

Practicing Recovery: Outreach and Engagement

Issue 4: September 2015



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A NOTE FROM THE PROJECT DIRECTOR



Laurie Curtis, MA, CPRP
Project Director, Recovery to Practice

“Outreach to people who ... are hesitant to use services is central to helping individuals to make positive connections to treatment, services, and supports.”

My neighbor lost a family member to a drug overdose. My best friend’s daughter was hospitalized in a mental health crisis. Several of my own family members are in recovery from mental health conditions or addictions, while others are not, at least not yet.

While we are able to talk more openly in society about mental health and substance use conditions, our nation still falls short in getting those who need help into care. In 2013, the U.S. Health and Human Services estimated that 60 percent of people with mental health conditions and nearly 90 percent of people with substance use conditions do not receive the behavioral health treatment and services they need.

In this issue of *Recovery to Practice*, we consider the role of engagement in recovery. *Engagement* is an umbrella term that describes the concept of an individual’s involvement with, participation in, and contributions to their health care, self-care, social networks, and communities. It encompasses three distinct, but related, behavioral health objectives:

- participating in treatment, services, or recovery supports;
- assuming an active role in decisions about personal health care and recovery; and
- taking responsibility for personal wellness and self-care activities.

Outreach to people who, for whatever reason, are not using services—or who are hesitant to use services—is central to helping individuals to make positive connections to treatment, services, and supports. Sustaining engagement over time, so that individuals can benefit from those services, requires developing respectful, honest, and collaborative relationships with each and every person. ●



A NOTE FROM THE FIELD



Scott Spicer, MPH, CPSS

A certified peer support specialist and co-founder of National Mental Health and Dignity Day, Scott Spicer has more than eight years of experience in the behavioral health field. His experience includes working with youth and adults in community and university settings, as well as in supported employment and case management programs. Scott served on the American Psychological Association's Recovery to Practice initiative from 2010 – 2014. You may contact him at scott@spicersconsulting.com.

From Outreach to Engagement

Outreach is a word we hear often in social services, but it is not always clear what it means. Why do outreach? What does outreach look like? How can practitioners be effective?

An important part of service delivery, outreach is especially useful in engaging people who may have barriers to accessing care, such as individuals who are experiencing homeless, were formerly incarcerated, are members of minority communities, or are youth and young adults. The key to effective outreach is taking the time to develop relationships with individuals and start “where they are.” This requires listening and interaction skills, patience, and a willingness to be flexible.

While there is no set formula, it is essential to meet individuals where they are. This means that we allow them to make changes when *they* are ready and not always offer solutions. We must take whatever time we need to build rapport, trust, and hope. Although we may not see results, providing supports and resources do have an impact and can help move people toward greater stability over time.

To provide outreach effectively, workers need to cultivate a sense of self-awareness. For example, my own background as a middle-class, educated, white male affects others’ perceptions of the support I offer. I need to be aware of how others may view me as well as any assumptions I harbor about others.

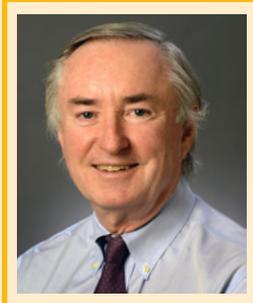
I must recognize that the first—or fifth—attempt to engage a person may fail. That is not a reason to give up, however. Subsequent follow up can chip away at barriers while demonstrating empathy and commitment to forging relationships. It is seeing the strengths of each individual—and nurturing those strengths over time—that most effectively banishes barriers to engagement and relationships through outreach. ●

“While there is no set formula, it is essential to meet individuals where they are.”



Outreach with People Experiencing Homelessness

By Jim O'Connell, MD, President, Boston Health Care for the Homeless Program



Jim O'Connell, MD, has been a doctor with the Boston Health Care for the Homeless Program for the past 30 years. He recently spoke with Livia Davis of the Center for Social Innovation about what he has learned about street outreach and engagement while caring for people who are experiencing homelessness.

There is still much to learn about how to engage people who have been so scarred by the system that they initially see us as the enemy. Many people we encounter on the street are reluctant to speak to us. This may be because they have had negative past experiences or it may be because of a mental health condition such as paranoia. The process of building a relationship of trust and care takes place over time. The first principle we learned is that *time* is the most effective outreach tool we have.

It takes time to get to know someone. We must be willing to simply be present and show our intention of being a reliable, consistent presence. This can take place over a cup of coffee at McDonald's or out on a park bench. Once the person experiences us as being trustworthy—as opposed to someone intruding in their lives—then we have a foundation for having a discussion about what the person needs. Once trust is established, we can be seen as being part of the person's recovery and healing.

The challenge for us—as clinical and professional teams—is that our day-to-day workloads make it hard to dedicate the time needed to build trust and engage the person, but if you can take the time, we've found that barriers disappear and conversation becomes disarmingly easy.

The second principle we adopted is that we must go where people are; we cannot wait for them to come to us. Living on the streets and in homeless shelters requires *immediacy* and all of one's attention. This is the immediacy of survival. We quickly learned that when we made a medical appointment further out than tomorrow, the person



almost never showed up. Thinking that the person would go to a strange place to talk to somebody they don't know about what's bothering them distantly is unrealistic. Consequently, we realized that we really have to go to them, and I think teams have to go to them.

The third principle we adopted for our outreach approach is that you need to have a constant and consistent presence. To be constant and consistent, that presence has to be a *team*, not an individual. One concern when we started Boston's Health Care for the Homeless project in 1985 was that well-intentioned people—such as me—would go out, spend six months or a year getting to know people, and then move on, which would not be fair to those who engaged with you. To address this problem, early on we adopted a team-based approach to continuity of care. All members of the team share fully in the care of each individual on the team's panel of patients. If one team member leaves, the loss is mitigated because the individual experiencing homelessness is fully familiar with the other team members. Our goal has always been to assure continuity of care with a team that shares fully in the care of a defined panel of patients.

Experience also taught us that the team is much stronger when it is *multidisciplinary*. The fourth principle that we put into practice is to fully integrate and co-locate medical care, behavioral health, case management, and peer support. Multidisciplinary teams—when given an opportunity to have a constant presence on the streets or in shelters—can really make a difference in people's lives. ●

Practice Pearls: Four Principles of Effective Outreach and Engagement

1. *Take whatever time you need to build a trusting relationship with the people you serve.*
2. *Meet people where they are; do not wait for them to come to you.*
3. *Work in teams to establish a constant, consistent presence and ensure continuity of care.*
4. *Build multidisciplinary teams, including primary and behavioral health, case management, and peer support.*



Becoming Who I Was Meant to Be

By Iden Campbell McCollum



Iden Campbell McCollum, CPRP, is the founder and executive director of The Campbell Center, an education and advocacy group for individuals living with and seeking treatment from mental health and substance use conditions. To learn more about The Campbell Center visit thecampbellcenter.org. You may contact Iden at iden@thecampbellcenter.org.

I am a transman or a person who identifies under the transgender umbrella. It took me many years to be able to live as my true self. Growing up in foster care, others considered me deviant and asked if I was gay. Throughout high school, I saw a therapist weekly, but I was unable to discuss the true cause of my depression and anxiety. Clinicians sought to cure me of homosexuality, although when asked if I were gay I honestly answered *no*. I lacked the ability to explain that while I was born a biological female, inside, I felt like a boy.

I have received treatment and been hospitalized in four states, received public mental health care in six states, and received housing in none. I shifted from practitioner to practitioner in order to get medication, but often I did without. As a result, I lost jobs, friendships, and romantic partners. I attempted suicide multiple times. In an effort to maintain my “stability,” I hid my identity, doing without the support and therapeutic services I needed.

What kept me going was the promise I made to myself: one day, I would help others get the support they needed while being their true selves. I went into the helping professions, working in corrections and in the disability field. I became aware of the “invisible people,” those living with mental health conditions or addictions. I became an advocate for those I worked with and believed I was making a difference. This advocacy, however, triggered my first adult mental health crisis and I needed support in an adult system of care.

I finally found an agency where I felt truly engaged, although they knew little about LGBT services. My treatment team—a team leader, a community support worker, and a part-time community support



worker—was exceptionally empathetic, caring, and willing to listen. They cared for me as a human being. For the first time, I was able to describe my experience using my own voice instead of phrasing it in their words.

The community support workers accompanied me to college registration, standing in line with me. They helped me handle the voices that said my co-workers were talking about me. Most importantly, they never told me to change my appearance to receive services. They supported me being my authentic self and I finally expressed that I knew I was transgender. I safely explored this newfound revelation with a psychiatrist, who provided resources to help me decide if transition was right for me.

I continue to work on being healthy emotionally, physically, and spiritually. It's hard work, but along the way I have found tools that provide tremendous support. In 2001, I discovered WRAP or the [Wellness Recovery Action Plan](#), which has supported me through many difficulties. Using this prevention and wellness process has enabled me to stay out of the hospital for the last 11 years. Due to my own success with WRAP, I was inspired to become a WRAP facilitator and an advanced level WRAP trainer.

To do outreach successfully, you must begin by understanding the community, especially the cultures

and diversity of the groups living there. Before making contact, it is important to realize that not all outreach strategies work with all people. When working to engage people in services, try various approaches. Several examples include holding social gatherings, employing email listservs, using social media, airing PSAs, distributing print materials, and running peer support groups.

Working one-on-one, doing street outreach means meeting people where they are. In Washington, DC, we often visit people under bridges, in parks, and libraries. Many are veterans, LGBT, teens and young adults, and people experiencing homelessness. We

have conversations, offer them a safe place, and provide information about available services.

I have come a long way from being the kid in foster care afraid of

losing housing stability to being an adult who has advocated for thousands—including myself—to have the stability we all deserve. I am fortunate that many wonderful people have supported me along the way. As in any life, there will be ups and downs, but I know that the downs provide opportunities for growth and connection. I will continue to do the work necessary to keep myself healthy and present while offering my support to those in the recovery community who seek the same. ●

“Working one-on-one, doing street outreach means meeting people where they are.”

5 TIPS

Five Tips for Making Meaningful Connections

SAMHSA draws from diverse experts to inform its work. These tips on effective outreach and engagement are drawn from practitioners, peer supporters, law enforcement officials, housing experts, people who have been homeless and chose to disengage from behavioral health services, and their families. Outreach and engagement are about cultivating relationships.

1



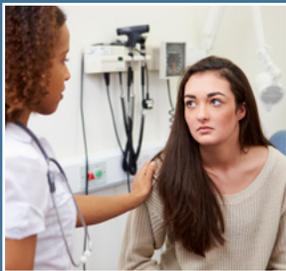
Meet people where they are: Seek them out and what is most important to them. This is more likely to be a pair of warm, sturdy boots than it is an appointment with a psychiatrist. Ask *"How can I make your life a little better today?"*

2



Engender hope and respect, and identify... a particular strength that the person has during each interaction. Find out what the person thinks is most important to their well-being and give it priority. Many pathways lead to engagement and recovery. Resistance and reluctance may be acts of honor, courage, and a desire for independence. Recognize that strength.

3



Be persistent: Show each individual—respectfully and without intruding on their privacy— your sincere concern for them. Return and suggest more options for support when they are ready to choose them. Sometimes peoples' lives seem defined by chaos as they find themselves in and out of public service systems: a homeless shelter, an emergency room, the corrections and judicial system. Here, persistence, walking with them on their journey, and reaching out to help is essential. *"If someone is not at the prison door when the person is released, we have lost that person."*

4



Respect worldviews: People have many reasons why they have not engaged in, or have dropped out of, behavioral health services. Some found that treatment did not help; others gave up when they did not see immediate change. They may have had a poor therapeutic relationship or another negative experience. They may have wanted greater involvement in the decisions affecting them or felt dehumanized and disrespected by language used. *"I don't want to get near a case manager: I don't want to be managed!"*

5



Be genuine: While the system is largely oriented towards eligibility, capacity, data, and scarce resources, never overlook the human factor in outreach and engagement. *"If you see someone who looks like they need a friend, reach out and be that friend."*



Baltimore's HOPE Wellness and Recovery Center

By Thomas Hicks

A participant-run Wellness and Recovery Center (the Center) for people who are experiencing homelessness and seeking mental wellness, HOPE—Helping Other People through Empowerment—began providing services in 2001. Our purpose is to help these individuals transition back into mainstream society by offering peer support programs with myriad drop-in services. The Center offers a place where people can access a computer, get a haircut, do their laundry, or take a shower. HOPE also links people to case managers who can help people get treatment and access to services such as housing vouchers, food stamps, transportation, and job-search assistance.

When people enter the doors at HOPE, we greet them by name and with dignity, respect, and empathy. Services typically start with a simple question: “How can we help you?” Our goal is to support and restore self-respect and build confidence within each person we serve. We also guide an individual to recovery, if that is their chosen path. Being supportive, encouraging, and empowering are vital engagement

tools. We do not treat people as if they are their diagnosis; we know it does not define who they are.

Our staff reflects the people we serve. The Center employs 12 certified recovery coaches, who share their lived experiences and serve as mentors, both in and out of the Center. Street outreach and engagement can be challenging. If a person is not ready to take care of their wellness, we leave information and wait. Once individuals decide to visit the Center, we guide them in their choice of programs to support healthy change. Wellness Recovery Action Planning—WRAP—is just one of the peer support groups that we run.

One lesson we have learned is that recovery is not a sad, lonely process. The healing power of laughter is a great recovery tool. As participants come to understand that recovery is possible and that they can enjoy themselves while recovering, planning for recovery becomes much easier. ●

Thomas Hicks is HOPE's executive director; you may reach him at thickshope@verizon.net.

“Being supportive, encouraging, and empowering are vital engagement tools.”



Meeting Folks Where They Are

By Jason A. Zimmerman, CPSC, CRE



Over the past eight years, Jason Zimmerman has worked as a peer counselor at the James H. Quillen Veterans Affairs Medical Center (VAMC), also known as the Mountain Home VAMC, located in east Tennessee. In this role, he conducts individual mental health assessments, facilitates WRAP (Wellness Recovery Action Plan) groups with veterans experiencing mental health conditions, and is a team member with the Psychosocial Rehabilitation Treatment Program. Before coming to the VAMC, Jason served as a medic in the U.S. Army from 1997 – 2003. You may contact him at Jason.Zimmerman@va.gov.

As a peer counselor working at a Veterans Affairs Medical Center (VAMC), I know first-hand how difficult it can be for a veteran to get mental health care. In rural Tennessee, there are at least two strong cultural aspects working against veterans seeking help. The first is an attitude embedded within military service itself. Veterans and people serving in the military often hear how we need to “be tough” and “soldier on.” It is my job to show the veteran that seeking solutions to a problem can be a sign of strength and resilience. It is OK to reach out for help, and there is no shame in that.

A second challenge comes in confronting the general attitude about mental health conditions that we often see in rural Appalachia. It seems that here—and perhaps in many other places as well—the concept of mental health treatment engenders negative attitudes and prejudice that we have to work through if we are to meet each veteran’s clinical needs and treatment preferences.

As peers, we reach many veterans by sharing our own experiences in recovery, what we have seen and been through. Building genuine, open relationships over time with another veteran who has a common, shared, lived experience makes it easier to engage that person in services. When the person learns that I, too, have faced many of the same hurdles that they face, they feel more comfortable or experience a newfound sense of optimism.



Many of the veterans I talk with struggle to manage the complexity of the Veterans Health Administration. Peer practitioners serve as a bridge to help with these challenges. Helping veterans who have stepped away from services to fully re-engage is often more difficult than connecting a person to services the first time. Barriers that peer practitioners commonly hear include bad experiences with medications, the system, or the way that treatment was delivered, especially when the veteran feels that they had little input into or control over decisions about their services. We know that self-direction and self-determination are core foundations for recovery.

When we describe how mental health treatment practices are changing—in terms of both medication and treatment options—we see a much higher engagement rate. For example, we now take a more holistic approach that focuses on the individual's overall wellness, not just the symptoms of a mental health or substance use condition. We consider how the condition affects the whole of the person's life—relationships, work, family, spirituality, recreation, and dreams. As the veteran learns about the possibility of holistic and self-directed care, it is not unusual to see the person become excited about the prospect of recovery. One of the guiding principles of recovery is that *hope* is the catalyst of the recovery process.

"We know that self-direction and self-determination are core foundations for recovery."

In particular, approaches based on self-direction and self-determination offer individuals new hope for recovery. We sit and talk with each individual about the many ways to be involved in directing their own care. When the veteran understands that they will be the one in charge and making the decisions, we see amazing results. Technology is an especially valuable tool to help the person feel in control of their care. New and exciting smartphone apps—such as PTSD Coach, Mindfulness Coach, ACT Coach, and PE

Coach—can help veterans and others track and manage how they are doing each day.

WRAP—the Wellness Recovery Action Plan—is another great recovery tool for veterans and people

in the military. As a WRAP group facilitator, I work with people during a three-week, 18-hour course to help them develop their personal wellness plans. This process also gives me a chance to spot others who may have potential to become good peer specialists and suggest that they consider this career. By becoming a peer specialist, veterans have the opportunity to turn a diagnosis—that was traditionally regarded as a weakness—into a strength. Having meaningful work and helping others not only makes me feel good, it helps give my life purpose, which supports me in my personal recovery. ●

WHAT'S NEXT?

Recovery Month

The theme for Recovery Month 2015 is *Join the Voices for Recovery: Visible, Vocal, Valuable!*, which highlights the value of peer support in educating, mentoring, and helping others. The theme also invites individuals in recovery and their support systems to be catalysts and active change agents in communities, and in civic and advocacy engagements. It encourages individuals to start conversations about the prevention, treatment, and recovery of behavioral health conditions at earlier stages of life.

[Find a Recovery Month event](#) in your area and learn more about local activities to support recovery efforts.

National
Recovery Month

Prevention Works • Treatment is Effective • People Recover

SEPTEMBER 2015

National Wellness Week

Join us in celebrating National Wellness Week during September 13 – 19. The week, always observed the third week of September, encourages people to improve their physical and mental health by making positive lifestyle changes. Practicing wellness provides an essential foundation for good health. Wellness, which means overall well-being, includes the mental, emotional, physical, occupational, intellectual, and spiritual aspects of a person's life. Incorporating aspects of the [Eight Dimensions of Wellness](#), such as choosing healthy foods, forming strong relationships, and exercising often, into everyday habits can help people live longer and improve quality of life. The Eight Dimensions of Wellness may also help people better manage their behavioral health condition and experience recovery.

SAMHSA created its Wellness Initiative to help increase awareness of health disparities among people with mental health and substance use conditions and the general population. The National Wellness Week is just one part of the initiative. Since the founding of National Wellness Week in 2011, at least 300 organizations in 46 states, Puerto Rico, and Guam have marked the week with more than 700 wellness-related events and activities. To learn more, visit <http://www.samhsa.gov/wellness-initiative>.



Connecting All Aspects of Health

SAMHSA WELLNESS INITIATIVE

RTP PRESENTATIONS

New York Association of Psychiatric Rehabilitation Services 33rd Annual Conference

Recovery at the Crossroad: The Choices and Changes Ahead

Kerhonkson, New York

[Learn more](#) or register to attend.

SEPT
16-18

Alternatives Conference

2015 (RTP presentation tentative)

Memphis, Tennessee

[Learn more](#) or register to attend.

OCT
14-18

2015 American Occupational Therapy Association/Occupational Therapy Centralized Application Service (AOTA/OTCAS) Education Summit

Denver, Colorado

[Learn more](#) or register to attend.

OCT
17-18

American Public Health Association Annual Meeting and Exposition

Chicago, Illinois

[Learn more](#) or register to attend.

OCT 31-
NOV 4

CONFERENCES & EVENTS

World Suicide Prevention Day

<https://www.iasp.info/wspd>

SEPT
10

National Suicide Prevention Week

<http://www.suicidology.org/about-aas/national-suicide-prevention-week>

SEPT
13-19

Mental Illness Awareness Week

<https://www.nami.org/Get-Involved/Raise-Awareness/Awareness-Events/Mental-Illness-Awareness-Week>

OCT
4-10

National Depression Screening Day

[Download](#) a free promotional toolkit.

OCT
8

WHO's World Mental Health Day 2015

Dignity in Mental Health

[Learn more](#) & download free planning resources.

OCT
10

2015 Annual Behavioral Health Care Conference

Behavioral Health Care IS Health Care

Rosemont, Illinois

[Learn more](#) or register to attend.

OCT
15-16

International Nurses Society on Addictions

39th Annual Educational Conference: Living, Teaching & Modeling in Addictions Nursing: Biopsychosocial Approaches

Charlotte, North Carolina

[Learn more](#) or register to attend.

OCT
21-24

American Psychiatric Nurses Association 29th Annual Conference

Collaborating in an Evolving Health Care System: Opportunities to Advance Psychiatric-Mental Health Nursing

Lake Buena Vista, Florida

[Learn more](#) or register to attend.

OCT
28-31

28th Annual National Prevention Network Conference

Seattle, Washington

[Learn more](#) or register to attend.

NOV
17-19

RESOURCES

Behavioral Health Services for People Who Are Homeless. Treatment Improvement Protocol (TIP) Series 55. Rockville, MD: SAMHSA's Center for Substance Abuse Treatment, 2013. Available at <http://store.samhsa.gov/product/TIP-55-Behavioral-Health-Services-for-People-Who-Are-Homeless/SMA13-4734>

Best Practices Compendium for Serious Mental Illness by L. Greenberg. Washington, DC: Medicaid Health Plans of America Center for Best Practices, 2012. Available at http://www.mhpa.org/_upload/SMICompendiumFINALweb_744522.pdf

Mental Health Service Users' and Practitioners' Experiences of Engagement in Assertive Outreach: A Qualitative Study by N. Wright, P. Callaghan, and P. Bartlett. *Journal of Psychiatric and Mental Health Nursing*, vol. 18, no. 9, pages 822 – 832. Available at <http://onlinelibrary.wiley.com/doi/10.1111/jpm.2011.18.issue-9/issuetoc>

Assessing the Evidence: What We Know About Outreach and Engagement by J. Olivet, E. Bassuk, E. Elstad, R. Kenney, and L. Shapiro. Homelessness Resource Center. Rockville, MD: SAMHSA's Center for Substance Abuse Treatment, 2009. Available at <http://homeless.samhsa.gov/resource/assessing-the-evidence-what-we-know-about-outreach-and-engagement-37555.aspx>

Building Partnerships: Key Considerations when Engaging Underserved Communities under the Mental Health Services Act (MHSA). Sacramento, CA: UC Davis Center for Reducing Health Disparities. Available at http://www.dhcs.ca.gov/services/MH/Documents/BP_Key_Considerations.pdf

Mental Health and Homelessness: A Guide for Mental Health Planning and Advisory Councils. Alexandria, VA: National Association of Mental Health Planning and Advisory Councils. Available at <http://www.namhpac.org/PDFs/homeless.pdf>



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