

**Recovery Principles:
An Alternative in Maricopa County
for Individuals Who Experience Psychiatric Symptoms**

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prepared by

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ackground.

The Maricopa County behavioral health delivery system continues to undergo transition. Change in nearly every aspect of service delivery is underway, or being planned. It has been the intention of this change to integrate the services at the community provider level, moving services previously performed by Regional Behavioral Health Authority (RBHA), such as case management, to the provider network. For many client groups, this transition has occurred or is in process.

For persons with serious mental illness, several complex issues have to be considered:

- The RBHA has been the vehicle to comply with the requirements of the Arnold v. ADHS Exit Stipulation and the ADHS SMI regulations, including SMI eligibility determinations, developing Individual Service Plans, managing grievances and appeals, client and service tracking. While decentralization could create better access to services, careful planning is needed to avoid sacrificing efficiency.
- The concept of a “clinical team” for every consumer with a range of specialists to assist the consumer in accomplishing his or her goals has never been fully implemented. Inadequate training, inadequate funding and the absence of a recovery vision has often placed the case manager at the center, more concerned about completing paperwork, complying with rules, and meeting deadlines, than about empowering the consumer. Psychiatric interventions including medication, have over emphasized medical model solutions that have taught consumers and their loved ones to expect a “chemical cure” instead of also learning self-reliance and self-advocacy.
- Over the years, the RBHA developed the “Strengths Model” of Case Management. Through training, progress was made in implementing the “Strengths Model” and creating the beginnings of a “consumer centered” system with strategies such as Peer Case Management teams, an ASH reduction program with emphasis on a supported housing model, and co-location of vocational services with Case Managers. However, over time, excessive rules and regulations, inadequate funding, and a case management agency that lacked a recovery vision has caused a shift to a culture of compliance rather than one of meaningful outcomes. A new model is needed with strategies that restore hope and empower both consumers and workers.

META Services is interested in joining with others to create an alternative. Our model will use a “Recovery” paradigm to put the consumer at the center. As described by Jacobson and Curtis, “Prompted by advocacy groups, the emerging literature, and concurrent demands to improve the effectiveness of public mental health services, a few state mental health systems have introduced

recovery into the public policy lexicon..... In many states, the introduction of recovery concepts into mental health policy has coincided with a shift towards a managed care approach to services financing and system accountability. In this context, recovery is envisioned as a set of guiding principles whose application can result in cost effective behavioral healthcare that suggest measurable treatment outcomes.”¹

Using recovery principles, the following outcomes will be sought:

- increase in employment,
- increased number of consumers living in their own homes,
- reduced treatment costs as measured by a reduction in total medication expenditure, reduction in the use of crisis services, and reduction in residential treatment costs.
- reduction in the frequency of involuntary commitment and jail.

Assumptions

The system design and discussion that follows is built on a several key assumptions. It is important to keep these assumptions in mind when considering the ideas presented. Without these understandings, the approaches and strategies may not seem believable or possible since the outcomes proposed are different from what is commonly expected and experienced in the current system.

- People with serious mental illness do recover. Numerous longitudinal research studies have demonstrated recovery rates at high as 68% among the severely mentally ill. Concerning these studies, Courtenay Harding, Ph.D., who studied back-ward state hospital residents of Vermont state mental institutions for an average of 32 years after their first admission, comments:

These studies have consistently found that half to two thirds of patients significantly improved or recovered, including some cohorts of very chronic cases. The universal criteria for recovery have been defined as no current medications, working, relating well to family and friends, integrated into the community, and behaving in such a way as to not being able to detect having ever been hospitalized for any kind of

¹Jacobson, Nora and Curtis, Laurie (2000). Recovery as Policy in Mental Health Services: Strategies Emerging from the States. *Psychosocial Rehabilitation Journal* (23/4), 333.

psychiatric problem. ²

| Study | Sample Size | Length in yrs | Subjects Recovered and/or improved significantly |
|---|-------------|---------------|--|
| M. Bleuler (1972). Burgholzli, Zurich | 208 | 23 | 53-68% |
| Huber et al. (1975). Germany | 502 | 22 | 57% |
| Ciampi and Muller (1976). Lausanne Investigations | 289 | 37 | 53% |
| Tsuang et al. (1979). Iowa | 186 | 35 | 62-68% |
| Harding et al. (1987). Vermont | 269 | 32 | 62-68% |
| Ogawa et al. (1987). Japan | 140 | 22.5 | 57% |
| DeSisto et al. (1995) Maine | 269 | 35 | 49% |

- Higher expectations create higher outcomes while low expectations decrease the potential for recovery and foster lifelong dependence on the mental health treatment system. While we will not always achieve the highest results, the belief that the person can recover from the trauma of their mental illness and live and support themselves in the community creates hope. This leads to a sense of self-efficacy and self-esteem that are the cornerstones of recovery and to improved outcomes.

Conceptualizing recovery as a possibility leads to the development of specific interventions and practices to promote it. Thus, the possibility of recovery becomes an expectation. ³

- Stigma and discrimination against the mentally ill are commonplace and even prevalent in our treatment system. A program or professional who labels the individual and limits recovery possibilities by discouraging a person with mental illness to take risks and

²Harding, Courtenay and Zahniser, James. “Empirical Correction of Seven Myths about Schizophrenia with Implications for Treatment”. *Acta Psychiatrica Scandinavica*, 1994: 90 supplement 384: 1140-146.

³Jacobson and Curtis.

participate in normal life activities such as work, independent living, relationships, and so forth, further stigmatizes that person. This is discrimination and should not be supported.

Under the direction of Otto Wahl, Ph.D., professor of psychology at George Mason University in Fairfax, VA, a research team surveyed over 1,400 consumers from every state across the country asking them about personal experiences with stigma and discrimination.

...consumers reported being frustrated and discouraged by repeated reminders of their incapacity and the expectation, often communicated by mental health care givers, that mental illness would preclude a full and satisfying life. Sometimes these ideas were conveyed through well-meaning cautions not to take on too much activity that might be stressful, “Even the people that try to help us,” observed one consumer, “treat us as though we’re helpless, and they try to protect us too much because they believe that we’re unable to help ourselves.”

Other times the messages were more directly discouraging and infuriating. “I was seeing this one psychiatrist,” reported one angry consumer, “...he told me just to accept that I’m going to have to be at home and in and out of hospitals. [He] told me that I was chronically mentally ill, with an IQ of 79, so to just go home and live with it. Since he told me that, I have gone back to graduate school, gotten an MSW and am working at a mental health substance-abuse clinic.”⁴

- Wellness, good emotional health, is a condition that can be achieved and maintained by persons with mental illness. This is a set of skills that the individual can learn and practice that shift the responsibility for each individual’s recovery away from the professional and to the individual who is empowered through information and choice.
- Recovery is not based in a medical model. While medications are necessary, they are seen as one of the tools, not the primary tool. According to recent research done at Boston University, mental health consumers who have recovered place medications as thirteenth on a list of things that helped them recover (LeRoy Spaniol, Boston University).
- The task of professionals in the Recovery Model is educational and coaching/supporting. A behavioral health system should be designed that teaches skills, creates hope, and supports the integrity of each person’s journey.
- The services provided should be those preferred by the consumer and delivered in the manner and location chosen by the consumer. Forced treatment does not produce recovery.

The ultimate example, the use of involuntary outpatient commitment (in Arizona the fourth standard of commitment, “persistently and acutely disabled”) should be reduced and

⁴Wahl, Otto F., “Confronting Stigma”. *Paradigm*. Vol. 5, No. 3. Summer 2000. p.15.

eliminated whenever possible. Research by Jean Campbell of the Well-being Project has shown that 47% of consumers subjected to involuntary hospitalizations said they would never return to an outpatient clinic.⁵ When involuntary treatment is used, it should still respect the consumer's treatment preferences through "Mental Health Advance Directives" and "Crisis Plans".

- Recovery is more cost effective. Service systems that help people recover will ultimately cost less money since as people recover they will become more self-sufficient and require fewer services.

.....it is expected that, over time, there will be.... a significant reduction in the need for mental health and emergency services as people with psychiatric symptoms effectively take responsibility for their own wellness and stability, manage and reduce their symptoms using a variety of self-help techniques, and effectively use the support of a network of family members, friends and health care professionals... (Copeland) ⁶

R eccovery.

The ultimate goal of the recovery movement, and of psychiatric rehabilitation, is the re-establishment of normal roles in the community, the development of a personal support network, and an increased quality of life.

The primary methods used to achieve this goal include:

- building on the existing strengths of each individual, and
- facilitating reintegration into the community.

Mutual support and self-help enhance this goal by adding an emphasis on the individual's right to direct his or her own affairs, including the mental health services they receive.

This treatment strategy is different from the traditional approach which focuses more on individual deficiencies instead of strengths; stabilization instead of recovery; connections to the treatment system instead of the community; and compliance with the regimes mandated by treatment authorities instead of individuals taking an active part in their treatment and in directing their own affairs.

⁵Campbell, J. and Schraiber, R. *In Pursuit of Wellness: The Well-Being Project*. California Department of Mental Health, Sacramento, CA, 1989.

⁶ Mary Ellen Copeland (2000). From her seminar description; "Mental Health Recovery Skills Seminar: Teaching Self Management of Psychiatric Symptoms", www.mentalhealthrecovery.com

The recovery process, as summarized in material produced by Boston University, is contingent upon the active participation of the consumer. The task of professionals is to facilitate recovery; the task of the consumers is to recover. Recovery may be facilitated by the consumer's natural support system; self help groups, families and friends, and the opportunity to have meaningful vocational roles. A common denominator in the recovery process is the presence of people who create hope. These are people who believe in and stand by the person in need of recovery, people whom one can trust to "be there" in times of need.

LeRoy Spaniol, Ph.D., associate executive director of Center for Psychiatric Rehabilitation at Boston University, describes recovery as follows:

Recovery is a common human experience. We all experience recovery at some point in our lives from injury, from illness, or from trauma. Psychiatric disability has a devastating impact on the lives of people who experience it. It is devastating because people with psychiatric disability are left profoundly disconnected from themselves, from others, from their environments, and from meaning or purpose in life. While the illness itself causes people to feel disconnected, stigma (negative personal, professional, and societal values, attitudes, and practices) further disconnects people and represents a serious barrier to building new connections.

Recovery is the process by which people with psychiatric disability rebuild and further develop these important personal, social, environmental, and spiritual connections, and confront the devastating effects of stigma through personal empowerment. Recovery is the process of adjusting one's attitudes, feelings, perceptions, beliefs, roles, and goals in life. It is a process of self-discovery, self-renewal, and transformation.⁷

Developing a recovery-oriented mental health system requires a shift that starts with our values, penetrates our language, reorients our thinking, and reforms our relationships. The Recovery Model is built upon principles articulated by William Anthony, Ph.D. of Boston University (1994):

- Recovery can occur without professional intervention.
- People who recover have people who stand by them and believe in them.
- Recovery can occur whether one sees mental illness as biological or environmental.
- Recovery can occur even though symptoms may reoccur.
- Recovery often changes the frequency and duration of symptoms.
- Recovery is not a linear process.
- Recovery from the consequences of being ill is often more difficult than recovering from the illness itself.
- Recovery does not mean that one did not have a mental illness.

⁷ Spaniol, LeRoy, Koehler, Martin, Hutchinson, Dori (1994). *The Recovery Workbook; Practical Copying and Empowerment Strategies for People with Psychiatric Disability*. Boston: Center for Psychiatric Rehabilitation.

Pat Deegan, Ph.D., Director of training at the National Empowerment Center, clinical psychologist and mental health consumer, sees recovery as a three-pronged process:

- the expression of hope,
- the willingness to try,
- the discovery that you can do and be again.

Pat offers some powerful suggestions that can guide the development of a recovery-oriented system:

- Creating hope filled environments that nurture and invite growth and recovery is an alternative to despair.
- We must stop exercising power over the people we work with. This only produces unnecessary dependency and learned helplessness. Perhaps we could.....work **with** people as a journey in which we both move, and are moved by, the people we seek to serve.
- Individuals with mental illness are not objects that need to be fixed. Such a connotation robs their sense of autonomy and self-determination. It places responsibility in the wrong place. It perpetuates the myth that they are not and cannot be responsible for our their lives, decisions and choices.
- We see in the face of each person with a psychiatric disability a life that is just waiting for good soil in which to grow. We are committed to creating that good soil.

Mary Ellen Copeland, consumer/survivor, educator and developer of the Wellness Recovery Action Plan (WRAP) describes three expected long-term outcomes from a recovery/self-management focus:

- A shift of focus in mental health care from symptom control to prevention and recovery.
- Significant reduction in the need for costly mental health and emergency services as people who experience psychiatric symptoms effectively take responsibility for their own wellness and stability, manage and reduce their symptoms using a variety of self-help techniques, and effectively reach out for and use the support of a network of family members, friends, and health care professionals.
- Increased ability to meet life and vocational goals, significant life enhancement, and gains in self-esteem and self-confidence as people become contributing members of the community.⁸

Model.

⁸ Copeland, Mary Ellen (1999). Handout from seminar “Dealing with Psychiatric Symptoms”. PO Box 301, West Dummerston, VT., 05357.

Built on the above principles, all activities of the system would be designed to help mental health consumers recover. Essential service components will include education, peer support, employment, housing, help with co-occurring disorders and crisis prevention/intervention.

Education. As a first activity, everyone who is part of the system; consumers, family members and staff should complete (strongly encouraged to) basic information courses in recovery. To create the shift to recovery, a training campaign should be initiated to create the essential foundation of knowledge necessary for the system and for consumers to recover. Concepts of wellness, hope, personal responsibility, self-advocacy, and support should be emphasized.

During the next year, META will create a Consumer Education Center. This will include a resource library, access to the internet at sites throughout Maricopa County with links to relevant internet web sites, and classes on a variety of recovery topics.

In addition to generic training in recovery, consumers should be offered opportunities to participate in specific training. Examples include:

- The Recovery Workbook. A thirty session course created by Leroy Spaniol, Ph.D. of Boston University designed to teach recovery skills. This course has been piloted in Phoenix during the past year with a group of consumers and professionals.

Dr. Spaniol describes the following purpose of the workbook:

1. to become aware of the recovery process.
 2. to increase knowledge and control.
 3. to become aware of the importance and nature of stress.
 4. to enhance personal meaning.
 5. to build personal support.
 6. to develop goals and a plan of action.⁹
- Wellness Recovery Action Plan (WRAP). This is system developed by Mary Ellen Copeland for wellness maintenance and recovery planning. Through this course consumers can create their own plan for wellness that includes daily maintenance tasks, relapse triggers, knowledge of early warning signs, and a crisis plan with advance directives. Ms. Copeland has created special training for “Mental Health Recovery Educators” The leadership of META Services has attended her one week train the trainer course, “Teaching Self-Management of Psychiatric Symptoms” at her Vermont training center and several META staff are certified as WRAP trainers.
 - Dialectic Behavioral Therapy. The DBT classes of Marsha Lenihan should be provided to teach new skills to consumers who try to solve problems with repetitive self-defeating behaviors.

⁹ Spaniol and Koehler

Peer Support. As has been repeatedly demonstrated, Peer Support for individuals who experience psychiatric symptoms, aids in the process recovery. One such report describes the reduction in the following ways:¹⁰

- Peer Support or self-help provides a social network based on common experience. Recipients of mental health services are often isolated due to stigma and discrimination within and outside of the mental health system. In this situation, socialization becomes an acute problem. When recipients come together in a Peer Support setting, they share common experiences which lead readily to the formation of social relationships.
- Peer Support facilitates moving from the role of always being helped to helping. Being helpless is a demeaning role in our society leading to low self-esteem and poor self-concept which in turn increases various distressing symptoms such as anxiety. The role of being a helper is a valued role and leads to improved self-esteem, providing a buffer from distressing symptoms and repeated crisis.
- Peer Support can offer specific ways of coping that come from personal experience.
- Those who successfully cope, serve as role models for people who cope less successfully.

The consumer survey discussed above conducted by Dr. Otto Wahl of George Mason University discusses how support is needed to combat the isolation caused by stigma.

Mental health consumers said that they experienced rejection and isolation as a result of their psychiatric diagnoses. Friends, co-workers and even relatives became uncomfortable around them, ceased to contact them or avoided them. “I think the thing that is most devastating for mentally ill people,” said one study participant, “is that they are completely ostracized by their friends. ...all of a sudden, the phone quits ringing and they quit coming to the house.” ...another consumer reveals, “Friends of mine had little to do with me. ...Christmas cards that we used to exchange in the past don’t happen any more. Telephone calls are few and far between.” Mental health consumers feel rejected and abandoned at the very time that they may be most in need of understanding and support.¹¹

META services is currently in process of developing a peer support resource. Having been funded by RSA with an establishment grant, consumers will be hired and trained as peer support specialists to provide peer support and teach recovery concepts to others.

¹⁰Office of Mental Health, New York State Bureau of Evaluation and Service Research, “The Meaning of Self-Help,” *Investigators*: Sharon Carpinello, Ed.D., and Edward L Knight, Ph.D., 1993

¹¹Wahl, Otto. p.14.

Employment. The experience of work, in and of itself, has proven to be a significant facilitator in the recovery process. Consumers who have been able to take advantage of employment opportunities tend to make significant progress in their recovery process and to use fewer behavioral health services. When they do use services, the duration of the service is shorter and less frequent. Consumers describe employment opportunities as a means of enhancing their self esteem and developing a sense of pride because they can be a productive member of society. They often mention the positive effects of increased responsibility, and the satisfaction of being able to give something to others, particularly in jobs where they can offer peer support. Cherie Boykin, in a publication by IAPSRS, relates a first hand account of the transformational value of employment opportunities:

My new role as drop-in center aide and peer support counselor was like a rebirth..... My perception had sealed me into a tomb. Since being diagnosed, I had no reason to do anything..... The new responsibilities gave my life a focus. I was able to look beyond my illness and see me. It gave me responsibilities and expectations for myself.....I looked at myself in the mirror each day and saw that I did have a smile, a laugh, and a personality. It made me want to get out of bed, go to work, and do a good job..... The feelings of being needed, expected, and responsible made a difference for me. I gained power and self-worth from making decisions that not only effected me but others. I began to see myself as a person that had something to offer and to contribute to society. My mental illness was not the end of everything but just a stumbling block or a different turn to which I had to adjust and build around.¹²

While RSA funds should be accessed when they provide opportunities that match the needs of the consumer, some systems have endorsed the concept of work as a recovery strategy by redirecting a percentage of mental health dollars to employment services, offering improved integration of all services and supports. The use of this approach was described by Phil Wyzick of West Central Services, Inc., Lebanon, New Hampshire at the 1999 ValueOptions Best Practice Conference in Boston. If indicators point toward a need for increased availability and flexibility in funding for vocational programs, META would be interested in exploring this option.

META has been successful with a similar model program where all the funding for treatment, support services, and employment was integrated. For the past three years, META Services has been the recipient of a HUD Continuum Care grant for homeless substance abusers, a program known as Another Chance. The goal of this funding was to help homeless substance abusers become employed and find permanent housing. Approximately one-third of the funds were set aside to issue housing vouchers (a section 8-like approach). With an emphasis on teaching recovery and then on placing and supporting consumers in employment, the housing money was not needed in the amount expected since many consumers were becoming gainfully employed and were able to pay for their own housing, reducing the cost of the overall project. In fact, a three year grant has now been

¹² Bledsoe Boykin, Cherie. "The Consumer Provider as Role Model" (1997). In C. Mowbray (ed.), *Consumers as Providers in Psychiatric Rehabilitation*. International Association of Psychosocial Rehabilitation Services. p. 374.

stretched to four years with the same funding, proving to point that a recovery-oriented system is cost effective.

The success of this program increased META's interest in employment opportunities. Recently META applied for and was awarded a establishment grant from RSA matched by funding from ValueOptions/St. Luke's Charitable Trust to develop a consumer operated business that will provided a range of employment opportunities for people who have a serious mental illness. The vision is to continue to build on this foundation by developing a range of employment opportunities for consumers as a means of supporting their recovery.

Housing. Since 1991, Maricopa County has been under a court order to develop a new and innovative service delivery system, as well as comprehensive housing resources (Arnold v. ADHS Exit Stipulation). This court order was based on a blueprint that required the RBHA "to develop and maintain a variety of housing and residential options... that integrate class members into the community to the greatest extent possible." A driving force behind this goal was to eliminate placements into substandard facilities, namely Supervisory Care settings. To date, Maricopa Co. continues to have approximately 600 consumers who have a serious mental illness placed in Supervisory Care settings. The reasons for this are two fold: the scarcity of affordable housing options; and the lack of innovative residential programs that are responsive to the unique recovery needs of each individual.

The dominate conceptual framework for residential services in Maricopa Co. is a linear continuum. Since people who are trying to recover from a serious mental illness often do not change in a linear fashion, nor at a predetermined rate, this model does not accommodate the highly variable recovery process that is unique to each individual. "Requiring a certain type of progress to occur in a certain framework can spell failure."¹³

Supported housing on the other hand can often be a flexible alternative that facilitates the recovery process. The main objective of supportive housing is to prevent hospitalization and to improve the quality of life.¹⁴ . It emphasizes consumer choice, and individualized supportive services on as needed basis that help consumers maintain a positive quality of life in the community.¹⁵

With the above in mind, META's approach to residential services will focus on creating supported

¹³ Ridgeway, P. and Zipple, A. (1990). "The Paradigm Shift in Residential Services: From the Linear Continuum to Supported Housing Approaches." *Psychosocial Rehabilitation Journal*. Vol. 13(4), 11-31.

¹⁴ Trainor, J.N., Morell-Bellai, T.L., Ballantyne, R., Bydell, K., (1993). "Housing for People with Mental Illnesses: A Comparison of Models and an Examination of Growth of Alternative Housing in Canada". *Canadian Journal of Psychiatry*. Vol. 38(7), 494-501.

¹⁵Branch, C., (1994). "Supported Housing: A Paradigm Shift in Housing Persons with Psychiatric Disabilities". Washington, D.C.: Mental Health Policy Resource Center.

housing alternatives, when residential program are needed, using them as transitional, and eliminating the utilization of Supervisory Care. Housing efforts will be directed to find a permanent home for every consumer, much like the META program Another Chance discussed above. Another Chance does use transitional residential facilities for the first three to six months of the consumers recovery, while the consumer is engaging in an intensive program of education, therapy and skill training. When the consumer is ready, they lease an apartment in their own name. Depending on income, some are eligible for a permanent housing subsidy. Others pay for their housing from their own resources and incomes. To help the consumer get established in their apartment, META, through the HUD grant often pays security deposits and purchases furniture and items to set up housekeeping. Case management and support services continue with varying intensity based on the individual's need.

A cost analysis should be completed to determine if the existing funds for residential programs where many consumers are currently living would be adequate to fund both a rent subsidy and the support services that will be needed to help the consumer succeed in housing of their choice.

Co-occurring Disorders: Substance Abuse/Mental Illness. It is well known that over 60% of people who have severe mental illness also have serious substance abuse issues. The problem is so wide spread that for the past year ADHS/BHS has supported a consensus panel to study the problem and develop recommendations. A vision statement and guiding principles have been created with the expectation that 20% of the funding for persons with serious mental illness will be re-directed to create integrated programming for consumers who experience both psychiatric and substance abuse problems.

Currently, META is the provider of the LARC service at META Center. Until recently, the focus of LARC programming was limited to consumers with substance abuse issues only. Those with severe mental illnesses were sent elsewhere. Now, the focus at META Center has been expanded to serve consumers who have both substance abuse and mental illness, providing assessment, stabilization, detoxification, and connection to continuing services.

META also provides a 90 day intensive outpatient program for substance abuse treatment as part of the Another Chance program for homeless substance abusers. Education and relapse prevention is the focus strengthened by peer support and self-help groups. This program could be expanded to strengthen the focus for consumers who have co-occurring disorders. For example, the work of Howie Vogel who has developed "Double Trouble" a modification of the 12 Steps of Alcoholics Anonymous for consumers with co-occurring mental illness and substance abuse will be included.

Crisis Intervention/Prevention.

While the current Individual Service Plan requirements include an "At Risk Crisis Plan", the instructions issued by the agency overseeing case management do not include the consumer's preferences: "This is a summary of the Consumer's decompensation systems. What do they look like when in crisis? What do they present like when they are at baseline functioning. History of violence? Successful past interventions. Clinical team recommendations. Supports and contacts that could assist during the crisis situation." (Internal ABS of Arizona procedure: AB112899). This

is not a recovery statement since it does not place the responsibility for the plan with the consumer. Crisis plans should shift to become practical and useful documents in which a consumer describes her/his preferences for care when the “wellness plan” does is not sufficient and they experience a crisis or relapse. As summarized by Jacobson and Curtis:

Crisis planning is premised on the argument that proactive and prudent decision-making can mitigate the negative consequences of crisis situations and diminish the use of coercive interventions such as involuntary commitment, use of restraints and seclusion, and forced medication. While they are doing reasonably well, consumers develop plans for managing future crisis. Building upon the recognition of triggers and the self-management skills emphasized in relapse prevention, crisis plans usually specify the signs and symptoms that the individual typically exhibits when in crisis and the individual’s preference for disposition at that point-including preferred treatment facility and medication. The consumers may appoint a representative to advocate for their interests and wishes and to look after their daily affairs, e.g., call employer, pay rent, and other bills.....¹⁶

The Mary Ellen Copeland WRAP mentioned above, includes as its fifth component a crisis plan. For any consumer who has completed a WRAP Crisis Plan, the plan would be honored at all the crisis facilities and programs. Its instructions and preferences for crisis intervention and care will be followed and given an opportunity to work before other interventions are initiated.

META Services is in the process of developing a third Urgent Care Center in the East Valley (UCE). While other the other META centers use recovery principles, the UCE will expand the recovery model. While for safety reasons, the facility will be “secure”, the focus of all activities in the center will be non-coercive and encourage consumer rights and consumer choice.

- The center will be community based and located in a non-institutional setting with as much of a residential atmosphere as possible with a range of crisis intervention service alternatives co-located at the site; mobile intervention teams, home stabilization services, alternative care beds (3-5 day acute beds as alternatives to hospitalization, and a crisis stabilization unit (remodeled after the San Francisco Progress Foundation “Acute Diversion Units”).¹⁷
- The UCE will always follow the consumer’s crisis plan (advance directive) when ever such a plan exists.
- The center will have as a policy goal the reduction or elimination of seclusion and restraint. The state of Pennsylvania over the past several years has nearly eliminated the use of

¹⁶Jacobson and Curtis. p. 337.

¹⁷Fields, Steven. “Progress Foundation, San Francisco.” In R. Warner (ed.) *Alternatives to the Hospital for Acute Psychiatric Treatment*. American Psychiatric Press. Clinical Practice Series #32. p. 57.

seclusion and restraint in their ten state mental hospitals by redefining seclusion/restraint as a treatment failure. Based on their success, they are now considering abolishing seclusion/restraint altogether. Learning from Pennsylvania, adequate staffing and rigorous training at UCE will be maintained to accomplish this goal. When seclusion and/or restraint (physical or chemical) are used they will be considered “safety interventions” and implemented as respectfully as possible, always accompanied by rigorous attempts to conclude the “safety incident” as soon as possible and engage the person in treatment.

- Outpatient commitment, in Arizona statute, the fourth standard of commitment, “Persistently and Acutely Disabled” (PAD), and forced medications will be used only as a last resort after diligent efforts had been made and documented to enlist the consumer in voluntary treatment. It will be the goal to reduce the use PAD commitment and eliminate it for consumers who have written a crisis plan with an advance directive unless, as part of the advance directive, PAD involuntary treatment is requested. Involuntary treatment would continue to be initiated, as a safety intervention, as the result of behavior that is dangerous to self or others when the consumer continues to refuse voluntary services.
- Consumers, employed by META as Peer Support Specialists, will be trained to offer peer support in the UCE program. Consumers tell us that one of the most powerful supports during the trauma of a crisis intervention is having a peer greet them in the crisis center or hospital. This program, the META Peer Support Registry, will be started in September, 2000, with a two week training for 10-12 consumers. After demonstrated competency, the Peer Support Specialists, under the META Director of Consumer Services, will be given paid peer support assignments at UCE and elsewhere.

Another example of a recovery-oriented program is META’s Home Stabilization Services (HSS), a crisis alternative provided by META for the past five years. Home Stabilization is an intensive two to three week program, staffed with a multi-disciplinary team that works with the consumer to resolve acute symptoms in their own home as an alternative to more restrictive out of home placements, even hospitalization. 95% of the consumers served by HSS resolve their crisis at home. The recovery focus of this program emphasizes several features:

- Consumer choice and preference come first. By choosing services in their home, consumers with acute symptoms have learned they can recover without having to be hospitalized. For many, this has been an empowering discovery.
- When the HSS is expanded this fall, HSS staff will begin offering consumers in the program the opportunity to learn a new tool, the Copeland “Wellness Recovery Action Plan”, teaching them that recovery is possible and helping them develop a “wellness toolkit”.
- As discussed above, consumers, employed by META as Peer Support Specialists, are being trained to offer peer support as an adjunct to the HSS service. The Peer Support Specialists will model recovery and create hope.

Conclusion. As the delivery system in Maricopa County evolves, META is dedicated to advancing the principles and concepts of recovery as discussed above. With input from our consumer leaders, we are redesigning our existing services to put the consumer at the center, thoughtfully and respectfully supporting their right to recover and choose what their recovery looks like. We are building a Consumer Services Department that will be a resource for peer support, consumer information, and community development. We are learning by careful listening to the experiences of our consumers and by educating ourselves about the experiences of recovery elsewhere in the country. We are participating in the debate of the issues of values and human rights that arise as we implement recovery-based services in our programs. These are the things that cause us to have hope for our consumers, our community, and for ourselves. And, we believe by carrying the message of recovery in our daily interactions with the consumers we serve in our centers and programs, the consumer voice will grow from the bottom up to create a transformation in our system that fills us all with hope, opportunity, and success. We are excited about the future and look forward to sharing it with the many that will join with us in the journey of recovery in Maricopa County.