

D. Recovery-Oriented Care is Effective, Equitable, and Efficient

Quality is considered a cornerstone for the DMHAS-funded system of health care. For care to be characterized by quality as well as its recovery orientation, it is essential that it be effective, equitable, and efficient. Effective care is that which has been shown to be useful in reducing illness and disability and improving functioning and quality of life. It may be based on several different types and levels of evidence, and reflects the best care a system can offer at any given point in time. Equity ensures that care is provided to all those who would benefit from it and speaks to the need to ensure that care does not vary in quality or effectiveness due to personal or social characteristics such as gender, ethnicity, race, sexual orientation, religious affiliation, geographic location, or socioeconomic status. Finally, efficiency results from the thoughtful allocation and management of resources in such ways that maximize access and effectiveness and minimize barriers and wasted time or effort.

It remains important ... that the services and supports offered are the best available for the persons being served at any given time.

As we noted in the Introduction, *effectiveness* has been emphasized in recent years through a focus on the ‘evidence’ base that has been established for any particular intervention. Ideally, this evidence would be collected scientifically and would meet rigorous criteria for having demonstrated the benefits it generates in relation to a given condition or combination of conditions. Unfortunately, very few practices have been evaluated in such a rigorous way and even fewer practices have been evaluated with diverse populations having complex needs. Being tightly controlled studies, many people served by the DMHAS-funded system of care would be excluded from randomized clinical trials due, for example, to co-morbid conditions, linguistic or cultural needs, or social-economic status and living situation. It therefore would be inappropriate for DMHAS to adopt a narrow vision of the nature of “evidence” and to limit the array of services and supports offered to those which have been evaluated through rigorous experimental trials.

It remains important nonetheless that the services and supports offered are the best available for the persons being served at any given time. In addition to the accumulation of scientific evidence, the utility of interventions can be determined based on the experiences and feedback of those individuals who have used them, the ability of such interventions to engage individuals who otherwise would not be served, and by the degree to which such interventions are requested or selected by the people for whom they are intended. Within this context, then, choice plays a key role in helping to identify which interventions are responsive to the needs of which individuals. It is especially important to take choice into account in this way because the few evidence-based practices that exist have been developed and evaluated with

narrowly defined populations. With recognition of this dimension of the current system, concerns with effectiveness necessarily lead to concerns with equity.

Equity, as noted above, relates to care being provided to all those who will benefit from it and in such a way that it does not vary in quality or effectiveness depending upon such factors as gender, ethnicity, race, sexual orientation, religious affiliation, geographic location, or socioeconomic status. While in some arenas this concern with equity might translate into a commitment to provide the same care to every person irrespective of their culture, race, etc., it is precisely this kind of ‘one-size-fits-all’ model which has not worked in medicine in general and in mental health and substance use in particular. The ample literature on health disparities mentioned earlier has demonstrated convincingly that equity can only be achieved by tailoring

While in some arenas...equity might translate into a commitment to provide the same care to every person irrespective of their culture, race, etc., it is precisely this kind of ‘one-size-fits-all’ model which has not worked in medicine in general and in mental health and substance use in particular.

care to the unique needs, values, and preferences of individuals and, on a broader scale, of the communities from which they come. It is for this reason that DMHAS views the primary mechanism for eliminating health disparities as being the provision of culturally responsive and competent care. In addition to ethnicity and race, cultural

competence requires care to be responsive to gender and possible trauma history, sexual orientation, religious affiliation, and social-economic status.

In this section of the Guidelines, we therefore reiterate some of the key principles and standards articulated by the DMHAS Office of Multicultural Affairs separately in its *Multicultural Behavioral Health Care: Best Practice Standards and Implementation Guidelines*. We also include principles and guidelines related to gender and trauma suggested by the DMHAS Women’s Services Practice Improvement Collaborative and several consultants who have been involved in introducing trauma-informed and trauma-sensitive care into the DMHAS-funded system of care over the preceding decade.⁴⁵ We address stigma and discrimination as barriers to equity and, in order to explicitly address the prevalence of co-morbid or co-occurring conditions within the populations served by DMHAS-funded care and their impact on a person’s access to effective care, this section also incorporates the suggestions of Commissioner’s Policy Statement #84 on Serving People with Co-Occurring Mental Health and Substance Use Disorders along with the Co-Occurring Enhanced Program Guidelines and Workforce Competencies developed by the DMHAS Workgroup on Co-Occurring Disorders.

⁴⁵ In particular, the work of Roger Fallot and Maxine Harris of Community Connections in Washington, D.C.

At this point in time, it is difficult to articulate guidelines for ensuring that care is provided in an optimally *efficient* manner. Much remains to be learned in this area, and there are ongoing efforts to collect the kinds of data which would enable practitioners to determine which forms of care delivered in which ways represent maximum efficiency. It is possible, however, to suggest that timely and responsive care offered earlier in the course of illness, or earlier in the course of a given episode, will be more cost and time efficient than care that is delayed or sought at a later point in time when the condition has wrought more havoc in the person's life and in the lives of his or her loved ones. It also is reasonable to suggest that it is more efficient to provide services in the least restrictive, least costly, and least intensive setting possible, and that systems need not recreate through artificial means those settings which already exist in the broader community. For the purposes of these Guidelines, then, efficiency will be interpreted primarily in terms of the intensity, location, duration, and timeliness of the care offered based on the suggestion that people will derive the most benefit from being able to access the services and supports needed at the time and for as long as they are needed, with the emphasis in care shifting from acute, institutional-basis services to more natural and community-based supports over time as the person progresses in his or her recovery.

It is more efficient to provide services in the least restrictive, least costly, and least intensive setting possible ...systems need not recreate through artificial means those settings which already exist in the broader community.

**You will know that you are providing effective,
equitable, and efficient care when:**

At the System/Agency Level

- D.1. Systemic structures and practices which inhibit the adoption of recovery-oriented practices are identified and addressed.**
- D.1.1.** Well intentioned efforts to provide a full continuum of care have led to a system in which people are sometimes expected to enter in, and progress through, a range of services in a sequential fashion as they stabilize and move toward enhanced functioning and independence. The misapplication of this model has led to systems of care in which individuals are then expected to jump through hoops in order to earn their way into less restrictive settings (e.g., an expectation that they prove they can prepare three meals a day or keep their living space clean before they can move out of a group home) or to earn the right to participate in preferred services (e.g., an expectation that they comply with medication before they will be referred to supported employment).

In addition to there being an accumulating body of evidence which demonstrates the failure of such a continuum approach and its lack of efficiency, this sequential movement through pre-existing continua of supports is inconsistent with the civil rights perspective noted above and contradicts current knowledge suggesting that recovery is neither a linear process nor a static end product or result. Rather, it is for many a life-long experience that involves an indefinite number of incremental steps in various life domains, with people moving fluidly between the various domains over time (as opposed to moving through them in a systematic, linear way). Rather than a pre-established continuum of services, what is necessary is a flexible array of supports that each person can choose from at different points in time depending upon his or her phase of recovery and unique needs and preferences. This array is also constantly evolving based on the input of persons in recovery, the experience of practitioners, and the research literature.

- D.1.2.** The structure of certain outcome indicators places significant pressures on agency staff to operate in a manner that they see as inconsistent with recovery-oriented care. For example, staff might like to support persons in making choices regarding their housing preferences, such as moving to a less intensive level of supported housing. They may legitimately be concerned, though, that they will be held accountable should the result of such a person's choice ultimately be a negative one. This accountability is not limited to the potential adverse events themselves, but is further accentuated through the agency's collection of mandatory performance data, such as statistics regarding the number of individuals who move from housed to homeless.

The resulting need to portray the agency's performance on such indicators as positive creates a strong incentive for the maintenance of stability as a desired outcome in and of itself. In contrast, a desired goal of recovery-oriented care is to promote growth, independence, and wellness; goals which sometimes involve the taking of reasonable risks that may result in interim set-backs. At both the agency and system level, quality management tools and outcome indicators are examined and mechanisms are built in to track the trade-off which sometimes exists as we support individuals in taking risks to grow and advance in recovery while requiring practitioner accountability within the system.

- D.1.4.** Quality assurance and independent audits by people in recovery and families are funded and coordinated. Outcomes and assessment of quality do not focus solely on the rating of services or supports, but on whether the choices people make are personally meaningful and whether recovery-oriented care leads to a valued community life.

D.1.5. Initial placement and service design currently is driven by practitioners' assessments of what the individual seeking services needs. While this assessment remains a critical element of the process, it also is coupled with questions, directed to the person and answered in his or her own words, which solicit the individual's perception of what care would be most helpful at the time. Individuals are engaged as active partners in their care in this way from the outset of treatment.

This can only be achieved with greater transparency in the system of care as a whole and with greater involvement of the person and family in all important decision-making processes, including the decision of initial level of care and team or program assignment.

D.1.6. Despite legislative advances in the past decade, the structure of federal and state disability, benefits, and vocational programs continue to impede the wish of many individuals of entering, or reentering, the workforce, thereby excluding them from an activity which many have described as a cornerstone of recovery. Rigid definitions of disability, earnings limits which perpetuate poverty, a lack of supported employment programs, and complex referral procedures drastically reduce the likelihood that individuals will access necessary supports and return to meaningful employment. To integrate employment within the larger system of care, the task of assisting people in pursuing employment and education is taken to be inherent to the responsibilities of the entire practitioner network, including those not specifically charged with work service or supported education activities.

D.2. The implementation of recovery-oriented care is currently both impeded and facilitated by funding, reimbursement, and accreditation structures. Ongoing efforts are made to lessen the barriers and increase the incentives offered by these structures to promote the creative formulation of recovery-oriented goals and objectives.

D.2.1. Rules and regulations dictating eligibility and reimbursement for Medicaid and other public programs must be adapted at the federal level over time for greater relevance to innovative, recovery-oriented approaches. Even though Medicaid is funded by federal dollars, it remains primarily a state-administered program, however, and considerable flexibility exists already in using these funds to support innovative, community-based, recovery-oriented services and supports.

D.2.2. Within existing funding structures, training and technical assistance is provided to practitioners implementing recovery-oriented practices to assist them in learning how to translate people's wishes into reimbur-

sable service goals and to describe their interventions in a manner that generates payment. Above and beyond these “necessary” (i.e., billable) services, the individualized recovery plan also incorporates action steps taken by both the person in recovery and his/her natural supports.

D.2.3. Operating in this manner is consistent with the growing understanding that recovery-oriented practices cannot be limited to being an add-on to existing care for which additional funding must always be secured. Rather, recovery-oriented care begins with discovering ways to be creative and flexible within the constraints of existing resources. In some cases, for example, braiding funds may enable collaborations to move beyond funding silos to provide people with flexible, highly individualized services.⁴⁶ Programs that successfully utilize such alternatives are expanded.⁴⁷

D.2.4. Self-directed funding opportunities are piloted both on a collective basis and through individualized budget programs. The Florida “Self-Directed Care” initiative is an example of such a program that shifts fiscal control from the hands of service providers to the hands of service users. Within this program, participants are given control of their service dollars and then are free to shop around to weave together the type and frequencies of services that may best respond to their individual interests and preferences. While this approach has proponents, there is also an inherent tension and uncertainty about whether there is any guarantee that high quality services will be available to purchase if there are no consistent funding underpinnings. A robust practitioner network is needed and it must be easily accessible.

D.3. Training and staff development is prioritized as an essential function to increase practitioners’ competency in providing recovery-oriented care.

D.3.1. As consensus emerges regarding the knowledge and skills needed to implement recovery-oriented care, this information leads to development of competency models, and these models are disseminated broadly as guidance for training programs and licensing bodies which prepare and accredit future and current providers of mental health and substance use care. These models also are used to address training gaps

⁴⁶Osher, D., Dwyer, K. & Jackson, S. (2004). *Safe, supportive, and successful schools step by step*. Longmont, CO: Sopris West; Poirier, J., Osher, D. & Tierney, M. (in press). Understanding the new environment of public school funding: How pupil services are funded. In C. Franklin, M.B. Harris & C. Allen-Meares (Eds.) *School social work and mental health workers training and resource manual*. New York: Oxford University Press.

⁴⁷Blessing, Tierney, Osher, Allegretti-Freeman, & Abrey. (2005). *Person-centered planning: Learning from other communities*, Washington D.C.: Substance Abuse and Mental Health Services Administration.

in pre-certification curriculum as well as ongoing professional development activities.

- D.3.2.** Once established, competency models—which are largely under-utilized—are incorporated into human resource activities (e.g., hiring, routine performance evaluation, promotion decisions, staff development targets, etc.) as a means of promoting accountability.
- D.3.3.** An analysis of current staff competencies and self-perceived training needs guide the development of on-going skill-building activities at the agency level. For example, practitioners are frustrated by the fact that they are overwhelmed by a constant stream of change mandates for which they receive little or no training or support. There are beneficial, self-reflective tools⁴⁸ that can be used to conduct a training needs analysis which identifies both strengths and areas in need of improvement as it relates to the provision of recovery-oriented care. Gaps in skill sets can be identified and prioritized for development.
- D.3.4.** Training in and of itself does not allow practitioners to develop the enhanced skill set and increased sense of efficacy that will allow them to carry out the complex responsibilities and roles of the recovery-oriented practitioner. Competency-based training therefore is coupled with on-going mentoring support, clinical supervision, recovery-oriented case conferences, and opportunities for peer consultation.
- D.3.5.** Agency leaders are involved in ongoing training so that there is consistency between proposed recovery-oriented practices and administrative structures. This allows direct care staff to be supported and allows agency leadership the opportunity to proactively identify and address systemic barriers that prohibit adoption of recovery-oriented practices.
- D.3.6.** Training and staff development activities are sensitive to the confusion which can be involved with the adoption of recovery-oriented practice. Recovery-oriented care does *not* imply that there is no longer any role for the practitioner to play. Rather, the practitioner’s role has changed from that of all-knowing, all-doing caretaker to that of a skilled educator, coach, mentor, cheerleader, or facilitator⁴⁹—roles that are not

⁴⁸Campbell-Orde, T., Chamberlin, J., Carpenter, S. & Leff, S. (2005). *Measuring the promise: A compendium of recovery measures, Volume II*. Boston: Human Services Research Institute.

⁴⁹Adams, N. & Grieder, D. (2005). *Treatment planning for person-centered care: The road to mental health and addiction recovery*. San Diego, CA, US: Elsevier Academic Press; Davidson, L., Tondora, J., Staeheli, M., O’Connell, M.J., Frey, J. & Chinman, M.J. (2006). Recovery guides: An emerging model of community-based care for adults with psychiatric disabilities. In A. Lightburn & P. Sessions (Eds.), *Community-based clinical practice*. Oxford University Press, New York.

always consistent with one's clinical training or expertise. One effective educational strategy is to use a combination of literature, outcomes or efficacy data, and personal accounts such as recovery dialogues to help practitioners learn the new roles of advisor, mentor, guide, coach, or supports broker.⁵⁰

Further, those involved in educating practitioners about self-determination and recovery-oriented care have found that acknowledging staff's fears and doubts, rather than dismissing or shaming them, is more likely to lead them to accept a new role in the lives of the people they serve.⁵¹ The application of sophisticated and effective clinical practices in the larger context of collaborative partnerships and self-determination is a training area that requires ongoing attention.

D.3.7. No matter how competent the workforce, no matter how ripe the culture, and no matter how compatible the funding mechanisms, recovery-oriented care will not become a reality unless people in recovery and their families understand it, are supported in using it, and come to view it as a basic expectation of quality care. Therefore training initiatives regarding recovery-oriented care do not neglect the needs of people in recovery and families to develop their own capacity to self-direct their treatment and life decisions. Some may already do this with great skill and acumen. Others may be reluctant to assume the seat of power, having been socialized by their culture⁵² or taught by practitioners and agencies that their preferred role is one of deferential compliance.⁵³ Ideally, training initiatives put all stakeholders, including people in recovery, families, and practitioners, at the same table.

D.4. Forces at the societal level (e.g., stigma, discrimination, lack of basic resources, etc.) that undermine recovery and community inclusion are identified and addressed.

D.4.1. A lack of basic resources and opportunities (e.g., jobs, affordable housing, primary medical care, educational activities) in the broader community significantly complicates the task of recovery for persons with mental health and/or substance use conditions. This lack of resources and opportunities often stems from inadequate knowledge

⁵⁰Jonikas, Cook, Fudge, Hiebechuk & Fricks. (2005). *op cit*.

⁵¹Holburn, S. & Vietze, P. (2002). *Person-centered planning: Research, practice, and future directions*. Baltimore: Paul Brookes Publishing.

⁵²Harry, B., Kalyanpur, M. & Day, M. (1999). *Building cultural reciprocity with families*. Baltimore, MD: Paul Brookes.

⁵³Katz, E. & Danet, B. (1973). *Bureaucracy and the public*. New York: Basic Books.

and skills on the part of community organizations regarding how to create welcoming and accessible environments for all people. Health care practitioners have significant expertise to address this skill and knowledge gap, and are prepared to offer supportive guidance and feedback at both the individual and community level. For example, consultation with an employer regarding the impact of a medication on an individual's stamina can lead to a reasonable accommodation in the work place which allows greater productivity and success on the job—an outcome which is ultimately beneficial to both parties. Provided appropriate support and consultation, many community members are excellent collaborators and become facilitators of community inclusion.

D.4.2. Despite the promise of such collaborations, discrimination against people with mental health and/or substance use conditions will most likely continue for the foreseeable future. Community collaborations and education are therefore coupled with efforts on the part of practitioners to recognize instances of discrimination, to understand relevant disability legislation (e.g., the Americans with Disabilities Act), and to develop effective relationships with state and local resources (e.g., the Connecticut Legal Rights Project, the Office of Protection and Advocacy, the Equal Opportunity Employment Commission, advocacy organizations, etc.) to facilitate individual's access to and support in self-advocacy. This type of knowledge is built within the consumer community so people in recovery can protect themselves by recognizing and rectifying instances of discrimination.

D.4.3. Agencies are cautious to avoid the establishment of 'one stop shops'. In an effort to respond simultaneously to individuals' complex needs while also protecting them from discrimination, agencies may develop in-house alternatives to community activities based on concern that the community will never accept individuals with mental health and/or substance use conditions. As a result, agencies may create in artificial settings activities that already exist in the natural community; e.g., developing in house medical clinics, movie nights, GED classes, social events, etc. Agencies providing a one stop shop may also inadvertently contribute to the development of chronic "patienthood" as well as the perpetuation of discriminatory practices in the community. It therefore is incumbent upon recovery-oriented systems to work with community partners to uphold their obligation to respect people with mental health and/or substance use conditions as citizens who have the right to be treated according to the principles of law that apply to all individuals.⁵⁴

⁵⁴National Council on Disability. (2000). *From privileges to rights: People labeled with psychiatric disabilities speak for themselves*. Downloaded from <http://www.ncd.gov/newsroom/publications/privileges.html>

- D.5.** Agency administrators monitor the treatment outcomes and satisfaction of individuals based on race and ethnicity, gender, gender identity, sexual orientation, trauma history, and religious and socio-economic background and implement changes in services and service delivery to address disparities.
- D.6.** Qualified interpreters are available within one hour for crisis situations and within twenty-four hours for routine situations. Information about qualified interpreters is maintained in the agency and the list of such resources is updated at least annually. Staff is trained and knowledgeable about when and how to utilize interpreters across diverse groups.
- D.7.** Practitioners make available and disseminate culturally-relevant and linguistically-appropriate information regarding local mental health and addiction services, as well as non-traditional and self-help resources in a wide variety of formats.
- D.8.** Staff has and uses an available list of culturally- and linguistically-accessible services within the facilities and throughout the community.
- D.9.** The agency's educational materials are made available to individuals served and reflect the language and culture of those persons.
- D.10.** The social and physical environment within the agency reflects the diversity and culture of the persons served. Waiting areas and offices display magazines, art, music, etc., reflective of the diversity of persons served.

At the Practitioner/Person in Recovery Level

- D.11.** Care is tailored to address individuality and uniqueness, taking into account how race and ethnicity, gender, gender identity, sexual orientation, trauma history, and religious and socio-economic background and their unique interests, strengths, and goals all play a role in people's needs, values and preferences. Prejudicial remarks are addressed immediately.
- D.12.** Initial and ongoing assessments include cultural factors which may affect treatment and rehabilitation services and supports. Bilingual/bicultural staff are available to assess individuals both in their preferred language and within the context of their cultural heritage.
- D.13.** Involvement of family members, friends, and natural supports in the assessment process is invited and documented in the person's record.

- D.14.** Individuals in recovery are viewed as a primary source of information for identifying barriers to recovery. Information is solicited from individuals who are diverse in their gender, race and ethnicity, sexual orientation, religious and socio-economic background, family make-up (e.g. primary caregivers), and trauma history to increase access of these populations to effective care.
- D.15.** Recovery plans respect the fact that services and practitioners need not remain central to a person's life over time. Currently, many systems lack clearly defined exit criteria and it is not uncommon for individuals to feel as if they will be attached to a formal system for life following their entry into care. This perception perpetuates a sense of chronicity through which individuals lose hope that they will be able to resume a meaningful and productive daily life beyond treatment. In contrast, exit criteria are established and used to engage people in a collaborative decision-making process regarding the potential advantages and risks of moving to a lower level of care, with effort being made to respect the individual's desire to "graduate." When a person is strongly advised against "graduation," there is evidence in the recovery plan of concrete steps being taken by the individual and the team to reach this ultimate goal. In establishing exit criteria, agencies take caution to avoid punitive measures by which individuals are discharged from services for displaying signs or symptoms of their condition.

Example of how this might look in practice:

A key component of effective care involves appreciating a person's cultural affiliations and the role of community resources in promoting and sustaining recovery. While practitioners will not always be intimately familiar with the nature of these affiliations or resources, they will be prepared to find out more about them as needed and to make connections to others members of these communities who can offer information, guidance, and/or direct support. This was the case for Shirley, who described how her counselor's attention to her faith and connection to her church helped to serve as a turning point in her recovery and in her life.

Shirley was a woman in her forties who had been through a detox program several times and each time had been referred to an outpatient program for ongoing treatment for an opiate addiction. Following discharge from detox, however, Shirley would soon pick back up with her drug-using friends and resume drug use, attending the program only sporadically and eventually being discharged for ongoing use and poor attendance. After three similar episodes of drug use followed by detox followed by inconsistent outpatient treatment followed by a resumption of drug use, the team

at the outpatient program decided that a new approach was needed to engage Shirley in care. Shirley was assigned a counselor who had recently taken training in motivational interviewing and the counselor began to practice her newly learned motivational interviewing skills with Shirley. In exploring what happened following discharge from detox, Shirley described returning to her old friends because, in her words, they “accept me as I am.” With her family having been alienated by her drug use and having no other friends except for her drug-using peers, Shirley quickly became isolated and lonely once back out in the community. And with no where to go and nothing to do during the day except for a few hours a week spent at the outpatient program, Shirley felt inevitably drawn back to her old friends. It was a trap that she could not find a way out of.

In further discussions, Shirley’s counselor asked her about other times or places in her life in which she had felt a similar sense of being accepted. Were these the only people in her life, was this the only community, from which she felt such a degree of understanding and appreciation of who she was and what she had to offer without asking or requiring her to change? Shirley first identified that the feeling of having to change to please people was very prominent in her family, and one reason for their falling out and no longer having contact with each other. She had always had a stormy relationship with her father in particular, who she described as ‘whipping’ her with his belt and hitting her whenever she would step out of line. She then pointed out that it was this same sense of having to change which she picked up from the outpatient program, and one reason why she only attended sporadically—she did not feel accepted there “as she was.” With the counselor’s persistence in focusing more on the positives and strengths, however, Shirley eventually recalled and disclosed that she had felt that sense of acceptance from her church prior to drug use. It was not only her family who could not tolerate her drug use, but it was her church as well, and this sense of rejection appeared to be even more devastating to Shirley than her alienation from her family. At least at church she had once felt accepted unconditionally, or so she thought.

When asked by the counselor how she knew she was no longer accepted at church, Shirley was at first stuck for an answer. She couldn’t recall anything happening that gave her that sense; in fact, she had stopped going to church once she started using, assuming that ‘addicts’ would not be welcomed there. Shirley had been raised in a Baptist community which had strong prohibitions against alcohol and drug use. She thought that her drug use—which had become common knowledge within this small community—would be cause for her to be humiliated and rejected. She had chosen, instead, to stay away from church altogether so as not to run this risk. As a result, she ended up feeling rejected nonetheless.

Talking about church did not seem particularly helpful to Shirley at first, as it only served to remind her of the sense of rejection she had felt and to add further to her sense of guilt over her drug use. Resuming drug use and resuming her friendships

with other people who were similarly using opiates was one way of blocking out or covering over this sense of guilt. How would talking about church change that? Over time, though, the counselor was able to ask Shirley if she had ever seen anyone else who had used drugs being humiliated or rejected from her church. Would Shirley be interested in contacting her pastor and asking him about the church's attitude toward people who had 'fallen' into drug use? Were not forgiveness and loving acceptance important aspects of her religion as well? Shirley declined calling her pastor because he was an intimidating figure, she was afraid of him and his potential response. Were there church elders, then, who Shirley might feel comfortable talking with instead? Was there anyone in the church community who she still had a connection with and who she could discuss her concerns with? After much hesitation, Shirley identified an older woman who had taught Sunday school and who had always been kind to her; someone she had felt she could go to when she was in trouble when she was younger. She, however, would not be comfortable calling this person. It had been too many years and too much had happened; too much "water under the bridge."

After much consideration, Shirley eventually became comfortable, though, with having the counselor call this church elder and ask her a few questions. When the counselor made the call, she was assured that no one would be turned away from the church and that many people still had very positive feelings toward Shirley; in fact, the elder said that they missed her at church and had been very worried about her. They had heard about her being out "on the streets" and wished that she would come back and let folks help her out. While Shirley was surprised by the counselor's report of this conversation, she still did not feel comfortable enough to return to the church on her own, being unsure of the kind of reception she would receive. The counselor then suggested that they could pay the church a visit together, and perhaps arrange to meet with the elder there as a gradual way back in. Once having arranged for Shirley and the elder to be in the same room back at the church, the counselor did not feel that there was much else that she needed to do to help Shirley reconnect. The hugs that were given and tears that were shed, by both parties, were adequate testament that the church community still held much significance for Shirley and that it had been very important for her to return.

Shirley's drug use did not immediately stop, of course. She continued to struggle with her addiction for a while, went through detox a few more times, and relapsed a few more times as well before she was able to make a solid enough connection back to her church community that she no longer needed the acceptance offered by her drug-using peers. In retrospect, though, Shirley, who described how her counselor's attention to her faith and connection to her church helped to serve as a turning point in her recovery and in her life.

Now that she had re-established this connection and had her life going in the right direction, she was confident that she would not go back to the life of addiction again. She now knew how much she had to lose, as she had lost it all once before.

What you will hear from people in recovery when you are offering effective, equitable, and efficient care:

- *The thought of getting discharged was so terrifying to me I almost didn't want to get well. But my case manager and I made sure that I had people and places I could go to for support when I needed it—and these folks had been involved in our work all along. It made a huge difference in my feeling good about taking the next step.*
- *I just didn't buy it when my clinician started talking to me about this thing called "consumer-driven care"... But she proved to me that she was for real in terms of making some changes in how we worked together— even referred me to a local self-advocacy center. I had been sitting back letting other folks call the shots, and then complaining when things got messed up. A Peer Specialist at the advocacy center called me out on it. I realized that I had gotten comfortable letting other folks make decisions for me, and I know now that I gotta take charge of my own recovery.*
- *My yoga class at the mental health center got cancelled, and instead, they gave us a coupon to try out some free lessons at the city Rec Department. At first I was so disappointed. But once I tried it out, I loved it. I now take pilates in addition to yoga and I also joined a hiking club. I feel healthier physically and mentally...*
- *My mental illness was the least of my worries when it came to getting back to work after I got discharged from the hospital. I was terrified about losing my benefits and my employer gave me a really hard time when I asked if I could come in a half hour late one morning in order to see my doctor. My therapist and I sat down and he helped me sort out what would happen to my benefits and gave me some great information about how I could talk to my boss and request some accommodations that would help me be successful on the job. I have been back now for almost a year, and I just got the Employee of the Month Award.*
- *I used to get so pissed when I got asked to sign off on the treatment plans my doctor had to send to the insurance company. Half the time, I could barely tell that it was MY plan. It didn't reflect any of the things I had said were important. My new doctor explained to me how the insurance and billing things work. And then we worked on the plan together. It still wasn't perfect, but at least I kind of knew where he was coming from and that he really HAD heard what I was trying to say.*

