

Recovery to Practice:

Developing Mental Health Recovery in Social Work



COUNCIL ON SOCIAL WORK EDUCATION

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**Social Work Recovery to Practice (RTP)
Steering Committee**

Charles Rapp, Lead Consultant
University of Kansas

Gwen Foster
CaISWEC

Wallace Gingerich
Case Western Reserve University

Joseph Rogers
National Mental Health Consumers' Self-Help
Clearinghouse

Susan Rogers
National Mental Health Consumers' Self-Help
Clearinghouse
Mental Health Association of Southeastern
Pennsylvania

Lauren Spiro
National Coalition for Mental Health Recovery

Patrick Sullivan
Indiana University School of Social Work

**Council on Social Work
Education Staff**

Julia Watkins
Executive Director

Jessica Holmes
Associate Director for Research

Cynthia Williams
Research Associate

Erin Bascug
Research Assistant

Mary Kurfess
Research Assistant

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Introduction

Mental health care in the United States has been called fragmented and limited in the scope of care, and it has been accused of being plagued by deficits and views of consumers as chronic. The mental health recovery movement seeks to remedy those ills. President Bush's New Freedom Initiative and New Freedom Commission on Mental Health, which began in 2002, helped to advance at a policy level what had begun as a consumer movement. The New Freedom Commission vision statement said:

We envision a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports—essentials for living, working, learning, and participating fully in the community.(President's New Freedom Commission on Mental Health, 2003, p.1)

The President's New Freedom Commission on Mental Health in 2002 helped to galvanize a movement to transform mental health care from an undertaking that perpetuates illness to one that gives hope for recovery. The commission envisioned a health care system in which the practitioners do not act on passive consumers, but rather one that engenders collaboration and partnerships between consumers and practitioners, a system that allows for choice. Through such a system it is believed consumers will be able to achieve recovery.

Following the New Freedom Commission the Substance Abuse and Mental Health Services Administration (SAMHSA) worked with hundreds of individuals—including consumers, family members, providers, and researchers—to create a statement about how recovery could be defined. The end result was 10 key components identified as crucial to recovery-oriented mental health practice (SAMHSA, 2006). The New Freedom Commission also provided a working definition for recovery:

Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual's recovery. (President's New Freedom Commission on Mental Health, 2003, p. 7)

As part of the ongoing process of creating change throughout the entire mental health service system, SAMHSA is now working with mental health professions to determine the level of infusion of recovery-oriented practice within specific disciplines. The Council on Social Work Education (CSWE), the national accrediting body for social work education, is representing the profession of social work in the Recovery to Practice (RTP) project in determining the depth and breadth of integration of recovery in social work.

Social Work and Mental Health

Social work is concerned with enhancing the well-being of people, groups, and communities through strengthening the opportunities and capacities of individuals and addressing conditions that limit human potential (CSWE, 2001, 2008). Social work emerged at the end of the 19th century out of the work being done by philanthropic organizations. These organizations included such groups as the Charitable Organization Societies, which employed “friendly visitors” to visit those in need, make assessments, and offer advice or aid; and the Settlement House Movement, wherein volunteers or staff moved into a house and from within the community worked to help individuals, solve policy level issues (e.g., exploitation by employers), and provide education to others in the neighborhood. Both the friendly visitors and settlement house workers were concerned with issues such as housing, poverty, and child welfare; both also greatly influenced the development of social work (Brieland, 1995).

What began with charitable volunteer work started to turn into a profession at the beginning of the 20th century as social work moved toward formalized education, unique skills, and its own literature. By the 1920s more than 17 schools of social work had been created (Brieland, 1995). The social work profession continued to grow, with a burst of development in the 1930s from the Federal Emergency Relief Administration and the Social Security Act (1935), the expansion of child welfare laws, and the end of World War II (Austin, 1997; Brieland, 1995). Again, substantial growth in the number of social work education programs occurred in the 1960s and 1970s, mostly in public universities (Austin, 1997).

Social workers are engaged in a variety of settings, operating in direct practice with individuals, families, and groups as well as practice in management, policy, and community organizing. The entry-level practice degree in social work is the baccalaureate degree (typically the BSW), which prepares students for generalist practice (CSWE, 2008). Practitioners with a baccalaureate degree often do work such as case management. The master’s in social work (MSW) is required for more advanced case work and management positions (Bureau of Labor Statistics, 2009). Many social workers also seek licensure to practice independently in mental health settings. Although each state differs in requirements, on average a social worker with a master’s degree will need to work approximately 2 years with supervision in a clinical setting before qualifying to sit for the licensure exam (Association of Social Work Boards [ASWB], n.d.).

Overall, social workers are estimated to provide almost half of all mental health services (National Association of Social Workers, 2011; Manderscheid & Henderson, 2000). Especially in rural areas, social workers may be the only mental health professionals available. According to the Bureau of Labor Statistics more than 640,000 social workers are employed in the United States. More than 130,000 of those are employed specifically as mental health and substance abuse social workers (Bureau of Labor Statistics, 2009). The number of social workers in all mental health organizations tripled between 1972 and 2000 (Manderscheid & Berry, 2006), and the number is expected to grow by 20% over the course of the next 8 years (Bureau of Labor Statistics, 2009). Moreover, there are many more social workers who work in the field of

mental health but do not identify primarily as a mental health social workers. For example, a 2006 study by the National Association of Social Workers (NASW) found that 36.8% of licensed social workers identified mental health as their primary sector of employment.

As of the October 2010 CSWE Commission on Accreditation meeting there are 470 accredited baccalaureate and 203 accredited master's of social work programs in the United States. This represents more than 100,000 enrolled students as of the fall of 2009; more than 52,000 baccalaureate and 47,000 master's students. Master's programs in social work offer concentrations for students in an area of specialization. In 2009, 49 master's programs offered a concentration in mental health and 39 programs offered a concentration in health and mental health. Many more programs simply offered a concentration in direct practice/clinical social work in which students could be placed in a mental health setting in the field.

The philosophical underpinnings of the profession and the theoretical frameworks that guide practice are consistent with the recovery movement. Furthermore, in 1951 Bertha Capen Reynolds gave a call to social workers that sounds not unlike the one being made by the recovery movement today:

The real choice before us as social workers is whether we are to be passive or active. . . Shall we be content to give with one hand and withhold with the other, to build up or tear down at the same time the strength of a person's life? Or shall we be conscious of our own part in making a profession which will stand forthrightly for human well-being, including the right to be an active citizen? (Reynolds, 1951, p. 175)

Reynolds' work and the work of others in the field gave rise to the strengths-based practice model, which will be discussed at length later. In spite of the philosophical kinship, it is not at all certain that recovery has been broadly accepted in social work theory or practice. Given the prevalence of social workers in the mental health field, there is a heightened need to understand the depth and breadth of acceptance and integration of recovery-oriented practice by social workers. Specifically, there needs to be a fuller understanding of the social, political, and economic background for social work practice, specific theories and methods used, early adopters (organizational, institutional, and individual), and any unique challenges to integrating recovery-oriented practice into social work.

Methodology

To develop a comprehensive picture of the current state of the social work profession, the history, prevalence, and integration of recovery-oriented practice in the field of social work was examined through a situational analysis. This analysis intends to address those contextual conditions that are external (e.g., economic, political, social, and technological factors in the United States and the mental health arena as a whole) and internal to the field of social work (social work education, practice, licensure, professional literature, professional associations and conferences, current theoretical trends, and individuals).

In the spring of 2010 the CSWE team met with its six-member RTP Steering Committee (who identify as consumers, social work educators, researchers, and practitioners) to develop a plan for the situational assessment. The assessment took place over the course of the year with an emphasis on qualitative methods such as focus groups and interviews. Quantitative methods were used via existing data sources such as the Annual Survey of Social Work Programs. There was an attempt to engage all stakeholders in the process—social workers, consumers, educators, students, and mental health agency leadership.

Unique Considerations

Social workers are perhaps unique from other mental health professionals in that some aspects of the recovery movement have been widely adopted by social workers in the strengths-based social work movement. Given the similarities between the strengths-based practice model and recovery, it was difficult to perfectly or comprehensively include or exclude literature in the review of recovery in social work. An attempt was made to include all relevant publications while excluding those that did not cover the full meaning of recovery. To convolute matters further, it is known that some of the recovery-oriented researchers in social work publish in non-social work journals, making it difficult to identify the extent to which social workers are engaged in the larger conversation about recovery. These caveats expressed, the team tried to be as comprehensive as possible given the timeframe for review.

Qualitative Measures and Strategies

The situational analysis largely focused on qualitative measures and strategies. Some of those measures were new initiatives for the RTP project (e.g., focus groups, interviews) and others made use of existing information (e.g., literature review). Nine qualitative strategies were used: focus groups, interviews, open discussion forums, soliciting consumer comments by e-mail, syllabi review, review of state documents and training materials, literature review, review of professional organizations and conferences, and site visits. A description of each strategy follows.

Focus groups

Two focus groups were conducted for the assessment. One focus group consisted of mental

health consumers. Consumers were broadly recruited through the use of flyers and e-mails, including an announcement on the National Alliance on Mental Illness (NAMI) electronic mailing list, which garnered a great deal of interest. Consumer focus group participants were also recruited through RTP Steering Committee recommendations from the lead consultant as well as Lauren Spiro, who represents the National Coalition for Mental Health Recovery, and Joseph Rogers of the National Mental Health Consumers' Self-Help Clearinghouse. The consumer focus group was facilitated by Charlie Rapp, the lead consultant, by phone on September 8, 2010. Three consumers were in attendance:

- a NAMI peer-to-peer mentor and mental health advocate
- a NAMI board member
- a University of Kansas Wellness Recovery Action Plan (WRAP) coordinator

The consumer focus group addressed consumer experience with social workers—what was helpful and not helpful in social work practice, whether the consumer felt like an equal partner in the treatment process, what social work students should be taught about recovery and culturally responsive practice. Consumer participants were compensated for their time with a \$50.00 Amazon.com gift card.

The second focus group was with social work educators and practitioners. Focus group participants were recruited using the CSWE *Focus* monthly e-newsletter and a blast e-mail to accredited master's of social work programs. The focus group was held in person on October 15, 2010, in conjunction with the CSWE Annual Program Meeting (APM) in Portland, OR. The group also was facilitated by Charlie Rapp. Five social work faculty members and one practitioner attended the focus group. The group had particular interest in the field of recovery, so the focus group addressed current recovery initiatives, recovery-oriented readings and assignments used, how to incorporate the consumer voice in the classroom, how to address student disclosure, challenges experienced, and ideas for what CSWE should do as part of the RTP project.

Interviews

In addition to the focus groups a number of individual interviews were held with stakeholder groups, including consumers, social work practitioners, mental health agency leadership, students, social work educators, social work education leadership, and social work field directors. A separate protocol was developed for each group, but broadly the interviews addressed awareness and knowledge of recovery, efforts to incorporate recovery-oriented practice, what social workers/students should be taught about recovery, and what interviewees would like CSWE to develop as part of the RTP project.

The interviews were conducted between July and October 2010 by phone. CSWE staff members facilitated the interviews. With participants' permission, the interviews were recorded to assist with note-taking and qualitative coding. Interview subjects were recruited through e-mail, e-newsletter, electronic mailing list announcements, identification by Steering Committee members, and by snowball sampling through asking interview subjects to identify other individuals who should interview. In all, more than 20 interviews were

conducted. Focus group and interview protocols were drafted in collaboration with the RTP Steering Committee and its lead consultant, and samples have been added to the appendix.

Open discussion forums

Two open discussion forums were held concurrent with conferences to allow for general conversation about social work and recovery. The first was held during the Alternatives 2010 conference on October 2, 2010. Joseph Rogers, Lauren Spiro, and Susan Rogers—members of the RTP Steering Committee—organized and facilitated a discussion group (“caucus”) at the conference that was intended to target consumers in a conversation about their experiences with social workers. The caucus was announced and promoted through the Alternatives Conference website and materials. Approximately 20 individuals attended the caucus meeting. The discussion focused on experiences with social workers and what social workers need to know in general and about the topic of recovery specifically.

The second discussion forum was held during the CSWE APM on October 15, 2010. Charlie Rapp facilitated the discussion, and CSWE staff members took notes. The discussion group was announced through the CSWE *Focus* and the APM final program. Seven individuals attended the discussion:

- 4 professors (3 of which taught mental health research or practice/policy)
- 2 California Social Work Education Center (CalSWEC) project coordinators
- 1 CalSWEC program director

The forum focused on individual recovery initiatives, barriers to recovery orientation, and what resources would be helpful as CSWE moves forward with the RTP project.

Soliciting consumer comments by e-mail

During recruitment of consumers for the focus group, the NAMI electronic mailing list in particular generated a lot of interest. Because the number of spaces allotted for the focus group was limited, CSWE staff members announced to interested individuals that input would also be accepted by e-mail or phone. The announcement focused comments on consumer experience with social workers and what social workers need to know about recovery. Several consumers sent in comments; others expressed interest in being involved with the project in the future.

Syllabi review

Over the summer in 2010 a call was sent out by e-mail from CSWE to all accredited master’s of social work programs ($N=201$) asking them to send in mental health syllabi. At the end of the collection period 36 programs (17.9%) had sent in one or more syllabi. The largest number of syllabi (6) was sent by Catholic University of America. The courses covered included community mental health, mental health/mental illnesses, diagnosis and assessment, substance abuse, mental health policy, co-occurring disorders, direct social work practice, responses to trauma, and mental health practice with specific populations (e.g., children and adolescents, adults, older adults, and families). Some of the courses mention recovery specifically in the title of the course, but most do not but have recovery and recovery-related terms throughout the syllabi.

State review

The team felt that it was important to examine state mental health policies, mission statements, funding streams, training resources, conferences, licensure, and publications. The review also tried to identify the underlying motivation for the state becoming involved in recovery-oriented practice and the involvement of consumers and family members. Given the limited time for a review, states known to have some recovery-related initiatives were identified by the Steering Committee and in the literature for inclusion in the review. Six states were included in the review: California, Indiana, Kansas, New York, Ohio, and Pennsylvania.

Literature review

An extensive review of the literature on mental health recovery and social work was undertaken, including leading social work journals, non-social work professional journals, books, and organizational materials. In all more than 90 sources were reviewed, which contributed greatly to the understanding of the current state of recovery in social work.

Review of professional organizations and conferences

Leading social work professional organizations, their printed materials, policies, and conference proceedings were reviewed for mental health recovery and recovery-oriented practice references. More than 15 organizations were included in the review, including NASW, CSWE, Association of Social Work Boards (ASWB), and the Society for Social Work Research.

Site visits

Team members visited two local agencies to get a sense of what structural and environmental factors may influence consumers even before they see a social worker. A team member also attended a presentation by several local social service agencies on their current work in mental health recovery.

Quantitative Measures and Strategies

Several quantitative measures also were used for this situational assessment. These were existing sources of data, which have been used to augment the understanding of recovery and social work based on the qualitative review. The sources included the Annual Survey of Social Work Programs; the NASW Workforce Studies; and Mental Health, United States. A description of each source follows.

Annual Survey of Social Work Programs

The Annual Survey is a census of accredited social work programs conducted by CSWE. The survey includes questions about enrolled students, graduates, and faculty. It also gathers data about student funding sources, graduate certificates offered, dual degree programs, concentrations, and field education placements. Each of these latter variables addresses mental health to some degree, so the datasets were included in the situational assessment. The response rates for the Annual Survey have been over 90% for several years.

NASW Workforce Studies

The NASW Center for Workforce Studies (<http://workforce.socialworkers.org>) conducted a survey of 10,000 licensed social workers that included questions about their job functions, skills, educational backgrounds, salaries, and workplace environments. The Workforce Center created several helpful reports, charts, and graphs about social workers in the mental health field. In particular, a special report on behavioral health was used for the situational assessment (NASW, 2006). NASW also makes the datasets available to scholars.

Mental Health, United States

The U.S. Department of Health and Human Services (DHHS) creates a periodic report regarding mental health in the United States. The report focuses in large part on mental health service providers, including social workers. Tables in the report show the number of social workers in different mental health settings and the number of social workers over time. Since DHHS has collected this data for some time, the number of social workers serving in different settings can be traced back to the 1970s (Manderscheid & Berry, 2006).

Issues and Questions Addressed

Key questions about mental health recovery and social work were examined using the qualitative and quantitative sources previously described. A description of each of the primary guiding questions follows. A matrix showing the use of sources as connected to each of the question categories can be found in Appendix A.

System-level regulatory policies (federal and state)

Mental health policy at the federal and state levels has a profound impact on social work services and ultimately on consumers. In the state review the team examined whether recovery was specifically mentioned in state mission/vision statements and policies; whether there was a mandate for including consumers in the decision-making process; and if so, how.

State funding, reimbursement, and regulatory mechanisms

Beyond the policy language, the availability of funding will also show the depth of commitment a state has to mental health recovery. Funding for system transformation, grants, and training when recovery is specifically mentioned was included in the state review.

Vision, mission, and reform initiatives

Other than the state and federal agencies, other individuals, groups, and organizations may be working for recovery-oriented practice, some specifically focusing on the 10 recovery components identified by SAMHSA. Using focus groups, individual interviews, open discussion forums, and review of professional organizations and conferences the team attempted to identify some of those individuals and agencies that have been working toward a common mental health recovery goal.

Organizational assessments

The structure of a social service organization, architecture of the building, recruitment and in-take practices, governance, and programming can profoundly affect the integration of recovery-oriented practice. Individual agencies and organizations that could serve as role models were identified by using site visits and attending local presentations, interviews, and open discussion forums.

Readiness assessments

One of the areas considered in the state review was the timeframe in which each state began to incorporate recovery-oriented practice and the impetus for change. The literature, such as the President's New Freedom Commission on Mental Health (2003) report also makes mention of some of these early adopters and what brought about change. This can help give a sense of what preparations were made for the paradigm shift and how successful the planning process was for bringing about change.

Service planning and implementation

The social work practice process was one of the main focus areas for the situational assessment. Interviews with consumers, practitioners, and agency leadership tried to assess the extent to which social workers treated consumers as equal partners in the process. A focus group, an open discussion forum, and e-mail exchange with consumers also built on this theme. Interviews, a focus group, and an open discussion forum with social work faculty members attempted to gauge the extent to which such partnerships were being taught in the classroom.

Training and technical assistance

The situational analysis also tried to gauge the extent to which training and technical assistance related to recovery-oriented practice is currently being included in social work education, professional organizations and conferences, and state mental health agencies. Using interviews, focus groups, and an open discussion forum with social work faculty helped to determine the extent to which specific programs were including content. The syllabi review further emphasized which aspects of recovery were being included in which courses. The review of professional organizations and conferences and the interviews with agency leadership helped to determine what social work-specific professional development events might have recovery topics included. Finally, the state review also included an examination of any recovery-related training available.

Contextual Conditions for the Social Work Profession

The multifaceted data collection methods and sources have been collated and synthesized in discussion of some of the major internal and external elements—historical, political, economic, social, and technological—that have affected the adoption of recovery-oriented practice in social work. The assessment of contextual conditions will specifically examine the history of recovery in social work, the 10 components of recovery defined by SAMHSA, other elements important to the recovery movement (participation of consumers, use of culturally competent practice, and trauma-informed care), and infusion of recovery concepts throughout the state mental health systems.

History of Recovery in Social Work

It is somewhat difficult to disentangle the history of mental health recovery in social work. Social work began out of a philanthropic movement at the end of the 19th century that pushed back on the institutionalization of the poor and orphaned. The first models of practice—friendly visitors and the settlement house movement—were premised on working with individuals in their own communities. As the profession emerged at the turn of the century, the common theme was concern for enhancing the well-being of individuals. Components of the recovery movement such as empowerment and respect have also been hallmarks of social work theory since its beginnings. For example, a quote from social worker Jane Addams in 1902:

We are gradually requiring of the educator that he [sic] shall free the powers of each man and connect him with the rest of life. We ask this not merely because it is the man's right to be thus connected but because we have become convinced that the social order cannot afford to get along without his special contribution. (Rapp, Saleebey, & Sullivan, 2005, p. 80)

The newly forming social work discipline built on the existing social sciences, psychology, and biology—making use of a number of different fields for the first schools. The resulting conceptual framework for social work practice was naturally one that pulled together these fields for a more holistic view of individuals, termed person-in-environment. The social worker is expected to understand and assess the biological, psychological, social, and spiritual aspects of an individual and the environment in which she or he resides. Such a perspective is still a standard of social work practice today.

In the 1980s the strengths model for case management developed at the University of Kansas. The strengths model has been picked up by many social workers since that time, and though there are differences in application, there are six common aspects identified. Strengths-based practice (1) is goal oriented, (2) is a systematic assessment of strengths, (3) recognizes that the environment is seen as rich in resources, (4) uses explicit methods for identifying strengths and goal attainment, (5) recognizes that relationships are hope inducing, and (6) recognizes that provision of meaningful choices is central and clients have the authority to choose (Rapp,

Saleebey, & Sullivan, 2005). Such a model for practice is clearly consistent with recovery-oriented practice.

The strengths model is important in tying together the earlier frameworks in a cohesive way that also brings hope to the process and equalizes the relationship, As Rapp wrote:

The importance of a strengths approach, however, is that: it is concordant with social work values; it dramatically expands the scope and venues of helping; it gives the client a critical role in the process; it redresses some of the excesses of the expert role; it summons community resources; it fulfills the obligation of the person: environment perspective by drawing upon the energies of body, mind, spirit, and environment in helping; its vocabulary is ordinary and it respects the indigenous psychology of all peoples (their theories); and it can create positive atmospherics in agency and organization. (Rapp, 1987, p. 25)

In spite of many theoretical similarities to recovery, there are areas in which social work practice has fallen prey to the same persistent focus on illness, labeling, and deficits, which dominates the mental health care system and sets the consumer apart to be acted on by the practitioner. The theoretical base of the person-in-environment and strengths-based perspectives (which call on social workers to empower consumers) and the Code of Ethics (NASW, 2008; which highlights self-determination and respect) are often found by the practitioner to be at odds with the day-to-day realities of social work practice in the mental health system. Social work practitioners who affirm recovery orientation are seeking concrete assistance in determining how to carry out recovery-oriented practice in such an environment. Others accept pieces of the recovery definition but have rejected others—resisting aspects such as self-direction. The current state of social work and how it has adopted or rejected recovery-oriented practice will be considered in more depth.

SAMHSA's 10 Recovery Components

The SAMHSA Consensus Statement on Mental Health Recovery (2006) identified 10 components of recovery: self-direction, individualized and person-centered, empowerment, holistic, nonlinear, strengths-based, peer support, respect, responsibility, and hope. Social work literature accentuates how social work is “uniquely qualified” (Carpenter, 2002, p. 87) to employ the recovery paradigm, listing the profession’s history and contribution to the movement through its strengths perspective and investment in forming and promoting the implementation of recovery (Carpenter, 2002; Scheyett, 2005; Starnino, 2009). Sources posit the profession’s place is noticeable because it contends with environmental and societal oppression, addressing empowerment and social justice in ways other helping professions might not (Scheyett, 2005). As King Davis notes, “defining social justice and participating in sustained advocacy to achieve it” rank highly as opportunities for the social work profession (Davis & Bent-Goodley, 2004). Social work theory emphasizes holism and person-in-environment, that is, the dynamic interaction of an individual with factors based in the environment (e.g., location, time, and family). Other sources state social work can negotiate better the complexities of community integration and mental health care (Farone, 2006).

Although peer-reviewed social-work specific literature recognizes the alignment of social work values and recovery orientation, it also outlines existing gaps in practice and education. Eack & Newhill (2008), for example, observe that there are no specific accreditation standards regarding “what social work students need to know about schizophrenia and other severe mental illnesses . . . [and] practicing social workers report feeling ill prepared for their work with this population.” A 2003 study of 71 graduate social work psychopathology courses revealed that a one-sided approach to mental health, leaning toward the biomedical, was being taught (Starnino, 2009). Many sources report that most social workers—the leading providers of mental health care—still identify with practicing under a medical model approach (Eack, 2008; Hodges et al., 2003; Scheyett, 2005). Though social work is consistent with recovery in theory and practice roots, social workers must “go beyond the valuative underpinnings of the profession,” recognizing the alignment and building on that (Buckles et al., 2008).

All interviewees were given the SAMHSA definition during interviews, and among most interviewees, there was broad acceptance of what has been written. However, the mental health agency leaders who were interviewed saw recovery as ambiguous, some embracing it as a “creative ambiguity.” Some reported that SAMHSA needed a way to operationalize the definition, and that the definition lacked focus on the subjectivity of the concept. Although interviewees viewed recovery as not directly opposed to the medical model, they felt the most important themes were hope and meaningful life after diagnosis (which may include friends, family life, work, etc., and not necessarily symptom management). They noted that labels such as *transformation* and *recovery* are now “buzz words” at national conferences but wondered about translation to practice. However, social worker conference materials along with interview data suggest that many social workers may not be aware of the SAMHSA definition of recovery. Many interviewees did not recognize the definition as it was read to them and still struggled with questions: “What does recovery *mean*?” or “How are you defining *recovery*?”

Understanding of classification and diagnosis of the *Diagnostic and Statistical Manual of Mental Disorders IV* (DSM-IV) was covered in the syllabi reviewed, as well as the ability to think critically and identify assumptions of fundamental mental health care. With the exception of evidence-based practice classes, models such as peer support were not explored in the sample syllabi. Evidence-based practice courses covered strategies including Assertive Community Treatment (ACT), motivational interviewing, “wellness self-management,” medication management, family involvement in recovery, supported employment, social skills training, peer support, and consumer-provided services, while also concentrating on client-centered problem-solving therapy and strengths-based perspectives. The hope and nonlinear components were not explicitly covered in the syllabi but may have been implicit in exploration of various practices, for example, in a section of class discussion titled, “Setting the Stage: Why are we talking about work for individuals with a diagnosis of serious mental illness? What is work?”

Major social work organizations, while not specifically integrating recovery into policies, list consistent components in standards. Some of the 15 professional organizations reviewed during the assessment featured explicit recovery references, even using terminology such as

self-directed, empowering, strengths based, and holistic [treatment]. Others reflected a more implicit understanding of the approach, using words such as *consumer driven*.

ASWB and NASW has approved continuing education courses in mental health that explicitly and implicitly support the recovery model, as do other social work organizations. Licensing and certification requirement also reflect either explicit or implicit recovery-oriented approaches.

The NASW Code of Ethics (2008), for example, stresses empowerment, social justice, self-determination, and the person-in-environment framework and focuses on the individual. The Code of Ethics also identifies six core values of social work that underscore treatment and practice compatible with recovery: service (particularly for those who most need and cannot afford it); social justice (recognizing the rights of mentally disabled persons); dignity and worth of the person; importance of human relationships; integrity; and competence. The organization's Standards of Practice for Clinical Social Work cites the importance of a "holistic approach to psychotherapy and the client's relationship to his or her environment" (NASW, 2008, p. 7) A published *Practice Snapshot* on mental health recovery includes tips for making social work practice more recovery oriented (NASW, 2006b).

CSWE, in its *Advanced Social Work Practice in Clinical Social Work* guide, includes competencies, knowledge, and practice behaviors that implicitly support recovery, such as "Establish a relationally based process that encourages clients to be equal participants in the establishment of treatment goals and expected outcomes" and "use multidimensional biopsychosocial-spiritual assessment tools" and "assess client's coping strategies to reinforce and improve adaptation to life situations, circumstances, and events" (CSWE, 2009, p. 9) Though the organization does not feature a mental health topical group (with special conference sessions) at its annual conference, more than 30 panels or paper sessions concentrated on mental health—including service use and cultural factors, student self-disclosure, and addictions and recovery. No panel or paper session titles focused specifically on recovery. CSWE's (2008) Educational Policy and Accreditation Standards (EPAS) emphasizes the "person and environment construct" and "dignity and worth of the person" and focus on the "enhancement of the quality of life for all persons" in the social work profession's purpose. In practice it also encourages social workers to work as partners with clients:

- *During engagement, "social workers develop mutually agreed-on focus of work and desired outcomes";*
- *During assessment, "social workers develop mutually agreed-on intervention goals and objectives"; and*
- *During intervention, "social workers implement prevention interventions that enhance client capacities" and "help clients resolve problems." (p. 7)*

The Society for Social Work Research, at its 2011 annual conference, focused on mental health through its topical group of the same name. The group included more than 50 paper or poster presentations on mental health, but only one specified recovery in the title (a presentation on a Taiwan study).

To assess how well each of the 10 components has been used, each of the components from SAMHSA's Consensus Statement will now be considered separately in terms of its prevalence and integration in social work education and practice.

1. Empowerment

Empowerment is defined by SAMHSA as the consumer having the "authority to choose" and participate in decisions, to "speak for themselves," to "gain control of his or her own destiny," and "influence . . . structures in his or her life" (SAMHSA, 2006). Empowerment is seen as integral to self-efficacy and recovery.

Although the term *empowerment* is more recent in origin, social work has had a strong commitment to consumer empowerment since its beginnings at the end of the 19th century (Rapp, Saleebey, & Sullivan, 2005; Simon, 1994). Empowerment in social work has focused on collaborative partnerships with consumers, emphasizing "capacities" rather than "incapacities," attending to person and environment (social and physical), recognizing the consumer as an individual, and placing concern on disempowered individuals and groups (Simon, 1994). The NASW Code of Ethics (2008) includes in its preamble: "Social workers seek to enhance the capacity of people to address their own needs."

The presence of empowerment was also evidenced in a review of social work mental health syllabi. The term *empowerment* was used in all 138 courses reviewed. In social work practice, empowerment takes many forms—for example, identifying strengths, providing resources, encouraging use of self-help programs, or participating in advocacy and protest (Buckles et al., 2008; Carpenter, 2002; Hodges et al., 2003; Simon, 1994).

Some recent literature on the concept of empowerment includes discussion of new approaches to empowerment, such as psychiatric rehabilitation, which has been encouraged by some due to funding availability and consumer demand. On a policy level, Scheyett posits increasing the power of persons with severe mental illnesses to increase advocacy and policy change. Barriers to empowerment, such as stigma, are also the target of much social work literature. Many observe that stigma blocks empowering opportunities to accomplish goals (Corrigan, 2007; Scheyett, 2005).

Of course, even though empowerment has been a dominant theme in social work practice since its inception, there are still many social workers who take a more paternalistic, deficits approach to practice. Indeed, the temptation to leverage power in the relationship is one with which each social worker must contend. As Ann Hartman wrote, a hierarchical relationship with consumers creates "a safe harbor in ourselves for all the unconscious desires to be superior" (quoted in Simon, 1994, p. 12). If that view is taken, the empowerment approach is not one that is simply achieved, but one that the practitioner must constantly assess and work toward.

2. Holistic

The SAMHSA definition of *holistic* reminds us that recovery must include a person's entire life: "mind, body, spirit, and community."

Social work has traditionally borrowed liberally from other disciplines in the development of theories and models. Two interrelated constructs that are important to social work practice are person-in-environment and the biopsychosocial-spiritual perspective. These constructs emphasize the importance of understanding the entirety of a person's life to practice effectively. CSWE's EPAS includes as one of 10 competencies necessary for social work practice, "Apply knowledge of human behavior and the social environment," further described as follows:

Social workers are knowledgeable about human behavior across the life course; the range of social systems in which people live; and the ways social systems promote or deter people in maintaining or achieving health and well-being. Social workers apply theories and knowledge from the liberal arts to understand biological, social, cultural, psychological, and spiritual development . . . Social workers critique and apply knowledge to understand person and environment (CSWE, 2008, p. 6).

And the NASW Code of Ethics (2008) says, "A historic and defining feature of social work is the profession's focus on individual wellbeing in a social context and the wellbeing of society."

Those writing in social work journals articulate well the concept of recovery and consumer relationships. Zeman and Buila (2006) speak to the need to carefully incorporate environmental context in client relations to ensure a holistic view. There are some recommendations for tools to use in practicing holistically. For example, Corrigan (2007) suggests using dimensional diagnosis with clinical judgment and flexibility, which describe a person's profile of symptoms on a continuum. Starnino (2009) recommends using integral theory to organize and connect the competing viewpoints—modern science paradigm, professional led community integration efforts, survivor/ex-patient movement, and contemporary mental health consumers—surrounding recovery orientation. Starnino avers this approach recognizes the contributions of each approach and considers each a "partial truth," none representing "all of reality" (Starnino, 2009, p. 835).

It follows that in practice social workers would be attentive to community services and networks resulting in assistance with housing, finances, health care and medications, and other resources (Farone, 2006). Other examples of holistic social integration include employment (which Buckles et al. [2008] assert has been given little attention), marriage, parenthood, shopping, civic engagement, friendships, supported education, and participation in peer-run organizations (Farone, 2006). Medical, functional, and psychosocial needs and community are also important factors mentioned in social work literature on recovery (Dallaire, 2009).

Interviewees stressed support for community living and person-in-environment outlooks, citing such tools as programs of ACT and calling for less focus on the medical model. Interviewees also mentioned involving family members in the recovery journey. Observations of social work conference presentations highlighted holistic approaches incorporating employment, parental support, educational support, and community involvement. Consumer interviewees specifically mentioned the importance of holistic support, including additional supports for parents to prevent the break-up of a family or assist in regaining custody of children.

The holistic component of recovery is consistent with the constructs taught in social work education. Given the myriad elements that should be considered throughout the recovery process, this too is a component that social workers must consider as a process, one that involves working with consumers to include all relevant aspects of life in recovery.

3. Hope

According to the SAMHSA Consensus Statement (2006), “Hope is the catalyst of the recovery process” and “people can and do overcome the barriers and obstacles that confront them.”

Social workers write that hope is generally recognized as necessary to the recovery process (Hodges et al., 2003). Throughout the literature the need to understand and actively affirm the recovery process—for example, through hope—stands as an imperative (Buckles et al., 2008). Social work literature points to the numerous studies citing empirical evidence of recovery from mental illnesses and research on recovery to instill the reality of hope into the profession (Carpenter, 2002). Corrigan (2007) stresses that diagnoses are not static and that recovery does happen, a subtle nod to the necessity of hope. The social work strengths perspective itself was seen as an indicator of hope, as it assumes the best of the consumer (Stromwall & Hurdle, 2003).

Farone (2006) considers consumer points of view, stating that clients in ACT services reported case managers’ persistence and refusal to give up (as well as their trustworthiness) mattered most in care. Literature further communicating this theme examines predictors and measures of hope, specifically in mental health self-help agencies, and calls for increased research on the relationship of hope to homelessness, severity of psychiatric symptoms, and self-efficacy (Hodges et al., 2003).

This need for hope was also echoed in the interviews with consumers. Whereas some interviewees spoke of the “challenge of chronic mental illnesses” in their experience, others gave examples of hope in practitioner–client relations. For example, a peer specialist receiving an award for her contribution to an agency thanked one interviewee “for believing in me fifteen years ago.” Hope, in the provider’s viewpoint, was seen as critical: “There is a point somewhere in their process where they say, ‘Someone else held the hope for me when I couldn’t,’ letting them know, ‘There’s a way out of this.’”

Both agency leadership and faculty interviewees reported “chronic thinking” as a challenge in transitioning to recovery orientation. Simon (1994) also suggests that practitioner cynicism can sabotage the entire recovery process. She suggests that it is not enough for the practitioner to engage in a series of empowering practices if the practitioner has no hope that the consumer can achieve recovery. Simon goes further to suggest that practitioners must be realistic and recognize the nonlinear aspect of the recovery process, so that they will not become discouraged. Chronic thinking and potential for practitioner cynicism will be two challenges to address in social work.

4. Individualized and person-centered

The SAMHSA Consensus Statement (2006) points out that there are many pathways to recovery and so the process must be based on the individual’s “strengths and resiliencies

as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations.”

Noting the recovery process as “a search for a unique and positive sense of who one is” (Carpenter, 2002, p. 6) highlights the individualized and person-centered element (Carpenter, 2002). Focus on the individual also is manifested in the knowledge that there is more than one path to recovery, that there is “no assumption that all individuals described as having the same mental disorders are alike in all important ways” (Corrigan, 2007, p. 34).

The social work curriculum has included a mandate for content on cultural diversity and competence (or sensitivity) for many years (CSWE, 2001, 2008). The current EPAS highlights not just the importance of understanding diversity, but also the need to be open and learn about diversity from individual consumers:

Social workers understand how diversity characterizes and shapes the human experience and is critical to the formation of identity. The dimensions of diversity are understood as the intersectionality of multiple factors including age, class, color, culture, disability, ethnicity, gender, gender identity and expression, immigration status, political ideology, race, religion, sex, and sexual orientation . . . Social workers view themselves as learners and engage those with whom they work as informants. (p. 4–5).

Likewise, the NASW Code of Ethics (2008) includes the statement that “social workers are sensitive to cultural and ethnic diversity.” This cultural sensitivity matched with the strengths perspective should be a powerful driver for individualized and person-centered care in social work.

Desired skills for social workers include assessments that match and mediate connections between individuals and their environments. The consumer’s interests and competencies provide foundation for recovery, because recovery offers different kinds of rewards to each person (Dallaire, 2009; Farone, 2006). Additionally, viewing clients as representations of a diagnosis—assuming a homogenous and static group—elevates stigma, so social workers must see consumers as individuals (Corrigan, 2007).

Interviewees reported respect for clients’ definitions of recovery and for their goals—as well as a focus on helping them reach those goals—reflects awareness of respect and an individual and person-center approach that is self-directed. Agency leadership spoke of self-directed care further, emphasizing that the individual is in control. Focus, too, lies on finding consumers’ strengths, helping them “reclaim their lives—or redefine what they want their lives to be.”

Faculty interviewees focused on important elements of individualized treatment, citing inclusion of such tools as WRAPs and psychiatric advanced directives as important to the concept of recovery. Consumer respondents also listed advanced directives and wrap-around services as optimal strategies for social workers, along with aid in “survival skills” such as employment and coping skills and the incorporation of spirituality in care. Further on individualized care, consumers listed experiences when “They just talked to me like I was

a person instead of a disease or a client . . . or just a case”—and not with medical jargon—as most desirable.

It seems that the biggest threat to individualization would be systematic or homogenized treatment. Rapp suggests that this threat of homogenization is an out-growth of a deficits approach:

To enhance and reveal people as individuals, then, assessment and treatment-planning methods need to be based on an exploration of a person's strengths. To do otherwise is to direct our minds and our practice toward 'standardized' human beings and thereby do injustice to the cardinal value of social work and mental health, which places the individual, in all of his or her elegance and uniqueness, at the center of our concerns, and ultimately to reduce the effectiveness of our efforts. (Rapp, as quoted in Saleebey, 1996, p. 58)

Emphasizing the strengths approach and ensuring that social workers have access to resources for referral and to the most current research on practice outcomes will be essential to effective individualized care. This is an especially salient issue for social workers in rural settings or settings with limited funds, where Internet access and expensive library journal subscriptions may be out of reach.

5. Nonlinear

As noted in the SAMHSA Consensus Statement, “Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience.”

Some of the social work literature does speak to the importance of the concept of nonlinearity for recovery. The theme of recovery being nonlinear surfaces in descriptions of personal experiences where the pathway to recovery often includes both steps forward and setbacks. Like self-direction and peer support, the nonlinear component is seen as integral to promotion of recovery orientation (Buckles et al., 2008). The idea of a continuum has been used to represent the recovery process (Farone, 2006). Some social work literature also notes how the concept of recovery as nonlinear is a departure from “clinical / treatment-oriented” concepts and notions such as “cure” or “symptom relief” (Dallaire, 2009, p. 143). Hardiman et al. (2008) point out that promoting an understanding by social workers of relapses as part of the recovery process is needed.

Interviews revealed attitudes about recovery's nonlinear element. Social service agency leadership and faculty interviewees noted that recovery is not a 12-step program to be completed and walked away from. Realizing how treatment should be holistic, they labeled it a “social recovery” as well, with community integration needed. Some participants noted that recovery does not mean “cure.” Interviewees stressed the need to see clients' readmission into facilities (or intermittent efforts at maintaining steady employment) not as failures but areas for growth. The thread of the continuum concept carries over from the literature.

Other faculty interviewees struggled with the nonlinear aspect of recovery, questioning whether recovery is a condition to be “maintained” or whether a person could “recover and not come back into the system.” Some tried to balance word choice between consumers who

“have recovered” and “are in recovery.”

Consumer respondents weighed in on the nonlinear aspects of recovery as well. They remarked that it is a slow process:

- *“Even during a setback, you’re in recovery.”*
- *“Recovery is a continuum. It comes in small increments.”*
- *“For some people . . . it goes from A to Z to X, then back to A again.”*

It is still uncertain how well-adopted the nonlinear concept is in social work. Although it was included in some of the literature, it was not mentioned as frequently in organizational documents or in the mental health syllabi. Whether the absence is due to its residing within another topic or a true lack is uncertain. As mentioned in the section on Hope (3), if the practitioner does not realistically understand the concept of nonlinearity in recovery, she or he will become discouraged and cynical about the recovery process.

6. Peer support

SAMHSA defines *peer support* as

Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community. (SAMHSA, 2006)

Community integration and peer supports were given attention in the social work literature also, with emphasis on their importance to self-efficacy and recovery (Buckles et al., 2008; Dallaire, 2009). Specifically, the goals of self-help mental health agencies also align with social work values of consumer strengths and self-determination, autonomy and dignity. Hodges and colleagues (2003) also explore the relationship between hope levels and consumers who are long-term members of consumer-run self-help agencies and find that consumers who use these services can be characterized as “resoundingly hopeful” (Hodges et al., 2003, p. 11). The writers suggest that practitioners consider referrals to consumer-run mental health organizations. This theme was also included via larger discourse on social supports to facilitate resilience and growth (Zeman & Buila, 2006).

Mental health agency leaders’ personal experiences also fed recovery practices they advanced in interviews. Some spoke of hiring peer specialists and their value in helping other clients. Social work faculty focus group participants noted how working in a consumer-operated organization greatly assisted their and students’ transformations to recovery orientation. Picking up on this thread, consumer interviewees suggested there should be student field placements at consumer-run organizations and noted that having peer role models facilitated their recovery journeys.

In spite of general agreement about the usefulness of peer support to recovery, the inclusion of such content in social work education appears mixed. A review of mental health syllabi

found a modest 18 direct references to peer support. This is also an area that is not expressly outlined in the strengths-based practice model. The implications will be discussed in the section on consumer inclusion throughout the process. This may be the area where social workers need the most assistance.

7. Respect

According to the SAMHSA Consensus Statement, “Community, systems, and societal acceptance and appreciation of consumers—including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery.”

Respect is often implied in the social work literature through instructions that will presumably lead to more respect for consumers. For example, social workers are encouraged to reflect on their own experiences to appreciate the consumer view as well as to evaluate their own biases, addressing stigma and promoting respectful interaction with consumers. The empowerment focus also indicates a respect for consumers (Corrigan, 2007). The term *respect* received modest inclusion in the mental health syllabi reviewed. But it may be included more broadly under different terminology. The NASW Code of Ethics (2008) lists “dignity and worth of the person” (NASW, 2008, p. 11) as one of the core values of social work. In an explanation of the value, the Code says:

Social workers treat each person in a caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity. Social workers promote clients’ socially responsible self-determination. Social workers seek to enhance clients’ capacity and opportunity to change and to address their own needs. (NASW, 2008, p. 11)

The same value, “dignity and worth of the person” is reiterated in the 2008 EPAS, as is an express mention of respect: “These values underpin the explicit and implicit curriculum and frame the profession’s commitment to respect for all people and the quest for social and economic justice” (CSWE, 2008, p. 2).

The literature also recognizes that social workers are not immune to the culture of stigma surrounding mental illnesses, because they are citizens of the world. Even their social work values cannot insulate them from discriminatory cognitions and practices. These perceptions affect the treatment of consumers (Dallaire, 2009; Buckles et al., 2008). Corrigan (2007) also posits that the act of diagnosis itself creates structural stigma, that is, the risk of seeing consumers in terms of their diagnoses only. Two elements seemed to affect practitioners’ respect for consumers positively – personal contact with consumers and empathy. Eack & Newhill’s 2008 study of 118 master’s of social work students found knowledge and contact significantly related to better attitudes toward persons with mental illnesses. Interestingly, knowledge was associated with positive attitudes only with those students who had increased personal contact.

Interviewees stressed respect of the individual as well as the individual’s culture for effective recovery orientation. Consumers felt that by advocating for clients, actively listening, empathizing, and asking how they could help, social workers could operationalize the concept of respect. Consumers reported that being treated as equals and having their choices

honored were central to the recovery concept: “[Recovery meant] that I could have my opinion and [the social worker] could have her opinion.”

Some consumers mentioned that social workers (and other mental health practitioners) could exhibit an “us versus them” attitude. Consumers stated that empathy would work to remedy those attitudes; as one focus group participant said: “People don’t believe that what happened to you could happen to them, and so they need to distance themselves from you, [creating] otherness.”

Two interesting suggestions for using technology to build empathy in social work students emerged in the focus group with educators. Several of the participants recommended an exercise by Patricia Deegan called “Hearing Voices” that uses an mp3 with multiple voices speaking to the participants while asking the participants to try to complete everyday tasks while listening (e.g., completing a mental health status exam). The exercise is intended to help social work students better understand the experience of consumers and the challenges inherent in accessing the mental health system. Another participant mentioned several exercises available in Second Life from the University of California, Davis that allow students to “experience” hallucinations and others that allow them to go through the intake process.

Respect for consumers is a central tenet to many of the guiding policy documents in social work organizations. The literature also supports the need for respect as critical to the recovery process. However, there is some evidence in the literature that social workers do fall prey to keeping a distance from consumers and falling into an “us versus them” mentality. Exercises, such as “Hearing Voices” could help build empathy and thwart the “us versus them.”

8. Responsibility

“Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps toward their goals may require great courage” (SAMHSA, 2006).

Responsibility is also implicit in competence foci of psychiatric rehabilitation and via social integration (Stromwall & Hurdle, 2003). The message of Dallaire and colleagues (2009) concentrates on developing and preserving autonomy, creating the capacity to influence the course of one’s life, exercised through decision making. As in the elements of empowerment and holistic care, responsibility is demonstrated through involvement with the “basic functions of life” (Dallaire, 2009, p. 144), for example, being involved as a citizen and consumer, which improve self-efficacy (Buckles et al., 2008; Dallaire, 2009).

Agency leadership interviewees incorporated responsibility and strengths-based models in their practice through hands-on experience. For example, one interviewee mentioned enlisting clients in long-term projects, stating that once consumers saw that they could complete such work, they felt ready for other tasks. Faculty interviewees also mentioned self-responsibility and skill learning as critical to recovery. Social workers at conferences also discussed the importance of independence, especially economic independence, stressing the benefits of employment. Some practitioners voiced a desire to shift the profession’s focus from aiding clients in securing disability compensation and toward policies and programs that assisted them in employment after treatment.

Consumer focus group participants spoke about the increase in workforce development through building pathways for consumers and family members into careers, which had resulted in a large number of social work students identifying as consumers or family members. In addition to social work workforce development, consumers stated that employment provided them with a routine, social networks, mental stimulation, and supportive environments—as did school attendance.

9. Self-direction

The SAMHSA Consensus Statement (2006) says of self-direction:

Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path toward those goals.

Although *self-direction* as a term is sometimes used in social work, it is more common to hear it referred to as *self-determination*. This concept has been central to social work practice since its beginnings. As stated by Gordon Hamilton: “Hardest of all to understand that in order to “make good” psychologically a person must be allowed not only to make good by his own efforts but also to make good in his own way.” (Hamilton, 1940, p. 45)

The literature affirms that self-direction is needed for mental health service change (Buckles et al., 2008). Social work literature also acknowledges that recovery orientation calls for services and supports chosen by the consumer and used as tools (Carpenter, 2002; Hodges et al., 2003; Stromwall & Hurdle, 2003). Dallaire and colleagues (2009) reassert recovery as reflecting the individual’s point of view rather than the clinician’s.

The literature also supports the broad acceptance of self-direction by social workers. One study of licensed mental health social workers found that 97.5% of respondents felt that self-determination is “important” or “very important” in practice (Taylor, 2006). Practitioner interviewees also commented on self-direction. They noted this as a concept of recovery, saying that consumers “make the decisions. They are partners and experts.”

Although there is acceptance of the idea of self-direction, it can be more difficult for social workers to put these ideas into practice on a day-to-day basis. The literature suggests that this could be due to the tension between desire to allow self-determination and concern for the client (e.g., feeling that the illness is too severe or impairment too great to allow for self-determination) or workplace policies (e.g., work in an agency that has mandated or involuntary treatment; Taylor, 2006). Some practitioner interviewees exhibited discomfort with emphasis on self-reliance and allowing consumers to select and participate in their recovery treatment: “They tend to be noncompliant. . . . Sometimes their illness will prevent them from participating.”

Interviewees had mixed personal experience with self-direction.

I worked with a client for four to five years. We had a rocky start. Then we had a conversation about what she wanted. Over time, she came up with goals. We used her passion for art and medication management to get her part-time work in the art field. Her motivation was her work.

Consumers in focus group insisted social workers should develop partnerships to aid the recovery process and cautioned professionals not to adopt a new term such as *self-directed* and apply it to old paradigms.

In summary, social workers are quite accepting of the concept of self-direction; it is one that has long been a part of social work practice. There are ethical dilemmas that mental health social workers face that leave practitioners uncertain about how to put self-direction into action on a day-to-day basis. In moving toward the curriculum development stage very specific activities and tasks should be included along with case studies to assist social workers' implementation of self-direction in practice.

10. Strengths-based

The SAMHSA Consensus Statement (2006) says the following about recovery being strengths-based:

Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee).

Much of the social work literature explored recovery through the lens of a strengths-based perspective, a leading paradigm of the profession (Carpenter, 2002; Hodges et al., 2003). In fact, the term *strengths-based* was developed by social workers in the 1980s; the term was first used by Bertha Reynolds and then picked up and formalized by faculty at the University of Kansas. As mentioned in the History section, the strengths-based perspective in social work includes other components from the SAMHSA definition, namely holistic, self-direction, hope, empowerment, and individualized. Based on this definition of *strengths-based*, it has the potential to radically affect social workers' attitudes toward practice with consumers away from one of stigma and chronicity to one of respect and hope:

A shift in paradigms from a pathology orientation to a strengths and resilience focus allows for a different way of thinking about people. It provides a framework for helping that uncovers strengths and the power within people. It is more than "add strengths and stir" to existing pathology paradigms. Instead, a shift in paradigms allows for new and creative ways to work with people that honor their skills, competencies, and talents as opposed to their deficits. (Saleebey, 1996, p. 59)

The strengths-based nature of recovery is implicit in much of the literature as well. An article by Stromwall and Hurdle (2003) states that the focus on competence encompasses strengths and is aligned with social work values. More explicit sources discussed strengths assessments and interventions that deemphasized problems and capitalized on strengths,

the challenge of growing through adversity, and patterns of resilience (Zeman & Buila, 2006). Social work literature also discusses the future of such a paradigm, encouraging the inclusion of strengths-based practices that have been shown to have statistically significant differences such as increasing social support, lessening the severity of symptoms, and positive employment outcomes. This literature also promotes approaches involving community development and individual placement and support models of employment services, under the umbrella of strengths-based social work practice (Rapp, Saleebey, & Sullivan, 2005).

Further, the literature frequently refers to general practice and education guiding standards of the profession such as the NASW Code of Ethics and the CSWE EPAS (Buckles et al., 2008). For example, the 2008 EPAS states that social workers “recognize, support, and build on the strengths and resiliency of all human beings.” (CSWE, 2008, p. 8)

A review of social work syllabi found that educators discuss cognitive approaches to social work focusing on clients’ problem-solving abilities and building on strengths. Strengths-based was one of the most commonly cited components of the SAMHSA definition in the syllabi (91 mentions). Practice strategies and policy analyses focused on individuals and their strengths and goals. Of course, as with any profession, there is not complete adherence to the strengths-based perspective. And Rapp warns of the danger of simply adding a positive spin to a deficits perspective that may be problematic for even some social workers who claim to adhere to the strengths approach.

We, as professionals, can sometimes deceive ourselves by thinking that we are using a strengths assessment perspective when we actually are reframing problems positively and thereby operating from a problem (or deficit) assessment perspective. ...Treatment plans based on a person’s strengths lead in an entirely different direction, and a result of developing strengths is usually greater autonomy. (Saleebey, 1996, p. 59)

Rapp’s point that the strengths-based perspective when used appropriately will lead to greater self-direction relates again to the interconnectedness and necessity of all 10 components. The strengths-based perspective is a particular contribution that social work has brought to mental health services in general and to recovery-oriented practice specifically. There is broad acceptance of the strengths-based approach in the profession. As Rapp warns, many social workers have differing and incomplete understandings of the approach, which can be detrimental to recovery-oriented practice. Clearly defining *strengths-based* and, again, offering concrete examples and exercises for what this looks like in practice will be critical to infusing it correctly in social work.

In summary, aspects of the 10 recovery components are widely accepted by social workers, historically and currently. Components that are particularly well-accepted are strengths-based, self-direction, individualized and person-centered, empowerment, holistic, respect, and responsibility. Some of those areas are accepted in theory, but social workers have experienced trouble when trying to put them into practice—especially self-direction and strengths-based. Components with which social workers will need particular help are peer support, nonlinear (little data), and hope.

Other Important Aspects of the Recovery Movement

Underlying the 10 components of recovery are other principles that have guided the recovery movement. The President's New Freedom Commission on Mental Health (2003), the report which helped to galvanize the recovery movement, mentions the importance of the participation of consumers and of having cultural awareness and sensitivity throughout the recovery process. It also discusses the need to further research and address the role of trauma in mental health care, which is then mentioned in the definition of individualized and person-centered. Each of these topics—participation of consumers in social work education and practice, culturally competent mental health practice, and trauma-informed care—will be examined separately for depth of integration in social work education and practice.

Participation of Consumers in Social Work Education and Practice

Consumer involvement is promoted in countless avenues in the literature. For example, one source recommends educating consumers by providing information about services and treatment options to ensure that consumers have choices and make choices (Carpenter, 2002). Scheyett (2005) recommends integrating clinical (micro) and community (macro) social work to maximize collaborative and participatory action, especially in alleviating the stigma of mental illnesses. Collaborative needs assessments and decision-making processes, along with provision of information to consumers and their family members, advances empowerment and social inclusion (Farone, 2006).

Hardiman and Hodges (2008) report that social workers score significantly higher (compared to other helping professions) in saying they treat clients as full equals in service planning. Still, Farone (2006) illuminates social work intraprofessional struggles through the example of practitioners reconciling consumer choice and empowerment with strategies of deciding when a client "would benefit from being pushed beyond the 'iron curtain'" (Farone, 2006, p. 33) to further experience. The elderly community was said to suffer under paternalistic approaches that reinforce dependence and offered limited roles for clients in the design of their mental health treatment (Dallaire, 2009). Reported challenges to recovery orientation involved social workers'"rigid adherence to traditional therapeutic approaches and the power differential" therein (Buckles et al., 2008, p. 259).

Many sources proposed ways to increase consumer participation, including hiring consumers as case aids, case managers, or other staff and provision of technical assistance for consumer-run organizations (Hardiman, 2008). In the interviews mental health agency leadership saw treatment as a partnership between the individual and the mental health system. They discussed experiences that included respecting decisions of clients even when they disagreed.

One director of a county mental health system in California gave a specific example of including consumers throughout the practice process—including policy decisions. He said that in 2003, when there was a state financial crisis, the mental health system was expecting \$20 million in budget cuts. The system leadership approached consumers and community members and partnered with them to sit down and create a plan together for how and where the cuts would be made; they were then able to give a unified plan to the politicians. This

worked very well, and the politicians accepted the recommended course of action—the cuts ended up being mitigated by windfall funding from another source, but the model is still used by the agency in making many decisions now.

This California agency is a stand-out example of how to include consumers at every stage—in recruitment/intake (peer-run facilities for those not ready to enter treatment); as peer specialists; having a significant number of peer staff members; having an office of consumer affairs, consumer advisory committees, and contracts with consumer-run agencies (including a mentoring program to help get these agencies started); and making wellness centers available for “postgraduates” (those who have achieved some level of recovery).

Faculty interviewees, too, included consumers in their teaching practice through having consumers as guest speakers and as co-teachers. Social workers’ conference materials also showed some interest in privileging consumer stories in research instead of the practitioner viewpoint. Some social workers presented work concentrating on consumer attitudes toward mental health policy and institutional responses to their needs and on what students should know for practice. One conference attendee noted, “I’ve learned more from my data collecting of personal stories than from any of my mental health courses.”

Consumer interviewees urged incorporation of more of these teaching techniques, with further integration of personal stories and histories of the consumer movement and mental health care in America.

Mental health syllabi mention the use of speakers, videos, and group discussion, but do not note whether these involve consumer stories. Only one course on evidence-based practice featured consumer stories (Gene Deegan, among others) in the list of required readings, along with literature on stigma. However, as noted in focus group and general discussion sessions with educators, consumer guest speakers were not always mentioned in the syllabi. Some courses used downloadable readers instead of textbooks, making it harder to uncover specific readings in such references.

As discussed in the Peer Support section, this appears to be an area where social workers could use additional assistance—both with recommendations for ways to include consumers in social work education and in practice. There are stand-out examples in practice (e.g., the agency in California) and in education, but these do not appear to be the norm. Strategies in the curriculum to get buy-in from social workers could include highlighting aspects of social work practice that support consumer involvement. For example, the idea of self-determination (akin to self-direction) could be introduced as one powerful reason for engaging consumers throughout the process and making sure that the consumers have ownership over the process. Specific examples and activities could assist social workers and educators to promote consumer involvement. For example, one of the recommendations from the focus group of educators was for CSWE to develop an anthology of consumer stories—those focusing on the consumer experience and especially experience with social work practitioners.

Culturally Competent Practice

The third goal listed in the President's New Freedom Commission (2003, p. vi) report was "Disparities in mental health services are eliminated." The report further states that "Mental health care will be highly personal, respecting and responding to individual differences and backgrounds. ... Services will be tailored for culturally diverse populations and will provide access, enhanced quality, and positive outcomes of care" (President's New Freedom Commission, 2003, p. 10).

Concern for practicing effectively with diverse populations, respecting difference, and fighting discrimination have been important aspects of social work practice since its beginnings. In fact, some of the first social workers in the settlement house movement were primarily working with immigrant populations, focusing not just on individual concerns but also on larger policy issues, such as worker rights. The importance is evidenced in the NASW Code of Ethics (2008): "Social workers are sensitive to cultural and ethnic diversity and strive to end discrimination, oppression, poverty, and other forms of social injustice." The CSWE EPAS (2008) notes that

Social workers understand how diversity characterizes and shapes the human experience and is critical to the formation of identity. The dimensions of diversity are understood as the intersectionality of multiple factors including age, class, color, culture, disability, ethnicity, gender, gender identity and expression, immigration status, political ideology, race, religion, sex, and sexual orientation. ... Social workers ... recognize and communicate their understanding of the importance of difference in shaping life experiences; and view themselves as learners and engage those with whom they work as informants. (p. 5)

Social work literature states that the treatment of those contending with the stigma and discrimination of being diagnosed with mental illnesses must have a recovery orientation. Those effects are said to be compounded for people of color as well as lesbian, bisexual, gay, and transgender (LGBT) communities (Buckles et al., 2008). This is so when traditional approaches fail to reflect sensitivity to cultural nuances. This inflexibility can lead to underutilization of services because of cultural misunderstandings or because of a practitioner's lack of knowledge and failure to connect clients to resources within culturally relevant communities (Buckles et al., 2008). Buckles and colleagues (2008) linked cultural competency challenges to further interference with recovery orientation when viewing lack of advocacy and the wide variation of underutilization of public mental health services by racial and ethnic groups in the United States.

Interviewees also cite cultural barriers—in the form of misperceptions of a client's culture—as a challenge in recovery orientation. Focus group participants also mentioned expanding the diversity discussion beyond access to mental health treatment toward more focus on the quality of that treatment.

Dallaire and colleagues (2009) make clear that the 10 components of recovery apply equally to elderly persons with mental illnesses, in their attempt to alleviate the "general pessimistic attitude regarding prognosis," which is "seen as 'hopeless' by health care practitioners"

(Dallaire, 2009, p. 142). Elderly clients may be underreferred for psychological or psychiatric consultation and viewed as incompetent or vulnerable.

In interviews, when asked about the concept of recovery and its connection with diversity, many members of agency leadership and faculty interviewees thought the concept itself and its emphasis on choice addressed cultural competency challenges, stating that recovery cannot take place outside the context of a person's culture, sexual orientation, or spiritual beliefs. Interviewees acknowledged that different communities responded to mental illnesses in myriad ways.

Aligning with the literature, interviewees felt that education, for consumers and the public, works to alleviate the stigma of mental health diagnoses, and educators especially emphasized culturally competent practice. Other practices they felt promoted attention to culture included wellness management, narrative therapy, language interpreters on site or via phone, diverse staff, and incorporating the National Standards for Culturally and Linguistically Appropriate Services in Health Care. They also mentioned that needs assessments can include cultural and social diversity. Centers serving specific communities—for example, LGBT community centers or those serving Middle Eastern communities—were also mentioned as addressing diversity and recovery.

Observations of social work conference presentations revealed a concentration on the intersection of culture and mental illness (service use, processing of mental health diagnosis, stigma, etc.). Discussions emphasized attending to race/ethnicity, economic status, trauma history, and spirituality and customizing interventions in these contexts. A presentation on the experiences of Black women living with severe and persistent mental illnesses cited a sample of women speaking on recovery: "This is my life. It's not something I need to *recover* from."

When probed further, the presenter stated that though these women were informed about the consumer movement and the recovery paradigm, there was little buy-in on their parts. Further research will probe whether the recovery paradigm is viewed differently based on culture. Also along this thread, other social workers have noted that assessment measures for certain mental illnesses, such as dementia, may not be appropriate for various cultures or education levels.

Some syllabi objectives called for students to consider culturally competent practice and understanding and respecting "how race, ethnicity, gender, and sexual orientation influence the choice and application of cognitive theory to social work practice." Culturally competent practice was also explored regarding client interaction with delivery systems, assessment tools, treatment plan development, intervention, and evaluation of work in these communities. They included evidence-based practice perspectives and methods to evaluate the strengths and limitations of these methods from multiple perspectives (including a cultural perspective). In various classes the cultural element was not featured as an addition to the basics of practice but was integrated throughout courses and coupled with student self-reflection, for example:

Throughout this entire course, we will be examining content of historically oppressed populations including ethnicity, gender, age, sexual orientation, religion/spiritual beliefs, socioeconomic status, language, differing abilities, geography, and developmental stages. These topics are crucial to those working with clients. Each student should be prepared to examine her or his feelings/attitudes regarding the above material.

Practice courses and those evaluating policies and legislation provided context involving concepts of healing and well-being of various cultures and religions, international aspects of health and mental health, and theoretical and practical models for evaluating the role of the individual within personal and community systems. These courses emphasized perspectives of marginalized, disfranchised, and underserved populations within Latino/a, African American, Asian American, elderly, and LGBT communities, and those in the state of California referenced the Cal-SWEC "Mental Health Competencies for the Advanced/Specialization Year."

In summary, culturally competent practice is an explicit and long-standing concern of social workers. It is an area that needs constant attention by practitioners. As stated in EPAS, it is not about learning a list of characteristics about a culture, but rather is a mindset of the practitioner as learner and the consumer as teacher. In this way, there are, of course, areas for constant improvement, perhaps particularly with older adults. Practicing effectively with individuals from other cultures also demands respect. Social workers might excel in particular with culturally competent practice in the community organizing and policy level work that must happen to enact change systematically, because these areas are standard in training for social work. It will be critical to include content on culturally competent practice in the recovery curriculum development phase of the project.

The Role of Trauma and Trauma-Informed Care

It is generally believed that many people with severe mental illnesses have been subjected to chronic violence and abuse in their formative years (APA/CAPP Task Force, 2007; Jennings, 2004). As adults these individuals can face further victimization and violence, which can take the form of interpersonal abuse, gang violence, homelessness, or other situations. They are also at risk for experiencing poor physical health and engaging in health compromising behaviors (e.g., substance use/abuse, suicidality, self-harm), which can have negative consequences across the lifespan (National Center for Trauma-Informed Care, 2010; Saakvitne, Gamble, Pearlman, & Tabor Lev, 2000). A personal history of trauma is thought to be one of the significant barriers to engaging fully in mental health recovery (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002).

The President's New Freedom Commission on Mental Health (2003) identified trauma as one of the understudied areas in mental health research and treatment. Not fully appreciating the interconnection between trauma history and mental health issues, service systems and providers were engaged in administrative and treatment practices that further exposed the vulnerabilities of this population and retraumatized them (Onken et al. 2002). Methods such as seclusion, restraint, involuntary administration of medication, not executing psychiatric advance directives, and abusive conduct by some professionals further disempowered consumers, triggered adverse reactions, and may have discouraged them from seeking

further treatment (National Center for Trauma-Informed Care, 2010; Onken et al., 2002; Scheyett, Kim, Swanson, & Swartz, 2007). Onken and colleagues (2002) along with SAMHSA's National Center for Trauma-Informed Care (2010) support the contextual consideration of trauma in mental health care treatment and changing the underlying emphasis "from *What's wrong with you?* to *What's happened to you?*" (Onken et al., 2002, p. 74, italics in original).

Trauma-informed care is an approach to individuals experiencing mental health issues that recognizes and respects their interpersonal, community, historical, or other exposure to traumatic experiences. Service delivery systems that operate through a trauma-informed lens are designed to augment consumer empowerment and participation while minimizing the possibility of retraumatizing these survivors. The therapeutic approaches offered as treatment for the symptoms and disorders associated with physical or sexual abuse are known as trauma-specific services (Jennings, 2004). Some common features of trauma-specific intervention programs highlighted by the National Center for Trauma-Informed Care (2010) include the promotion of respect, knowledge, empowerment, hope, and partnerships to support recovery for consumers/survivors.

As part of a recovery-based education, social work practitioners and students need to learn to be vigilant when it comes to recognizing the presence and the meaning of trauma in the lives of the consumers/survivors they serve. Social work educators and field supervisors have a responsibility to prepare MSW students with the therapeutic knowledge and skills they need to approach posttraumatic stress disorder (PTSD) and other signs of trauma and model sensitivity, respectful consideration, and support for consumers. Accepting the right of consumers to self-direct their recovery pathway and develop partnerships with their providers is also a necessary component of trauma-informed recovery (Buckles et al., 2008).

The lack of comprehensive trauma knowledge and treatment practices among social workers was one theme that arose from the Alternatives Conference consumer discussion group. Several participants commented on their negative and retraumatizing experiences involving social workers and other professionals within the mental health system. Feeling disempowered and denigrated by providers was to hinder healing from a traumatic past and the move toward mental health recovery.

The biggest thing that was so frustrating was that, even though it was in the record that I had a traumatic brain injury, they had no understanding whatsoever of the effects of trauma. That was clear up to 2004. It was me educating them about what I needed. ... No matter what I said, they kept going back to those diagnoses and discounting everything I said. I would be so traumatized by the assessments that I could not hold on and the social workers did not know how to advocate for me. Today we have PTSD as our diagnosis, but still we do not have treatment that meets us there, so we stay stuck. We need our social workers to be advocates for continuity of care.
[Alternatives participant A]

I felt dismissed, patronized, demeaned and ignored in the system. Everything I was taught as a child in my trauma was reinforced in my journey through the system.
[Alternatives participant B]

It was noted during the discussion group that women's experiences with trauma and substance abuse were not fully appreciated by social workers, and that assessments conducted during initial interface with the system can be traumatizing. One participant explained that her "over-the-top response" to certain circumstances was pathologized by providers who did not understand it as an adaptive reaction; within the broader context of her traumatic childhood experiences, her reactions made sense. Several consumer participants linked systemic experiences such as these to conditioning in the medical model and disease-orientation that predominates the field of social work. Alignment with medical- and disease-focused perspectives creates a disconnection from providers fully understanding and embracing recovery concepts.

We do trainings on the 10 components of recovery and trauma-informed care to staff. Because they're immersed in the medical model, they pick up on things like self-direction and responsibility and safety but their meaning for those is something else than ours. So I see that, even though they're being educated, they're applying words that they don't fully understand to old practices and they're getting the same result in the end. I think that's one of the big problems we're not looking at more closely. [Alternatives participant A]

One of the mental health agency leaders interviewed for this project (also identifying herself as an MSW and consumer) mentioned that she has developed training curriculum for her recovery-oriented centers on multimodal recovery from the effects of trauma. A member of the Fordham University faculty shared that a colleague at the university was recently awarded a grant focusing on trauma-focused evidence-based practices with children. The study involves training staff members at field sites and field instructors and placing social work students in those agencies. Two universities (Boston University and the University of Denver) offer trauma certificates through their schools of social work. Although the Boston University Trauma Practice Certificate content mentions recovery-based values (e.g., client empowerment, self-determination), it was not interpreted by the interviewee as a recovery-infused certificate. This information about trauma certificates was volunteered and was not an inclusive examination across all programs; therefore, other social work schools may be offering similar opportunities. Other than the few instances cited, the need for trauma-informed practices was not discussed by agency leaders, faculty leaders, faculty members, or field instructors. However, it should be noted that none of the protocol questions presented to interviewees specifically addressed this topic.

Of the various mental health syllabi collected from 35 schools of social work, 16 schools had syllabi featuring or mentioning trauma. The research team did not specifically request trauma-informed syllabi, and many of the CSWE accredited programs did not participate in the curricula collection efforts; therefore, the social work schools listed below are not a representative sample across all programs. Although many of the courses mentioned concepts and terms consistent with recovery practice (e.g. strength based, resilience, evidence-based practice), not all of them explicitly introduced the recovery philosophy within their curricula. Syllabi from the social work schools that clearly expressed a recovery orientation or introduced recovery principles and mentioned trauma content included

- University at Buffalo, State University of New York (SUNY)
- Binghamton University, State University of New York (SUNY)
- Greater Rochester Collaborative MSW Program (NY)
- Yeshiva University (NY)
- University of Maryland
- University of Hawai'i
- University of Southern California
- California State University–East Bay
- San José State University (CA)
- Case Western Reserve University (OH)
- University of Washington
- University of North Carolina at Chapel Hill

The course descriptions and 11 outlined objectives for the “Evidence-Based Mental Health Practice” courses offered by the University of Buffalo, Binghamton University, and Yeshiva University (2009) feature the same template. At the conclusion of the course, one of those shared objectives is that students will be able to “describe unique components of assessment and treatment planning that are relevant for each evidence-based practice, client trauma history, and co-existing substance abuse problems for people with serious mental illness” (Dulmus, 2010, p. 2).

The “Evidence-Based Mental Health Practice” course at the University at Buffalo uses an online format and includes an impressive array of guest speakers (e.g., provider agency and consumer-run leadership, researchers, the NYS Commissioner for Mental Health) and outlines different aspects of evidence-based practices for serious mental illnesses each week. Trauma is one of three topics covered in the last session (Dulmus, 2010).

The University at Buffalo also offers a “Mental Health and Disability in Social Work” course that uses a “trauma-informed, human rights” lens to consider mental health policy issues and their impact on social work practice (Keefe, 2010, p.1). Students critically examine evidence-based practices and trauma-informed care as part of this course. One of the assignments is to examine the service record of a particular client at his or her field placement site to evaluate the effectiveness of the interventions, consider whether the services were offered in a sensitive and enlightened way with regard to the client’s trauma, and possible policy implications. Another assignment is to develop a multiunit skills series for application with a client or group that is consistent with trauma-informed principles and evidence-based practices (Keefe, 2010).

The Greater Rochester Collaborative, another SUNY MSW program, offers the “Diagnostic Process: A Strengths-Based Social Work Perspective” course for foundation year students. The course introduces DSM IV-TR alongside strength-based perspectives. In addition to the DSM IV-TR and other texts, students are required to read three first-person accounts written by consumers: *An Unquiet Mind: A Memoir of Moods and Madness* (Jamison, 1997), *Scattershot:*

My Bipolar Family (Lovelace, 2008), and *The Center Cannot Hold: My Journey Through Madness* (Saks, 2007). The recovery model is discussed early in the course, and PTSD is covered during one session. The course assignments that demonstrate a recovery orientation include writing a summary of one of the three consumer accounts and answering questions on the concepts of mental health recovery infused in that literature; exploring a certain diagnosis and planning how the student would explain the affects to the person and family; and how the student would incorporate mental health recovery into an intervention plan for diagnosed individuals (Russell, Meath, Russell, & Auberger, 2010).

At the University of Maryland the “Clinical Social Work in Relation to Chronic Mental Illness” course covers evidence-based practices and recovery components. Trauma, dually diagnosed substance abuse disorders, and cultural and gender competent approaches are also covered within this curriculum. Students are required to get involved in a National Alliance for Mental Illness (NAMI) event. The instructor also provides an extensive list of memoirs, narratives, and a few fictional accounts of mental illnesses, many of which offer first-person perspectives shared by consumers and family members. Students are required to complete an assignment on a selected consumer publication addressing contextual elements (e.g., culture, historical, race, class), stigma, the influence of family and social relationships, and impressions about the treatment experiences recounted by the author. The second major assignment requires students to complete a case study; they are to identify and discuss an evidence-based treatment practice that fits well with the presenting mental health disorder and to take into account cultural, racial, ethnic, and gender differences between the consumer and themselves and consider how that might influence the approach to care (Gioia, 2009).

The “Systems of Recovery from Mental Illness” course offered by the University of Southern California is also recovery-based. The central assignment in this class is to create a client centered strengths-based plan for recovery. Within that plan, trauma and significant losses experienced by the consumer must be addressed. In the conclusion of this plan the student must discuss recovery elements (e.g., hope, empowerment, self-responsibility, achieving meaningful roles). The topic of trauma is also covered in one of the class sessions. During the semester this class takes a field trip to the Village of Long Beach, which is a recovery-oriented service provider (Mayeda, 2010).

Of the three social work schools from which specific trauma related syllabi were collected, the terms *evidence-based practice* and/or *strengths-based* were mentioned by most schools, but a recovery aligned practice perspective was not specifically emphasized in any of these courses. The University of Denver offers a course titled “Trauma and Recovery in Social Work Practice” that is the introductory course to their trauma certificate program. Although several concepts such as strength, resilience, and empowerment are mentioned in the syllabus, a recovery-orientation is not apparent (Bussey, 2009). “Treatment of Trauma” at the University of Minnesota takes an ecological approach to trauma and takes into account the diversity among trauma survivors but does not use any language to indicate a recovery slant. One of the guest speakers for that course included a medical director from the PTSD team at a VA Medical Center (Shannon, 2010). In “Social Work Responses to Trauma: Intersections of Policy, Community, and Clinical Practice,” a course offered by The Catholic University (2010), trauma, empowerment, and strengths-based theories are presented to students and a social justice framework is used.

Six state departments of mental health (California, Indiana, Kansas, Ohio, New York, and Pennsylvania) were reviewed for the presence of a recovery foundation and trauma-infused approaches and training. Although all of the states featured recovery-oriented philosophies, New York and Pennsylvania featured the most content on recovery and trauma-informed care.

A report prepared for the New York State Office of Mental Health (New York OMH) by the Recipient Advisory Committee, a body that included current/former consumers and advocates, recommended that mental health practitioners abide by consumers' Advance Directives and WRAP instructions, eliminate forced treatment, and discontinue restraint and seclusion practices to prevent further retraumatization experienced by consumers (New York OMH, 2004). Both New York OMH and Pennsylvania's Office of Mental Health and Substance Abuse Services (Pennsylvania OMHSAS) reported on their efforts to curb seclusion and restraint practices at mental health centers and hospitals they monitor (New York OMH, 2010a; Pennsylvania OMHSAS, 2010a; Smith et al., 2005). In 2009 Pennsylvania was lauded as a national leader in the reduction of seclusion and restraint practices (NAMI, 2009). The inpatient State Hospital Network in Pennsylvania uses a treatment team approach and touts their diminished use of seclusion and restraint statewide, equating restraint use with "treatment failure" (Pennsylvania OMHSAS, 2010a).

A focus on trauma-informed care influenced the New York OMH to promote guidelines for "comfort rooms," specified environments within an inpatient setting where children or adults are encouraged to self-regulate and alleviate stress. These skills are then promoted as de-escalation practices that can be used by the individual after hospitalization (New York OMH, 2009). Offering the use of these calming spaces is an alternative approach to relying on restraint (i.e., physical, medication) or seclusion methods (New York OMH, 2010a).

Some recent trauma-informed training opportunities include a SAMHSA effort to provide training to 200 New York professionals and paraprofessionals in 2009. The 15-module Trauma, Addictions, Mental Health and Recovery model was used as the foundation for the training (New York OMH, 2010a). In March 2010 New York OMH sponsored a training event, Positive Alternatives to Restraint and Seclusion. For excellence in reducing restraint and seclusion, monetary awards were given to 11 organizations. These incentive funds were made possible through a SAMHSA award to New York OMH (2010).

Pennsylvania's OMHSAS offers a co-occurring disorders Web resource featuring literature, tools, training resources, and certification information for professionals (<http://pa-co-occurring.org>). One trauma-specific continuing education opportunity highlighted by Pennsylvania OMHSAS and offered through Drexel University as part of a co-occurring mental and substance use disorders training series is titled "Co-Occurring Disorders: Trauma-Informed Treatment." This course and others in the sequence are offered to mental health professionals working in licensed and credentialed programs funded by Pennsylvania OMHSAS or the Department of Health/Bureau of Drug and Alcohol Programs, and whose programs are preparing for licensure as an integrated treatment program or are seeking to be certified as co-occurring competent. Anyone seeking certification as a co-occurring disorders professional or as a certified co-occurring disorders professional diplomate in Pennsylvania can also participate in this training series. The trauma-specific course mentioned above

examines the effect of trauma across various life stages and gender differences in how men and women experience complex trauma and dual disorders. Course objectives include having students be able to

describe the CSM-IV-TR diagnosis of PTSD and its implications for treatment; differentiate complex traumatic stress disorder from PTSD; define trauma-informed treatment; cite examples of the impact of trauma on treatment outcomes of persons with CODs [co-occurring disorders]; examine different evidence-based and promising practices for persons with CODs and traumatic histories. (Drexel University, 2010, p. 3)

A number of excellent trauma-related initiatives are taking place at the state level with training opportunities and in schools of social work with trauma-informed practice courses, certificates, and research. With almost half of the schools submitting recovery-oriented syllabi explicitly including content on trauma, it appears that social work educators have recognized the importance of the topic to recovery. Although some additional work may need to be done, a wealth of resources is available already for integrating trauma-informed practice.

Infusion of Recovery in the Mental Health System

In April 2010 members of the RTP Steering Committee encouraged CSWE researchers to focus on six states they felt were exemplars for recovery transition and integration. These six states were California, Indiana, Kansas, New York, Ohio, and Pennsylvania. A profile was developed for each state using information (e.g., publications and reports, departmental mission/vision statements, policy planning and implementation documents) found on their respective Department of Mental Health websites, which was viewed as evidence of their recovery foundation. The information gathered was reviewed for the presence of the 10 Recovery Principles articulated by SAMHSA, examples of state engagement in and encouragement of recovery-based practices, relevancy to social work education and practice, perceived challenges to recovery implementation, and recovery-oriented training opportunities, conferences, and licensure among other indicators.

Although commitment at the leadership level and some progress toward integration was evident across all six states, it was determined that California and New York were the states most comprehensively and successfully engaged in recovery infusion efforts. Both experienced recent funding and legislative successes that contributed to the drive, vitality, and depth of their recovery efforts. Some of the key factors and events supporting their achievements are outlined below.

California

The President's New Freedom Commission on Mental Health (2003) provided national recognition to a California-based program being implemented across 38 counties. This successful model, the inception of which was supported by Assembly Bill 34 (Mental Health Services Act [MHSA], 2009), offered integrated services to adults experiencing homelessness and serious mental illnesses. It demonstrated "that services provided through programs

that allow flexibility in financing care do, indeed, produce positive outcomes that benefit individuals, families, and society while most efficiently using resources” (President’s New Freedom Commission on Mental Health, 2003, p. 44).

The passage of the transformational Mental Health Services Act (MHSA) in 2005 and its subsequent reaffirmation in May 2009 was largely responsible for creating a funding stream dedicated to recovery related growth in the state (MHSA, 2009; Mental Health Services Oversight and Accountability Commission, 2010). Following the passage of the MHSA, California’s Department of Mental Health (California DMH) promoted mental health workforce enhancement through supporting comprehensive training and technical assistance opportunities (California DMH, 2006) at statewide and local levels. For example, an interagency agreement between California DMH and the University of California resulted in the creation of the statewide Mental Health Social Work Stipend Program, which is executed by CalSWEC at the University of California, Berkeley School of Social Welfare. A focus on professional, culturally competent, and recovery-centered development for social work graduate students at 17 participating schools is supported through MHSA stipends, standardized curriculum competencies, training opportunities, and the appointment of onsite personnel to coordinate and provide ongoing implementation support at the universities (CalSWEC, 2009). In addition, each county mental health department has produced a workforce, education, and training plan for local in-service training, building career pathways, expanding internships and fellowships, and using financial incentives to encourage career development. Many counties have opted to provide scholarships and stipends for employees, consumers, and family members to study for careers in clinical social work.

New York

New York State’s OMH has also made significant strides toward instilling recovery and is firmly invested in financing recovery-based enterprises. The fundraising acumen of New York OMH is exhibited by recently acquired federal and private grants (e.g., U.S. Health and Human Services Medicaid Infrastructure Grant for “New York Makes Work Pay;” SAMHSA State Incentive Grant to Build Capacity for Alternatives to Restraint and Seclusion, SAMHSA Transformation Transfer Initiative Grant for Recovery Center development, Bristol-Myers Squibb Foundation grant for researching and piloting ACT Step-Down Approaches; New York OMH, 2008, 2010a, 2010b). Dedicated funding allocated by New York legislators enabled New York OMH to launch and support two Centers of Excellence for Cultural Competence (OMH, 2010a). The Center of Excellence housed at the Nathan Klein Institute for Psychiatric Research also secured NIMH funds to develop a Center to Study Recovery in Social Contexts, which in turn informs New York OMH’s strategies (New York OMH, 2007). In partnership with the New York State Office of Alcoholism and Substance Abuse Services New York OMH supports the Center for Innovative Practices, which promotes the evidence-based practices of Wellness Self-Management, ACT, Individual Placement and Support, and Integrated Care for Dual Diagnoses (New York OMH, 2010a).

Another notable feature of New York OMH’s approach that has not been observed in any other state reviewed is the use of technology to provide public Web-based access to a variety of recovery-oriented statistics and outcome progress reports. New York OMH provides publically available data on mental health demographics, trends, and services using charts

and graphs. The Balanced Scorecard tracks recovery-oriented mental health consumer outcomes and New York OMH performance outcomes. Other data available on the website include Adult Housing, ACT Reports, Assisted Outpatient Treatment Reports; Children Teens and Family Indicators Portal; Clinic Plus Services Statistics, County Profiles Portal; Patient Characteristics Survey Portal (New York OMH, 2010a).

Finally, although New York's comparative impact in the legislative realm has not been as seismic as California's transformative MHSA, some of their recovery-friendly advances include state dictated expansion of Medicaid eligibility and the Mental Health Parity and Addiction Equity Act of 2008. The latter legislation requires employer-sponsored health plans for companies over a certain size to provide coverage for mental health and substance abuse conditions on par with other health problems and addresses better coordinated primary care and specialty mental health care, promotion of preventive services, workforce development initiatives, and other recommendations to improve service quality (OMH, 2010a). New York's Mental Health Parity legislation was lauded in a recent NAMI State Report Card as an innovative policy supporting consumer recovery (NAMI, 2009). The state's most recent recovery-oriented program targets incorporation with licensing procedures. Currently, more than 50 programs are licensed to provide Personalized Recovery Oriented Services across the state. Through a decrease in funding for Continuing Day Treatment, New York encourages more counties and organizations to consider Personalized Recovery Oriented Services licensing.

Other State Review Findings

Department of mental health mission and vision statements, department documents mentioning recovery policy and implementation plans, and state training materials were reviewed for the presence of the 10 SAMHSA Recovery Components. All 10 components were mentioned by two-thirds of the states reviewed ($n=4$). One-third of the states reviewed ($n=2$, California and Kansas) mentioned only nine of the 10 components; *nonlinear* was the missing concept. *Hope* was cited by all states and appears to have been an especially salient concept in three states; it was heavily mentioned in the literature reviewed for New York, Ohio, and Pennsylvania.

Federal Funding and State Department of Mental Health Buy-in

The importance of federal financial support in addition to funds dedicated by states to support their recovery efforts cannot be overemphasized. Four states (Indiana, Kansas, New York, and Ohio) have recently been awarded SAMHSA grants that fund various recovery-based projects (Indiana Division of Mental Health and Addiction [DMHA], 2010; Kansas Governor's Mental Health Services Planning Council [GMHSPC], 2010a; New York OMH, 2010a, 2010b; Ohio Department of Mental Health [ODMH], 2010a, 2010b). It was unclear whether California has also received federal funding or is relying on MHSA state-based funding.

All six of the state departments of mental health explicitly mention recovery in their mission statements, vision statements, and/or strategic planning documents (DMH, 2005; DMHA, n.d.; Kansas Department of Social and Rehabilitation Services [SRS], 2010a; ODMH, n.d.a.; New York OMH, 2010a; Pennsylvania OMHSAS, 2005). They seem to be unanimously committed

to advancing the recovery philosophy and they feature a variety of recovery-focused conferences and training opportunities, most of which are sponsored or supported in part by their respective departments of mental health.

Some recent examples of conferences and training opportunities featuring recovery content include

- 18th Annual Forensic Mental Health Conference, Patton State Hospital (California, 2010)
- Training in Culturally Competent, Recovery/Resiliency-Oriented Assessments and Service Plans (California, DMH, 2006)
- Shifting to the Recovery Culture: Program/Line Staff Level Trainings and Cooperative Team Building (California, DMH, 2006)
- Recovery: Moving from Concept to Practice Conference (Indiana, DMHA, 2009)
- Psychiatric Medications in the Recovery Process: What a Case Manager Should Know—online training (University of Kansas School of Social Welfare, 2010)
- Families in Recovery: Skills in Working with Families of People With Severe Mental Illness (University of Kansas, School of Social Welfare, 2010)
- Mental Health Recovery: Practices, Services, and Research (New York University, Silver School of Social Work, 2010)
- Focus on Integrated Treatment—online training (New York, Center for Practice Innovations, 2010)
- Wellness Management and Recovery (Ohio Coordinating Center of Excellence, n.d.)
- Co-Occurring Disorders: Trauma-Informed Treatment (Pennsylvania, Drexel University, 2010)
- Co-Occurring Disorders: Recovery-Oriented Clinical Interventions (Pennsylvania, Drexel University, 2010)

Some select recovery-based recommendations that state departments of mental health have made and/or programs they promote/support include

- Supported housing (California, Indiana, Kansas, New York, and Pennsylvania)
- Supported employment (California, Kansas, New York, Ohio, and Pennsylvania)
- Cultural competency (California, New York, Ohio, and Pennsylvania)
- WRAP (California, Indiana, Kansas, and Pennsylvania)
- Wellness Management and Recovery (New York, Indiana, and Ohio)
- Media/social marketing campaigns (Indiana and Kansas)
- State-wide referral/resource hotline run operated by consumers and family members (Ohio)
- Certified Recovery Specialists or similar peer-support training (Indiana, Kansas, Ohio, and Pennsylvania)
- Coordinated Centers of Excellence (CCOEs) and Centers of Excellence (COEs), which research and promote evidence-based practices (New York, Ohio, and Pennsylvania)

- ACT Center (Indiana)
- School of Social Work Office of Mental Health Research and Training (Kansas)
- Fidelity to evidence-based practices tied to state funding support (Kansas)
- Compliance with evaluations on the impact of services and supports on consumer and family outcomes is tied to operating certificates for state-licensed clinics (New York)
- Integrated dual disorder treatment support (Kansas, New York, and Ohio) and training and professional certification in co-occurring disorders (Pennsylvania)
- ACT (Indiana, New York, Ohio, and Pennsylvania)

Early Engagement in Recovery Practices

Many of the states claim that they were involved in recovery activities prior to the release of the President's New Freedom Commission on Mental Health Final Report (2003). Although many of the departments of mental health had not fully articulated a recovery stance at that point, early engagement in practices may have provided these states with a competitive advantage as the federal position on recovery and federal funding opportunities were taking shape. According to the documents reviewed, Ohio appeared to be the first state engaged in recovery activities in the middle to late 1990s (Beale & Lambric, 1995). As for the rest of the states reviewed, engagement in recovery activities was first mentioned by California in 1999 (MHSA, 2009), Indiana in the early 2000s (Indiana DMHA, 2007), Kansas prior to 2003 (Kansas SRS, 2006), New York between 2002–2004 (New York OMH, 2004), and Pennsylvania around 2003 (Pennsylvania OMHSAS, 2005).

Four of the states reviewed (California, Kansas, New York, and Pennsylvania) specifically cited the New Freedom Commission Report as an influence on their strategic direction (DMH, 2005; GMHSPC, 2010a; OMH, 2010b; OMHSAS, 2005). Whether their articulation of a recovery-orientation came before or after the release of the federal report, all six states appear to have embraced recovery relatively early on, and that may have positively influenced their ability to take next steps toward infusing recovery into their departments of mental health.

Consumer Stakeholder Presence and Involvement

All of the departments of mental health reviewed involve consumer and family member stakeholders as representatives on various policy advisory boards and/or working groups. Additionally, all six states demonstrated examples of engagement in peer support and supporting consumer and family member employment. Four states (California, Indiana, Kansas, and Ohio) mentioned that they provide mental health funds to support consumer-run organizations or offer grant funding opportunities to these groups (DMH, 2006; Mental Health Services Oversight and Accountability Commission, 2010; CA DMHA, 2007; SRS, 2010a.; ODMH, n.d.b). Indiana, Kansas, Ohio, and Pennsylvania were commended by NAMI (2009) for their efforts to promote consumer and family involvement (e.g., policy development, service design/delivery) or for offering opportunities for consumers and family members to give service satisfaction input.

Some examples of peer support engagement include

- California's and New York's emphases on providing mental health agencies with tools

to support consumer employment (DMH, 2006; Cornell University Employment and Disability Institute, 2009);

- Ohio's use of consumer and family member employees to facilitate their Toll-Free Bridge phone line, which offers mental health resources and referral and ODMH customer support (ODMH, n.d.d);
- Indiana's certified recovery specialist training (ICRSP, 2010);
- Kansas' Intentional Peer Support Training (2010); and
- New York's forensic/peer specialist 6-month training, internship, and job placement program (not an OMH initiative, but sponsored by Community Access; OMH, 2010a).

CCOEs and COEs

Three of the states reviewed support CCOEs or COEs (Coordinated Centers of Excellence and Centers of Excellence) that contribute to research on evidence-based practices, investigate promising best practices, and provide technical assistance to advance the use of established evidence-based practices. New York, Ohio, and Pennsylvania feature CCOE/COEs and were among the states recently commended by NAMI for their progress on evidence-based practices (NAMI, 2009). The activities of the CCOE/COEs provide robust examples of how research and technology can be optimally utilized to advance recovery-based practice.

New York has established two COEs for cultural competence (OMH, 2010a); one of these centers manages an NIMH grant-funded Center to Study Recovery in Social Contexts (OMH, 2007). Additionally, New York has developed a Center for Practice Innovation, which advances Wellness Self-Management, an ACT Institute, Individual Placement and Support, and Integrated Care for Dual Diagnoses (OMH, 2010a). Ohio sponsors seven CCOEs: centers established to further supported employment, Wellness Management and Recovery, and Integrated Dual Disorder Treatment, as well as a Center for Innovative Practices, Mental Illness and Developmental Disabilities, Criminal Justice, and a Cluster-Based Planning Alliance (ODMH, n.d.c). Pennsylvania funds one mental health and justice COE (Pennsylvania Mental Health & Justice Center of Excellence, n.d.), which is charged with identifying intervention points to prevent persons with mental illnesses from entering or falling deeper into the criminal justice system. The charge is executed through cross-systems mapping services and training for those who come into contact with persons with mental illnesses through the criminal justice system (Pennsylvania Mental Health & Justice Center of Excellence, n.d.). Philadelphia, PA, also has instituted a crisis intervention team model, making certification in mental health and public safety available to its police department (Philadelphia Police Department, 2009).

NAMI Grading the States Findings

In 2009 NAMI surveyed states on their progress in four main areas: (1) health promotion and measurement; (2) financing and core treatment/recovery services; (3) consumer and family empowerment; and (4) community integration and social inclusion. NAMI highlighted specific innovations and challenges to progress in each state in addition to bestowing rankings. With a grade of "B," New York was awarded the highest overall rating of the six states reviewed. California, Ohio, and Pennsylvania received overall grades of "C." Kansas and Indiana were given "D" ratings (NAMI, 2009).

Among the states surveyed in the current analysis Indiana, New York, Ohio, and Pennsylvania were commended by NAMI for their progress on evidence-based practices; three of these four states also host CCOE/COEs (NAMI, 2009). Additional praises from this organization on innovative state practices supporting mental health recovery are infused throughout this report.

Some of the critical issues among these states raised by the NAMI report focused on funding, housing, acute and inpatient services, crisis intervention, and criminal justice. Funding barriers were noted for California and Ohio; it was recommended that California needed to make the funding distribution to its counties more efficient, and Ohio was encouraged to reinstate support and surpass its current funding levels. Housing shortfalls were noted in New York, and supported housing problems were observed in Kansas. Five of the six states (California, Kansas, New York, Ohio, and Pennsylvania) had shortcomings in acute and inpatient care service options according to NAMI. Indiana was commended for the increase in crisis intervention team programs, but New York and Pennsylvania were asked to expand on these types of programs. Ohio was considered to be a national leader in alternatives to incarceration and community reentry for individuals with mental illnesses, but California, Indiana, Kansas, and Pennsylvania were found to be lacking in these areas (NAMI, 2009).

Common Challenges to Recovery Systems

In addition to some of the urgent needs identified by NAMI, the documentation reviewed for each state revealed some of the pressing issues being recognized by the departments of mental health. Particularly, funding challenges in the wake of the recession was a widespread concern. All six of the states reviewed were apprehensive that budget cutbacks in mental health funding prompted by the economic downturn would undermine financing for legislative initiatives and recovery projects and would hamper future progress; the effects of their budgetary constraints were already being documented by some states (Mental Health Services Oversight and Accountability Commission, 2010; DMHA, 2009b; GMHSPC, 2010b, 2010c; New York OMH, 2010a; ODMH, 2010a; Pennsylvania OMHSAS, 2010b). In some cases states are considering federal and other funding options to support mental health initiatives, have further prioritized and readjusted their expenditures, engaged in restructuring services, and scaled back on the goals they could reasonably achieve.

Mental health workforce recruitment, retention, diversity, education, and training were other key issues identified by the states assessed. Indiana, Kansas, Ohio, and Pennsylvania expressed concern about workforce issues and have engaged in strategic planning efforts for improvement (DMHA, 2010b; GMHSPC, 2010b; ODMH, 2010c; Pennsylvania OMHSAS, 2005). One specific concern raised by the Indiana Transformation Work Group (DMHA, 2010b), and a theme shared across some RTP Steering Committee interviews, was that much of social work and other mental health practitioners' subspecialty experience is guided under supervision, and that the skills of these supervisors may not always align with current best practices. As previously mentioned in this report, both California and New York have been successful in passing legislation addressing mental health workforce development and their respective departments of mental health support professional training and technical efforts for the benefit of the workforce.

Indiana and Kansas are especially concerned with recruitment and retention of qualified

mental health professionals for their rural areas (DMHA, 2010b; GMHSPC, 2010b). Another unique concern for rural/frontier communities is that many evidence-based practices are established on findings from urban-based programs and may not necessarily be a universal fit in all locations (Kansas SRS, 2009). Kansas may be an emerging model state for identifying and overcoming barriers to evidence-based practice development for these special populations as they are in the process of implementing pilots in rural areas.

Aside from financial and workforce issues some additional struggles facing mental health providers, including social workers, were identified. These challenges could present barriers to recovery transformation. Challenges include the following:

- Budgetary constraints and cutbacks, especially since the recession
- Quality of mental health workforce recruitment, retention, diversity, education, and training
- Adherence to a medical model orientation (DMHA, 2010b; Pennsylvania OMHSAS, 2005)
- Lack of continuity between and across the system and “silos” that characterize traditional service structures (DMHA, 2010b, p. 25; Cornell University Employment and Disability Institute, 2009, p. 10)
- Traditional service systems are not grounded in recovery/best practices/evidence-based practice (Achara, 2009)
- In some cases service providers are not comfortable partnering with peer recovery personnel and consumers (Achara, 2009)
- Provider trepidation; that is, whether “recovery approaches devalues the role of professional intervention”; whether “recovery oriented care increase[s] provider exposure to risk and liability”; and “how will we pay for implementing recovery oriented care and supports?” (Achara, 2009, slide 49)
- Certain obstacles face consumers from a cultural perspective: past experience leading to system distrust; stigma/discrimination for mental illnesses; ongoing racial/ethnic/cultural discrimination; personal and institutional discrimination; differing definitions about wellness and mental illnesses (OMH, 2010a).

Findings From Interviews, APM General Discussion, and Alternatives Conference Discussion

Of the more than 20 individual interviews facilitated by the CSWE research team, 10 were conducted with professionals working in states specifically targeted throughout this analysis. Four interviewees were from California, four were from New York, one was from Kansas, and one was from Ohio. The general discussion included seven participants, five of whom were faculty or agency leaders from states specifically targeted throughout this analysis (California, Kansas, and Ohio).

These interviews and discussions conducted with academics (i.e., administrators, faculty, and field instructors) and agency leaders were reviewed for any feedback on the recovery impact of their respective state departments of mental health. Although their comments are not intended to be representative of all social workers in their particular regions, their level

of expertise in the field and opinions provide valuable anecdotal evidence as to whether the recovery intentions at the state policy level are permeating education and practice.

Three of the interviewees from California were leaders or faculty at universities involved with the MHSA Mental Health Social Work Stipend Program run by CalSWEC; two were also coordinators for the CalSWEC mental health training program. All of these interviewees spoke to the importance of MHSA funding and the stipend on recovery training and curriculum development efforts. One interviewee said that she was “lucky to be in California” and “wouldn’t have been this knowledgeable if [the MHSA] hadn’t been sponsored.” At the same time, the academic participants believed that the concept of mental health recovery could not be considered as “infused” throughout their social work departments. The effort was more likely to be described as “a little bit fragmented” or as a work-in-progress with some faculty committed and others without knowledge of recovery or reluctant to endorse the philosophy and practices.

Although students are being exposed to a recovery curriculum at a California university, one interviewee explained that recovery is not the primary model students are exposed to in their department of mental health internships. She spoke about the time and organizational effort it takes to complete paradigm shifts in the mental health setting. The interviewee at another California university also faces the ongoing challenge of “recruiting internships that embody recovery values”; she believes that there are not enough mental health internships for students available at agencies in which a recovery-orientation is a central tenet. In the interviews with field directors representing New York and Ohio institutions, with one of those universities being located in an urban hub and the other a more rural setting, it was articulated that the competition for field placements that embraced the social work values of their department, matched the interests and skills of their students, and gave them practice experience that solidified core competencies were viewed as more critical goals than whether an agency they worked with was embracing a recovery-oriented framework.

The fourth interviewee from California was an administrator representing a public mental health agency. He spoke about the vision statement for the California DMH, how that model has influenced partnerships with client-run agencies, and the infusion of peer employees in his agency. His department offered opportunities for social work faculty members to observe an organization in a week-long immersion “so that they could see what the recovery concepts look like in practice” and share this experience with students in the classroom. His remarks that he felt recovery was “adopted in some of the [social work] programs more than others” concurred with the faculty members’ assessment that infusion was not complete.

When defining the concept of recovery, the administrator remarked that “For us the concept of recovery is a little ambiguous, but it is a creative ambiguity (medical, social, or 12 steps) ... the meaning is still in development.” He explained that the meaning of recovery is “not antithetical to the medical model.”

All four of the New York interviewees were involved with schools of social work, either as faculty leaders, professors, or field directors. Several commented on New York State’s efforts toward a recovery framework. New York University had formed collaborative partnerships

with New York OMH, the New York City Department of Health and Mental Hygiene, and the Center to Study Recovery in Social Contexts at the Nathan Klein Institute. Fordham University and New York University interviewees described a project sponsored by OMH that, through an agreement with certain deans, involves their schools of social work. Participating social work programs introduce students to an elective course and colloquia on evidence-based treatment models (i.e., ACT, Wellness Self-Management, integrated dual-disorders treatment, family psycho-education, and supported employment) that prepare students for mental health field placements.

New York interviewees from multiple schools suggested that although some progress had been made, recovery had not been fully adopted by all faculty members yet. One interviewee spoke about the tension social workers face between asserting professional prestige and engaging in recovery practices and client-directed care.

According to the California-based faculty and several New York interviewees, it appears that the medical model still represents a very powerful philosophy across social work fields of practice. One interviewee described the conflict between the medical model and recovery and declared that you “can’t teach [a] medical model framework then tag on recovery. It’s inconsistent.”

Another New York University interviewee explained it in the following manner:

Surprisingly enough with all our talk about empowerment and . . . client-centered services, social work is still a fairly conservative profession especially in terms of preparing clinicians and offering clinical services. So I think we have a lot of weight in the profession toward the medical model, just like medicine, nursing, some of the other fields as well. I think we’re still working to rise above that.

The field director interviewee from two schools in Ohio spoke about the efforts of her state’s department of mental health over the last decade to endorse the recovery concept. As a result of being awarded a training grant, she and a colleague developed and taught a course on community-based practices, evidence-based practices, and recovery. In total the course has been running for 6 years; recovery was included in the syllabus for the first 4 years but has not been part of the course most recently. She explained that it was not a deliberate idea to remove recovery but was a decision based on student interest and evaluations, limited course time, and a perceived duplication of content (i.e., recovery is similar to strength-based content).

She and her co-instructor found that the “recovery model is hard to implement.” She explained that the way it was taught at the state level included theory and general principles but not many concrete suggestions on how to teach it or implement it in practice. One central question she had that was never addressed by the training she received was “is recovery an overarching philosophy or a practice model? . . . This needs to be clarified for professors and students.” She did not find the topic of recovery to lend itself well to a “practice lab” for students, unlike other topics covered such as motivational interviewing or cognitive behavioral therapy.

She believes that the state could do a better job promoting the recovery model in various agencies but also acknowledges that the ODMH does not have control over every entity with which social workers engage (e.g., child welfare, health care, corrections). She believes that in Ohio “recovery practice is strong in the community mental health centers and state psychiatric hospitals.”

A general discussion participant from a school in Ohio concurs that the concept of recovery is present in her state but adds “not to say that there’s the corresponding culture of recovery in the traditional service agencies.” She is currently partnered with a consumer-run organization and a social work graduate student/consumer in a research project investigating the impact of peer support programs. This research was funded by Ohio.

The final individual interview from the representative states was conducted with a consultant and trainer at a school in Kansas who also had previous experience running a community support agency. Although she did not refer much to the impact of state policy, she did mention that partnerships between agencies and universities have reinforced recovery concepts, the training of peer specialists, and evidence-based practice fidelity. In her experience at a busy agency, having the support of the university to guide her organization’s efforts toward meeting evidence-based requirements was invaluable. At the agency level she feels that many are concerned with keeping afloat in a time of economic instability rather than making a recovery transformation. Additionally, she believes that the way social work practitioners were educated and trained in the past poses a challenge for their embrace of recovery in the future:

For so many of us who were traditionally trained so many years ago, some of the relationships we have to build and some of the strategies we use in treatment contradict what we may have learned initially in training – in terms of partnership with the people whom we’re working with and complete involvement with clients from their own individual treatment to advisor groups to looking at program design and setting policy and program evaluation. So I think it’s just a big paradigm shift for people who haven’t been exposed to it.

The idea that practice educators reinforce what they themselves learned, which in many cases is not recovery, and influence the next generation of social work practitioners was discussed by consumers in the Alternatives Focus Group:

I’ve taken some master’s level classes. The older teachers are more traditional in their point of view and think they can teach as they were taught. The newer teachers are more hip. They’re more in tune with the consumer movement. (Alternatives participant C)

They teach the way they’re taught because that’s their belief system. (Alternatives participant A)

An APM General Discussion participant commented that “Practice teachers/instructors many times stop practicing because with tenure track you have hardly any time to do that. So they

get stuck wherever they were when they left.”

One interviewee also spoke about how traditional practice course content emphasizing psychopathology and diagnosis are still being covered in the classroom.

I’ve had a couple MSW students placed with me who also had diagnosed illness and felt very uncomfortable in class because the language was pretty stigmatizing, pretty limiting. Sort of the belief that once you’re diagnosed with schizophrenia, it’s a life sentence of treatment and underachievement. The coursework doesn’t really bring the human being to the forefront; its diagnosis and systems, course of treatment and diagnosis. None of those things are very hope inducing.

She believed that the antidote to this should be instructors creating a comfortable environment and students feeling comfortable enough to disclose their mental health histories. She felt that having exposure to people with mental health diagnoses as colleagues in the workplace can change organizational culture and reduce stigmatizing beliefs; this transformation was witnessed at her own agency.

From the APM General Discussion a faculty member from a school in Illinois spoke about how challenging it has been to learn about recovery. Her experience has led her to believe that the recovery dialogue has been absent in her state. Needs observed during her practice experiences prompted her to educate herself about the recovery philosophy; however, at points in the discussion she expressed a sense of isolation.

I am looking for ways to incorporate recovery oriented material into my classes because I know that in my own training as a social worker when I was going through my master’s program I got zero on it. And then I think just through being in the field and everything else, I came to realize how important that was . . . But as far as my experience there is absolutely nothing; it doesn’t exist. It’s not anything I’ve ever heard on any curriculum or training or class. I’ve taught at a variety of schools. I’ve taught at a school in Illinois. I come from another school in Illinois so it’s not anything that’s in the language of people who are being trained. But it’s an issue I care about very deeply and so I’m just interested to hear what’s going on with the field and how at least I can do my piece in terms of figuring out how I can incorporate it more and students can learn about it more.

Special Issue: Evidence-Based Practice and Recovery

The evidence-based practice movement has been growing in momentum in social work education and practice in recent years. Evidence-based practice and practices was mentioned in a number of places in the literature and interviews; therefore, it seemed important to consider how recovery-oriented practice and evidence-based practice fit together.

The growing emphasis on evidence-based practice is not in conflict with recovery-oriented concepts and service transformation (Bond, Salyers, Rollins, Rapp, & Zippel, 2004; Solomon &

Stanhope, 2004; Torrey, Rapp, Van Tosh, McNabb, & Ralph, 2005). Although consumers are a heterogeneous population and treatment options should never be one-size-fits-all, practices that have been rigorously tested and consistently show promise for consumer recovery should be used by social work practitioners. Social work professionals need to include consumers in the development of their own treatment plans; part of this care partnership between consumer and provider requires the social worker to share expertise about available options that have yielded positive results for others (Tunner, n.d.). In fact, “evidence-based practices, as a technology, cannot succeed without the consumer being integrally involved in informed decision-making” (Torrey et al., 2005, p. 97).

A strong support network functioning within the mental health system is necessary to ensure successful implementation and the continuity of evidence-based approaches (Tunner, n.d.). Informed mental health policy at the federal and state levels can have an enormous influence on what treatment strategies are investigated, invested in, and promoted to consumers.

Several practices for adults with severe and persistent mental illnesses have been recognized as evidence-based and also encourage community integration opportunities and quality of life improvements for consumers; these include supported employment, ACT, family psychoeducation, illness management and recovery, integrated dual disorders treatment, and appropriate medication management (Bond et al., 2004). A later study investigated state challenges to implementing the first five evidence-based practices listed. According to feedback from stakeholders within state and local agencies, consumers, and family members, each evidence-based practice required a variation of conditions and monitoring for success (Isett et al., 2007). The assets noted by the researchers present when implementation was successful were as follows:

First, regulations were being aligned to be commensurate with the needs of an evidence-based system of care. States also found or created new ways to finance these practices that compensated providers fairly for their efforts, both for ongoing implementation and at start-up. Second, states were providing leadership to the mental health system to move toward dynamic and effective treatment centered on the consumer. Third, states were providing training to frontline clinicians to implement the evidence-based practices with high fidelity, and they were linking those training efforts to quality assessments and infrastructure needs. (Isett et al., 2007, p. 920)

Despite the advances in research on evidence-based approaches and recovery, many consumers are not directly benefiting from evidence-informed service practice. Rather, they are continuing to receive treatment that is not as effective (Torrey et al., 2005). Hardiman & Hodges (2008) attest to the difficulties in reaching consensus on core elements of a recovery-based model of practice and defining the role of recovery across federal and state policy and mental health systems of care. Dissemination of knowledge and information may not always reach the frontline practice settings, and if they do, the capacity for these organizations to implement best practices and meet rigorous standards of fidelity may not be present (Hardiman & Hodges, 2008). Other identified challenges to consumers achieving community integration that is aligned with the recovery process include stigma within the mental health treatment system, lack of coordinated and integrated care options, and access issues (Bond et al., 2004).

A number of the mental health syllabi collected from the 35 participating schools of social work mentioned or featured evidence-based practice content. Again, the samples of syllabi collected for this research project are not representative of syllabi across all social work programs. Syllabi from social work schools that focused on evidence-based practices from a recovery orientation came from

- University of Louisville (KY)
- University of Pennsylvania
- University of California—Berkeley
- University of Maryland
- California State University—East Bay
- San José State University (CA)
- University of Southern California
- California State University—Long Beach
- San Diego State University (CA)
- SUNY Binghamton University (NY)
- SUNY University at Buffalo (NY)
- Yeshiva University (NY)
- University of Nevada Las Vegas

Syllabi exemplars from some of these schools are outlined below. The reasons why these courses stood out from all the rest of the syllabi submitted are also discussed.

“Psychosocial Rehabilitation for Individuals With Serious Mental Illness,” offered at San Diego State University, is an especially comprehensive didactic example that uses a variety of teaching methods to impart an understanding of the topic (Mathiesen, 2010). Students are required to explore an evidence-based treatment practice for a certain diagnosis and target population of interest to them. At one point in the course the instructor expects participants to make a visit to a psychosocial rehabilitation and recovery agency and critique its model and practices. The instructor provides a list of programs and persons affiliated with rehabilitation and recovery programs locally from which students can choose. Using information from their site visit experience, students are then charged with identifying a service gap and are required to propose a new program using evidence-based interventions. Local guest speakers appear throughout the course to discuss evidence-based practices, and a consumer panel also presents for students.

The “Clinical Social Work in Relation to Chronic Mental Illness” course was previously outlined in the trauma-informed section (Gioia, 2009). Evidence-based practices, evidence-based interventions, and cultural competency are heavily stressed. Class sessions cover evidence-based practice topics such as illness self-management, ACT, medication management, family psychoeducation, supported employment, integrated dual disorders treatment, and promising practices such as supported education and peer support. In addition to assignments designed to expose the student to a consumer viewpoint, a major case-study

assignment requires students to apply an evidence-based approach to a disorder and describe any unique cultural considerations that may affect treatment.

At the University of Pennsylvania “Mental Health Policy” (Evans & Hadley, 2007) discussed the historical context and development of mental health treatment from colonial through present times as well as the introduction of the evidence-based practice movement. The influence of the President’s New Freedom Commission, the recovery model, and the consumer movement were discussed. Topics discussed and materials reviewed included NAMI Grading the States Report; funding from a variety of sources (i.e., federal, state, private); peer support; and legal, housing, employment, and criminal justice policies affecting consumers.

The “Best Practices in Mental Health and Disabilities” distance learning course featured at the University of Nevada Las Vegas does not explicitly mention coming from a recovery perspective but covers consumer and family advocacy movements, clubhouses, and other recovery consistent topics (Overcamp-Martini, 2009). Undergraduates and graduates were welcome to take the course together, albeit with differing requirements. Master’s students had to analyze the Program of Assertive Community Treatment model and Nevada’s Olmstead Plan. Several PBS online videos are used to introduce the prevalence of mental health issues among incarcerated populations; these videos are cited in the recovery resources section below. The instructor also utilizes various YouTube videos to supplement the course.

In summary, the recovery-oriented practice and evidence-based practice models need not be in conflict with one another. Many of the social work education programs have already begun integrating evidence-based practice concepts and specific evidence-based practices into their syllabi. The ways in which the two models can build on one another and be included in the classroom and field should be included at the curriculum-writing stage of the project.

Target Audience for Curriculum Development

The situational assessment has shown how in many ways social work is particularly well-suited and prepared for mental health recovery. Historically, social workers have had a concern for components of recovery cited in the SAMHSA Consensus Statement (2006), especially empowerment, holistic care, the strengths-based perspective, self-direction, and respect. Furthermore, the work of social workers to eradicate discrimination and stigma and recognize and engage difference is also consistent with the concerns of recovery. There is evidence that some social work educators and practitioners have already become involved in the recovery movement and have begun implementing it in courses and practice.

The situational assessment has also shown that there are some areas in which social work is not entirely embracing the full meaning of recovery or where very little evidence exists that anything is being done at all. In particular, the components of peer support and the involvement of consumers throughout the process seem to be lacking. Some of the discussions appear to uncover a true partnership, but others indicated a paternalistic type of practice taking place in which the consumer was not an equal partner in the process. Some individual faculty members and practitioners stood out as being particularly concerned

with including the consumer voice, but these do not appear to be the norm. The other area of concern is that in many of those areas in which there is theoretical kinship with recovery, there appears to be some cognitive dissonance. For instance, social workers may believe in the strengths-based approach but in practice are working from a deficits model.

To affect a paradigm shift, change must be as systemic as possible. It is with that mandate in mind that the CSWE team recommends social work practitioners, and particularly those serving as field instructors, as the target audience for curriculum development.

Social work practitioners comprise a multifaceted group that intersects with the mental health system at many different points. Practitioners can have an effect on recovery through their direct service to consumers and families, at the organizational and administrative leadership level, and/or can influence social work students when they serve as field instructors. Even if they are not immediately supervising the students in practicum placements at their agencies, to varying degrees practitioners can have an indelible influence on the culture of those agencies and their embrace of recovery principles, which shapes the experience of the next generation of social workers.

In social work education all students are required to participate in field education to graduate. Field education, also called the signature pedagogy of social work, is intended to “socialize” students to “perform the role of practitioner” (CSWE, 2008, p. 8). The CSWE EPAS further state:

The intent of field education is to connect the theoretical and conceptual contribution of the classroom with the practical world of the practice setting. It is a basic precept of social work education that the two interrelated components of curriculum—classroom and field—are of equal importance within the curriculum, and each contributes to the development of the requisite competencies of professional practice. (CSWE, 2008, p. 8)

Students must complete at least 400 hours of field education at the baccalaureate level and at least 900 hours at the master’s level (CSWE, 2008). Many programs require completion of more than the mandated minimum hours. Programs can structure the field education program as they like, but typically baccalaureate students begin field education their senior year and master’s students begin one field placement in their second semester with a year-long placement (in area of concentration) in the second year. Each year there are more than 14,746 baccalaureate and 30,037 master’s students in field placements. Of these, approximately 1,100 (7.6%) baccalaureate placements and 6,100 (20.4%) master’s placements are in settings identified primarily as mental health or community mental health. Of course, many other settings could also provide opportunities in mental health (e.g., military, family services, child welfare).

Field instructors are those practitioners who are working in the field and serve as supervisors to social work students. The 2008 EPAS mandates that field instructors must have a degree in social work to supervise students. Programs are also required to provide “orientation, field instruction training, and continuing dialog with field education settings and field instructors” (CSWE, 2008, p. 10). A single field instructor could supervise more than one student, and the Annual Survey of Social Work Programs collects data only on the number of students

in field placements, so it is unknown exactly how many field instructors currently serve as supervisors; however, even assuming that only one-third of the placements are unique, that would be a pool of approximately 15,000 practitioners.

For the focus of the curriculum development phase it is recommended that we use the partnerships that already exist between mental health agencies and universities to target practitioners, while also affecting students—the future practitioners. CSWE, through the field directors/coordinators at each accredited social work program, could promote and disseminate the training. Within a single year there would be the potential to reach thousands of practitioners and through them, even more students. There are some existing examples of agency–university partnerships to infuse recovery.

- Kansas has a requirement for their Community Psychiatric Support and Treatment providers to take the recovery-focused “2-Day Basic Case Management” course offered by the University of Kansas, School of Social Welfare. This curriculum is co-taught by a social worker and a consumer/advocate (University of Kansas, School of Social Welfare, 2010).
- One county mental health system in California that has multiple field instructors onsite has brought together social work faculty members for a week of immersion at the Mental Health America Village, one of the programs cited by the President’s New Freedom Commission as a model. The immersion process helped faculty to experience what mental health recovery looks like in the field. The director of the mental health agency said that it helped to provide continuity between what students were learning in the classroom and field.

Developing curriculum targeting field instructors was also supported by one of the APM General Discussion participants, who remarked:

Curriculum for field instructors may be the way to go. Field instructors are still people who connected you with the school and probably the next step. They need that exposure, information and because you are working with agencies you’re quietly changing the agencies.

Thousands of practitioners serve as field instructors every year in social work education. If field education is where students are socialized to the profession, then we should take advantage of this unique existing partnership between classroom and field to infuse mental health recovery in social work. Although the specifics have yet to be determined, existing means of communication and structures are in place that will assist with this model.

Opportunities and Challenges: Curriculum Development and Training

There are a number of opportunities and challenges to developing and implementing training on recovery-oriented practice for social work practitioners. Each of these elements will need to be considered and addressed prior to launching the curriculum development phase.

Opportunities

Though not currently used to promote recovery-oriented practice, the interaction between school of social work field directors and practitioners acting as field instructors is rife with opportunities to train on recovery orientation. CSWE also has a number of resources within its structure or partners that are important to consider.

Broad Acceptance of Ideas of Recovery

Social work theory is congruent with the principles of recovery—empowerment, self-direction, strengths-based, holistic, and respect are explicit long-standing components of social work education and practice. Getting social workers to accept the principle of recovery and recovery-oriented practice will likely not meet with a great deal of resistance. What is perhaps the greatest opportunity may also be the greatest challenge, as will be discussed further in the section on Challenges.

Special Role of Social Work in Recovery

Social workers have the potential to play a special role in the recovery movement. Social work's historic connection to many of the recovery principles means that there may be broad acceptance of recovery-oriented practice. Social workers are also trained in advocacy, policy practice, and community organizing; such skills could play an important role in working toward infusion of recovery at the organizational and state levels. The recovery curriculum will have to take these special roles into consideration and build on the strengths of social workers to help bring about the broadest possible change.

Council on Field Education

CSWE's Council on Field Education is tasked with enhancing the quality of field education and with providing "support for field directors and educators" it also "produces and disseminates relevant knowledge" (CSWE, n.d.). There are currently 15 members of the council, all of whom have had experience working with field education in the last 2 years. The council also selects members to serve as representative chairs for the Field Education track at the CSWE APM. The field education track at APM is consistently one of the most popular for abstract submissions and in number of attendees to individual sessions. The council also has an electronic mailing list with connections to field directors at accredited social work education programs. With this prominence and its many connections, the council will be an important partner throughout the curriculum development and training process.

Training Events and Continuing Education Units (CEUs)

Many universities host an annual mandatory seminar to which at least one field instructor from the agency must attend. Other universities use new-instructor orientation, joint workshops with other universities, end-of-year conferences, and/or symposia to touch base with their field instructors and open discussion on specific topics. Social work education programs also provide training throughout the year for their field instructors as a benefit for giving their time to supervising students. Equipping schools of social work with train-the-trainer modules in this setting can make field instructors the experts who take the training back to their programs for further dissemination.

Other training opportunities to consider are the CSWE APM (October/November), the Society for Social Work Research annual conference (January), NASW state chapter conferences and events, and events held by the regional field education groups.

All these avenues would be connected to CEUs accepted by ASWB for keeping a social work license current. CSWE is already recognized as a provider of CEUs by the ASWB, which will make the process of offering CEUs for a recovery-oriented training much easier.

Online Clearinghouse

CSWE could also serve as an online hub for social workers to receive the latest research, training, and teaching tools on recovery. Many interviewees expressed a desire for easily accessible tools that were inexpensive, considering budget cutbacks in many agencies and university departments. The CSWE website has the capacity to provide videos, quizzes, and searchable collections of resources (e.g., syllabi, bibliographies, exercises). The website is easily managed by staff members in-house.

Online Training

If all or part of the training will be made available online, the CSWE Gero-Ed Center would be a valuable resource. The Gero-Ed Center has experience in all the stages of developing distance education courses with embedded video, exercises, and quizzes. The Institutional Research division of CSWE has also provided brief training webinars.

Field Placement Contracts

University field directors, during their site visits with agencies, agree on a contract for the field placement. These contracts establish goals and learning objectives for the student experience and include social work values and language. Recovery practice could be affected through these contracts, with CSWE providing a toolkit for integration of recovery practice in such a document.

Building on Existing Diversity and Recovery Climate

Many practitioners and field instructors interviewed stressed the need for social workers to always consider culture and spirituality in practice. They spoke of respect for clients as the key component of recovery, along with reaching out to the client's "base community." Reporting use of narrative therapy; motivational interviewing; solutions-focused practices; an internal family systems model; and strategies that support culture, religion, sexual orientation, and gender, they desired support in working with different cultures beyond race/ethnicity (e.g.,

homeless communities) and training that involves information on peer supports. The research team could capitalize on field instructors and practitioners currently identifying with recovery practice as models and peers through which to reach and educate other social workers.

Building on Existing Partnerships

As the CSWE team conducted interviews, focus groups, and discussion groups, team members asked participants whether they would be interested in staying involved in the RTP project. We were pleased to find many enthusiastic individuals from various stakeholder groups who were interested in working with us throughout the process. A number of sister social work organizations such as NASW, SSWR, and ASWB also work closely with CSWE and will be important to include in the next phases of the project. A beginning list of some individuals and social work programs that have already begun infusing recovery into practice is located in the Appendix B.

Challenges

Although there are a number of opportunities that make social work and the specific target population, field instructors, particularly appropriate for training on recovery-oriented practice, there are also some challenges to the implementation.

Competing Definitions and Putting Theory Into Practice

Social work literature enumerates several challenges to recovery orientation, among them use of the medical model. Cited as a paradigm that extinguishes the hope necessary for recovery, the medical model stands out as inconsistent with social work values but nonetheless is still very much in use. Rapp addressed this dissonance when he wrote about the ways in which social workers “trick” themselves into thinking that they are implementing strengths-based perspective, when they are in fact using a deficits approach (Saleebey, 1996). This may be the biggest challenge: that social workers may readily accept the principles of recovery but then be unwilling or unable to make appropriate changes to practice. The remedy will be careful and full definitions of terms, coupled with specific examples, exercises, and tools for use in practice.

Differentiating Recovery-Oriented From Strengths-Based Practice

There are many similarities between the strengths-based model as defined in social work and the recovery-oriented practice model. There are some differences, however, and defining those differences and convincing social workers that the additional areas in recovery-oriented practice are essential will be a challenge. One example of differences is the emphasis on peer support in recovery-oriented practice. This is also an area in which we found a real lack in social work education and practice. In the curriculum development phase we will need to highlight the differences between strengths-based and recovery-oriented practice and spend particular time arguing for the importance of those factors not addressed by the strengths orientation.

School of Social Work Buy-In

Concerning marketing of recovery tools, CSWE will need to gain buy-in from school of social

work deans, faculty, and field instructors to have maximum impact. Field directors and instructors who have not practiced in some time (and even those who are currently practicing but have not had updated training) may not be familiar with the recovery paradigm. This may pose a challenge because certain recovery practice elements may appear to contradict the training these practitioners have had (medical model focus, therapeutic relationships that privilege the provider as expert, etc.).

Recovery in Field Placement Assessment

Further challenges surface in getting social work programs to link recovery in assessment of appropriate student field placements. Field directors spoke of factors considered when adding field placement agencies, among them whether wellness management was focused on, a respect for clients in practice, even whether recovery services and peer consultants were present. However, many field directors spoke of the countervailing pressures considered when searching for field placement agencies, recovery falling low on the list at times. Programs must account for the number of students they have versus the number of placements available and the number of other social work programs in the service area competing for placement agencies; often directors have little leeway to also contemplate implementation of the recovery paradigm. As some, especially rural-area, directors stated, “[We] take whatever field placement we can get.”

Training Level and Content

Current levels of recovery awareness vary, as suggested by data collected for the Situational Assessment. Some practitioners would like references to articles and books, whereas others would like to read case studies and see videos of consumer viewpoints or of actual role-plays representing what does and does not work in client relations. Some practitioners would like training to focus on mental illnesses and critical use of the DSM-IV, and others want modules to target societal issues that affect recovery.

Given this context, distilling the appropriate level of recovery orientation (or correct recovery tools) for social work practitioners will be a challenge taken up during the preparation of the curriculum and pilot testing phase of the project. Because many practitioners have at least heard *recovery* as a buzz word in their fields, one strategy may involve training avenues outlining specific additions to work with clients according to practice setting (hospital, mental health facility, etc.). One interviewee noted that it may be easier to target community mental health specialization areas first.

Given the diversity of positions held by field instructors, it will be important to include curriculum targeted not only to frontline workers but also to those in supervisory positions. Even those field instructors who are not supervising others within their agency do have supervisory roles over students, and so should benefit from content focused on the particular issues of coaching and mentoring in a recovery model.

Although the RTP Steering Committee will work more on the actual content of the training in year two of the project, it seems clear that at a minimum the training should include the 10 components of recovery (including a discussion of the contrasts with the strengths-based model), the importance of involving consumers in practice, cultural competency, trauma-

informed practice, and a discussion of how recovery-oriented practice fits with the evidence-based practice movement.

It will be critical for the training to include very concrete ideas about how to incorporate recovery into practice on day-to-day basis. For example, simply telling social workers to include consumers in practice would likely not result in change. Giving the practitioners specific options for ways to include consumers in practice is much more likely to lead to behavior change. The examples should take into account situations in which the practitioner will have organizational support for change and those when they will not have such support. In fact, the curriculum should include strategies for how to enact change in the organization to move toward a recovery orientation.

Funding and Other Program Constraints

Again and again, practitioners and field instructors remarked on budget constraints. This will affect any new initiative undertaken by departments or agencies. CSWE's job in executing training will be to integrate those modules in existing agency and university processes or make them virtually available at no cost.

In addition, there are state-level budget constraints to consider, especially in the context of health care reform, posing both a challenge and an opportunity. Opportunities are on the long-term horizon via upcoming mental health training grants that will be available for university-level training to prepare practitioners for careers in integrated care settings. During the health care reform transitions, the challenge posed will be that of sustaining agency focus on recovery orientation in traditional health care settings and in insurance reform. Possible effects of such reform could include cuts in services and a de-emphasis on major reforms such as recovery as agencies face funding and staffing challenges.

Overall, there are significant opportunities for infusing recovery into social work practice. CSWE will need to establish buy-in with faculty and practitioners serving as field instructors, possibly through peers already using the recovery paradigm. Helping practitioners overcome cost concerns is an overarching concern. CSWE is also faced with the challenge of making recovery practice concrete for practitioners, offering practical guides they can use in relationships with consumers.

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Appendix A: Social Work Programs, Individuals, and Agencies as Resources for Curriculum Development Phase

Social Work Programs

- California State University, Long Beach
- California State University, Los Angeles
- Case Western Reserve University
- New York University
- San Diego State University
- Southern Connecticut State University
- State University of New York, University at Buffalo
- University of California, Davis
- University of Kansas
- University of Pennsylvania
- University of Southern California
- University of Toledo

Individuals (Social Work Affiliated and Others)

- Dr. William (Bill) Anthony, executive director of the Center for Psychiatric Rehabilitation, and professor at Boston University
- Dr. Beverly Buckles, Loma Linda University
- Dr. Patricia Deegan & Associates, LLC
- Dr. Catherine Dulmus, University at Buffalo, State University of New York School of Social Work
- Dr. Sue Estroff, Department of Social Medicine, University of North Carolina School of Medicine
- Dr. Deborah Gioia, University of Maryland School of Social Work
- Dr. Sally Mathiesen, San Diego State University School of Social Work
- Dr. Nancy Meyer-Adams, California State University, Long Beach School of Social Work
- Dr. Michael Mancini, St. Louis University School of Social Work
- Dr. Steven Onken, University of Hawai'i at Manoa School of Social Work
- Dr. Mary Ann Overcamp-Martini, University of Nevada Las Vegas
- Dr. Deborah Padgett, Silver School of Social Work, New York University
- Dr. Carolyn Provenzano, University of Louisville, Kent School of Social Work
- Dr. Ruth Ralph, senior research associate (retired), Edmund S. Muskie School of Public Service, University of Southern Maine
- Dr. Priscilla Ridgway, Yale School of Medicine

- Dr. Anna Scheyett, University of North Carolina at Chapel Hill
- Dr. Phyllis Solomon, University of Pennsylvania
- Dr. Victoria Stanhope, Silver School of Social Work, New York University
- Dr. Lynn Videka, Dean, Silver School of Social Work, New York University
- Leslie Young, University of Kansas

Agencies, Organizations, and their Affiliates

- Appalachian Consulting Group, GA
- Tonier Cain, team leader for the National Center for Trauma Informed Care
- California Social Work Education Center (CalSWEC), University of California, Berkeley, School of Social Welfare
- Dr. Michael Hogan, commissioner of the New York State Office of Mental Health
- Institute for Recovery and Community Integration, PA
- Nathan Klein Institute for Psychiatric Research, NY
- National Alliance on Mental Illness (NAMI)
- National Association of Peer Specialists, MI
- Ann Rider, executive director. Recovery Empowerment Network, AZ
- Bebe Smith, social work director of STEP program at UNC Hospital
- Dr. Marvin Southard, director of the Los Angeles County Department of Mental Health
- Ali Swiller, associate director of Threshold Clubhouse, NC
- U.S. Psychiatric Rehabilitation Association, MD
- The Village, Long Beach, CA

Field Directors and Field Placement Faculty Members

- Candy Elson, San Diego State University
- Kathy Osborne, North Carolina State University
- Francine Pratt, Tarleton State University
- Jo Anne Smith, Governors State University

Appendix B: Selected Recovery-Oriented Mental Health Syllabi

Alder, C. W. & Pace, F. (Fall 2008). SW 690A: Special Topics. Ohio University Department of Social Work.

Alder, C. W., & Pace, F. (Winter 2008). SW 690A: Mental health colloquium. Ohio University Department of Social Work.

Alder, C. W., Pace, F., & Lassiter, K. (Winter 2006-2007). SW 598: Mental health colloquium, independent study. Ohio University Department of Social Work.

California State University, East Bay (n.d., a). SW 6505: Micro practice: Community mental health. Department of Social Work.

California State University, East Bay (n.d., b). SW 6515: Advanced mezzo practice: Community mental health. Department of Social Work.

Conroy, M. (Fall 2009). ScWk 281: Social work in health/mental health (Course code 48531; Section 1). San José State University School of Social Work.

Dulmus, C. N. (Fall 2010). SW 557: Evidence-based mental health practice. University at Buffalo, State University of New York School of Social Work. MSW Program.

Etnyre, B. (Spring 2010). Soc W 548: Advanced practice I. University of Washington School of Social Work.

Evans, A. & Hadley, T. (Spring 2007). SW 799/899: Mental health policy. University of Pennsylvania, School of Social Policy and Practice, Social Work Program.

Gioia, D. (Spring 2009). SWCL 730: Clinical social work in relation to chronic mental illness. University of Maryland School of Social Work.

Keefe, R. H. (Fall 2010). SW 572A: Mental health and disability social work. University at Buffalo, State University of New York School of Social Work.

Kola, L. A. (Fall 2010). SSWM 563: Social work interventions in co-occurring mental and substance use disorders. Mandel School of Applied Social Sciences, Case Western Reserve University.

Mathiesen, S. G. (Spring 2010). SW 781: Seminar—Psychosocial rehabilitation for individuals with mental illness. San Diego State University School of Social Work.

Mayeda, S. (Fall 2010). Social Work 618: Systems of recovery from mental illness. University of Southern California School of Social Work.

Meyer-Adams, N. (Winter 2010). SW 677: Social work practice in mental health. California State University, Long Beach School of Social Work.

Overcamp-Martini, M. A. (Summer 2009). SWK 471/671: Best practices in mental health and disabilities. University of Nevada Las Vegas, School of Social Work.

Pirich, C. (Fall 2010). SW 580B 01: Evidence-based mental health practice for social workers. Binghamton University, State University of New York. College of Community and Public Affairs.

Provenzano, C. (Fall 2010). SW 615-50: Mental health. University of Louisville, Kent School of Social Work.

Roberts-Lewis, A. (Fall 2009). SOWO 840: Adult mental health: Theory and practice. University of North Carolina at Chapel Hill School of Social Work.

Roberts-Lewis, A. (Spring 2010). SOWO 761: Alcohol, tobacco, & other drugs (ATOD): Social work practice with culturally diverse populations. University of North Carolina at Chapel Hill School of Social Work.

Rollo, C., & Kleiner, D. (Spring 2010). SWCL 771: Evidence-based mental health treatment with children and adolescents. University of Maryland, Baltimore, School of Social Work.

Russell, R., Meath, M., Russell, B., & Auberger, K. (Spring 2010). SWK 508: Diagnostic process: A strengths-based social work perspective. Greater Rochester Collaborative MSW Program. College at Brockport, State University of New York.

Swarthout, J. (Fall 2009). SW 561: Dual disorders: Assessment and intervention with clients with chemical dependence and mental disorders. University at Buffalo, State University of New York School of Social Work.

Syms, C. (Fall 2009). SW 560A: The nature and treatment of alcohol and other drug problems. University at Buffalo, State University of New York School of Social Work.

Yeshiva University (Fall 2009). SW 6682: Evidence-based mental health practice. Wurzweiler School of Social Work.

Appendix C: Trauma-Informed Practice Resources

- National Center for Trauma-Informed Care (sponsored by SAMHSA) - <http://www.samhsa.gov/nctic/>
- APA/CAPP Catalog of Clinical Training Opportunities - <http://www.apa.org/practice/resources/grid/catalog.pdf>
- Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services - <http://www.theannainstitute.org/MDT.pdf>
- Triad Women's Project and Wisdom of Women Support Groups – <http://www.prainc.com/wcdvs/pdfs/Fact%20Sheets/Innovations%20Fact%20Sheets/FL%20Innovations%20from%20the%20Sites%20Final.pdf> (see also Fearday & Cape, 2004)
- Tonier Cain—Heeling Neen Documentary - <http://www.healingneen.com/short.html>
- *Strong at the Broken Places: Turning Trauma Into Recovery* (Cambridge Documentary Films video; interviews with survivors of trauma) - <http://www.cambridgedocumentaryfilms.org/Strong.html>
- Trauma focused cognitive-behavioral therapy Web-training (National Crime Victims Research and Treatment Center) – free 10-hour Web-based learning course for those with a master's level education or current graduate students in the mental health discipline. The focus is on child trauma. - <http://tfcbt.musc.edu/>
- Work by Linda Morrison and Sue Estroff [Alternative Participant recommendations] – “that conditioning [treating responses as disordered when they really are normal within context of the trauma experienced] is part of the enculturation process of the culture of disease mentioned earlier in the desire for an anthropological look at the culture the social workers will be entering.”
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 - Young, A. T., Green, C. A., & Estroff, S. E. (2008). New endeavors, risk taking, and personal growth in the recovery process: Findings from the STARS study. *Psychiatric Services*, 59, 1430–1436.
 - Henderson, G. E., Estroff, S. E., Churchill, L. R., King, N. M. P., Oberlander, J., & Strauss, R. P. (2005). Social and cultural contributions to health, difference, and inequality. In *The social medicine reader*, vol. 2 (2nd ed.). Durham, NC: Duke University Press.
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- o Estroff, S. E. (1999). A harmony in three parts: Utopian treatment for schizophrenia. *New Directions in Mental Health Services*, 1999(83): 13–19.
- o Estroff, S. E. (1999). The gaze of scholars and subjects: Rights, roles, and obligations in ethnographic research. In N. M. P. King & J. Stein (Eds.), *Beyond regulations: Ethics in human subjects research* (pp. 72–80). Chapel Hill, NC: UNC Press.
- o Estroff, S. E., Swanson, J. W., Lachicotte, W. S., Swartz, M., & Bolduc, M. (1998). Risk reconsidered: Targets of violence in the social networks of people with serious psychiatric disorders. *Social Psychiatry and Psychiatric Epidemiology*, 33(Supplement 1), 95–101.
- o Swanson, J. W., Estroff, S. E., Swartz, M., Borum, R., Lachicotte, W., Zimmer, C., & Wagner, R. (1997). Violence and severe mental disorder in clinical and community populations: The effects of psychotic symptoms, comorbidity, and disaffiliation from treatment. *Psychiatry*, 60(1), 1–22.
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Appendix D: Recovery Tools and Resources for Practitioner Curriculum

- Profile WRAP, Wellness Management and Recovery, ACT, integrated dual disorder treatment (IDDT), and other evidence-based practices, and Advance Directives.
- Some samples of recovery training topics relevant for practitioners can be found within the University of Kansas, School of Social Welfare “Mental Health Strengths Trainings” offerings (2010), Drexel University’s “Co-Occurring Mental and Substance Use Disorders Series” (2010), Cornell University Employment and Disability Institute’s *Foundations to Recovery* catalog (2009-2010), and *California’s Mental Health Cooperative Programs: Training & Technical Assistance Topics* offered by DMH (2006–2009).
- CalSWEC (n.d.), in partnership with Loma Linda University, offers five Mental Health Curriculum Modules and associated materials (e.g., instructor’s guides, handouts, exercises, bibliographies) that were developed for use by social work educators but might still be informative material to consider while formulating a curriculum for practitioners. The module topics are (1) recovery, stigma, and discrimination; (2) co-occurring disorders; (3) specialized interventions for children and transition aged youth with severe emotional disabilities; (4) specialized mental health interventions with older adults; and (5) collaboration between child welfare and mental health services.
- Include integrated treatment models for co-occurring disorders. For example, Ohio, New York, and Pennsylvania have contributed to research and developed curricula on this topic. Ohio runs the IDDT CCOE (ODMH, n.d.c), New York offers Integrated Care for Dual Diagnoses support through the Center for Practice Innovations (2010), and Pennsylvania offers co-occurring disorders training (Drexel University, 2010) and certification (PA-CO-OCCURRING.ORG, n.d.).
- Include information about the federal benefits that those who are homeless with disabilities might be entitled to and the barriers to obtaining this type of support. Include information about training resources for professionals such as SSI/SSDI and Outreach, Access, and Recovery (Kansas Department of Social and Rehabilitation Services, 2010b).
- A case example for practitioners engaging in recovery planning with consumers is provided within the ODMH Outcomes-Based Recovery Planning presentation (see Slides 30-37 of this presentation at <http://www.mh.state.oh.us/assets/consumer-outcomes/training/recovery-plan.pdf>).
- Three excellent charts adapted from the work of various researchers and agencies compare traditional approaches/culture/pre-recovery system to mental health recovery approaches/culture/enhancing system (OMHSAS, 2005, pp. 27–31).
- “Breaking the Silence” is an example of a mental health educational program including lesson plans, board game, and posters for elementary, middle, and high school students. Topics include facts/myths, causes, symptoms and warning signs of mental illnesses, treatment and prevention. It can be delivered by classroom teachers and does not require subject matter expertise to facilitate (OMH, 2010a).

- *A Framework for Planning* was incorporated into several foundations to recovery courses (Cornell University Employment and Disability Institute, 2009–2010). The description is as follows:

To truly be of service to a person who is interested in recovery, providers must sometimes engage in non-traditional methods for listening to and learning from the individual. This requires a belief in the person's ability to lead us toward identifying the best service and supports. *A Framework for Planning* provides a structure to work toward this end. (p. 9)

- Boston University's "Making Decisions" Empowerment Scale was one resource used by Ohio to gauge consumer outcomes. The scale incorporates 28 items and five subscales. The subscales are self-esteem/efficacy, power/powerlessness; community activism, optimism/control over the future; and righteous anger.
- The New York OMH Bureau of Cultural Competence launched a [Cultural Competence](#) website in 2010 offering research, resources, assessment tools, and training.
- The Cultural Competence COE at the Nathan Klein Institute developed a [Toolkit for Modifying Evidence-Based Practices to Increase Cultural Competence](#).
- New York's Statewide Plan outlined many local recovery initiatives occurring outside OMH. For example, a lesbian, gay, bisexual, transgender, and queer toolkit developed by Mental Health Association (MHA) Ulster County and other partners titled *Enhancing Cultural Competence: Welcoming Lesbian, Gay, Bisexual, Transgender and Queer People in Mental Health* (OMH, 2010a).
- The California DMH catalog (2006–2009) offers Training in Culturally Competent, Recovery/Resiliency-Oriented Assessments and Service Plans. This train-the-trainer format is facilitated by the California Institute of Mental Health.
- The California DMH catalog (2006–2009) also offers Client Culture Presentation for Staff and Clients. This is presented by the California Network of Mental Health Clients and is mandated for counties by the state under cultural competency requirements.
- "Co-Occurring Disorders: An Overview of Psychopharmacology," one of the courses offered in the Co-Occurring Mental Health and Substance Abuse Disorders Training Series (Drexel University, 2010), covers evidence-based practices for educating consumers and family members about the use of medication as recovery tool, addresses cultural differences in beliefs about medication, and discusses the role of "personal medicine" and alternative therapies.
- Pennsylvania and New York use Network of Care, a Web-based resource, links providers, community members, and consumers/family members with research, recovery-based treatment and service information, e-training modules, social networking, and personal health tools (to include secure storage).
- Free incremental online training and distance learning models are a way to educate practitioners, academics, and students who are more isolated from recovery-oriented communities. The Focus on Integrated Treatment curriculum offered by New York OMH seeks to educate and inspire participants through the use of recovery stories, clinical case examples, interactive exercises, and panel presentations featuring experts. For support beyond these training modules, the Center for Practice Innovations provides webinars, Ask the Expert forums, and discussion boards (Center for Practice Innovations, 2010).

- Bellack, A., Mueser, K., Gingerich, S., & Agresta, J. (2004) *Social skills training for schizophrenia: A step-by-step guide*. New York, NY: Guilford. This is an evidence-based manual for social skills training that presents Social Functioning Interview and Social Adaptive Functioning Evaluation assessment tools.
- California Social Work Education Center (CalSWEC, n.d.). CalSWEC Mental Health Curriculum Modules. Available online at: <http://www.llu.edu/science-technology/socialwork/calsweccurriculummodules.page?> [Downloaded 1/5/11]
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- Farkas, M. (2007). The vision of recovery today: What it is and what it means for services. *World Psychiatry*, 6, 4-10.
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- Navasky, M., & O'Connor, K. (Writers, Producers, & Directors). (2005). The new asylums [Television series episode]. In D. Fanning (Executive producer), *Frontline*. Boston, MA: WGBH Educational Foundation. Retrieved from <http://www.pbs.org/wgbh/pages/frontline/shows/asylums/> Features Ohio state prisons and a state-by-state analysis of the incarceration status of people with mental illness.
- Navasky, M., & O'Connor, K. (Writers, Producers, & Directors). (2009). The released. In D. Fanning (Executive producer), *Frontline*. Boston, MA: WGBH Educational Foundation. Retrieved from <http://www.pbs.org/wgbh/pages/frontline/released/> Features Ohio state prisons and follow-up with previously profiled prisoners.
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- Westly-Clark, H. & Power, A. K. (2005). Women, Co-Occurring Disorders, and Violence Study: A case for trauma-informed care. *Journal of Substance Abuse Treatment*, 1(2), 145-146.
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1701 Duke Street, Suite 200
Alexandria, VA 22314
www.cswe.org

