

F. Recovery-Oriented Care Maximizes Use of Natural Supports and Settings

Given its focus on life context, one tool required for effective recovery planning and recovery-oriented practice is adequate knowledge of the person's local community, including its opportunities, resources, and potential barriers. This knowledge is to be obtained and updated regularly at a community-wide level for the areas in which a program's service recipients live, but also is to be generated on an individual basis contingent on each person's interests, talents, and needs.

Historically falling under the purview of social work and rehabilitation staff, the function of identifying, cataloguing, and being familiar with community resources both within and beyond the formal health care system can be carried out by staff from any discipline with adequate training and supervision. In most cases, however, this expertise will reside with local community-based practitioners rather than with inpatient or residential staff located at a distance from the person's community of origin. In such cases, close coordination between inpatient/residential and outpatient staff will be required to obtain and integrate this information into the individualized recovery plan. Regardless of how it is provided, a comprehensive understanding of the community resources and supports that are available to address the range of a person's needs as he or she identifies them is essential to the recovery planning process across the continuum of care.

Regardless of how it is provided, a comprehensive understanding of the community resources and supports that are available to address the range of a person's needs as he or she identifies them is essential to the recovery planning process across the continuum of care.

Asset-based community development is one useful strategy for developing this comprehensive understanding of local resources and supports. Based on the pioneering work of Kretzmann and McKnight,⁵⁹ asset-based community development (ABCD) is a widely recognized capacity-focused approach to community development that can help open doors into communities for persons who have been labeled or otherwise marginalized, and through which people in recovery can build social capital and participate in community life as citizens rather than solely as recipients of care for mental health and/or substance use conditions.

⁵⁹Kretzmann, J.P. & McKnight, J.L. (1993). Building Communities from the Inside Out. Chicago, IL. ACTA Publications.

Through the cultivation of mutually beneficial relationships, ABCD has been shown to be an effective technology for capitalizing upon the internal capacities of low-income urban neighborhoods and rural communities, particularly as the depth and extent of associational life in these communities is often vastly underestimated. Whereas community development has historically been deficit- or problem-based and fueled by “needs assessments” and “needs maps,” ABCD operates on the premise that every person in a community has gifts, strengths, skills, and resources to be contributed to the community and that community life is shaped, driven, and sustained by the contributions of an involved and interdependent citizenry. Capacity, strength, and resources are also derived from community associations (religious, civic, recreational, political, social, etc.) and from community institutions (schools, police, libraries, parks, human services, etc.).

Asset-based community development is a participatory process that involves all persons in mapping the resources and capacities of a community’s individuals, its informal associations, and its structured institutions, as a means of identifying existing, but untapped or overlooked, resources and other potentially hospitable places in which the contributions of people with mental health and/or substance use conditions will be welcomed and valued.⁶⁰ Information about individuals, community associations, and institutions is collected through the sharing of stories and in one-on-one interviews that foster the development of personal relationships.

The relationships, resource maps, and capacity inventories that result from this process serve to guide on-going community development and provide a means by which people can expand their existing social networks and involvement in community activities. Pride in past achievements is strengthened, new opportunities for creative endeavor are discovered, resiliency is experienced, and hope is sustained. It is important to note that the primary producers of outcomes in this process are not institutions but individuals strengthened by enhanced community relationships. ABCD ultimately helps people in recovery derive great benefit from access to a range of naturally occurring social, educational, vocational, spiritual, and civic activities involved in their return to valued roles in the life of their community.

You will know that you are maximizing use of natural supports and settings when:

At the System/Agency Level

- F.1.** Agencies provide both formal and informal supports aimed at increasing the engagement and contributions of a diverse range of people. For example, agencies offer multi-family psycho-education and

⁶⁰McKnight, J. (1992). Redefining community. *Journal of Social Policy*, Fall/Winter, 56-62.

support groups as well as informal social gatherings. Engagement of other natural community supports beyond family members might also be facilitated by the establishment of “community collaboratives.” Collaboratives bring together, on a regular basis, leadership from agencies within the system of care as well as from the community at large. They focus on developing a shared vision to guide their work as well as on the capacity-building of services that promote long-term recovery, community integration, and career advancement, e.g., supported education/career retraining and employer consultation regarding reasonable workplace accommodations.

Collaboratives may be led by leadership from LMHAs or substance use treatment agencies, but should also include representation from the following: the Bureau of Rehabilitation Services, Adult Education, community colleges, Departments of Recreation, Regional Work Force Development Boards, faith/religious communities, college Offices for Disability Services, local business leaders and Chamber of Commerce members, providers of primary medical care, and other local stakeholders where appropriate. Expanded partnerships with community organizations will result in greater utilization of their services and activities by people in recovery. As such, representatives from these organizations should be included in the recovery team when appropriate and when desired by the person in recovery.

- F.2.** People in recovery and other community members experience a renewed sense of empowerment and social connectedness through voluntary participation in civic, social, recreational, vocational, religious, and educational activities in the community. Opportunities for employment, education, recreation, social involvement, civic engagement, and religious participation are therefore regularly identified and are compiled in asset maps, capacity inventories, and community resource guides. These informational resources are made available to individuals on their initial agency orientation and are updated over time as knowledge about the local community grows.
- F.3.** Community leaders representing a range of community associations and institutions work together with people in recovery to carry out the process of community development.
- F.4.** Asset maps and capacity inventories created collaboratively by actively involved community stakeholders reflect a wide range of *natural* gifts, strengths, skills, knowledge, values, interests, and resources available to a community through its individuals, associations, and institutions.

In other words, they are not limited to social and human services or professional crisis or emergency services (e.g., the botanica).

- F.5.** Agencies engage in collaborative partnerships with a range of services and supports to aid recovery planning. Service and support options are available to individuals that are sensitive to gender, race, ethnicity, sexual orientation, trauma history, religious affiliation, social-economic status, and each person's unique interests, values, and preferences.
- F.6.** Community development is driven by a creative, capacity-focused vision identified and shared by community stakeholders. It is neither deficit-oriented nor driven by needs assessments and needs maps.
- F. 7.** Asset maps and capacity inventories include a range of options that recognize the connections people make based on their gender, race, ethnicity, sexual orientation, trauma history, religious affiliation, social-economic status, and their personal and family interests and activities.

At the Practitioner/Person in Recovery Level

- F.8.** People in recovery and other labeled and/or marginalized persons are viewed primarily as citizens and not as clients, and are recognized for the gifts, strengths, skills, interests, and resources they have to contribute to community life.
- F. 9.** High value is placed on the less formal aspects of associational life that take place, for instance, in neighborhood gatherings, block watch meetings, coffee klatches, salons, barbershops, book groups, knitting and craft circles, restaurants, pubs, diners, etc.
- F.10.** The relational process of gathering information about community assets and capacities through personal interviews and sharing of stories is recognized as being as important as the information that is collected.
- F.11.** **Forces at the societal level (e.g., stigma, discrimination, lack of basic resources, etc.) which undermine recovery and community inclusion are identified and addressed.**
- F.12.1.** 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. This lack of resources and opportunities often stems from inadequate knowledge 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.

- F.12.2.** Long-term recovery is often enhanced by meaningful occupation. Work, whether volunteer or paid, offers people the opportunity to play social roles that are valued by their community. Job sites offer new relationships based on competencies and strengths, in addition to enhanced income. Rather than waiting until symptoms or substance use abate before attempting employment, many people find that their symptoms or use are actually reduced by working as meaningful involvement is a healthier alternative to social isolation and empty time. Practitioners therefore encourage people to pursue employment that is of interest to them, and people in recovery actively pursue employment, unless they specify that they are not interested in employment at the time.

Example of how this might look in practice:

Perhaps as one legacy of de-institutionalization or, alternatively, out of concern related to the ready availability of drugs and alcohol in the community, practitioners are concerned at times about encouraging people to participate in activities which lie beyond the borders of the health care system. And “a life in the community,” as envisioned by the President’s New Freedom Commission on Mental Health, is indeed fraught with risks, challenges, and difficulties. It is, however, where the vast majority of individuals with mental health and substance use conditions wish to live and also where they have the right to do so. Recovery-oriented practitioners view the community as offering opportunities as well as challenges, pleasures as well as risks, and successes as well as difficulties, as in the story below.

Robert was a man in his early 30’s from an Irish background who had grown up in a small town outside of Boston. As do many people when they develop a serious mental illness, Robert had moved to the city and had unfortunately become disconnected from his family. Also like many first generation American immigrants, Robert had been expected to finish school and acquire a profession, helping to support his large family. While his three brothers went on to college and took secure, well-paying jobs, Robert had dropped out, wandered around the country, and had refused to work—even in the family business. Eventually his parents insisted that he move out, and Robert landed in a working class neighborhood in Boston, alone, on disability, and with not much to live for.

Robert appeared to have few, if any, goals, except for wanting a girlfriend and a car. His recovery mentor did not know what to do for Robert, as he was already connected to services, dutifully took his medication, and maintained his one room

within a SRO not far from the clinic. Otherwise, Robert remained aloof and suspicious, and would not divulge much information about his history or interests. Based on Robert's few expressed goals, the recovery mentor explained that if Robert wanted a car he should get a job so that he could afford to buy and maintain one, and that if he wanted a girlfriend he should find places to hang out where he might meet women. In response to this suggestion Robert initially looked puzzled and then explained to the recovery mentor that he already had a place to hang out where there were plenty of women, at least on the weekends, but that he couldn't meet or attract them because he didn't have a car. The problem was not access or proximity, but not having his own wheels. "What self-respecting woman," he asked, "would go out with a 33-year old man who didn't have his own car?"

Rather than pressing the point about getting a job to be able to afford a car, the recovery mentor was intrigued to learn that Robert did, indeed, have a place to "hang out." Apparently, Robert spent most afternoons and evenings sitting at the bar of a neighborhood pub, chatting with the bartender and other regulars and watching sports on one of the several television sets suspended above it. He was a Red Sox, Patriots, and Celtics fan, often stayed until the bar closed around 2 a.m., and then returned to his room to sleep well into the late morning. After lunch at the social club and attending to any errands or appointments, Robert would then return to the pub for the rest of the day. All he needed, as far as he was concerned, was a car and girlfriend.

When the recovery mentor discussed this new information with Robert's psychiatrist, they both became concerned about Robert spending all of his time at a bar and wondered how much he was drinking and what effect his drinking was having on the efficacy of his medications. Perhaps Robert was not benefiting as much as he might from the medicine, and perhaps his progress was stalled, because he was drinking too much, perhaps even on a daily basis. They agreed that what Robert needed was to start attending AA meetings or, if he did not agree to that, then perhaps to join the dual disorder group at the clinic. Robert, they surmised, was one of those people who had had an undetected co-occurring addiction and needed more intensive treatment.

When the psychiatrist and recovery mentor tried to discuss these concerns with Robert he denied drinking alcohol at all and insisted that he was a "tea totaller." When they expressed doubts in his veracity he became angry, shouting at the two of them that they could come with him to the pub if they wanted to and find out for themselves if they didn't believe him—before promptly storming out of the office. Robert then didn't show up for his regular appointments with the recovery mentor for several weeks and repeatedly hung up on him when he called, insisting that the recovery mentor was "in cahoots" with his parents and could no longer be trusted.

After several weeks and several offers, Robert finally agreed to meet the recovery mentor at the pub. The recovery mentor explained that he was willing to

take Robert up on his offer and to find out for himself, as long as Robert would agree to his doing so. They met at the pub the next afternoon, and Robert proudly introduced the recovery mentor to the bartender and some of the other customers, saying that he was an ‘old friend’ visiting from out of town. The recovery mentor was impressed with the familiarity with which Robert addressed and chatted with the people there and his level of apparent comfort, wondering what had happened to Robert’s usual aloof and suspicious demeanor. It then occurred to the recovery mentor that he had never seen Robert outside of the clinic before, and that perhaps his paranoia was increased when he was in such a setting. His medical record, after all, noted that Robert had had several involuntary hospitalizations in the past and perhaps was not comforted by being in a mental health setting. He did appear to be comforted, however, by being in a pub.

When the recovery mentor commented on how “at home” Robert appeared to be in a pub, Robert explained that it should be no surprise as he was virtually raised in a pub. The family business, as it turns out, was a neighborhood pub, and all family activities and events revolved around the pub. He did his homework at the pub, had his meals at the pub, brought his dates to the pub, and, eventually, got kicked out of the pub. His fond reminiscences of family life quickly turned sour, as he related that his father and three brothers were all “drunks.” Respectable, responsible drunks, perhaps, but drunks nonetheless. He had never fit in, and when he reached sixteen and still wouldn’t join them in drinking, tensions in his family only increased.

Robert was clearly spent after disclosing so much personal information to the recovery mentor, and quickly turned his attention to the horse race on ESPN. The recovery mentor took the opportunity to jokingly inquire of the bartender about Robert’s preferred beverages and found out that Robert did, in fact, drink a lot of tea along with a fair amount of tonic water and lime. Armed with lots of new, rich, and interesting information about Robert to ponder, and to discuss with the psychiatrist, the recovery mentor left the pub that afternoon wondering why he didn’t leave his office, and the clinic, more often.

What you will hear from people in recovery when you are natural supports and settings:

- *All those years I spent in Social Skills groups, I met the same 20 people I knew from Clozaril Clinic and the Clubhouse. It didn’t exactly expand my social horizons! Now I am playing basketball in one of the city leagues and there is this girl I’ve got my eye on who comes to the games. My therapist and I have been talking a lot about how I could strike up a conversation with her.*
- *I just wanted to get back to my life: my friends, and my job, and my church activities. My recovery was important, but it didn’t matter so long as I didn’t*

have those things in my life to look forward to. It was those things that kept me going in my darkest days.

- *Just having a place to hang out, where I blend in with the crowd... where no one knows me as a patient on the ACT team. That is when I am most peaceful.*
- *It wasn't enough for me to just get better. I appreciated everyone's help, but I felt like such a charity case all the time. What really made a difference was when my counselor helped me to get a volunteer position at the local nursing home. Sometimes I read to the folks, or we play cards. It may not be fancy, but it feels right to me. I don't just have to take help from everybody else, I have valuable things to give back in return.*
- *I knew all about the places where folks could go to get help if you had a problem with drugs or mental illness. What I had forgotten about was how to have FUN! My case manager gave me this terrific list of low-cost activities that happen right around the corner from my apartment, and I never even knew this stuff was right under my nose. It's opened up a whole new world for me. I made some great friends, and one of them is even looking for some part-time help in her art store--so I'm gonna get a job out of it too! Things happen in the strangest ways sometimes...*

The Importance of Not Overlooking the (not so) Obvious



“We’ve considered every potential risk except the risks of avoiding all risks.”