions and loses credibility when they send away people in crisis, a coping skills class without consumer staff as models, a homeless outreach program without medications, substance abuse treatment, or trauma therapy).

As a field we are only beginning to integrate these values into a full recovery culture. Here is an attempt to describe elements of an integrated recovery culture for a "readiness inventory":

(1) High inclusion of consumers: Numerous consumer staff not just in special consumer jobs, reducing us- them distinctions (shared bathrooms, work areas, meetings, hard to tell who the staff and consumers are), safety based on "community watch" rather than separating and forcibly guarding consumers, consumer choices and input into goals, treatment plans, program services, multiple roles besides treatment recipient, reduced boundaries, use of respectful, non-stigmatizing clinical language.

(2) Leadership and administration that treats the staff the way we want them to treat the consumers: Emphasizing staff hope, empowerment, responsibility (giving them control over some funds, choices, "high risk- high support"), and meaningful roles Encourage staff to take on multiple roles besides professional so consumers can take on multiple roles besides patient, lot's of individual expressiveness. Valuing every staff as an expert in something. Encouraging staff to be emotionally expressive and open about themselves with consumers and each other.

(3) Creating a counter-culture of acceptance: Ability to welcome and include difficult, socially undesirable, noncompliant people, "no fail" rules, outreach to dropouts, minimize "lost to follow-up". Including charity as well as treatment. Minimal coercion, rules to follow, exclusions, "hoops to jump through". Staff accessibility both inside and outside building and after hours. Ability to make individualized, collaborative plans. Staff are willing to engage in emotional, "real" relationships with consumers instead of keeping them at a "professional distance". Staff have a subjective awareness of what the consumer is going through and feels like.

(4) Holistic, integrated care focused on the person not just their illness: Treatment plans, services, outcome measurements focused on quality of life. Generalist staffs organized into teams with overlapping parts, not separate specializations. Limited "It's not part of my job". Collaboration with other social agencies (Social security, Section 8 Vocational Rehabilitation, Children's Services, probation and parole) rather than referrals to other treatment programs. Integration of substance abuse treatment for every staff and program. Staff knowledge of life situations, not just diagnosis. "Doing whatever it takes".

(5) High utilization of rehabilitative, recovery, and illness management techniques within a conscious framework of recovery promotion: Regardless of funding availability a prioritization of these services (supportive housing, employment, education, training, coaching, illness self management, psycho-education, ACT). Staff knowledge of recovery stage, goals, and individual progress ("What is the rehabilitation value of this activity?").

These elements can be further delineated and even measured to create a recovery readiness inventory tool.