Medical Model versus Recovery Model:

An Analysis of the S.C. Department

Of Mental Health's Approach to Treatment

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Table of Contents

I. Introduction

> *"Words, like the chisel of the carver, can create what never existed before rather than simply describe what already exists. As a man speaks, not only is the thing which he is declaring coming into existence, but also the man himself."* - Martin Heidegger

Martin Heidegger was one of the most important philosophical figures of our time His work has had tremendous influence on philosophy, literature, and psychology. It literally changed the intellectual map of the modern world. His best known book, *Being and Time*, is generally considered to be one of the most important philosophical works of the 20th century. Heidegger's work remains controversial due to his involvement with national socialism (M Heidegger, 1927) This is not unlike the controversy or opinions surrounding the topic at hand; recovery versus medical model.

I once heard someone say, "A lot of people ask me what the difference is between a *medical model* of treatment for mental illness and a *recovery model*. You want to know what that difference is, in a nutshell? The *medical model* treats me like a disease; the *recovery model* treats me like a person." Recovery is what the client does. Facilitating the recovery is what the staff does, either through psychopharmacology or psycho-education. Treating mental illness with medicine suppresses symptomology. Which is the better model?

II. Problem Statement

This project will examine the difference between the medical treatment model in our state mental health system versus the recovery philosophy approach to mental health treatment. It will attempt to extricate staff attitudes and biases towards the recovery model of behavioral health care in contrasts to a traditional medical model of treatment.

Proper investigation of this problem will yield proof of the efficacy of the recovery model/philosophy or the medical model approach toward mental health treatment.

Why is this problem?

The variations of the current approaches to behavioral treatment within the agency lends itself to less reliable outcome measures, thwarts client empowerment and promotes inconsistencies of care for the population SCDMH serves. SCDMH must begin to view the clients we serve as individuals who can begin their recovery (not cure) from their mental illness, with the appropriate medication, therapy and tools of empowerment to lead a productive life. That is, versus seeing this population as a never ending source for custodial care and medication dispensing. This type of client maintenance keeps staff employed rather than enhance the quality of life for the individuals served by SCDMH.

III. Historical Viewpoint

In February of 1989, the S.C. Department of Mental Health, with support from the National Institute of Mental Health, hosted a national conference entitled "The Role of the Public Mental Hospital in a Community-Based System of Care." The purpose was to explore how other states shifted to community-based services, how they defined priority populations, and how they planned and located services. Although it was not known at this time, this venture would become one of the Department's flagship programs toward the recovery efforts.

The outcome of this conference was the initiation of the Transition Leadership Council. An unprecedented collaboration between mental health professionals, government, mental health advocates, and consumer representatives, was formed to spearhead the movement of South Carolina's mental health delivery system Towards

Local Care. The council determined that the services necessary for the successful transition of patients into the state's communities did not exist and needed to be developed. It was also clear that some patients could not be safely discharged into the community and would continue to be cared for in S.C. Department of Mental Health facilities until appropriate services could be created (Curlee and Miller, 1998).

Even today, some communities are struggling to develop community-care programs. They have a shortage of appropriate residences and sometimes face opposition to these from neighborhood residents, have no crisis-care center to handle short-term acute situations, lack employment opportunities, and, particularly in rural areas, lack good basic medical services.

The Community Plan of Care

In 2001, the South Carolina Department of Mental began creating a culture of recovery, reflecting the belief that mental illnesses are treatable disorders and that people living with mental illnesses can and do recover-a belief shared by South Carolina's consumers and SCDMH employees.

The plan to shift to a system based on recovery, a system located and delivered in the community, is outlined in Making Recovery Real, a blueprint focusing on high priority goals and the successful evidence-based or promising practices to realize them. Priorities recognized in Making Recovery Real include:

-Caring for the adults, children and families affected by serious mental illnesses and significant emotional disorders

-Achieving goal in collaboration with all stakeholders

- Assuring the highest quality of culturally competent services possible

-Eliminating stigma and promoting the philosophy of recovery

IV. Recovery Principles and Values

In 2005, the South Carolina Recovery Steering Committee (SCRSC) submitted the following definition of *Recovery* for review and adoption by the South Carolina Department of Mental Health. The Recovery Steering Committee was comprised of mental health stakeholders and SCDMH community and hospital clinical and administration staff.

The group held periodic meeting to help forge a recovery culture with the department. It was charged with bring new ideas, programs and initiatives to the state to facilitate the recovery concept throughout the system of care.

After gaining the approval of the Department's Board of Commissioners the following served as the official definition of Recovery, and is used to guide the "Action Plan for the Implementation of the Recovery Model at the South Carolina Department of Mental Health.

'Recovery is a process by which a person overcomes the challenges presented by a mental illness to live a life of meaning and purpose.'

To support this definition of recovery and its mission, the SCRSC asks that the SCDMH establish within and throughout its organization an environment where the process of recovery can be experienced by people who have mental illnesses by the setting of agency-wide goals that create, support and maintain the following principles/values:

1. Recovery happens when people take responsibility for their mental health and begin to direct the course of their lives.
2. All people have strengths and talents that they can use to establish a life in recovery.

3. People in recovery and services providers must focus on health holistically, being aware of mind, body, spirit and environment.
4. Meaningful work, safe housing and pleasurable leisure are necessary components of recovery.
5. People with mental illnesses must be given choices about all aspects of their lives, and they must be supported in these choices even when there exist a likelihood of failure.
6. People in recovery need valuable roles in the community.
7. People in recovery may still experience symptoms.
8. Having adequate finances to meet basic needs is vital to recovery.
9. People recover in partnership with family, friends and professional mental health workers and in communities where public and private service providers and advocacy groups work in partnership to provide support.
10. Hope is one of the most vital components of recovery.

In order to reflect current Best or Evidenced–Based Practices, there is a need to merge all intervention models, including medical, psychological, social and rehabilitation. Evidence-based programs are programs that have been shown to be effective by scientifically rigorous evaluations. Evidence-based best practice programs should not be confused with programs that simply purport to represent best practice though lack the independent evaluations that validate their assessment of effectiveness. The vast majority of prevention, intervention and treatment as well as supervisory programs related to drug abuse, juvenile delinquency and adult crime have not been rigorously evaluated. This is true for most programs regarded as "best practices", however, there are a considerable

numbers of programs that exemplify evidence-based best practice some of which are noted in this appendix. Evidence-based best practice programs are not only effective in the services they provide, but, also, represent a very good investment which they can demonstrate. As a result, public and private funding agencies are usually more inclined to fund evidence-based programs given the programs immediate return in effective service and as a model for future quality program development..

SDMH Mission Statement: "To Support the recovery of people with mental illnesses"

Mental illnesses are real medical disorders, just like diabetes, cancer or heart diseases. One in five South Carolinians will experience a mental disorder in life. Less than half of these people will seek the care they need. The stigma or shame associated with mental illnesses is the primary factor keeping people from seeking help. Treatments for mental disorders are highly effective-85 percent of patients have a very good response to current medication and therapy programs.

The people of the South Carolina Department of Mental Health served about 98,000 consumers last year in the 17 community mental health centers, five hospitals and two nursing care centers. Ninety percent of the consumers receive their care in the community setting, in addition:

-SCDMH served about 35,000 children each year.

-SCDMH has approximately 5,000 employees and 9,050 volunteers.

-All SCDMH facilities, inpatient or community-based, are accredited by either the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or The Rehabilitation Accreditation Commission. (CARF).

-In South Carolina, state budgetary stresses have challenged agencies like SCDMH to put

increased emphasis on efficiency and cost-cutting. This year that fact is even more evident.

On July 1, 2008 the DMH budget was reduced by two percent or $2.3 million in state appropriations. Additionally the agency was asked to cut another 12.8 percent or $23 million. Later in the fall, the Department was asked to further cut some seven (7) percent or $14.6 million off of the budget. This represents about four (4) million or 20 percent of the base budget for DMH state appropriations. Overall, DMH stands to end up with some $63 million less than we started out with this fiscal year.

For the Department of Mental Health, this challenge is being met every day, as management consolidates services, case workers take on more clients, and everyone works harder with fewer resources. Despite these budget shortfalls, all SCDMH employees, from maintenance staff to administrative personnel to executive directors, are committed to keeping the clients, those who live with mental illnesses, as the focus of their work. High quality, accessible care will continue to be available to South Carolinians who seek to recover.

Best Practice At SCDMH

Many of the Department's existing programs are already contributing to this developing culture of recovery, helping South Carolinians with mental illnesses live successful, meaningful lives. For example:

-SCDMH School-Based programs provide professional mental health counselors to one-third of the state's middle and high schools. The School-Based program is the nation's largest, helping some 12,024 students in their own environment in 2001.

-In its tenth year as a key program, SCDMH's Toward Local Care (TLC) effort is helping South Carolinians live and recover in their home environments. The TLC program

consistently meets its goals to help people in the transition from inpatient facilities to the community, help them avoid re-hospitalization and reduce the cost of care. TLC builds services that use other critical local supports like family, friends, and faith communities to offer employment, learning, leisure pursuits and other human or clinical support.

Aiken Barnwell Mental Health Center (ABMHC) celebrated the grand opening of the newly established Helping Encourage Recovery Options (HERO) Center on October 24, 2007.

The philosophy of the center is "Shared Decision Making," a person-centered clinical method that encourages clients and clinicians to collaborate on treatment decisions and which involves work with a Certified Peer Support Specialist (CPSS), a paraprofessional who is a current or former client of mental health services. The Shared Decision Making model is currently being used by the Dartmouth-Hitchcock Medical Center in New Hampshire and the Wyandot Center in Kansas City, KS.

At the center, a CPSS will assist each client in gathering information about his or her diagnosis and learning about interventions like lifestyle changes, talk therapies, medication, legal procedures, advanced directives, and others. Certified Peer Support Specialists Wayne Moseley and Cynthia Smith will operate the HERO center with guidance from Dr. Greg Smith, Medical Director, and Tamara Smith, LMSW- Program Director for the Community Support Programs.

ABMHC receives support and mentoring on this project from Dr. Robert Drake and Katherine Clay of Dartmouth-Hitchcock Medical Center; Charlie Rapp and Melanie Riefer of the Wyandot Center in Kansas City, KS; and Dr. Patricia Deegan of Pat Deegan Ph.D. & Associates, LLC. Additionally, ABMHC is proud to have Mental Health America-South Carolina as a partner in this endeavor. South Carolina SHARE, the

National Alliance on Mental Illness (NAMI) and the Substance Abuse & Mental Health Services Administration (SAMHSA) have also provided literature and resources for the center.

Aiken Barnwell Mental Health Center is one of seventeen Community Mental Health Centers in South Carolina operating under the auspices of the South Carolina Department of Mental Health. Aiken Barnwell serves 2,267 children, families and adults, and has a primary mission to serve clients with serious and persistent mental illness. This is one example of recovery at work within the Department. Other mental health centers offer a variety of recovery-oriented programs also.

Partnering With Advocacy Groups

As SCDMH provides care and builds a system of recovery, it relies on relationships with statewide advocacy organizations to provide support to South Carolinians with mental illnesses. In addition to the work these groups provide in legislative education and support of SCDMH's statewide boards, partnerships with community-based groups that empower consumers result in a higher quality of life, more effective treatment and recovery programs and increased public awareness. These partnerships include:

-A program with Mental Health Association in South Carolina (MHA) to restore historic SCDMH cemeteries and annual trainings to help South Carolina faith leaders recognize and support people with mental illnesses in their congregations.

A Provider Education Program by the National Alliance for the Mentally Ill (NAMI) of South Carolina that helps SCDMH care providers see mental health issues from the family's perspective and provide services addressing such issues.

The participation by many SCDMH clients in SC SHARE's (Self-Help Association Regarding Emotions) Recovery for Life program, a 10-week, small-group recovery training helping consumers build life skills and reach their potential. Cooperative efforts with Federation of Families of South Carolina, Protection and Advocacy System for People with Disabilities, the South Carolina Psychiatric and Psychological Associations and the University of South Carolina are also making the dream of recovery come true for South Carolina's consumers.

V. Contrasting Treatment Approaches : An Integrated System of Care

The South Carolina Department of Mental Health has a presence in every South Carolina county. Each of the 17 community mental health centers has clinics or specialty offices, helping bring recovery to all the state's citizens. The last half-century has seen a revolution in mental health care treatment, as new medications and a community mental health movement have resulted in more and more people receiving care in their home environments. This improved care philosophy keeps people in their jobs, in their families, in their faith communities and with their friends as they walk their road to recovery.

Only 10 percent of SCDMH's consumers receive their care in a hospital setting. Inpatient facilities like the old South Carolina State Hospital, once home to thousands of patients, have greatly reduced populations as a growing number of support services help people get better and stay out of hospitals. Recovery, like life, happens in the community.

VI. Implementation Feasibility: Creating a Culture of Recovery

The South Carolina Department of Mental Health is creating a culture of recovery, a team of people and resources that help restore hopes and dreams for South

Carolinians with mental illnesses. The core belief of the recovery model of care is that people living with mental disorders can and do get better in their own personal, diverse way. Following the SCDMH Mission, this belief in recovery will drive the agency's reform initiatives and community planning as mental health care in South Carolina engages and involves the consumer, focuses on strength, and keeps people living and succeeding in their communities.

In addition to extensive community-base care options, quality of life aspects like housing and employment will be key components of the culture of recovery. All services will be culturally appropriate, designed with an appreciation of people's various backgrounds, needs and supports systems.

Community Resource Development and Public Education

SCDMH's Community Resource Development Program (including the Volunteer Program) and public education efforts are connecting South Carolinians with the clients in the SCDMH system of care, providing another layer of support for clients and breaking down the stigma of the public. More than 9,050 volunteers give their time and talent to the work of SCDMH, helping people in a variety of ways from offering canoe trips to leading worship services. The total value of time and resources donated to SCDMH's consumers last year exceeded $5,500,000.

Public outreach efforts, including the ongoing anti-stigma campaign, help South Carolinians face mental illness issues with honesty and respect, and help people come to terms with these disorders. Programs like awareness walks and The Art of Recovery project allow consumers to share their messages of recovery as the community learns that people with mental illnesses are more than just a diagnosis.

In 2004 the Recovery Attitudes Survey results (314 DMH staff) revealed that

clinical staff viewed recovery as *a modification of older paradigms in mental health rather than a unique and individual process that is client driven and transcends empowerment.*

Staff training was developed (Keys to Recovery) to impact outcomes from the survey to implement the models (eight recovery domains) and effective practices to support the recovery process system-wide. Training utilizes a modular format that allows for unique staff training needs of individual programs (clients, Pyscho-social Rehabilitation Services, management, and medical staff)

As effective and valuable as the trainings have been, there has been no systematic follow up to measure application outcomes or effectiveness to create observable improvement in recovery based practice. (contract goals for 2006-2007 have included development of a computerized training model that would incorporate a measurement of knowledge and competencies related to recovery)

Studies have shown to measure recovery as an endpoint, specified dimensions of recovery must be identified, operationalized, and measured reliability and validity over time. Problems in operationalizing philosophies or incorporating them into the fabric of the system lies with the broadness of recovery concepts and the inability to identify specific characteristics or components that lend themselves to measurement or evaluation.

Similar instruments for testing recovery available are less likely to have better levels of validity and reliability because they are less individualized to the nature of SCDMH system and explore fewer components of recovery. The recovery culture inventory is a research based observational tool that can be used by outside evaluators, staff, evaluation teams, and or client program evaluators to explore the overall recovery

culture of a program as evidenced by the physical environment, content of program activities, the policies and procedures, and the utilization of available resources within and outside the program (L. Leech, 2007).

In *modern medicine*, a specialist understands and uses the holistic bio-psychosocial approach encompassed in the medical model. "Many people criticize, and psychiatrists apologize, for the use of the 'medical model'. We propose that psychiatrists should use the medical model to improve and validate bio-psychosocial psychiatric medicine. We propose that the 'medical model' is a process whereby, informed by the best available evidence, doctors advice on, coordinate or deliver intervention for health improvement. It can be summarily stated as 'does it work?'."

Medical model is the term cited by psychiatrist Ronald D. Laing in his *The Politics of the Family and Other Essays* for the "set of procedures in which all doctors are trained." This set includes complaint, history, examination, ancillary tests if needed, diagnosis, treatment, and prognosis with and without treatment. Sociologist Erving Goffman, in his *Asylums*, favorably compared the medical model, which was a post-Industrial Revolution occurrence, with the conduct in the tinkering trades (watch, radio, The medical model of disability is a model by which illness or disability is the result of a physical condition, is intrinsic to the individual (it is part of that individual's own body), may reduce the individual's quality of life, and causes clear disadvantages to the individual (Laing, R.D., 1983).

As a result, curing or managing illness or disability revolves around identifying the illness or disability, understanding it and learning to control and alter its course. Therefore, and by extension, a compassionate or just society invests resources in health care and related services in an attempt to cure disabilities medically, expand functionality

and/or improve functioning thus allowing disabled persons a more "normal" life. The medical profession's responsibility and potential in this area is central.

The medical model of disability is often cited by disability rights groups when evaluating the costs and benefits of various interventions, be they medical, surgical, social or occupational: from prosthetics, "cures", and medical tests such as genetic screening or preimplantation genetic diagnosis. Often, a medical model of disability is used to justify large investment in these procedures, technologies and research, when adaptation of the disabled person's environment might ultimately be cheaper and more attainable.

Some disability rights groups see the medical model of disability as a civil rights issue, and criticize charitable or medical initiatives that use it in their portrayal of disabled people, because it promotes a negative, disempowered image of people with disabilities, rather than casting disability as a political, social and environmental problem. Various sociologists (Zola, Parsons) studied the socio-cultural aspects of "normalcy" and the pressure it exerts on individuals to conform (Laing, R.D. , 1983).

It is not enough just to survive, but rather to live a life of meaning and purpose. Some feel the Recovery Model can be very effective for patients who have a reasonably good understanding of their illness and their needs related to that illness; however, in my years of working with patients with serious mental illnesses, this can break down for patients who don't have an understanding that they have a mental illness. They often view their treatments as unnecessary.

When patients suffering from serious mental illnesses, such as schizophrenia or bipolar disorder (manic-depressive illness) are asked what they want, it is not unusual for

the answer to be that they want all treatments stopped and to be immediately released from care. The very nature of serious mental illnesses is often the patient's lack of understanding that he/she has an illness and treatment is needed for that illness. This is especially true during acute exacerbations of their illness; however, they may even continue to lack insight after effective treatment has been provided.

Patients with very serious mental illnesses make up the vast majority of patients in state mental hospitals. Ultimately if good care is not provided, patients suffer and funding agencies (Department of Health and Human Services) will not fund such care.

Finally, the best care may be provided by a blending of the Medical Model and the Recovery Model, not a "religious" shift to either model.

The "medical model" represents an approach to issues of mental health that incorporates aspects of both science and biology without being synonymous with either. Reflecting as well an extended professional medical tradition, the "medical model" has strengths and limitations of its own that need to be evaluated in their own terms. In the following we do so with the objective of showing in what ways a useful broader perspective on mental health can be achieved by incorporating additional insights from scientific, biological, and cultural perspectives.

Like all humans, proponents of the "medical model" profess an ideal that may conflict with other personal aspirations and hence be less than fully followed at any given time and in any given life. Our concern here is not with the impact of temptations that influence all human beings (wishes for power, prestige, or money, for example) but rather with the significance and usefulness of the ideals and insights themselves.

One can't, we believe, argue with the value of a commitment to the alleviation of human suffering, nor with the recognition that some cases of human suffering are most

effectively relieved by people who have special training and experience and who are willing not only to make that available to others but to take on some measure of personal responsibility for the their well-being. The history of medicine includes many success stories of this sort, and the aspiration to have others recognize and take some responsibility for alleviating our own suffering is deep and at times productive in all of us.

That being said, it is important to recognize as well that the successes of the "medical model" ought not to be taken as evidence that it is an effective means of dealing with all cases of human suffering. The model reflects successes in dealing with cases of human suffering that involve relatively simple cause/effect relations producing "symptoms" that are generally accepted as debilitating and undesirable (traumatic injury to parts of the body other than the brain, infectious disease, and so forth).

As understanding of biological organization advances, it is becoming increasingly clear that both simple cause/effect relations and clear dichotomies between desirable and undesirable should in general be recognized as the exception rather the rule. This caution is particularly relevant in dealing with issues of mental health, as is becoming increasingly clear with increasing understanding of the complexity of the brain, in and of itself and in interaction with other brains. In this sort of context, "expertise" may require redefinition, involving not only attention to what is common to all human beings but also the skill of being able to identify and work with what is distinctive in individual human beings.

Objectivity

Just as the "medical model" evolved in the context of a particularly simple set of a challenge, so too did the "science" which it borrowed from and reflects. Scientists

are increasingly being forced by their own observations to recognize that "objectivity", in the sense of an understanding stripped of all idiosyncratic characteristics of human understand ring, is not only not achievable but not even desirable (see Revisiting Science in Culture; see also bat, Stanford). Contemporary research on the brain is among the most significant pointers in this direction (see Getting It Less Wrong: The Brain's Way).

The "medical model" appropriately encourages practitioners to be aware of personal interests and perspectives that might influence their treatment of others, to be skeptical of such idiosyncratic characteristics, and to continually reassess their value in part by comparing them to the perspectives of others in a wider professional community. In these terms, an aspiration to "objectivity" (defined as that which has been tested against the perspectives of others) has demonstrated value in a wide array of contexts. What needs to be more widely recognized, however, is that "expertise" is only as good as the array of observations and perspectives which it reflects. There is no legitimate basis for claiming expertise or authority based on an abstract conception of "objectivity". And substantial reason to believe that, in more complex situations, some measure of "subjectivity" (intuition, gut feelings, counter transferences) can be valuable.

Perhaps the single most significant challenge to the "medical model" from the biological sciences has to do with "norms" and their relation to "ideals". Contemporary understandings of the evolutionary process suggest that biological organisms (including humans) are best thought of not as unavoidable deviations from some intended "norm" but rather as significant variants, components in a ongoing process of exploring viable living systems out if which further variants will arise. One may, for one reason or

another, identify norms at any given time in such continually varying populations but there is no biological foundation for characterizing them as "ideals". Indeed, the very concept of an "ideal" becomes problematic in the light of an ongoing evolutionary process.

The relation of "patient", "doctor", and "culture"

Several things follow from this that offer challenges to the "medical model", particularly in the arena of mental health. The most obvious is perhaps that traditional practices of assessing health by objective measures easily made from outside a person may be inadequate. The internal subjective experiences of a person are important, and can be at least as relevant as weight, blood pressure, immune system status, and so on.

Still more importantly, effective mental health care needs to acknowledge the existence in people of some measure of influence on their own conditions and lives, and indeed to encourage the development of increased individual agency. The "patient" needs to be thought of not as a passive recipient of repairs but rather as someone actively engaged in their own shaping and reshaping of themselves.

These considerations have significant ramifications at interpersonal and larger scales. When the primary task is to assist another person in the shaping and reshaping of themselves, the task of the "doctor" is even less amenable to definition in terms of a pre-conceived "ideal" state and requires instead a willingness to support and engage in a process of exploration that may move in totally unexpected directions and have consequences for both parties to the interaction. A detached "objectivity" needs to give way to a more bidirectional engagement.

On a still larger scale, it needs to recognized that problems in shaping and reshaping oneself may have their origins within the "patient" but may equally have their

origins in interactions with others, and/or with the broader culture within which they are working.

The "medical model" presumption that someone who is suffering has a problem within themselves is too limiting. In the absence of a biological "ideal", effective mental health care requires acknowledging that effective therapies may require not only personal change but participation in cultural change as well. In this context, the most "efficient and rapid" therapy may sometimes not be the optimal one. But, 'this is the way we have done things , so why should we change" attitude still persists in some circles.

VII. Conclusion

The "medical model" has its strengths in some arenas, particularly those in which there is substantial consensus among humans as to what constitutes a "problem" and such problems reflect situations involving fairly simple cause-effect relationships. In other arenas, of which mental health is a significant example, the "medical model" has clear limitations. Among these are:

- an over-reliance on "categories", "ideals", and "objectivity"
- a failure to appreciate the significance of internal experiences
- lack of appreciation for diversity and for the essential role played by individuals in their own evolution
- lack of appreciation for the role of culture in mental health

One of the best descriptions of recovery was put in a slide presentation by a staff at SC SHARE, Inc., Beth Padgett, who wrote: *Recovery: What It Is, What It Isn't and What It Can Be*

1 Recovery is not simply taking medication and going to a day program.

2 Recovery is developing a full-range recovery program including exercise,

education, relationship building, therapy, life skill development, support groups, self-help/12-step groups, and more. (B. Padgett, 2007)

The two entities (medical and recovery model) must co-exist to be most effective. But the reality is that the more the clients that become empowered, the less the medical model will have influence on their treatment. While there have been tremendous strides in the psycho-pharmacology the trend for owning one's illness is being embraced by the thousands. For may years mental health professionals have seen themselves as 'casemanagers' for the population begin served. One client put it this was, "I am not a case, and I don't need to be managed."

Why Recovery?

The following information is to support the inclusion of Recovery in the State Plan FY08-09 list of priorities. The SC Department of Mental Health defines recovery as "a process by which a person overcomes the challenges presented by a mental illness to live a life of meaning and purpose." The principle of recovery must be an expectation, not the exception. In light of the advent of the budget cuts, I believe that it is still imperative that the Department continue to pursue recovery-oriented measures that are cost-neutral, as some of those stated previously.

Recovery should be embodied throughout all aspects of the DMH. It must permeate the attitudes, environment, treatment and delivery of services everyday. In order increase awareness, recovery must be infused not only in our policy but our practice as well. It is the recommendation and intent to empower those individuals who have a mental illness while encouraging participation in their plan of care toward recovery. We are currently exploring opportunities to enhance the recovery concept with SC SHARE,

SC DMH Client Affairs Division, Mental Health Centers and our inpatient facilities. But again, the current state of fiscal affairs will and is having an impact on what we do. Given additional funding for recovery, DMH can institute a systematic approach to developing more opportunities for clients and providers in the centers and inpatient facilities, to include:

* Focus on the outcomes of mental health care, including employment, housing, self-care, interpersonal relationships, and community participation and client satisfaction.

* Focus on community-level models of care that coordinate multiple mental health and human service providers.

* Maximize existing resources by increasing cost-effectiveness by utilizing Peer Support Specialists for training

* Use mental health research findings to influence the delivery of services.

Medical outcomes are better over longer periods of time. Many people will need to take medication for a long time in order to control symptoms and prevent relapse. As people get older their symptoms may change and/or become less severe. Changes in symptoms may lead to different medications being prescribed and this may assist medical recovery.

A number of factors can be used to predict medical recovery but these are only indicators. Factors, which suggest that a good recovery is likely, include:

- Good adjustment prior to the start of the illness;
- A family with no history of schizophrenia;
- Developing the illness at an older age;
- Sudden onset of the illness; and,
- Onset of the illness following a major life event.

Progress and recovery can be helped significantly by positive attitudes and

constructive support from family, friends and professionals. Providing training and support to enable people with mental illness to regain social skills and life skills, to engage in work or education will all assist in recovery. Some people with a diagnosis of mental illness will continue to experience symptoms, much of the time or periodically. If, through support and training, they can learn to live fulfilled lives, despite their illness, then they can be thought of as recovered.

Recovery, in the sense of leading a fulfilled life, despite an illness, requires a belief by both the person with the illness and those around them that the ill person will recover. It requires a commitment to recovery and a recovery strategy, as well as resources to enable recovery and opportunities to share personal growth with others also seeking to recover. Finding a sense of meaning and purpose even in suffering is often thought of as a useful step. For some individuals the illness itself and the adversity associated with it may stimulate personal growth. For others the journey to recovery will feel hard. How far and how quickly each individual recovers will vary widely and it is important to recognize and value every step no matter how small.

VIII. Recommendations

I would recommend the following to enhance the recovery philosophy throughout the Dept. of Mental Health:

1. Recovery Friendly Calendars- Each day of the week will either outline a quote or explain something productive for individuals to do for their overall health and wellness pertaining to recovery.
2. SCDMH adaptation of a recovery logo
3. Establishment of a recovery friendly business handbook that will outline recovery friendly businesses and/or agencies within the state. The handbooks are to be

distributed to both clients/case managers for linkage of services.

4. Hold a Recovery Kickoff Celebration- one day event that takes place the first Friday of each month.
5. Recovery Retreat- could be held annually with both staff and clients (compliance of medications, money mgmt, able to complete ADL's, no recent hospitalizations)
6. Promote and distribute Recovery relaxation CDs (relaxation/stress reduction techniques and/or music)
7. Increase usage of the SCDMH mascot, "Chipper", the chipmunk, within Social Events, especially in school settings.
8. CRCF Recovery: allowing Certified Peer Support Specialists to go out into licensed CRCF community and spread the message of recovery to residents and solicit possible referrals to SCDMH.
9. Adaptation of a recovery quote: (i.e., taking responsibility and control of your mental disease and going beyond traditional care, etc...)

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