



Practicing Recovery: Value of Family Support

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A NOTE FROM THE DIRECTOR OF CMHS



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Olmstead: Community Integration for Everyone

June 22 is the 15th Anniversary of the Olmstead decision commemorating the Civil Rights Division of the US Department of Justice enforcement of Supreme Court's decision in Olmstead v. L.C., a ruling that requires states to eliminate unnecessary segregation of persons with disabilities and to ensure that persons with disabilities receive services in the most integrated setting appropriate to their needs. For more information, visit <http://www.ada.gov/olmstead>.

The love and support of family is one of the most valuable recovery resources for a person with serious mental illness. However, advocating for a loved one with a serious mental condition can be stressful, confusing, and exhausting. As a result, family members often experience a host of emotions, including sadness, guilt, grief, and acceptance. This means ensuring needed supports are in place for families is an important component of supporting individuals with serious mental conditions.

SAMHSA supports families in a variety of ways. We develop and disseminate evidence-based practices that help families and their loved ones learn more about mental conditions, treatment, and recovery. We support early intervention to treatment, which can change the course of an individual's life and provide a future that is purposeful and filled with possibilities. Through SAMHSA's Statewide Family Networks, we help improve community-based services for children and adolescents with mental health challenges and their families. SAMHSA also supports multiple programs that increase access to care.

These programs work. Take, for example, the story of a young adult from New York. Thanks in part to SAMHSA's Mental Health Block Grant 5 percent set-aside, he was able to access treatment within 6 months of developing symptoms of psychosis. John's clinician and treatment team developed an individualized treatment plan that allowed him to start working. He is now employed 30 hours a week and saving to move out of his parents' home. Most importantly, John's family shared, "We have our child back."

Family members play an essential role in their loved ones' recovery, particularly for loved ones with serious mental conditions. SAMHSA—working closely with its federal partners, state agencies, national organizations, family members, and individuals in recovery—continues to promote the science and practice that is making a difference in many lives. Together, we work to provide hope, build resilience, and support recovery for individuals and their families whose lives are affected by serious mental conditions.



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Even Mothers Can't Always Fix What's Broken...

By Lisbeth Riis Cooper



Lisbeth Riis Cooper is the cofounder and vice chair of the CooperRiis Healing Community, an in-patient therapeutic program that helps to ignite hope and desire in individuals whose lives have been impeded by mental illness or emotional distress. To learn more about the healing community, visit the website at CooperRiis.org. Readers may contact Lisbeth by email at lisbeth@CooperRiis.org or by phone at (828) 231-1000.

As parents, we want to fix whatever is not working, be it a broken knee, a car, a dishwasher. However, when a family member experiences mental health challenges, we quickly realize that we are unable to “fix” the person. In the face of this reality, despair, anger, and sorrow become the norm, and the slow process of learning to accept one’s limitations begins.

While my story may be similar to that of other families’ stories, it is also deeply personal and unique. Trying to help my daughter deal with her mental health challenges made me feel that I was left holding broken pieces that could not be put back together again. These shattered feelings resulted from my personal despair as well as the difficulty and frustration of trying to navigate a piecemeal, dysfunctional mental health system. I started to think of *managed care* as *mismanaged care*. This disjointed system—something that I could not fix—reduced my daughter from being a young woman with amazing talents and remarkable potential to a mere diagnosis. Where was her peace of mind? Where was my hope? Repeatedly, we were told to learn to live with her illness, to stop being unrealistic, and to stop thinking that her condition would change.

Little did I know how much my daughter’s distress would affect my own health; the unrelenting stress caused me to develop debilitating asthma. All the while, however, I steadfastly refused to lose hope or stop breathing. I kept thinking that perhaps recovery was *real*, not just a word.



Often, we feel that it is only possible to meet despair with anger. Instead, I chose to turn my anger into action. I asked my husband, Don, to join me in starting a nonprofit residential healing community. Although he had been looking forward to a leisurely retirement, I managed to convince him otherwise. We wanted to spare other individuals and their families some of the pain that we had endured and to introduce them to the power of a healing community. We wanted to create a place where hope, purpose, acceptance, and community would be commonplace. A place where everyone would be treated with kindness and respect. In our community, we would ask each person *“What is your dream?”* instead of *“What is your diagnosis?”* Most importantly, we wanted to invite folks into our hearts and let recovery begin. Today, Don will tell you that this is the most meaningful work he has ever done.

“We wanted to spare other individuals and their families some of the pain that we had endured and introduce them to the power of a healing community.”

A couple of years ago, I read a SAMHSA study that said relapses could be reduced by up to 75 percent over a three-year period if the family had received mental health education. Every time I think about that statistic, I get chills: chills of hope and excitement as I image the unleashed power we as *families* hold in the recovery of our loved ones! In our healing community, treatment would be person-oriented—encompassing the individual’s body, mind, and soul—and include comprehensive family education about mental health.

Our inspiration and model was the Spring Lake Ranch Therapeutic Community in Vermont, where we first learned about the power of community and had our first recovery experience. Our daughter spent six months there and experienced a sense of peace and possibility for a better future, as did we.

As our vision became reality, we did not lay a stone or make a decision without reflecting on what our daughter would want. We questioned whether the setting would be peaceful and right for recovery, and if our community would be meaningful and purpose-driven.

Through the philanthropic generosity of so many, we opened the first CooperRiis Healing Community near Tryon, North Carolina, on June 15, 2003; a second campus opened in Asheville, North Carolina, in 2010. Since then, a dozen homes facilitating community reintegration into college, work, and independent living, have joined the two campuses. To date, we have helped almost 900 residents achieve and sustain their highest levels of functioning and fulfillment. With the help of a supportive community, these neighbors and family members have gone on to being students, teachers, artists, lawyers, homemakers, and dentists.

While we cannot recover **for** someone else, we can recover ourselves, which in turn nurtures the flame of hope in others. Although a mother cannot always fix what has broken, it will not stop her from trying to secure the best outcome for her family. ●

5 TIPS

Five Principles of Family-Centered Care

Health problems often have a disruptive, stressful, and challenging impact on people using services, their family members, and significant others. Engaging individuals and families as partners in the care process, involving them in decision making, and providing support at critical points in the process, such as care transitions, are key to successful integrated practice and the recovery process. The following questions are based on the principles of family-centered care, which have been drawn from groups such as Key Family Voices, the Maternal and Child Health Bureau, the American Academy of Pediatrics, and the Institute for Patient- and Family-Centered Care.

1



How Do You Share Information? How do you know that you are sharing information in an open, objective, and unbiased way?

2



Are You Respecting and Honoring Differences? In what ways have you integrated the cultural traditions of the people you serve and their families? How have you elicited preferences for care among the people you serve and their families? How do you know if you have been successful in doing this?

3



In What Ways Do You Engage the People You Serve as Collaborative Partners? Are you inviting the people you serve and their families to share their needs, strengths, values, and abilities with you? Do you incorporate these into a process of shared decision making?

4



How Do You View Outcomes of Care Plans? Do you consider desired outcomes of medical care plans as being flexible and not necessarily absolute? Do you engage in negotiations with the people you serve and their families?

5



How Do You Ensure that Care Is Provided in the Context of Family and Community? Do you understand the context of the people you serve? Do you learn about their home life, school, daily activities, and quality of life within their community?

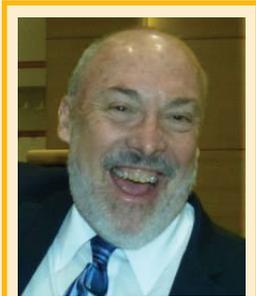
Engagement in family-centered care requires practitioners who know service recipients and their families, understand their problems and assets, and are able to offer specific assistance for their problems.

Adapted from Kuo, D. Z., Houtrow, A. J., Arango, P., Kuhlthau, K. A., Simmons, J. M., & Neff, J. M. (2012). Family-centered care: Current applications and future directions in pediatric health care. *Maternal and Child Health Journal, 16*(2), 297–305.



The Family and Recovery

By Patrick Sullivan, PhD



Patrick Sullivan is Professor at the Indiana University School of Social Work. A graduate of the University of Kansas, he was directly involved in the development of the strengths model of social work practice. Dr. Sullivan also served as the State Director of the Indiana Division of Mental Health and Addictions in the mid-1990s. You may contact him at wpsulliv@iupui.edu.

In an address at the annual meeting of the American Psychiatric Association in 1959, the renowned Karl Menninger reminded his peers: “Each of us here who has been in practice for more than a decade has seen the ‘hopeless case’ recover. And we have sometimes seen, or so it seemed, that a mother’s or father’s indomitable hope was a factor in this recovery.”¹ In speaking about hope, recovery, and the power of family, in many ways Menninger was well ahead of his time.

Professionals have not always been so kind to families. Often seen as a significant factor in the etiology of severe and persistent mental illnesses, or at the least contributing to the exacerbation of symptoms once challenges were at hand, everything from purported faulty communication patterns to pathological mother-child relationship unfairly put many families in a negative light.

Thankfully, perspectives have changed. Perhaps it began with the heroes and heroines that Menninger saluted more than a half-century ago, but clearly the formation of NAMI in the late 1970s gave families a strong voice that they have used to shift prevailing perspectives. Pathbreaking professionals—such as Harriet Lefley, Agnes Hatfield, and Phyllis Solomon²—also challenged the prevailing tendency toward family blame and spoke to tangible ways that practitioners could be supportive and helpful.

1 Menninger, K. (1959). The academic lecture: Hope. *American Journal of Psychiatry*, 116(6), 481–491.

2 Hatfield, A. B., & Lefley, H. P. (Eds.). (1987). *Families of the mentally ill: Coping and adaptation*. New York: Guilford Press.



Today, we are well aware that what we call *recovery* is a process that has individual, interpersonal, and social aspects, and thus by extension, families are important partners in this journey. Family-focused work, in particular what is often called psychoeducation, has long been an established, evidence-based practice. Recent research reviews confirm the utility of this method.^{3,4}

In general, direct work with families on practical matters has been shown to reduce relapse and hospitalization rates. While a wide range of models and approaches exist, in general, professional practitioners have an important role to play in four broad areas—emotional support, education, crisis intervention, and skills training. The type and intensity of emotional support needed varies with each situation, but is undoubtedly critical when a diagnosis has been offered. Many families experience fear, grief, and the sense of overwhelming responsibility. Practitioners must provide family members with direct support and help them build sources of support outside the mental health system.

Families want answers to key questions. With the publication of the first edition of E. Fuller Torrey's

3 Dixon, L., McFarlane, W., Lefley, H., Lucksted, A., Cohen, M., Faloon, I., ...Sondheimer, D. (2001). Evidence-based practices to families of people with psychiatric disabilities. *Psychiatric Services*, 52(7), 903–910.

4 Lucksted, A., McFarlane, W., Downing, D., & Dixon, L. (2012). Recent developments in family psychoeducation as an evidence-based practice. *Journal of Marital and Family Therapy*, 38(1), 101–121.

*Surviving Schizophrenia*⁵ more than three decades ago, the importance of providing basic information in plain language was underscored. While a greater understanding of serious mental illness and recovery exists today, the need for clear and jargon-free information is still critical.

For the practitioner—regardless of discipline—being both hopeful and honest about the future is important, given our inability to predict with certainty how any individual's recovery journey will unfold and the still imprecise science of treatment. Further, some families also need help on concrete items such as enrolling for essential benefits, supporting the appropriate use of prescribed medication, and accessing important community resources. Optimally, a partnership develops among the person receiving services, the family, and the professionals providing services.

One important caveat remains. Helping family members—whether parents, siblings, significant others, or children of a parent challenged with a mental illness—does not absolve providers, policymakers, nor society as a whole from their responsibility to develop the needed resources and supports necessary for persons with lived experience to enjoy the maximum level of freedom and independence they desire. ●

5 Torrey, E. F. (2014). *Surviving schizophrenia: A family manual* (6th ed.). New York: Harper Collins.



REORDER: Recovery-oriented Decisions for Relatives' Support

Outcomes from a research study suggest that an active, shared decision-making process can enhance family engagement and a person's recovery.¹ The study compared results from participants in a **REcovery-ORiented DEcisions for Relatives' Support** (REORDER) intervention with those who were involved in "care as usual" over a four-year period.

A group of 226 veterans with serious mental disorders² and receiving outpatient care at one of three large Veterans Administration medical centers participated in the study. Participants were divided into two groups, and 111 people were assigned randomly to the REORDER program. Throughout the intervention, participants identified and discussed their recovery goals with their provider, who was trained specifically in the REORDER curriculum.

Participants decided the extent to which they wanted to involve their family—as defined by the participant—in supporting them to achieve their recovery goals. Identified family members were invited and offered education and guidance about how to help the veteran achieve his or her recovery goals.

The REORDER program provided person-centered strategies and decision-making preferences that helped participants to make informed choices about the level and type of family involvement that they preferred. The clinicians used those choices as the basis for guiding the family members in supportive roles.

The study showed that the intervention had a robust impact on family involvement in care. Moreover, the participants obtained benefits from the shared decision-making process, including an enhanced sense of recovery and reduced fear and concern about family involvement. For more information, contact Lisa B. Dixon, MD, MPH, at dixonli@nyspi.columbia.edu. ●

1 Dixon, L. B., Glynn, S. M., Cohen, A. N., Drapalski, A. L., Medoff, D., Fang, L. J., ... Gioia, D. (2014). Outcomes of a brief program, REORDER, to promote consumer recovery and family involvement in care. *Psychiatric Services*, 65(1), 116–120.

2 Chart diagnoses included schizophrenia, schizoaffective disorder, bipolar disorder of any type, major depression with psychotic features, or psychotic disorder not otherwise specified.



Recovery-Oriented Health Care: Interdisciplinary Practice Webinar Series

July – September 2015

This summer, join your colleagues from across the country as we explore interdisciplinary recovery-oriented practice through the Recovery to Practice (RTP) summer webinar series!

The Substance Abuse and Mental Health Services Administration's (SAMHSA's) RTP initiative collaborated with professional organizations in addiction counseling, peer support, psychiatric nursing, psychiatry, psychology, and social work to develop six discipline-focused curricula on recovery-oriented practices. This webinar series will draw from these exciting materials, making the RTP principles accessible to all behavioral and general health practitioners working in multidisciplinary and integrated practice settings.

Speakers from multiple disciplines will present an interdisciplinary introduction to recovery-oriented practice. The introduction will deliver pragmatic content to supervisors, decision makers, educators, researchers, practitioners, and students across disciplines in behavioral and primary health settings. Register now to explore how recovery-oriented practice can enhance both the delivery and the experience of quality care.

July 27: Recovery and Recovery-oriented Care: Foundations and Future Considerations

July 29: Healthcare Reform and Recovery

August 3: Culturally Competent Care in Recovery-oriented Settings

August 5: Including Family and Community in the Recovery Process

August 10: Peer Services: Creating an Environment for Success

August 12: Evidence-based Practice and Recovery-oriented Care

August 17: Building Recovery-oriented Systems

August 19: Whole Health and Recovery

August 26: The Role of Medication and Shared Decision Making in Recovery

August 31: Partnership, Engagement, and Person-centered Care

September 2: RTP Applications: Incorporating Recovery-oriented Practice Competencies in Practitioner Training

September 3: Integration of Medical and Recovery Models

Registration information

Participate in individual events or the whole series. Register early, space may be limited. All events will be held from 3:00 – 4:00 p.m. (ET)

All events will be closed captioned and recorded for future access. Transcripts will be available upon request.

No CEUs are available, however, certificates of participation will be provided upon request.

To register, copy and paste this link into your browser:

https://ahpnet.adobeconnect.com/e59o9w416eq/event/event_info.html



National
Recovery Month
Prevention Works • Treatment Is Effective • People Recover
SEPTEMBER 2015

**JOIN THE VOICES
FOR RECOVERY**

visible, vocal, valuable!

Every September, SAMHSA sponsors Recovery Month to increase awareness and understanding of mental and substance use conditions, celebrate the people who recover, and honor the practitioners and service providers who make recovery possible. There's still time to plan and promote your own Recovery Month event, so take advantage of the many resources conveniently packaged in the Recovery Month Toolkit and visit <http://www.recoverymonth.gov> to learn more.

CONFERENCES

Come and meet the RTP staff!
We will be presenting at the following conferences.

AUG
5-7

**Florida Alcohol & Drug Abuse Association & Florida Council for
Community Mental Health**

Behavioral Health Annual Conference Advancing Health, Wellness & Recovery | Orlando, FL

AUG
20-21

InterNational Association of Peer Supporters

2015 National Conference: Cultivating a Culture of Compassion | San Antonio, TX

AUG 31-
SEPT 3

National Home & Community Based Services Conference

Washington, DC

SEPT
8-10

Illinois Alcoholism and Drug Dependence Association

2015 Annual Conference | Lisle, IL

National Minority
Mental Health Awareness Month
JULY

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