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CAPSS NEWS

Client Affairs / Peer Support Services, A Quarterly Publication from the SCDMH Office of Client Affairs

Special Interest:

Recovery Concepts

We hope to expand an understanding of recovery by presenting a brief overview of the historical development of humane care and by presenting different perspectives on recovery.

Highlights:

Recovery Concepts

Recovery, it is such an elusive concept meaning different things to different people. Many still seem to regard recovery with much skepticism today. Some professionals feel that recovery for the people they serve is a pipedream, they are just "too sick" or insist that if failure to progress is because we are unmotivated, non-compliant, manipulative, lack insight or are just plain lazy. Other professionals and lay persons alike go so far as to question how those who celebrate their recoveries and encourage others were probably misdiagnosed, never "sick" to begin with. Still others profess a belief that while persons with mental illness can achieve levels of rehabilitation do not believe that we could become "recovered".

What seems to hold true for most is that being diagnosed with a severe persistent mental illness is overwhelming, to the individual, their families and loved ones. It is reasonable to assume that most people, in general, are not well equipped to deal with the impact that a diagnosis of any major illness. It is also reasonable to assume that our personal expectations and beliefs about the type illness experienced heavily impacts our responses to them.

It is no wonder then that we have such a hard time determining what recovery is and how do we know when if we have done it. In the next few issues of CAPPS we hope to expand an understanding of recovery by presenting a brief overview of the historical development of humane care and by presenting different perspectives on recovery.

We hope that this will promote and encourage honest, open discussions on how you view recovery and the impact it has on the way you promote recovery in your own life whether you are a client, professional, family member or friend.

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Beginnings

The start of the 18th century is often referred to as the Age of Enlightenment or the Age of Reason terms coined by writers of the time. They postulated that society itself was emerging from centuries of darkness and ignorance, shifting from old ideas, traditions and institutions to period of thought fueled by science, reason, new approaches and solutions and respect for humanity; in short an Age of Enlightenment.

At the beginning of the movement persons who deemed "insane" were generally viewed as wild animals that had lost their ability to reason. While not held "morally" responsible for their behavior, they were never the less subject to scorn and ridicule by the public, often kept in "madhouses" in atrocious conditions, often in chains and neglected for years, subject to horrific "treatments" that included among other things beatings, bloodletting, starvation, and isolation.

Continued on pg. 2

Recovery Concepts continued. For enlightened thinkers throughout Europe and then the United States the result was the concept of Moral Treatment.

Moral Treatment resulted partly from an understanding of psychiatry/psychology of the time and partly from religious or "moral" beliefs. Moral Therapy is based on the concept of mutual respect, that care should be kind and personal, with an emphasis on occupational therapy, religious exercises, amusements and games and that the intimidation, the use of physical violence and/or restraints should be avoided. In the United States the most well know proponents of Moral Treatment were Benjamin Rush (1745-1813) a well-know and thought of physician at the Pennsylvania Hospital founded in 1751, Dr. Samuel Woodward Superintendent of the Worcester Massachusetts State Hospital in the 1830's & 1840's and Dorothea Dix (1802-1887) a Boston school teacher who fought for humane treatment and care of not only the mentally ill but also the poor and prisoners. She is credited with helping to establish more than 30 state hospitals.

By the end of the 19th century and into the 20th, Moral Treatment was quickly eroding. Hospitals were under-funded, large, over-crowded, run-down and isolated. The principals of respectful, kind, individualized care gave way to "custodial" management or the warehousing of human beings. The emphasis was on security, social as well as institutional isolation, and physical restraint.

Critics of Moral Treatment have made valid arguments that it centered on "victim blaming", was oppressive to persons whose religious views differed from the treatment providers and generally treated patients like ill-behave children, but it is hard to not argue that was a more humane approach and still influences treatment today.

The Medical Model

Moral Treatment gave way to the Medical Model approach to treating psychiatric disorders. Viewed from this perspective mental illnesses are characterized as a chemical imbalance(s) and/or organic malfunction(s) of the brain. Psychiatric illnesses are viewed chronic, often disabling, lifelong conditions requiring medication(s) to stabilize symptoms. Many have argued that this approach allows psychiatric illnesses to be viewed no differently that any other type of medical illness or disease thereby reducing stigma and improving treatment.

Countless numbers of people who have been diagnosed with psychiatric illness would argue that neither medicine nor society treated their "illnesses" in the same way that any other chronic condition is treated. Psychiatric patients in general hospital setting are isolated, that they we are viewed with at best skepticism and often with disdain by other medical professionals.

In addition the medical model approach places the "patient" in an extremely passive role, leaving treatment decisions up to the experts. As a result many people are demanding systems of mental health care adopt new models of treatment emphasizing a philosophical shift to treatment. The President's New Freedom Commission on Mental Health states that …The Nation must invest in the infrastructure to support emerging technologies and integrate them into the system of care. This new technology will enable consumers to collaborate with service providers, assume an active role in managing their illnesses, and move more quickly toward recovery.

So, how does this type of transformation take place? The following article **Recovery: Changing From A Medical Model To A Psychosocial Rehabilitation Mode** was written by Mark Ragins, M.D. a board certified psychiatrist specializing in community mental health, and a staff psychiatrists at the Village Integrated Service Agency in Long Beach, CA. in one view. **(Reprinted with permission)**

Ever since Kraeplin defined schizophrenia, or dementia praecox, 100 years ago, as a chronic, unremitting, gradually deteriorating condition, it has been difficult to talk credibly about or work towards recovery with severe mental illness. The relationship between treatment professionals, patients and their families has frequently been frustrating, unsatisfying, and non-collaborative often to the point of coercion. Clients and families are often waiting for their illnesses to go away, or be cured, in order to go on with their lives and are angry at professionals for not helping them, or doing anything for them, since their lives are not improving at all. At present, most people on all sides have abandoned the process entirely out of despair. Very few psychiatrists treat the chronically mentally ill and increasing numbers of patients are described as "treatment resistant" and families are "burned out" and disengaged. The result is the abandonment, neglect and deterioration we see all around us. All this hopelessness exists despite clear evidence of the growing efficacy of our treatments, and more benign outcomes than traditionally thought. I would argue that the problem may be as much in our conceptual model of treatment and recovery as in the inherent nature of the conditions. Schizophrenics in third world countries are regularly reported to have better outcomes than here. Also people with schizophrenia who explain their conditions spiritually, instead of medically, apparently fare better. The medical model tends to define recovery in negative terms. Symptoms and complaints need to be eliminated. Illnesses need to be cured or removed. Patients need to be relieved of their conditions and returned to their pre-morbid, healthy, or more accurately not-ill state. A comfortable treatment relationship between powerful healing professionals and helpless patients complying with orders they need not really understand results in a clear recovery.

Continued on pg. 3

Concepts continued This model tends to break down for chronic medical conditions. Striking examples can be found in most nursing homes. Even with common illness like hypertension, recovery is difficult to conceptualize within this model. Has a person who takes blood pressure medication permanently resulting in normal blood pressure recovered? How about a person who alters his diet, exercises, eats less salt, deals with stress better and normalizes his blood pressure without medication? Hypertension is often asymptomatic even untreated. How would we assess a person who has no treatment, lives a normal life, has high blood pressure throughout but never suffers any complications like strokes or heart attacks? If we were to move on to more complicated chronic illnesses like diabetes, psychiatrists' favorite medical analogy, the model would be even more inadequate in conceptualizing recovery.

For severe mental illness it may seem almost dishonest to talk about recovery. After all, the conditions are likely to persist, in at least some form, indefinitely. How can someone recover from an incurable illness? The way out of this dilemma is by realizing that, whereas the illness is the object of curative treatment efforts, it is the persons themselves who are the objects of recovery efforts. The medical model handles this by making it a two-step process. First, treat the illness, and then rehabilitate the person. The net effect is often to delay recovery indefinitely while medical cures for the illness are being sought. There is also a discordance between the professionals focusing on the illness, while the people focus on their entire lives.

This often leads to a serious communication barrier with many people complaining that their doctors don't talk to or listen to them. The two processes of cure and recovery are, although interrelated, not absolutely dependent on each other, and can and should be pursued concurrently.

A broader perspective can be obtained by examining other established treatment models that conceptualize the recovery process and the helping relationship in very different ways than the medical model. Within the 12-step model for treating substance abuse disorders, and increasingly other psychological conditions, people are "in recovery" if they admit .they are alcoholic, stay sober, and work a program. Just being a "dry drunk" really is not enough. Put into more theoretical terms these elements of recovery are:
1. Accepting having a chronic, incurable illness, that is a permanent part of them, without guilt or shame, without fault or blame.
2. Avoiding complications of the condition (e.g. by staying sober).
3. Participating in an ongoing support system both as a recipient and a provider.
4. Changing many aspects of their lives including emotions, interpersonal relationships, and spirituality both to accommodate their illness and grow through overcoming it.
People must take responsibility for their own recoveries, helping themselves for their own benefit. ("it won't work if you're doing it for someone else." "No one can do it for you.") Treatment professionals are eliminated entirely from the process replaced by "a higher power" and a network of sponsors and self-help groups.

Medical rehabilitation tends to conceptualize recovery more in terms of function than pathology. A person can recover from a stroke by being able to walk or talk again even though the brain cells are still damaged and can never be normal again. Neither permanent pathology, treatment, nor adaptation invalidates a recovery if people have met their functional goals. Treatment professionals are therapists who act as coaches helping to design a rehabilitation plan in which they support the patients' efforts to achieve a series of functional goals. Their relationship often focuses around motivating and focusing the patients, own efforts to help themselves.

Within rehabilitation, there is more of a concordance between the professional and the patient, than within the medical model, because both are clearly focused on treating the person and not the illness. Patients can experience active recovery regardless of the state of their illness. Spiritual healing is a more complex and diverse field. Recovery tends to depend upon first achieving internal changes conceptualized either spiritually (for instance, "open your heart to God" or "purify your soul") or in terms of transcendent health and balance (either internally as in "balancing yin and yang" or "detoxifying your system" or externally as in "coming into peace with Mother Earth" or as in astrology). After achieving this state of "grace" or "balance" the illness is expected to be relieved automatically or "miraculously" This process of first achieving transcendent health and then relieving the illness is the exact opposite of the medical model where first the illness is treated and then the person can achieve higher goals. In fact, treating an illness medically first is often equated with betraying spiritual faith and therefore antagonistic to God and spiritual healing. In mental health we tend to overtly exclude spiritual aspects of life and treatment although they may be very important to our clients. Even still, many clients will attribute their recoveries to someone "really believing in me" or "seeing something inside me that I couldn't see" or "really caring about me not just because it was their job." These moments, whether conceptualized spiritually or not, clearly impart a state of acceptance and love, prior to relieving the illness. We may not even realize this is happening, and usually have not designed the treatment plan or ... relationship trying to maximize it, although it may be the most central factor in our clients' recoveries. Indeed, treating a person as a "case" or a collection of symptoms is generally perceived as highly dehumanizing and makes feeling "whole," "well," "loved," or even "understood" almost impossible. **Continued on pg. 5**

Tips to Surviving the Holidays
By Bobbie Lesesne

The Holiday season is packed full of love and joy! **No!** Well, maybe it isn't always. The very season that is supposed to bring so much happiness, actually brings a lot of stress and heartache for many.

Even during a "normal" year holidays, can actually be a difficult time for many of us. This year with all the grim, dire predictions and the economy in a huge slump, just listening to news reports gives me the "Hibbie Gibbies," or better know as a panic attack.

Even though I still feel a void this time of year for those, I have lost, I count my blessings, and I have a lovely family to spend this time with each year. However, I have had to learn what to do and how to survive to keep myself well, because in the past, I let my emotions rule me.

For those less fortunate, feelings of isolation and loneliness can magnify during these times of warmth and cheer. Christmas and Thanksgiving more than any other holiday time means "Family Togetherness," or at least that is what the Norman Rockwell paintings and all the TV ads depict. In reality, Christmas especially, a religious holiday, which turned into a big promotional event for retailers, puts a huge amount of stress on all of us to live up to an imagined ideal.

The National Institute of Mental Health (NIMH), estimates that there is a 15% increase (this number may increase) in the number of people who will be seeking professional help during this holiday season. If you do have thoughts of hopelessness and despair, which is triggered by the season, don't be ashamed to ask for help. Actually, it is a very wise thing to do if the need is there.

Listed below are some tips and a few tricks, although not exhaustive, have helped others and me in coping with the holiday season, and make the holidays, what we want them to be, but add your own and make it personal:

- Take care of yourself. Talk to your family and friends about your expectations for the holiday. Don't put pressure on yourself, and tell your friends and family that is what you are going to do.
- Write letters, phone calls or give a card with a note instead of worrying about buying a gift.
- Volunteer in a homeless shelter kitchen
- Attend Church, especially on Christmas Eve or Day
- Stick to you wellness plan as much as possible to stay balanced, don't over schedule yourself, even pamper yourself
- Don't fall back into the "child role or sick role" when with family
- Anticipate problem areas or hot spots and have a plan of action with a friend or family member that is between the two of you.
  1. Go for a walk, or more bluntly- Get ME out of here
  2. Say, I need a break, get some fresh air
  3. Remember you may not want to stay with family over night
  4. Say, let's not discuss the past or bad memories, no drama
  5. Go out and play with a pet
- Focus on what you are doing not what others are doing, be mindful.
- Don't think in black or white terms, a good time or bad time, find things, people, who give you a boost, or you be there for them.
- Don't worry about the small stuff, if your home isn't in perfect order, your gifts aren't wrapped perfect, the cookies are store bought, and remember no one is perfect, and the odds are no one will really care.

Finally, these two holidays only come once a year, repeat I will survive; I will survive**, breathe**, and eat with out guilt! That is what the New Year is for … a diet.

Peace be with you and yours this holiday season and all next year!

Bobbie

Dear Fellow CPSS's:

I am grateful for each and every one of you and the work that we do to help those we care about. Thanksgiving is a special time to give thanks for all those we love and to thank our Creator for the blessings He has given to each of us. May God richly bless you all this holiday season, and as you give thanks to Him, remember that it is more blessed to give than to receive. May God put a song in your heart today! I do it along with the clients in my groups to empower them to think positively and to focus on gratitude as a daily discipline to help them take action for change in their lives.

John Martin, CPSS Santee / Wateree

Tell? - Don't Tell?

Self-Disclosure and Its Impact on Individuals Who Receive Mental Health Services

Deciding to reveal that you receive or have received treatment for a mental illness is not an easy decision. A diagnosis of mental illness can carry a lot of unwanted and unwarranted baggage.

The stigma is associated with mental illnesses have resulted in discrimination in housing, employment, and health insurance. It is a major reason people delay or refuse treatment and hinders recovery.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has released a new report which reviews existing public health literature on how people who receive mental health services can be affected when they disclose this fact to others. Entitled "Self-Disclosure and its Impact on People who Receive Mental Health Services," the report which is also based on a series of interviews with individuals involved in this process examines the potential benefits and risks of this experience.

The report assesses the consequences for a number of perspectives including different societal settings and the unique considerations mental health professionals may face when disclosing their own use of mental health services.

Developed by SAMHSA's Center for Mental Health Services (CMHS) this report also offers specific recommendations on what kinds of further research are needed on this topic as well as other factors that individuals contemplating self-disclosure may want to consider.

This monograph examines current literature related to self-disclosure and provides the findings from a series of key informant interviews to examine the factors that promote or hinder self-disclosure. Books, articles, and Web sites were analyzed in order to glean key findings and implications regarding the disclosure of mental illness in various arenas.

Some of the questions examined included the following:

- Why should a person disclose that he or she has received mental health services?
- What are the advantages and risks of disclosure?
- What factors facilitate disclosure?
- Is there a safe way to disclose?
- What impact does self-disclosure have personally and systemically?

To download a copy of the report or to order a print version, go to http://mentalhealth.samhsa.gov/publications/allpubs/sma08-4337/

Concepts continued Psychosocial rehabilitation is a growing movement in community mental health today. One of the main roots of psychosocial rehabilitation is the consumer movement which arose primarily as a reaction against the psychiatric establishment. The theory remains strikingly anti-medical model and many proponents are still very angry about the coercive, abusive, infantilizing, dehumanizing, isolating, condescending, stigmatizing, destructive aspects of traditional mental health systems. They have progressed from self-help groups to clubhouses, based on the Fountain House model, and the consumers have become "members" If not entirely member run, these programs generally have considerable consumer input with member governments, advisory board representation, and "consumer-staff."

"Empowerment" is the central concept as people work to help themselves. They take responsibility for developing coping skills and adapting to help themselves recover from mental illness, to become "survivors." The focus is on strengths rather than weaknesses, people rather than illnesses.
The other main root of psychosocial rehabilitation is psychiatric rehabilitation. As developed at Boston University, UCLA, and elsewhere, this approach features a "stress-vulnerability" model of mental illness. Clients are taught skills to overcome deficits and to reduce stress in order for their illnesses to become less symptomatic and for them to become more functional. Skills taught include symptom management, social skills, vocational skills, activities of daily life, educational skills, etc. Vocational rehabilitation often emerges as a primary focus because in our society work is the single best way to obtain an identity other than that of a mental patient and to integrate into the community.

Continued on pg. 6

Concepts continued Options often range from agency-run training job sites to competitive community supported employment with a "choose-get-keep" model. Supported education and housing have developed along similar lines. These two roots, the consumer movement and psychiatric rehabilitation, are beginning to merge into a recovery-rehabilitation model with many shared goals and techniques.
The Village Integrated Services Agency, in Long Beach, where I work, has expanded the Psychosocial model to include both typical services like social, vocational, clubhouse and housing, and generally segregated services like money management/payee, substance abuse, case management teams, medication, crisis response and even hospitalization all within a managed care, capitated funding scheme.

The psychosocial rehabilitation model for treating severe mental illness can incorporate many useful aspects of the other conceptual models while excluding harmful aspects of the medical model. Instead of viewing recovery negatively, in terms of symptoms to be relieved, illnesses to be cured, and treatment and medication to be ended, recovery can be viewed positively in terms of things to be actually recovered. These things may be grouped into three broad categories:
1. Functions may be recovered - as in the ability to read, to sleep restfully, to work, to have coherent conversations, to make love, to raise children, to drive a car, etc.
2. External things may be recovered - as in an apartment, a job, friends, playing in a band, a spouse, a car, family relationships, stereo, TV, educational programs, etc.
3. Internal states can be recovered as in feeling good about oneself, peace, self-identity other than mentally ill, responsibility for oneself, etc.

Unfortunately, even the word recovery has inherent negative connotations implying that people will get back things they used to have but lost due to their illnesses and that they will, ideally, go back to the "good times." There are, in fact, many legitimate recovery goals that are to get things people never had before their illnesses (if there was a "before"). The "good times" may more realistically be attained by going forward to the future rather than backwards to the past. Whether people actually had things their illness took from them or whether it took away the chance to get things that they had expected to get and visualized getting, they will often experience a strong sense of loss and victimization. Borrowing from the trauma recovery model, they must accept their victimization in order to stop being victims and become, instead, "survivors' Those people who either never had any vision of themselves as ever having anything, or who remain permanently in the victim role will have great difficulty recovering. The medical model tends more often to perpetuate the idea of being a permanent victim of "a chemical imbalance" and to take away hopeful visions of the future, (e.g. "you'll never be able to work") than to promote recovery.

These positive sets of objectives on the path to recovery are clearly more associated with quality of life than with the medical model objectives. In fact the symptom levels and severity of illness levels bear little relationship to function or quality of life. Similarly, the common goal of getting off medication is often particularly counter productive in attaining a higher quality of life. Positive recovery objectives are also, in large part, able to be worked towards actively and collaboratively, and are generally observable and accountable, non-stigmatizing, humanizing, and hopeful.

Although professionals are excluded from 12-step programs, most spiritual recovery programs, and even most psychosocial rehabilitation and consumer-run mental health programs, the model does not require this exclusion. What does need to be excluded, instead, are the heavily ingrained medical model traits of professionals: professional distance, emotional detachment, absolute authority, strict hierarchies, invulnerability, etc. What does not need to be excluded is special knowledge, training, skills and experience, caring and even healing spirit. As alluded to before, psychosocial rehabilitation can help people recover regardless of their medical/clinical treatment.

Medication, psychotherapy and case management can all be successfully adapted to the psychosocial rehabilitation model. Medication prescription becomes a process of education, consultation and collaboration. Psychotherapy becomes a variety of therapeutic relationships in more natural settings and within more adult-to-adult relationships. Case management becomes personal service plan goal setting, support and facilitation. There is a need for more professionals to work in psychosocial rehabilitation settings to learn how to adapt their clinical treatment methods to the psychosocial rehabilitation model.

Many consumer groups speak of the need for "exits" from the mental health system and want to get out of treatment. This "negative recovery goal" is difficult to reconcile with the substantial ongoing benefit from treatment and medication many. clients receive. This conflict often leads to agonizing results. From a "positive view" of recovery those same "exits" are actually "entrances" to our community. The need is not so much to leave treatment or medication as to enter life.

Continued on pg. 8

Beckman's Recovery Conference By Brenda Johnson, CAC

Beckman Mental Health Center held its annual Recovery Conference in May at the Mount Zion AME Church in Promised Land, S.C. Each year the conference is planned in conjunction with the mental health centers Client Advisory Committee which meets quarterly and with only 4 meetings a year the planning seems to be continuous. The advisory committee develops the agenda and makes recommendations for speakers and ideas of which agencies to invite to provide information about their program and services to our clients. Greg Bullard, Director of Community Support Services, Greg Ross, the Entitlements Coordinator and I take the information from the advisory committee and start putting together all of the pieces to make the conference happen.

This year, Beckman Center Director, Melanie Gambrell, welcomed the more than 200 clients, staff, agency and community representatives that attended. She introduced Jeffery Ham, the Program Manager who works with the Toward Local Care & Recovery / Continuity of Care programs in the office of Community Mental Health Services. Jeff made stirring comments on recovery and self-empowerment.

Greg Bullard acted as the emcee for the conference and introduced Katherine Roberts, Director of the DMH Office of Client Affairs. Katherine shared her personal recovery story and encouraged clients to take active roles in advisory boards to make their voices heard and to offer feedback on issues, programs, what works well, and where improvements can be made.

One of the more moving conference events was the sharing of personal stories of recovery. Several clients shared their journeys with the audience. They spoke of accomplishments, the impact of stigma and the importance of respect and dignity. They reminded us about how important family and friends are and how vital it is to set goals and the importance of self-determination. We would like to thank Direct Pharmaceuticals who generously provided a Wal-Mart gift card to each client who told their recovery story

To provide information about what is available in the surrounding communities' tables were set up around the room. Information was available on community adult education/college programs and the services available to assist students with disabilities. Employment information from agencies such as Vocational Rehabilitation and the Employment offices was offered to clients. The Social Security Administration sent a representative that could provide information on programs and services that help people enter the work force, return to work, and enter and/or return to school without jeopardizing their benefits. Our hope is that as our clients would use this information to begin them on or assist them with their recovery journeys.

A highlight of each conference is the Recovery Banner contest. The Banners were displayed along the walls in the Conference center. Each banner that was submitted received a framed "Outstanding Banner" award and the winning banner also received a trophy. This year's winner was chosen by our visitors from SCDMH Administration Office in Columbia.

For the past two years we have had "Elvis" to sing during lunch. Elvis donated his much appreciated talent to us free of charge and told a bit of his own Recovery story. This year he was unavailable and the Advisory Committee debated about what type of entertainment to have for the lunch hour. They decided on a Praise Dance. A Praise Dance is a dance that gives reverence to God through dance. We asked the church if they knew of someone who could help us with this and they provided us with a very much talented lady Latisha Williams Leverette We would like to thank Latisha for donating her time and talent.

We would like to thank our local Mental Health America (formerly the Mental Health Association) for their financial support. Four the last four years they have graciously provided much needed funds to assist us in paying for lunch and cleanup fees and this year they gave out free t-shirts at their information booth.

Finally, we are very grateful to Mt. Zion AME Church for the use of their wonderful conference facility and all of the time and effort heir members gave to provide such a great lunch. They have been great to work with each year!

All in all each year a lot of planning and working with others to partner in putting on this conference each year, and it is always a challenge and often we hit bumps, but it is always worth it.

OCA Calendar

For Information on the CPSS Training Schedule please call Bobbie Lesesne at 803-898-7490 or email her at BAL30@SCDMH.org

Peer Support Certification Training Schedule

Week 1	Week 2	Testing
2/17-20/09	2/23-26/09	TBA
5/18-21/09	5/26-29/09	TBA
8/10-13/09	8/17-20/09	TBA
10/19-22/09	10/26-29/09	TBA

CAC Bi-Monthly Meetings The CAC's meet every other month from 11am to 1 pm. All employees who do not live in the Columbia area (Cola. and Lexington) may tune into the meeting via the SCDMH video conferencing system at their main center location. **2009 Dates:** February 9th, April 13th, June 8th, August 10th, October 12th and December 14th

To see the entire Client Affairs Training Calendar Go to:
http://www.state.sc.us/dmh/client_affairs/training_calendar.htm

Concepts continued "Community integration' something most programs do very poorly, if at all, is the door they are looking for. At the point of walking through that door we should find ourselves alongside our clients working to fight stigma and to improve our deteriorated communities. The relationship between service provider, client, and family needs to be fluid and to change depending on the goals being most actively pursued. The service provider may need to be medical consultant, coach, mentor, friend, peer, advisor, sponsor, student, customer, fellow patient, political activist, or even confessor to best help a person recover. As we use various aspects of ourselves, clients will be exploring, rediscovering, even recovering, various aspects of themselves and becoming whole people.

This multifaceted, flexible relationship almost always feels more real, more human, and more reciprocal than the traditional professional-patient relationship. The client feels more valued and the service provider feels less drained.

Most people with severe mental illness are not permanently incapacitated, infantile, helpless beings whom we need to protect. They may occasionally need that, but for the most part they can have dreams, hopes, plans and choices, take risks and be responsible for the consequences. Often times what we are preventing or protecting them from is actually the opportunity for change, growth, experiencing reality, self-confidence and, ultimately, recovery itself.

Every other aspect of their person besides "incapacitating illness" is often ignored and invalidated, and withers away from neglect. The "high risk-high support" and "focusing on strengths instead of weaknesses" philosophies of the psychosocial rehabilitation model reverse these harmful trends.

To move to a truly collaborative relationship, massive rethinking and retraining will be needed on all sides; professionals, clients, families, and even society in general. Although the medical model has frustrated and failed-us, it is still extremely strong, entrenched and pervasive. It is stunning how many of us, whether neighbors, police, teachers, landlords, crime victims, doctors, store owners or whomever, refuse to relate to people with severe mental illnesses as anything but walking symptoms and to mental health programs as anything but places to contain and control them.

Yet, the time for change appears to be upon us and with it, perhaps, the opportunity to enhance the quality of life for the whole community.

In the next issue we will present additional perspectives of recovery

CAPPS is a quarterly publication of the SCDMH Office of Client Affairs. Please email or send ideas, information, articles, and announcements to Katherine Roberts, kmr50@scdmh.org at SCDMH Medical Director's Office Suite 314, 2414 Bull Street Columbia, SC 29202, fax 803-898-8347

Background Artwork for CAPPS is provided by SCDMH Art of Recovery
To view the on line gallery of client artwork go to: http://www.state.sc.us/dmh/aor/aor_home.htm