

ARTICLE

**Creating a Recovery-Oriented
System of Behavioral
Health Care: Moving from
Concept to Reality**



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This article describes challenges and successes seen in the first four years of efforts the state of Connecticut has made to reorient its behavioral health system to promoting recovery. Beginning in 2000, the Connecticut initiative was conceptualized as a multi-year, systemic process that involved the following interrelated steps: a) developing core values and principles based on the input of people in recovery; b) establishing a conceptual and policy framework based on this vision; c) building workforce competencies and skills; d) changing programs and service structures; e) aligning fiscal and administrative policies; and, finally, f) monitoring, evaluating, and adjusting these efforts. Following descriptions of the first four steps, the authors offer a few lessons that might benefit other states engaged in similar processes of transformation.

Keywords: *recovery, recovery-oriented care, system transformation*

Transformation...is nothing short of revolutionary....It implies profound change—not at the margins of a system, but at its very core. In transformation, new sources of power emerge and new competencies develop (DHHS, 2005).

Revolutions begin when people who are defined as problems achieve the power to redefine the problem (McKnight, 1992).

The first quote above was taken from the *Federal Action Agenda* recently released by the U.S. Substance Abuse and Mental Health Services Administration detailing the steps to be taken in implementing the recom-

mendations of the President's New Freedom Commission on Mental Health. Both the *Action Agenda* and the Report of the New Freedom Commission—which share the same subtitle of *Transforming Mental Health Care in America*—make a clear and compelling case that nothing short of such a “revolution” will be adequate in ensuring that every American facing the challenges posed by serious mental illness will be able to participate equally in the promise, and reality, of recovery. The second quote, from McKnight, captures a key element of the understanding of and approach to this revolution taken by the State of

Connecticut in its efforts to transform its system of publicly-funded behavioral health care into one that is fully recovery-oriented and culturally responsive. This article describes some of the challenges and early successes seen in the first four years of these efforts and offers a few lessons for other states engaged in the process of transformation.

Connecticut's recovery initiative appears to be unique in two respects. First, it began in 2000, several years prior to release of the New Freedom Commission Report. More importantly, it also was conceptualized from the beginning as a systemic initiative, targeting the statewide system of care as a whole rather than creating a few new so-called recovery programs or attempting to add new recovery-oriented elements, such as peer support, onto the existing system of care. In this way, Connecticut's efforts presaged the New Freedom Commission's emphasis on system transformation, viewing the revolution entailed in recovery as warranting an entirely new approach to the design and delivery of care. This initiative was conceptualized to involve several interrelated steps which were expected to unfold over a multi-year period, including a) developing core values and principles based on the input of people in recovery; b) establishing a conceptual and policy framework based on this vision of recovery; c) building workforce competencies and skills through training, education, and consultation; d) changing programs and service structures; e) aligning fiscal and administrative policies in support of recovery; and, finally, f) monitoring, evaluating, and adjusting these efforts. To date, many of the tasks associated with steps a – c have been taken, with the majority of DMHAS efforts focusing currently on steps d and e. In what follows, we will

limit our discussion to the first four steps.

Foundation of Connecticut Initiative: Redefining the Problem

In September, 2002, the Connecticut Department of Mental Health and Addiction Services (DMHAS) became the first state mental health authority in the country to adopt a Commissioner's Policy on Recovery that made recovery the overarching aim of its publicly-funded system of care. This policy was the culmination of two years of intensive consensus development activities involving all of the state's various stakeholders, and was based squarely on the vision of recovery articulated by the state's consumer community. This ball had been set into motion two years previously, when the newly appointed Commissioner, Thomas Kirk, Jr., invited the state's two major organizations led by and for people in recovery to draft a recovery platform to guide the state's reform efforts. After several months of debate and deliberation, these two organizations—one of which was made

up primarily of people in recovery from addiction, while the other was made up primarily of people in recovery from mental illness—were able to agree on a core list of recovery values and principles. These values and principles, summarized in Table 1, were taken as the framework for the state's recovery initiative, providing the first example of the type of revolution described by McKnight above, in which people who have been defined as problems in the past acquired the power to redefine the problems, and their potential solutions, in their own terms.

The process of drafting the Commissioner's recovery policy did, in fact, literally involve the development of several such definitions. First was a definition of what the state's Department of Mental Health and Addiction Services had agreed to accept as a core meaning of the term "recovery." Leaders in the state appreciated well that the term recovery had become the source of many confusions and misunderstandings over the preceding few

TABLE 1—RECOVERY CORE VALUES AND PRINCIPLES

Direction	Participation
Equal opportunity for wellness	No wrong door
Recovery encompasses all phases of care	Entry at any time
Entire system to support recovery	Choice is respected
Input at every level	Right to participate
Recovery-based outcome measures	Person defines goals
New nomenclature of recovery	Programming
System-wide training for culturally diverse, relevant, and competent services	Individually tailored care
Consumers review funding	Culturally competent care
Commitment to peer support and to consumer-operated services	Staff know resources
Participation on boards, committees, and other decision-making bodies	Funding
Financial support for consumer involvement	No outcomes, no income
	Person selects provider
	Protection from undue influence
	Providers don't oversee themselves
	Providers compete for business

years, and saw development of an explicit consensus on the concept to be a significant, and necessary, step forward. As a result, the policy—based both on the input of people in recovery and on the psychiatric literature—defined recovery as “a process of restoring a meaningful sense of belonging to one’s community and positive sense of identity apart from one’s condition while rebuilding a life despite or within the limitations imposed by that condition.” What is conspicuously absent in this definition is any mention of cure, reduction in symptoms, restoration of functioning, and/or abstinence from al-

cohol and other drugs. While surprising to many of the state’s behavioral health providers—who assumed recovery in behavioral health was the same as recovery in primary health, and thus meant amelioration of the illness—this definition was consistent with the recovery core values and principles articulated by the state’s consumer community and with the disability and civil rights model of addiction and mental illness which has been promoted by people in recovery across the country (e.g., Deegan, 1992, 1993; White, 2001, 2002). By adopting this sense of recovery as the overarching aim of its system

of care, DMHAS took an additional step down the revolutionary path of having its major responsibilities redefined by the population it serves.

As suggested by this definition, shifting from a medical model to a disability/civil rights model of recovery held a number of important implications for the way DMHAS conceptualized and provided services and supports for people with psychiatric disabilities. Rather than being encouraged to be compliant with treatment, people with serious mental illness were to be encouraged and assisted in continuing to pursue their hopes and dreams despite

TABLE 2—BASIC COMPONENTS OF RECOVERY IN SERIOUS MENTAL ILLNESS*

Being Supported by Others: Recovery is not done alone. Becoming interdependent in one’s community and having supportive others and role models, whether they be family members or friends, professionals, community members, or peers provides encouragement through the difficult times and to help celebrate the good.

Renewing Hope and Commitment: Having a sense of hope and believing in the possibility of a renewed sense of self and purpose, accompanied by desire and motivation, is essential to recovery. This sense of hope may be derived spiritually and/or from others who believe in the potential of a person, even when he/she cannot believe in him/herself.

Engaging in Meaningful Activities: Expanding and occupying normal, functional social roles (e.g., spouse, worker, student, taxpayer, friend, etc.) and making worthwhile contributions to a community of one’s choice is a cornerstone of recovery.

Redefining Self: Perhaps the most consistent aspect of recovery, redefining self involves reconceptualizing mental illness as simply one aspect of a multi-dimensional identity rather than assuming a primary social role as “mental patient.”

Incorporating Illness: Often described as a first step to recovery, acknowledging and accepting the limitations imposed by one’s illness helps one discover talents, gifts, and possibilities that allow a person to pursue and achieve life goals despite the lingering presence of disability.

Overcoming Stigma: People must recover from the social consequences and societal stigma associated with illness as well as from the effects of the illness itself. Recovery involves developing resilience to stigma and/or actively fighting against it.

Assuming Control: People must assume primary responsibility for their transformation from a disabled person to a person in recovery. Assuming control over one’s life and rehabilitation contributes to the redefined sense of self as an active, effective agent. Opportunities must be available for people to make choices, and people must also be afforded opportunities to take risks to fail, and to learn from their own mistakes as well as from their successes.

Managing Symptoms: Although complete symptom remission is not necessary, being able to manage symptoms in some way is a part of recovery. Recovery involves periods of good and difficult times, setbacks and accomplishments, and times when symptoms may be more or less controlled. A shift occurs from simply receiving services to actively participating in and using treatments of one’s choice to bring symptoms under a degree of control.

Becoming Empowered and Exercising Citizenship: As a sense of empowerment and control over one’s life emerges, people in recovery begin to demand the same rights (e.g., the right to decide where to live, whom to love, how to spend one’s time) and take on the same responsibilities (e.g., paying taxes, voting, volunteering) as other citizens.

* (Davidson, O’Connell, Tondora, Staeheli & Evans, 2005)

their disability. Barriers to pursuing personal aspirations were addressed through rehabilitation and the provision of supports, but the primary emphasis was to remain throughout on the person's pursuit of the life he or she wished to lead in the communities of his or her choice. "Recovery-oriented care" was defined in the same Commissioner's Policy as care that "identifies and builds upon each person's assets, strengths, and areas of health and competence to support the person in managing his or her condition while regaining a meaningful, constructive sense of membership in the community." Thus, instead of treating and/or rehabilitating people, the system's primary responsibility became that of supporting people in their own efforts to manage and overcome (a) behavioral health condition(s) in the process of rebuilding their lives. To connote this shift in responsibility and locus of recovery from the expertise of the provider to the efforts of the person with the disability, the state's initiative also informally adopted the motto of The Home Depot, which suggests "You can do it. We can help."

Beyond Definitions to Practice: Operationalizing Recovery

While this early conceptual work in defining recovery and recovery-oriented care was clearly necessary in order to give the state a vision to move toward, arriving at such a consensus obviously had limited impact on practice in and of itself. In order to move the statewide system from the concept of recovery to the reality of actually providing recovery-oriented care, DMHAS then undertook a number of processes in partnership with the state's consumer, family, and provider communities and with support from the Yale University Program for Recovery and Community Health. These processes included elucidating various components of recovery and, on the basis of these

components, operationalizing the ways in which these components could be promoted through practices and the provision of supports. In terms of mental health, for instance, this partnership was able to identify nine basic components of recovery in serious mental illness based on members' personal and professional experiences and on review of first-person accounts and the psychiatric rehabilitation literature. These nine components are described in Table 2.

Each of these nine components was then used as the basis for identifying and developing recovery-oriented practices and supports. As is evident in the one example offered in Table 3 below of being supported by others, this "bottom-up" approach involved people with psychiatric disabilities describing first what recovery looked like for them (column 1), deriving from that what practices and supports needed to be provided to promote recovery (column 2), and from that deriving the ways in which programs and systems needed to be structured and managed in order to provide such supports and practices (column 3). At each of the levels of practices, supports, systems, and programs, it then became possible to develop instruments for measuring recovery-oriented care, recovery-enhancing environments, and recovery-oriented provider competencies; tools which became useful in the next phase of the initiative.

As a next step in the process of operationalizing recovery, each of these dimensions was converted into survey items to create an agency "Recovery Self-Assessment" (RSA). This tool—which has been described in detail in an earlier issue of this journal (O'Connell, Tondora, Evans, Croog & Davidson, 2005)—was then used to initiate a dialogue with providers and engage them in a process of

self-assessment as a first step in their own efforts to adopt a recovery orientation. In DMHAS' efforts to roll out the recovery initiative in a way that was consistent with its own recovery philosophy—i.e., practicing what it was preaching—providers were asked to identify their own assets and strengths prior to reflecting on those areas that needed to be aligned with the principles of recovery-oriented care. There were three versions (person in recovery, family member/advocate, and provider) of the 36-item self-assessment tool that contained concrete, operational items to help program staff, persons in recovery, and significant others to identify practices in their agencies that either facilitated or impeded recovery. To the surprise of many DMHAS staff who had become accustomed to hearing provider complaints about unfunded mandates and the added burden of filling out new forms, the RSA was met with enthusiasm from the provider community (as evidenced by an initial response rate of 120%), who welcomed the tool as a first glimpse into what this confusing new use of the term "recovery" was likely to mean on the concrete level of everyday practice.

A second measure of providers' knowledge of recovery also was developed based on the domains described above, and was then used in the workforce development components of this initiative, which we describe next.

Training Staff to Provide Recovery-Oriented Care

To undertake the initial developmental work that would be involved in the extensive efforts needed to retrain providers across the state in recovery-oriented care, DMHAS was able to secure funding from a Community Mental Health Strategy Board that had been charged by the legislature with reinvesting dollars saved from the closure

TABLE 3—ILLUSTRATIVE EXAMPLE OF OPERATIONALIZING “BEING SUPPORTED BY OTHERS” AS ONE DIMENSION OF RECOVERY IN SERIOUS MENTAL ILLNESS

Person In Recovery: <i>To me, recovery means...</i>	Direct Support Provider: <i>I can support people in their recovery by...</i>	Manager/Administrator: <i>I can lead an organization that supports recovery by...</i>
having people I can count on being loved and accepted as I am and for who I am having people in my life who believe in me even when I no longer believe in myself having something to give back to the community being viewed as a worthwhile human being by others, and feeling like one myself helping others when they need me, and having things of value to offer them . . .	assisting them in developing lasting connections to natural supports and their communities including these natural supports in the recovery planning process assisting them in getting their basic needs met, e.g., managing benefits and finding financial resources, food, shelter, and safety believing in them and sharing that belief with others valuing and exploring spirituality as a potentially critical source of support in their lives . . .	educating staff and others about natural support networks and how to foster them developing educational and other programs for families, community leaders, and members of natural support networks offering to host local, regional, state-wide, and national consumer and family support programs valuing and fostering use of peer support and self-help throughout the agency developing mutually beneficial ties with the local community to fight stigma and foster welcoming social environments . . .

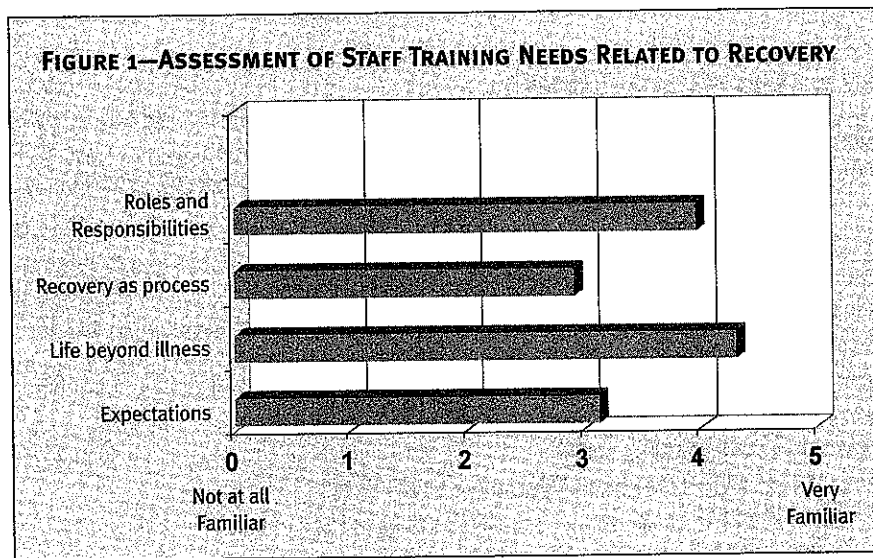
of two state hospitals. These funds were used to implement a Recovery Education and Training Institute, which was a collaboration between the DMHAS Education and Training Division and the Yale Program for Recovery and Community Health. In addition to introductory sessions on the emerging DMHAS Recovery Paradigm, Institute faculty developed curricula and offered intensive trainings in a number of areas, including functioning as a recovery guide, person-centered planning, recruiting and working with peer staff, peer support, cultural competency, motivational interviewing, fundamentals of supported community living, and asset-based community development and working with natural support systems. To date, over 4,500 providers have participated in one or more of these offerings, ranging from a half-day workshop to an 8-week, 24-hour course.

As an additional component of the Recovery Institute, DMHAS invited agencies to apply to become Centers of Excellence in Recovery-Oriented

Practice. Although no new funding was provided as part of this initiative, selected Centers would receive free training, consultation, and technical assistance from Yale faculty. In the initial round of invitations, 9 Centers were selected from over 40 applicants. These Centers were then assisted in becoming exemplary programs in one or more of the following areas: outreach and engagement, peer-run programs, supported community living, recovery guide skills, person-centered planning, and culturally-specific care. In addition to working with each Center’s leaders, staff, clients, and other key stakeholders to design and implement a model program, Institute faculty also assisted the Centers to become internship sites for further technology transfer/knowledge dissemination activities.

To guide Institute faculty in designing and delivering training and technical assistance, a 36-item instrument was developed based on the DMHAS Recovery Model addressing providers’ knowledge of and attitudes toward

such issues as consumer directedness, the individual nature of recovery, cultural competence, self-determination, strengths-based care, choice and risk-taking, illness and symptom management, involvement in meaningful activities, overcoming stigma, redefining self, hope, and the non-linear nature of the recovery process. Items on this instrument, which has come to be called the Recovery Knowledge Inventory (RKI), followed a Likert-style response format and were framed in such a way as to minimize effects of social desirability; i.e., responses to items did not follow the same direction (positive responses for half of the items reflected a stronger recovery orientation, while for the other half positive responses reflected less of a recovery orientation). The needs assessment which was conducted with staff from the nine Centers of Excellence using the RKI yielded the following results, depicted in Figure 1, which also were published in a previous issue of this journal (Bedregal, O’Connell & Davidson, 2006).



What these data suggested is that staff more readily appreciated the need for people to define themselves beyond the identity of “mental patient” or “addict” and understood that other people in recovery, i.e., peers, could be helpful in this process. Staff also appeared to understand the different roles of the person with the behavioral health condition vs. those of the health care provider, recognizing that recovery is not only made possible by their skillful intervention but also requires the active involvement of the person. They appeared less sure, however, about what realistic expectations they could have with respect to client choice and the nature of the person’s participation in his or her own recovery; in other words, what their clients could *do* to improve their own condition. Finally, staff had the least knowledge about the nature of the recovery process itself, the role of symptom reduction and management in recovery, and the ways in which people pursue recovery outside of formal treatment and rehabilitation settings. These findings have since been incorporated into the training curricula for the Institute.

Changing Programs and Service Structures

With at least a basic understanding of the recovery paradigm and its implications for practice having permeated the statewide system, it then became time for DMHAS to begin to focus on changing the services and supports it provided, both through its state operated facilities and through its contracts with private, non-profit agencies. The nine Centers of Excellence described above provided some impetus for such changes, but other changes were stimulated by the creativity and innovation of providers and agencies. As one example, a consumer council worked with a provider network in one part of the state to secure funding for and to create a peer-run program in two local emergency room crisis intervention units. Peer advocates were trained and deployed to the units to offer peer support, assist with clients’ basic needs, and advocate for and facilitate their discharge planning. This program came to be viewed as so successful in reducing wait time and episodes of restraint and/or seclusion in emergency rooms, and in reducing eventual inpatient length of stay, that word quickly spread around the state and other hospitals began to adopt this program.

In addition to the development and dissemination of other peer support approaches and programs, the major shifts that have been seen in the state system thus far have had to do with moving from an acute care model of treating discrete episodes of illness to a longitudinal, recovery management model that views both addiction and serious mental illness as long-term conditions that require an ongoing relationship between the person and the health care system. This shift has been in response to the research literature and advances in the field more generally, but also has been in response to what people in recovery have identified as their most significant need and the most significant facilitator of their recovery: having someone I can trust who will stick with me over time, through the good times and the bad, to support me in my recovery.

In contrast to common concerns expressed by providers, a recovery management model does not require people to participate in intensive services for indefinite periods of time, silting up caseloads and further draining scarce agency resources. Rather, in a recovery management model people have immediate access to those services and supports they may require at any given time, but then are encouraged to develop and utilize natural and community supports, outside the formal health care system, as much as possible. As in other long-term illnesses, the system’s expectation is that people will figure out or learn how to manage and live with their illness over time, requiring less intensive and less costly interventions as they gain or regain independent functioning. This model enables the person to minimize the role of the behavioral health system in his or her life as the impact of the illness is also minimized, and to maximize his or her pursuit of a normal life in his or her natural community.

It appears to be essential in this model for people whose illnesses wax and wane over time, or are responsive to life events, to have access to the system—and subsequently to people who know the person and who the person can trust—over time and when needed. In this respect, behavioral health care need be no different from other disease management models for people with other long-term illnesses. For people with the most severe forms of these conditions, however, a disability model may be more appropriate in that there will be a need for ongoing support. As with physical disabilities, such support may be needed as long as the person remains disabled and as long as the system is oriented toward helping this person reclaim his or her life. That is, supported education and employment will be valued (and funded) to the degree that the system is oriented toward facilitating the access of people with psychiatric disabilities to school and work. Costs saved through decreased reliance on acute care settings can be redirected for this purpose to fund what Connecticut DMHAS has come to refer to as “recovery support services.” Typically costing much less than intensive clinical programs with questionable effectiveness (e.g., day hospitals), these supports often can be provided by appropriately trained peers, offering the system two positive outcomes for the price of one.

The introduction of recovery support services leads to the convergence of the DMHAS recovery initiative with another initiative in which many other state systems are also engaged at this time, involving the construct of evidence-based practices. Connecticut’s recovery initiative has been framed not only as consistent, but as intrinsically interwoven, with a focus on the existence, or lack, of evidence supporting the various services and supports offered. While some providers argue that

there is not yet an adequate evidence base to justify the introduction of recovery and recovery-oriented practice—and thus view this initiative as contradictory to a concurrent emphasis on evidence-based practices—we view this argument as stemming from a fundamental misunderstanding of the nature of recovery. Not only is there over a thirty year history of accumulating evidence that establishes improvement to be as common, if not more common, than prolonged disability in serious mental illness (Davidson, Harding & Spaniol, 2005), but effectiveness in behavioral health is to be assessed in relation to the degree to which services or supports promote recovery as their primary outcome. In other words, the evidence that is being sought or established is evidence of the degree to which an intervention contributes to a person’s recovery, not the degree to which recovery contributes to a given intervention’s effectiveness. Providers who suggest that they want to wait and see how the introduction of recovery improves the quality of care provided and the outcomes produced, presumably before they adopt a recovery orientation themselves, are thus missing the point. The response we have made in Connecticut to these kinds of reservations has been “If what you are doing now is not oriented to, and does not promote, recovery, then why are you doing it, and, more importantly, why are we paying you for it?”

Rather than contradicting or conflicting with a recovery orientation, then, this is one of the ways in which an emphasis on “evidence-based practice” has been extremely useful in contributing to system change. Discontinuing costly services for which there is no evidence of effectiveness offers a ready source of funds for reallocation, either for practices for which evidence does exist and/or for practices that people in recovery identify as useful to them and

which they request (e.g., housing and employment supports).

To guide providers in their efforts to transform their own services, and eventually to enable the system to hold providers accountable for their adherence to recovery values and principles, DMHAS lastly has been in the process of generating practice guidelines for recovery-oriented behavioral health care. To date, these guidelines cover nine domains, briefly described in Table 4 below. This table labels and provides a brief description of the focus of each domain and offers a couple of abbreviated examples of standards in each area. While an initial set of practice guidelines have recently been published (Tondora & Davidson, 2006), they remain very much a work in progress at this time.

Discussion: Or What We Think We Have Learned Thus Far

While we still consider ourselves to be relatively early on in the transformation process, we think we have learned several valuable lessons that we offer to other systems embarking on this, or a similar, process of culture change. These lessons revolve around two major issues.

A first issue has been recognizing that recovery does not refer to any specific service, intervention, or support (which can be more or less recovery-oriented) but to what people with psychiatric disabilities *do* themselves in order to manage their illness and/or get their lives back. Recovery thus does not refer to anything that service providers—no matter how well-intentioned or recovery-oriented they may be—can do *to* or *for* people. Our initial inclination as service providers or managers may be to decide what recovery means and how to implement it for people with serious mental illnesses, no different from how we have decided other things for them in the past. This

TABLE 4—DRAFT PRACTICE GUIDELINES FOR RECOVERY-ORIENTED BEHAVIORAL HEALTH CARE

Domain	Degree to which practices . . .	Sample standards
Primacy of Participation	Place emphasis on the participation of people in recovery and their loved ones in all aspects and phases of the care delivery process.	People in recovery comprise a significant proportion of an agency's board of directors. Administration enforces ethical practice through supervision and proactive human resource oversight.
Promoting Access and Engagement	Facilitate swift and uncomplicated entry into care and identify and remove barriers to receiving care; address basic needs.	People can access a wide range of services from many different points. Staff examine organizational barriers or other obstacles to care before concluding that a client is noncompliant with treatment.
Ensuing Continuity of Care	Ensure continuity of the person's most significant healing relationships and supports over time and across episodes and agencies.	Motivation is no longer viewed as a pre-condition for treatment but as one outcome of interventions oriented to address pre-action stages of change. People have a flexible array of options from which to choose which allow for a high degree of individualization.
Employing Strengths-Based Assessment	Balance critical needs that must be met with the resources and strengths that people possess to assist them in the process.	An individual's needs are not captured by a label or diagnosis, but by an accurate description of his or her functional strengths and limitations. Strengths-based assessment is conducted as a collaborative process and all assessments in written form are shared with the individual.
Offering Individualized Recovery Planning	Are based on an individualized, multi-disciplinary recovery plan developed in collaboration with the person and any others that s/he identifies as supportive.	The planning process solicits the individual's unique goals and these are documented in the plan in the individual's own words. The person's cultural background, identity, and other social affiliations are incorporated and addressed in all aspects of recovery planning.
Functioning as a Recovery Guide	Remove personal and environmental obstacles to recovery, link the person to the community, and, where not available naturally, serve as a mentor in processes of recovery.	Providers are willing to offer practical assistance in the community contexts in which their clients live, work, and play. Efforts are made to identify sources of incongruence between the person and his or her environment and to increase person-environment fit.
Identifying and Addressing Barriers to Recovery	Identify and address characteristics in the service system and the community, as well as factors intrinsic to the person's behavioral health condition(s), that unwittingly contribute to the creation and perpetuation of chronicity and disability.	Providers are aware of the importance of stigma and discrimination in the lives of people with behavioral health disorders. A person's symptoms are explored not only in terms of the difficulties they pose, but also in terms of their potentially adaptive function in his or her efforts to cope with the illness and other life stressors. Delusions, for example, may be understood as one component of a person's efforts to understand his or her experiences of hallucinations and disordered thought processes.
Community Mapping and Development	Involve a participatory process of mapping the resources and capacities of a community as a means of identifying existing, but untapped or overlooked, resources and potentially hospitable places in which contributions of a person with a disability will be valued.	People in recovery are viewed primarily as citizens rather than as clients and recognized for the gifts, strengths, skills, and resources they have to contribute to community life. Institutions do not duplicate services that are widely available in the community through individuals and associations.

represents a major, if nonetheless fairly common, mistake, which dooms a recovery initiative to failure. As recovery belongs to people with psychiatric disabilities, and as it is up to them to define what it is and what it entails, it is key that people in recovery lead the way. Leading the way involves developing a positive vision of recovery and recovery-oriented care, and working collaboratively with other stakeholders to develop a shared sense of where people in recovery and providers collectively are headed as a system of care.

The second, related, issue involves recognizing that recovery cannot be an "add on" to existing services, supports, or systems. Promoting recovery needs rather to be the overarching aim of all services and supports; otherwise, we need to ask why we are devoting scarce resources to them (e.g., to ensure community safety). As a corollary, individualized recovery planning provides a holistic framework for integration of various other system initiatives (e.g., evidence-based practice, cultural competence, trauma, co-occurring disorders), all of which need to be re-oriented to support recovery (e.g., how does attending to someone's trauma history, or substance use, or cultural background, promote his or her recovery?). If, in this way, all roads need to lead to recovery, then it makes little sense for providers or system managers to respond that they will be happy to "do recovery" as soon as they are given new resources for this purpose. The focus of transformation rather needs, at least initially, to be on changing and realigning current policies, practices, procedures, services, and supports to be oriented toward, and effective in, promoting recovery. Not until we have succeeded in ensuring that all available behavioral health dollars are allocated in ways which effectively maximize each person's and family's chances for recovery will we be

justified in making strenuous arguments for additional resources. It also will not be until we have succeeded in these efforts that we will have a sufficient constituency base and the political credibility needed to be effective in doing so.

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