A CURRENT SNAPSHOT OF THE RECOVERY MODEL:
WHAT’S WORKING, WHAT’S NOT WORKING,
AND WHAT COULD BE IMPROVED

A Project

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by

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Division of Social Work
Abstract

of

A CURRENT SNAPSHOT OF THE RECOVERY MODEL:
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This research study aims to investigate mental health and drug and alcohol (AOD) service providers and staff’s level of knowledge, belief in and use of the recovery model. This study also hopes to better understand the overall culture of the county agency, incorporating and upholding a recovery-oriented perspective and model. Using an online survey, 50 staff in the mental health and alcohol and drug departments of a rural CA county responded to a questionnaire consisting of 15 questions. Main qualitative findings include: specific training on the recovery model is needed, as some AOD and mental health staff did not receive any training, some participants feel that other coworkers may need to further develop their knowledge and competency in utilizing recovery-oriented practices, some participants questioned whether the recovery model can be used in all contexts, it is desirable to have improved coordination and communication between the mental health and AOD departments, and a more conducive environment within the county system will benefit the implementation of the recovery model. This agency does utilize a wellness recovery plan for all mental health consumers, has begun a process to
improve communication between departments for consumers, and requires all staff to attend diversity trainings. The quantitative data revealed strong to moderate relationships among the 5 tested variables of competency, belief, implementation, training, and agency culture. However, there are no significant correlations between these five variables and professional degree and/or professional level of schooling. This study’s findings support the current literature on the need to further investigate how service providers understand and implement the recovery model, as well as increase positive collaborations between mental health and AOD departments to further promote the integration of recovery-oriented services. Social workers need to take an active role in engaging and supporting the advancement of the recovery movement within mental health and AOD services.

__________________________, Committee Chair
Francis Yuen, DSW, ACSW

_________________________
Date
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As an undergraduate student, I used to read the acknowledgments page of theses and dissertations for fun. I found them overly dramatic and incredibly entertaining. I remember telling myself, “I will never act as “sappy” in my future acknowledgments page.” Upon completing my Masters in Social Work, I now understand why these individuals felt compelled to write heavy loaded acknowledgements that seemed so ridiculous at the time. I now understand what it means to loose countless hours of sleep while delicately balancing a heavy course load, challenging internships, family and friend relationships, and the guilt of not living a “normal” life. I now realize this because there is absolutely no possible way to perfectly acknowledge and thank in words, the individuals who have literally ensured both my survival and success. How is it possible to express my gratitude to the very people who help stabilize my emotions during times of stress, remain by my side during a two-year period of an intense relationship with my books and essays, and provide endless support and encouragement as I made a transformation to having social work become my way of life? These people are my family and friends, my partner, my professors and mentors, and without them, I would not be the well-prepared, passionate individual I am today. I can officially say that as I write this acknowledgment page, I proudly claim the ownership of being the sappy, overly emotional, quite dramatic graduate student who is ambitiously ready to take that bold step into the next stage of my life as a social worker.
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allowed me to successfully find my place in this big old world. I am truly blessed to call you my parents. To Dylan and Luke, thank you for being two amazing brothers who bring me laughter, pride, and happiness. You both inspire me and I thank you for hugs and comfort over the years. To my Grandma and Grandpa, thank you for all the prayers and words of encouragement, for all your cheering and rooting, and for always reminding me of your love. To my Oma and Opa, thank you for exhibiting what it means to have a big dream, take a big risk, and work hard for what you want.

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Chapter 1

Statement of Problem

I see my life as a healing process, not as a mental illness. There are still days when I feel hopeless, depressed, and apathetic. I have not eliminated the chemistry of my humanity. The gamut of emotions is a human experience. I do not think of myself as someone with an illness, but I must address the imbalance. I maintain my self-care, psychiatry, exercise, proper nutrition, and connectedness with others. (Virginia Organization of Consumers Advocating Leadership [VOCAL], 2009, p.129)

What does it mean to have a mental disorder? What does it mean to be mentally ill? Throughout history, the concept of a mental disorder and mental illness have undergone many revisions. One thing that has remained relatively constant is the stigma attached to being given a mental diagnosis and being defined mentally ill (Whitley and Campbell, 2014). This stigma consequentially influences both the services an individual with this label receives, as well as the way society treats and perceives an individual. The quote above represents individuals living with a mental diagnosis, living with mental illness, coming forward in an effort to fight against the label, to fight against the stigma, to fight against mental illness defining his/her life. Beginning with the deinstitutionalization of state mental hospitals, the rocky path towards the recovery movement has been paved by individuals living with a mental diagnosis. Although progress has been made, the recovery movement continues in order to shift the focus on how to define, view, and help those living with mental illness.
Before discussing what the recovery movement is, it is important to first define mental disorder. According to the American Psychiatric Association, a mental disorder is defined as a “significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g. a painful symptom) or disability (i.e. impairment in one or more important areas of functioning) or with significantly increased risk of suffering death, pain, disability, or an important loss of freedom” (2000, p.x). Given this definition, it is assumed that mental illness is within the individual (Walsh, 2013, p. 12). This further reinforces the stigma that is attached to a mental diagnosis, assuming that there is something inherently wrong with the individual. Often this exacerbates the unfavorable reality of mental illness defining an individual’s life, enabling others to have difficulty looking beyond an individual’s mental diagnosis to view the whole person, who s/he really is within.

For those who may not live with mental illness or have a loved one with a mental diagnosis, the necessity to know about and support the recovery movement may seem insignificant. Yet, current research shows that mental illness is increasing within the American population. Over a twenty year span, from 1987-2007, the number of individuals who are currently living with a mental disorder that qualifies as a disability and therefore can receive Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI), increased from one in 184 to one in seventy-six (Angell, 2011). As a percentage of the United States population, a National Institute of Mental Health, NIHM, study revealed that between the years of 2001 and 2003, 46 percent of people met the American Psychiatric Association (APA) definition for having a mental
illness at least once in their life (Angell, 2011). Given these high and increasing rates of mental illness, it is also important to take into consideration the high comorbidity between severe mental illness (SMI) and substance use disorders. The National Survey on Drug Use and Health reports that in 2002, approximately 23 percent of adults with SMI also had a co-occurring substance use disorder (2004). The issue of mental illness therefore becomes more significant and complex, as individuals living with a mental disorder may also be living and dealing with a substance use disorder. Therefore the recovery movement also becomes more significant, as it can be utilized within both the mental health and the substance use fields.

Regardless of the severity of mental illness or the comorbidity with substance use disorders, services are often required or encouraged. Specifically for those individuals living with severe and persistent mental illness (SPMI), the structure and philosophy guiding services can make a huge difference in the outcome of an individual’s life. The predominate model within mental health services has been the medical mode, which largely focuses on accomplishing “stability” through medication compliance, reducing hospitalization, and working with the individual and family to accept a life of persistent illness (Perese, 2007). This approach in services justified the assumption that mental illness resides within the person, allowing the mental diagnosis to be the primary focus. Over time, there has been a push to transform the focus of services from suppressing symptoms to one of global health and overall well-being (Walsh, 2013). The recovery movement represent this transformation, introducing efforts to radically shift the focus of accomplishing “stability” to incorporating the recovery model to structure services that
foster hope and self-sufficiency. The recovery model embraces the concept of recovery, which is viewed as both a process and an outcome, in which the individual defines his/her own life, allowing for creative and meaningful expression and connection to others and the community (Perese, 2007).

The recovery movement is complemented by the World Health Organization’s (WHO) definition of health being “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity,” in an effort to move towards “health-oriented” services instead of “illness-oriented” services (Slade, 2010). In addition, the recovery movement recognizes that recovery is a universal experience that everyone encounters within their life (Anthony, 1993). For example, a family member may die, in which other family members’ lives are changed forever, the pain of losing that person is always with them, but eventually each family member successfully reaches recovery. By reaching recovery of the loss of a loved one, it does not mean that each individual is a changed person or that the death now has to define each individual’s course of life. This is much how the process of recovery from mental illness can be viewed, in that recovery is a journey that is defined by the individual.

Although the recovery movement has been consumer driven, the recovery model is recognized as the guiding principle for mental health services (Sands & Gellis, 2012). As mentioned earlier, the recovery model is also being implemented within alcohol and drug services, and there has been an effort by the Substance Abuse and Mental Health Services Administration (SAMHSA) to merge the definition of recovery within both the AOD and mental health fields. Understanding that consumers are the driving force behind the
recovery movement, it becomes apparent that service providers need to therefore know how to work from and deliver recovery-oriented practices. Although consumers support services guided by the recovery model and agencies comply with policies that support the recovery movement, it comes down to the service providers who either promote recovery through fostering hope and empowering the consumer or undermine recovery by establishing hopelessness and dependence (Williams and Tufford, 2012). Recognizing the role of the service provider, there has been a growing amount of literature that has focused on how to determine and rate the competency and ability of service providers to work from the recovery model. In an effort to continue bettering services for individuals with SMI, it is essential to examine how agencies are ensuring that service providers are supporting and delivering services that support the recovery movement.

**Background of the Problem**

Supporting the recovery movement and embracing the recovery model within services does not mean that all consumers and services providers do not recognize the significant contributions medicine has made to the mental health field. Rather, the criticism falls on systems and services that are solely driven from the medical model, in which the emphasis is placed on symptoms, deficits, and organic, biological problems, resulting in a dehumanizing process where the whole individual is ignored (Carpenter, 2002). Even though much progress has been made, transitioning entire systems and agencies from a medically based model to a recovery based model takes time and requires extra effort to train and maintain service providers’ knowledge on the recovery model. Unfortunately, the average service provider will most likely have a lot of
knowledge and skills about treating illness and very little knowledge and skills about fostering well-being (Slade, 2010). Therefore, a greater emphasis needs to be placed on not only providing trainings and supervision for service providers, but to also have a way to determine service providers’ knowledge about how to effectively work from the recovery model.

For the purpose of discussing how agencies and service providers are ensuring the delivery of recovery-oriented practices, it is important to understand the history of the recovery movement. As previously mentioned, the recovery movement and the concept of recovery within mental health developed from consumers speaking about their experiences of survival, healing, and coping with mental illness (Sands & Gellis, 2012). In addition, the recovery model is backed by empirical research that indicates a positive trajectory specifically within the mental health field, but also within the AOD field (Sands & Gellis, 2012). As a concept, recovery can be understood as both a philosophy and as a model (Walsh, 2013). In this sense, recovery is both a process and an outcome, in that the recovery model structures services that help consumers through their recovery process, as well influencing policy that is created to further support recovery-oriented services. The fact that the concept of recovery does not translate to a specific model or code of conduct, but rather act as a guiding philosophy or attitude, makes it difficult for it to be effectively implemented through services. Regardless, at its core, the concept of recovery supports an individual living with mental illness to direct their own journey of recovery, defining their own life that instills hope, empowerment, and integration within the community.
Despite the multiple ways of understanding the concept of recovery, there have been several widely accepted definitions of recovery. A widely cited and accepted definition of recovery is from Anthony (1993), stating, “recovery is a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness.” In 2004, a national consensus conference developed the following definition of recovery: “mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential” (U.S. Department of Health and Human Services, 2004). As mentioned earlier, SAHMSA has tried to create a unified definition for the concept of recovery within the mental health and AOD fields. There unified definition states: “recovery from mental disorders and/or substance use disorders…[is a] process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” (SAHMSA, 2012). Utilizing this definition, SAMHSA states that there are four “dimensions” specific to the recovery process: health, home, purpose, and community. It is within these four dimensions along an individual’s recovery journey that the mental health and AOD fields still diverge. Within mental health, the recovery process is viewed as flexible and person-centered/directed, whereas within AOD, the recovery process loses flexibility in that “abstaining from use of alcohol, illicit drugs, and nonprescribed drugs” (SAHMSA,
is a requirement for being considered “in recovery” (Bein, 2014). These recovery definitions directly translate into the way the recovery philosophy and model are utilized and implemented.

The recovery model works at three transformational levels: the micro, meso, and macro level (Walsh, 2013). At the macro level, policies at the state and federal level are enacted to require the incorporation of recovery-oriented practices within programs (Walsh, 2013, p.15). At the meso level, consumers and professionals are able to develop additional programs and resources that enhance the availability of recovery-oriented services. At the micro level, the consumer as an individual defines their own recovery process, assuming greater power and working to create deeper meaning within their own life. Through these three transformational levels, mental health recovery proponents have been able to challenge and influence the structure of agencies and programs (stigmatizing, focus on symptom suppression and medication compliance) and the philosophy and paradigms that drive professional practice (practitioner as the expert and gate keeper) (Bein, 2014).

Utilizing these three transformational levels, currently recovery oriented mental health services has been the supported goal initiated at a federal level through the President’s New Freedom Commission Report (Bartholomew, 2010). And at the micro level, consumers are working on defining their own recovery process, regardless of choosing to engage in services or not. But what about at the meso level; how is the delivery of recovery-oriented services by professionals being measured, how can one tell whether a professional understands and utilizes a recovery-oriented philosophy? This is
significant, because as previously mentioned, a professional’s recovery knowledge and/or “blind spots” can either foster recovery core values such as hope and resiliency, or fuel the continuation of negative medically based approach to dehumanizing the consumer (Bein, 2014). Therefore it becomes essential to understand how service providers and professionals comprehend the recovery model and are able to implement it into practice so that consumers feel empowered and respected, self-determination is upheld, the process is consumer directed, collaborative, and there is mutual engagement and discovery (Bein, 2014, p.92). To continue progress in the recovery movement, more focus needs to be placed on how service providers and professionals are upholding recovery values and utilizing recovery-oriented practices.

**Statement of the Research Problem**

The successful progression of the recovery movement has resulted in the acceptance and support of recovery-oriented services. This increased acceptance and support now needs to be met with “reliable and valid measure[s] of recovery” to further assist consumers in their recovery process and assess whether service providers are competent in understanding and implement recovery-oriented practices (Corrigan, Salzer, Ralph, Sangster, and Keck, 2004). Focusing on the clinical side or recovery, there needs to be a better understanding of how service providers are learning about, comprehending, and implementing the recovery model. In addition, given the shared definition of the concept of recovery within both the mental health and AOD fields, it is also significant to look at how service providers from both fields are upholding and utilizing the recovery model. In both situations, given a mental health or substance use diagnosis can result in long-
term need and involvement with service providers (Williams and Tufford, 2012). Therefore service providers often play a pivotal role in assisting consumers in their recovery process. Whether a service provider fosters or neglects the concept and philosophy of recovery can directly affect the outcome of a consumer’s recovery process.

**Purpose of the Study**

This research study aims to investigate mental health and drug and alcohol service providers and staff’s level of knowledge, understanding, belief in and use of the recovery model. In addition, this study hopes to better understand the overall culture of the county agency, suggesting the level it incorporates and upholds a recovery-oriented perspective and model. Many individuals who seek mental health services, also struggling with a drug and/or alcohol problem. Therefore, it is important to look at two service departments that often times are serving the same individual. In addition, there has been a movement to beginning fusing these two services together, to better meet the needs of individuals. This has resulted in a movement towards merging the definition of recovery for both mental health and drug and alcohol. Since there has been a diverging difference in the concept of recovery for mental health and drug and alcohol fields, it becomes relevant to understand how service providers and staff in these two fields are understanding and utilizing the concept of recovery, as well as the recovery model. Focusing on mental health and AOD service providers and staff at the county agency will hopefully provide comparative and statistically data analysis that will yield results to show how these two departments exemplify the recovery model. Including all staff members in these two departments, not just service providers, will allow this study to
understand how all employees are working from the recovery model as well as look at the overall culture created by the county agency. Suggestions can be made to determine if specific trainings are needed to improve the level of integration of the recovery model. In general, this study will provide a current snapshot of the recovery model within a small county agency.

**Theoretical Framework**

There are several main theories that are useful in framing the discussion; this study specifically draws upon the ecological, strengths based perspective and the empowerment perspective. For social workers, incorporating an ecological perspective is essential, as it allows for the individual to be viewed within the given context or environment. The individual is seen as a whole person, not just his/her symptoms or difficulties. Utilizing a strengths based perspective, allows for an individual’s strengths to be focused on, further supporting an ecological perspective. Incorporating empowerment perspective highlights that with correct knowledge and resources, an individual can develop skills to engage in a process of transformation (Carr, 2003). Further, this process can be applied to an entire group, in which independence can be achieved (Boehm & Staples, 2002). Through this perspective, service providers and staff’s level of understanding, belief in, and use of the recovery model can be examined. In addition, the shift of the overall county agency from a medical model to a recovery model can be analyzed. This theoretical framework allows for the county consumer’s perspective and well-being to be taken into consideration, while also examining issues of social class, race/ethnicity, and political, economic, and ideological power.
Historically, the mental health system has been structured by the medical model, which has taken a reductionist approach to examining the individual with mental illness. The recovery movement largely began from consumer’s efforts to collectively come together, speak out against the reductionist medical model, and empower one another. The recovery perspective, incorporating an ecological and strengths based approach, aims to view the whole individual, rather than reducing the individual to their mental health diagnosis or symptoms. Practitioners utilizing a recovery perspective work with the individual in a client-driven manner, incorporating the individual’s strengths to help restore hope and develop resiliency along the individual’s recovery process. In this regard, the practitioner’s role is to work with the individual, empowering the individual to define his/her own recovery.

**Definition of Terms**

To gain a better understanding of the stated research problem and study, several terms need to be defined. It is important to understand both the conceptual and operational definitions of terms used throughout this research. These definitions are used and supported by the research questions, methodology, and analysis of the study.

**Recovery Model:** A model of practice that translates to the work and interaction with consumers of both mental health and drug and alcohol services, by service providers and staff, which represents and supports the recovery movement, the main recovery principles identified by SAHMSA and the notion that recovery refers to “…a consumer’s journey toward wellness and emphasizes his or her primary role and responsibility in achieving wellness” (Walsh, 11).
Mental Health Service Provider and Staff: Any individual who is a current employee within the mental health department, and who may or may not be a certified and credentialed mental health practitioner, and may or may not provide direct services to consumers.

Drug and Alcohol Service Provider and Staff: Any individual who is a current employee within the drug and alcohol department, and may or may not be a certified and credentialed drug and alcohol practitioner, and may or may not provide direct services to consumers.

Training Mediums: Various workshops, classes, discussions, forums, and speaker panels that provide a learning environment specifically on the topic of the recovery model.

Agency Culture: The overall recovery-oriented environment produced by the county, specifically looking at the mental health and AOD departments, which provides services to and is perceived by county consumers.

Assumptions

There are several premises that need to be outlined in order to best understand the base of the arguments presented later in this paper. First, it can be assumed that this researcher believes in the use and positive effectiveness of the recovery model within a mental health agency context. This further assumes that consumers of mental health services, would largely support a recovery based agency that has staff trained in a recovery oriented perspective. Given these two premises, this researcher is not trying to assert that the recovery model is the only and/or best way to organize and work with consumers of mental health services. Lastly, this researcher is in support of further
merging mental health and drug and alcohol services. Consequentially, this would aid in the further development of a mutual definition of recovery for consumers utilizing services for both mental health and substance use needs.
Chapter 2

Review of the Literature

In order to better understand the context of the research questions, taking a multi-disciplinary approach is helpful. It is important to draw upon scholarly research and articles from the following fields: mental health, drug and alcohol, organizational development, and social work.

Mental Health Stigma

Stigma is a word often associated with behaviors and/or people whom are deemed deviant and often classified as “less than” within society. Originating from ancient Greek language, meaning “brand” or “mark,” the concept of stigma has developed within the academic fields through the founding work of Goffman (1963) and Foucault (1995) (Whitely and Campbell, 2014). Drawing upon Goffman (1963) stigma can be defined as a “deeply discrediting” characteristic that transforms an individual into “a tainted and discounted one,” who can then bear the “mark” of stigma resulting in public criticism, disapproval, rejection and discrimination. Unfortunately, for individuals who suffer from a mental health and/or addiction diagnosis, stigma can be one of the largest obstacles to overcome. Specifically for individuals with severe and persistent mental illness (SPMI), stigma can result in insufficient health care, housing, employment opportunities, support and trust from the community and others, alienation, and discrimination (Perese, 2007). Historically and currently, the stigma around mental health has remained strong with little improvement. It is perpetuated in the language used to describe “negative” aspects and the portrayals of mental illness within media, which instill fear of those who are
mentally ill. This results in negative perceptions and beliefs about individuals with mental illness, resulting in fear and mistrust. One study found that “nearly two thirds of respondents would not welcome a group home for individuals with mental illness in their neighborhood, and three fourths would not welcome independent apartments” (Perese, 2007). A mental health diagnosis is truly like receiving a “mark” or “brand” that results in dictating the course of one’s life.

A mental health diagnosis does not mean one experiences stigma only within the outside community and society. Unfortunately the stigma surrounding mental health is also entrenched within the services systems and institutions accessed by mental health consumers. The treatments programs and services offered, as well as the beliefs and behaviors of service providers and staff, can all further transmit and reinforce the stigma of having a mental health diagnosis. Often, the result is that an individual’s resiliency, sense of hope and self-worth, and strengths are devalued, while the idea that an individual will experience a downward progression is promoted (Bein, 2014). In culmination, this makes an individual’s recovery journey much more complex, as one learns to navigate the reality of enduring stigma due to mental illness.

Current research shows that individuals with SPMI are still experiencing high levels of stigma today, despite efforts from policy makers and consumers (Whitely and Campbell, 2014; Perese, 2007). In addition, research also suggests that there are specific factors that can help alleviate the negative effect of stigma, which include services that utilize recovery-oriented services, promoting recovery, empowerment, and peer support (Whitely and Campbell, 2014). Given this knowledge, Whitely and Campbell (2014)
conducted a five year (2008-2012) qualitative longitudinal study in Washington D.C. to examine the behavioral and psychological strategies used by individuals with SPMI to manage stigma they experience. The study found that participants did not perceive stigma and discrimination as “common experiences” but rather perceived it as “potential problems” that caused the participants to remain “vigilant, taking various preventative measures” (Whitely and Campbell, 2014). In addition, participants expressed actions of normalizing their mental illness by comparing it to a medical diagnosis. What is significant to recognize, is that all the participants in this study were receiving rehabilitation services including medication management, supported employment, illness management programs and support housing. This further supports other research which has found that these types of services are all positive factors in reducing stigma and fostering recovery (Whitely and Campbell, 2014).

Consumers have also come forward and spoke about the significant factors that allowed them to deal with and overcome the effects of stigma due to their mental illness. Holly Henderson is a consumer diagnosed with schizoaffective bipolar mixed disorder, who now writes various pieces of literature, speaking out about her recovery process. In discussing her recovery process, Henderson (2004) states:

Accepting the diagnoses was, for me, most difficult because I had to overcome my own stigma about being one of them. I had wrongly lumped together all people with mental illnesses and considered them to be lazy, immature and/or stupid. I had always believed a mentally ill person, while maybe having problems, really needed most of all to just pull him or herself up by the
bootstraps. Such thinking had always led me to dismiss any need for therapy and medication for myself. (p. 3)

Individuals are not born in vacuums, rather they are influenced by what is observed and felt from society. Like Henderson expressed, her stigma was driven from commonly held stereotypes about individuals with mental illness. These stereotypes are continuously perpetuated throughout society and contribute to the stigma experienced individuals with mental illness. As research suggests no decline in the stigma surrounding mental illness, it is imperative to focus on the factors that have shown to reduce the negative impact of stigma, such as the use of recovery-oriented services and the proper support of service providers.

**The Recovery Movement**

Originating as a consumer movement and followed by the implementation of policies, the recovery movement has progressed in its development, acceptance, and applicability to service systems. Patricia Deegan is both a consumer and a clinical psychologist, who has been a key leader within the recovery movement. Drawing upon her words about the meaning of recovery, she states “‘Recovery is a decision to meet the challenge of disability…People experience themselves as recovering a new sense of self and purpose within and beyond the limits of disability’” (Henderson, 2004). Within this process of recovery, the focus is on wellness of the whole individual, supporting that individual to define their own meaning of a satisfying and productive life (Henderson, 2004; Lukoff, 2007; Oshodi & Rush, 2011). Over time, the recovery movement has
gained momentum, with research providing evidence for its effectiveness when integrated into services.

The recovery movement gained momentum in the 1980s, with many consumers coming forward to speak about the concept of recovery and what recovery from mental illness meant to them. Interestingly enough, there has been longitudinal studies conducted as early as the 1970s which dispute the assumption of chronicity or downward progression for individuals with mental illness and show that a large majority of these individuals actually experience complete or partial remission of symptoms, can obtain work, and create a meaningful life (Carpenter, 2002; Lukoff, 2007; Oshodi & Rush, 2011). These studies help to break down the stigma around mental health and restore an essential factor in the process of recovery, hope. It has been and continues to be one of the main visions of the recovery movement to challenge the medical model’s emphasis on symptom reduction, confronting service provider’s assumptions and stereotypes of what life means when having a mental health diagnosis.

It is important to understand that recovery is a dynamic and multidimensional concept. One of these reasons is because recovery is both a general philosophy and a variety of models (Carpenter, 2002; Walsh, 2013). There are various models of recovery that both help guide consumers through their recovery journey, as well as guide policy makers to implement recovery-oriented services (Walsh, 2013). Recovery is a philosophy in the way it is understood and incorporated, comprising an attitude about how consumers can lead a self-directed life, where they feel valued and worthy, even if that does not include the help of professionals. Combined, both the models of recovery
and the recovery philosophy emphasis that there are various measurements of recovery, reinforcing that recovery does not look the same for everyone, and that there must be a variety of series to meet all dimensions of recovery (Anthony, 1993).

The recovery movement has led to many advancements in the delivery of services for mental health consumers, but there remains work to be done. Creating a service environment that incorporates the recovery philosophy and delivers recovery-oriented services consisting of various models of recovery can be difficult. This can be difficult because in order to transform services that have been delivered under the traditional medical model, requires a paradigm shift in which service providers themselves must alter their ideas about mental illness as well as how to treat individuals with mental illness (Oshodi & Rush, 2011). It is also difficult to transform the delivery of services to meet fundamental values of the recovery model, so that consumers maintain the primary control concerning their treatment and care (Oshodi & Rush, 2011; NASW, 2006; Williams and Tufford, 2012). As consumers themselves have stated, as well as what research has shown, recovery-oriented services that emphasis the concepts of strengths, empowerment, and hope by reinforcing the individuals sense of control, allows for consumers to develop a greater sense of control over their own life and recovery process.

Currently, research reveals that although there is a greater awareness and understanding about the attitudes, knowledge, and skills that promote recovery, there is still evidence to suggest that service systems have not transformed to emphasize recovery and resiliency over illness and disability (Williams & Tufford, 2012). Davidson and White (2007) suggest that some of this resistance to service systems fully embracing the
recovery model is due to persistent ambiguity and a lack of clarity about what recovery means. For example, service providers may view recovery as “…abstinence, an absence of symptoms, or the amelioration of deficits” while consumers may view recovery as “…having a safe, dignified, and gratifying life in the presence of ongoing disability” (Davidson & White, 2007). These issues are at the forefront as consumers, policy makers, and professional supporters work hard to continue the advancement of the recovery movement.

**Recovery within Substance Use and Mental Illness**

**What recovery means in the alcohol and drug field.** The concept of recovery originated in the alcohol and drug (AOD) field. Recovery originally meant that an individual was recovering from a substance use disorder (NASW, 2006; Davidson & White, 2007; Bein, 2014). Although the concept of recovery has been integrated into the mental health field, there are some defining points between how the two fields utilize and define “recovery.” In the AOD field, an individual is not considered “in recovery” unless they have been able to reach and maintain full abstinence from any type of addictive substance. Recovery is achieved through very structured programs that emphasis strict guidelines and traditional follow a 12-step philosophy (Bein, 2014). Within the addiction community a large emphasis is placed on peer-based mutual support groups, while addiction service systems typically focus on treatment and relapse prevention (Davidson & White, 2007). For individuals with a co-occurring disorder or a desire to decrease use without obtaining full abstinence, navigating the addiction community and service system can be challenging.
What recovery means in the mental health field. The concept of recovery first began making a prominent appearance during the 1970s during the community support movement (Davidson & White, 2007). Beginning as a consumer movement, the concept of recovery became an integral factor within the mental health field with the 1999 Report on Mental Health in the US Surgeon General and the 2003 President’s New Freedom Commission (Davidson & White, 2007). Through the voices of mental health consumers, recovery is defined as a process and journey, in which the individual has a right to define their own life, in an effort to redefine one’s identity, re-establish self-worth, emphasize strengths, resiliency and hope, and place the primary focus on well-being and wellness. Recovery is supported by services that foster a client driven approach where collaboration between the individual and practitioner is encouraged (Bein, 2014). Similar to the AOD field, there has been an strong emphasis on peer-support within the consumer community, with a greater emphasis on symptom management and treatment within the mental health service systems.

Merging two fields. The national survey on drug use and health (2004) reports that in 2002, 17.5 million adults (18 or older) in the United States had a serious mental illness diagnosis within the past year. The same survey estimates that approximately 23 percent (4 million) of those adults with a serious mental illness diagnosis also met the criteria for a substance use disorder (National Survey on Drug Use and Health, 2004). This is a rather large difference compared to the estimated 8 percent of individuals who only meet the criteria for a substance use disorder. What these statistics highlight is the high comorbidity between a mental health disorder and a substance use disorder. Some
research suggests “… mental illnesses and addictions co-occur within the same person as frequently as they exist independently of one another” (Davidson & White, 2007). Such evidence has resulted in an increased awareness for the need to address co-occurring disorders. SAMHSA has addressed this issue by developing a working definition of recovery that applies to both mental health and alcohol and drug (AOD). This working definition was released in 2011, being described as “a blended definition…” that is “…vague, and general, and doesn’t stress abstinence” (Alcoholism & Drug Abuse Weekly, 2012). SAMHSA’s definition states, “Recovery from Mental Disorders and/or Substance Use Disorders: a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” (2012). This definition highlights commonalities between recovery for both disorders, in that “…recovery is a personal and individualized process of growth that unfolds along a continuum, with multiple pathways leading to recovery” (Davidson & White, 2007). Research has shown that consumers with both a mental illness and/or an addiction have described recovery as a “process,” in which transformation is unpredictable and often occurs in multiple states (Davidson & White, 2007).

Unfortunately, SAMHSA’s definition has faced criticism from both the addiction field for not stressing abstinence is necessary for recovery, as well as consumers in recovery stating they would prefer a distinction between mental health and AOD recovery (Alcoholism & Drug Abuse Weekly, 2012). There is still more research and efforts needed to clarify and merge both the definitions and services for recovery in both the mental health and AOD fields. Davidson and White (2007) discuss the challenge of
integrating mental health and addiction services, providing evidence for the historically “uneasy relationship” between the two service fields. The authors further argue that the development of the recovery movement within both the mental health and AOD fields offers a viable environment for merging these two fields together. Other authors, such as Bein (2014) highlight the need to address that historically mental health and AOD services have operated in completely different silos, only offering parallel treatments for individuals diagnosed with a co-occurring disorder. This is concerning, since many county agencies still operate in this manner. Evidence suggests that when an individual must separate themselves – receiving parallel services from two different departments – the treatment tends to be nonintegrated resulting in poor prognosis (Bein, 2014). In order to continue the advancement of the recovery movement, policy makers and agencies must reexamine the structure of their services and departments to better incorporate recovery-oriented services for all consumers.

**Understanding and Implementing the Recovery Model**

Evidence suggests that there is still a lack of understanding about the recovery model and how it should be effectively implemented within services delivered. As previously discussed, transforming an entire service system to ensure that the recovery model and philosophy is satisfactorily understood and implemented by all service providers can be extremely challenging. This is challenging because often there is a set of assumptions that comes along with an individual receiving a diagnosis as “a borderline,” “a meth addict,” or “a schizophrenic” (Bein, 2014). These set of assumptions are not only held by society in general, but can also be reinforced by service
providers, resulting in the delivery of services to a passive client (Bein, 2014). For service providers to deliver recovery-oriented services, there must be an understanding of moving away from the traditional paradigm where the focus is on client compliance and adherence to the set treatment plan, to the client directing the process in an effort to re-engage with the defining their life by developing goals and creating meaning (Slade, 2010; Bein, 2014). In general there must be an understanding of how to support a consumer’s recovery process, by providing services that promote the well-being of an individual rather than treating the illness.

Another difficult aspect of understanding and implementing the recovery model results from the premise that there is no one set process or outcome of recovery. Therefore, services must be flexible and adaptable to fit the needs of the consumer, ensuring that an individual’s strengths are the focus point rather than one’s deficits (Oshodi & Rush, 2011). Service providers working from a recovery-oriented perspective must juggle the expectations of an agency, in that there are treatment plans with the intention to see improvement in functioning, in addition to supporting peer support and empowering the consumer. In a response to this, some agencies have adopted a team approach, providing an integrated network of care which includes: medical, rehabilitation, and case management (Williams & Tufford, 2012).

There are several models that support recovery and have been utilized within agencies. One of these models is the evidenced-based psychosocial intervention called illness management and recovery (IMR) program. IMR “is a comprehensive, curriculum-based approach designed to help people with SMI overcome barriers to
wellness and accomplish meaningful goals that define their personal recovery” (Garber-Epstein, Zisman-Ilan, Levine, and Roe, 2013). Research has shown that IMR can easily be delivered by service providers from a variety of professional backgrounds, as long as service providers work from a recovery-oriented perspective by building rapport, focusing on a consumer’s strengths, and fostering hope (Garber-Epstein, Zisman-Ilan, Levine, and Roe, 2013).

Another successful model for recovery that can be implemented by service providers is the Wellness Recovery Action Planning (WRAP), which is a manualized self-management recovery program that assists consumers in identifying both internal and external resources that support recovery (Starnimo, Mariscal, Holter, Davidson, Cook, Fukui and Rapp, 2010). WRAP is an effective recovery-oriented service because it allows the consumer to create their own strategies that support self-directed care (Starnimo, Mariscal, Holter, Davidson, Cook, Fukui and Rapp, 2010). Like the IMR, the WRAP is a model of recovery that can be easily adapted into existing service systems. Utilizing outcome measurement tools, such as the Developing Recovery Enhancing Environments Measure (DREEM), and the Recovery Star, a tool used by consumers to measure their recovery progress, allow an existing service system can determine how “recovery-oriented” there services are (Mental Health Foundation).

The Role of the Service Provider

As an individual with a mental illness diagnosis and/or a substance use disorder, it is likely that one will have contact with an array of service providers. For many individuals with SPMI, service providers become a main source of support and contact
throughout their recovery process. Research has shown that because of this constant contact, the role of the professional service provider can be pivotal in the individual’s recovery process (Anthony, 1993; Lukoff, 2007; Williams & Tufford, 2012; Garber-Epstein, Zisman, Illani, Levine & Roe, 2013). Working from the recovery model can be difficult for the professional service provider to bring to action the recovery philosophy. A recovery-oriented service provider realizes that they do not hold the power to recovery, the consumers does, and that the primary role of the service provider to simply help facilitate recovery, while the consumer defines what recovery means (Anthony, 1993).

As discussed earlier, this can be challenging, especially if a service provider is working within a service system that still primarily focuses on symptom management and places the power role in the hands of the service provider.

The NASW has recognized that there is a lack of clarity about how to work from a recovery-oriented perspective, especially when an individual’s personal safety may be at risk. In a paper published by the NASW (2006), the authors discussed how to “practice” the recovery model within mental health so that the process is still client directed, but the service provider is also upholding their ethical responsibilities. For example, the NASW article suggests that when a consumer expresses an idea or plan that may seem irrational to the service provider, then the service provider’s primary role to facilitate a discussion with the consumer to help them understand the realistic implications and possibilities of that decision. Service providers must realize that they can help explain and tease out a situation, but the final decision always belongs to the consumer, following through with the responsibility to “support the dignity of risk and
the right to fail” (NASW, 2006). The NASW encourages service providers to understand and accept that assisting consumers in making their own decisions, regardless of whether they are good or bad, is essential in their recovery process and development of independence (2006). Several tips that NASW (2006) provides to service providers to work from a recovery-oriented perspective is to always talk directly to the consumer, engaging s/he in the conversation, always be open to discussing a consumers request, remember the effect of body language and communication skills, and respect consumer’s cultural differences.

Recognizing the significant role that a professional service provider can play in a consumer’s life, there has been a shift in research to understand the impact of practitioner professional background in delivering services to consumers. One study did just this by examining whether the delivery of IMR would differ dependent upon whether the practitioner was a mental health professional, peer providers, or paraprofessionals, by comparing consumer outcome in IMR (Garber-Epstein, Zisman-Illani, Levine, and Roe, 2013). There was a total of 252 participants, all individuals with SMI receiving psychiatric rehabilitation services within the community, some receiving IMR and other receiving standard treatment. The findings suggested that “regardless of practitioner background, consumers who received the IMR intervention demonstrated significant improvement compared to the control group” (Garber-Epstein, Zisman-Illani, Levine, and Roe, 2013). Further analysis revealed that when a service provider received sufficient training and supervision on the delivery of IMR and working from a recovery-oriented perspective, there were positive outcomes regardless of professional background. This
study’s findings support previous research that examined the differences in effectiveness between professional and paraprofessionals interventions, and no differences in outcomes were found (Chistensen & Jacobson, 1994; Solomon, 2004; Garber-Epstein, Zisman-Illani, Levine, and Roe, 2013).

Other studies have focused on gaining consumer’s insight and perspective on what it looks like when a service provider is working from a recovery-oriented perspective. One study specifically explored the perspective of individuals diagnosed with schizophrenia on their professional service providers, in an effort to develop professional competencies for utilizing the recovery mode (Williams & Tufford, 2012). Qualitative interviews were conducted with 40 individuals diagnosed with schizophrenia. The study’s findings support other current literature, suggesting that “areas of skill and attitude that relate to promoting recovery…” include “…use of time, talk, and teamwork” (Williams & Tufford, 2012). Participants specifically stated that service providers who took the time to help an individual, and were willing to talk with them beyond their symptoms, made a significant impact in their recovery process. This supports other literature concerning the role of the service provider and how to implement recovery-oriented practices. From a consumer’s standpoint, it is important to feel that a service provider allows space for the recovery process and engages on a deeper level that simply treatment and management of symptoms. For the service provider to instill hope and empower the individual, developing a genuine relationship is fundamental to the successful recovery of a consumer.
Effectiveness of the Recovery Model

Originating as a consumer movement, consumers themselves are proof for the effectiveness of the recovery model. Consumers continue to speak out and share the significant impact service providers who work from a recovery-oriented perspective make in their recovery process. In addition, consumers help to continue providing feedback on how to better the delivery of services and the current models of recovery that currently exist. Sawyer’s (2011) is a consumer who has written several articles discussing her experience of being institutionalized at a young age, enduring shock treatment, and how several psychiatrists and therapists helped her recover and develop a successful professional career. Sawyer (2011) talks about a specific period of time where she was barely speaking to anyone in the hospital, until a young psychiatric intern came along. Remember him, Sawyer (2011) states: “I felt that he took me seriously: he didn’t talk down to me or lecture me. We could make jokes together. The camaraderie did wonders for my self-esteem. In the spark of a good pun, we were peers; we connected.” Sawyer (2011) further describes that:

Even as emotionally compromised inpatients, most of us were aware of the quality of the psychiatry residents treating us. I sensed which ones were afraid of patients and which were comfortable with themselves and with us as fellow humans. I could tell who spoke past me, who delivered canned speeches without noticing if I was listening, who worried about being contaminated if touched. Looking back, I can say that the best psychotherapists understood their work as a
collaboration with each patient. They were not afraid to journey together through an unknown and possibly dangerous land. (p.8)

Sawyer’s (2011) perspective is similar to what other consumers have expressed, as well as what research has shown. Consumer’s opinions and perspectives have been further incorporated into developing various programs that fit the recovery model. Researcher’s then test these various programs and models of recovery, examining their effectiveness in promoting recovery, based upon consumer’s response and outcome. Current research suggests that there are a variety of program and models of recovery that have proven to be very effective. One of these, is the Collaborative Recovery Model, which emphasizes key recovery values while drawing upon evidence-based practice for establishing and setting goals (Slade, 2010). Preliminary evaluations of the Collaboration Recovery Model suggest that it is effective and positive, resulting in an improvement in service provider’s attitudes and knowledge about recovery (Slade, 2010).

Further research is being conducted utilizing the Recovery Assessment Scale (RAS) to measure how effective current service systems are in promoting and facilitating recovery for consumers (Corrigan, Salzer, Ralph, Sangster, & Keck, 2004). The RAS was used in a multistate study on consumer operated services, interviewing 1,824 individuals with SMI, to measure hope, meaning of life, quality of life, symptoms, and empowerment (Corrigan, Salzer, Ralph, Sangster, & Keck, 2004). Findings revealed that half to two-thirds of the participants no longer needed hospitalization, were able to obtain some level of work, and were living within the community, further supporting other research that suggests recovery from SMI is a reality for many (Corrigan, Salzer, Ralph,
Sangster, & Keck, 2004). The participants in this study identified several external factors that they feel attributed to their recovery process. Some of those external factors included: a connection to others, support from family, friends, and service providers, and most importantly “…having people who believe that the consumers can cope with and recover from their mental illness” (Corrigan, Salzer, Ralph, Sangster, & Keck, 2004).

Having access to a service system that no only promotes recovery-oriented services, but ensures that staff understand how to work from a recovery-oriented perspective, can create the positive environment necessary for recovery.

Looking at existing models of recovery, Roe, Hasson-Ohayon, Salyers, and Kravetz (2009) conducted a study that investigated the perceptions of consumers after using IMR for one year. Findings suggested that participants perceived IMR as helpful, specifically within improving cognition, coping, and social support, and that it allowed them to learn new information and develop hope for recovery (Roe, Hasson-Ohayon, Salyers, & Kravetz, 2009). A similar study was conducted to examine the Wellness Recovery Action Planning (WRAP), focusing on participants ability to achieve key recovery related outcomes (Starnimo, Mariscal, Holter, Davidson, Cook, Fukui and Rapp, 2010). Results were positive, providing evidence that WRAP results in consumers having an increase in “…self-reported hope and recovery-related attitudes” as well as showing improvement in symptoms. This is significant, as both IMR and WRAP are models of recovery that can be integrated into existing mental health service systems. And as research suggests, both IMR and WRAP are proving to be effective models of recovery.
Looking at how to integrate these models of recovery into existing service systems, one study explored consumer’s and service provider’s perspectives on using a computerized version of IMR (Wright-Berryman, Salyers, Kemp, Mueser, & Diazoni, 2013). Findings revealed that consumers and providers did perceive some barriers to implementation, such as lack of computer skills and access to computers. But findings also suggest that consumers and providers found the IMR program, and required less prepping and time of the providers. Other service systems have turned to restricting their allocation of money for various services. The Village, an agency in inner-city Los Angeles that works with individual with SMI and are homeless, did exactly this. Undergoing a “fiscal paradigm shift,” The Village transformed their allocation of money from spending 28% on acute hospitalization, 23% on long-term care, and 23% on outpatient therapy to spending 41% on individualized case management, 25% on work, and 12% on community integration (Slade, 2010). Reports have shown positive results since The Village committed to this shift (Slade, 2010). There are a variety of programs and models of recovery that have been proven to be effective and result in positive outcomes for consumers. It is up to consumers to continue speaking up about the necessity for more recovery-oriented services and for policy makers to ensure that service systems are utilizing these proven programs and models of recovery.

**Resistance to the Recovery Model**

Despite the advancements of the recovery movement, the many consumers that speak about their recovery process, and the evidence that suggests recovery-oriented services result in positive outcomes for consumers, there is still resistance to the recovery
Beyond the stigma that still surrounds a mental health diagnosis and the difficulty in transitioning a service system and its providers from a traditional medical model approach to embracing a recovery philosophy and model, there are valid points of criticism and resistance that need to be addressed. Some of the resistance to the recovery model results from the fact that the recovery movement has been consumer-driven, therefore often resulting in consumers being more “recovery minded” than professional service providers are (Walsh, 2013). This can create some discomfort, leading to the focus of services being placed on the distinction between consumer choice and service provider’s treatment plans (Walsh, 2013). Discomfort, combined with a lack of support, can result in service providers having resistance to fully embracing recovery-oriented practices.

Oshodi and Rush (2011) also speak to resistance that results from the debate over recovery being understood as a process or an outcome, or both. With the emergence of evidence-based practices, it becomes difficult to decipher if the recovery model is compatible with this, especially if it cannot be defined as strictly a process or an outcome. Oshodi and Rush (2011) further explain that “while evidence-based practice emphasizes external scientific reality, the recovery model stresses the importance of the phenomenological, subjective experiences and autonomous rights of persons who are in recovery.” For some, the fact that in a recovery model, the treatment decisions for a consumer may not be solely based on scientific facts can be very disconcerting. Given that within the mental health service system there is a wide variety of providers that come
from a medical background, utilizing a recovery-oriented perspective can be perceived as completely wrong and foreign.

Both human service professionals and consumers have raised concerns about the recovery model. Walsh (2013) presents a discussion about these concerns, stating that for human service professionals the main concerns are: focusing on recovery and incorporating this into services may be a burden due to service providers that are already stretched thin, the belief that recovery is only a possibility after the intervention of professionals, recovery-oriented services are sometimes not billable or evidence based in nature, the difficulty with devaluing the role of the service provider, allowing for consumer choice increases risk and liability, and the reality that many service systems make it difficult to fully embrace and implement a recovery-oriented perspective. Consumers concerns include worrying that consumerism may result in responsibility being completely shifted from the service provider to the consumer, and that the recovery philosophy may create the assumption that all consumers fully recovery, further stigmatizing those that do not (Walsh, 2013). Much concern and resistance comes from a need to further define the concept of recovery and what it means to deliver services from a recovery-oriented perspective. In addition, the resistance proves a need to address the tension that still results from mental illness being viewed as an organic, biological issue only to be treated from evidenced based, medical approaches.

**Creating an Agency Culture to Support the Recovery Model**

Although the New Freedom Commission on Mental Health declared the recovery model as the basis for mental health service systems, it did not follow up with additional
funding and support to ensure the transition of existing service systems to implement recovery-oriented services (Walsh, 2013). Despite the consumer support of recovery and the evidence to suggest positive outcomes of programs and models of recovery, creating an agency culture that fully support the recovery philosophy can be challenging. Oshodi and Rush (2011) acknowledge this challenge, commenting that for this reason it is imperative that all stakeholders become active participants in ensuring the incorporation of the recovery philosophy and the implementation of recovery-oriented services within service systems. The United States slightly lags behind other countries such as New Zealand, Australia, England, and Scotland, where government policy has made requirements to use a recovery approach, in addition to mandating that mental health professionals must demonstrate their competency for utilizing a recovery-oriented perspective (Oshodi & Rush, 2011; Walsh, 2013).

In an effort to hold all stakeholders accountable for transitioning a service system to one that promotes and implements recovery-oriented services, several authors have made suggestions. Dinniss (2006) suggests that the recovery philosophy and model should be part of every psychiatrists trainings. This can be extended to state that all service providers, regardless of professional or schooling background, should be required to have training on the recovery model. This would ensure that all service providers in a service system understand the concept of recovery and have general knowledge about how to deliver recovery-oriented services. A second suggestion, is that there needs to be continued research to perfect an efficient and easily used tool to measure how recovery-oriented services are within a service system (Dinniss, 2006). Although several
measurement tools have been developed, they are currently not being utilized in all service systems.

It is the recovery movement’s vision that one day all service systems will foster a culture that promotes the recovery and wellness philosophy, while drawing upon evidence based and recovery-oriented practices. As previously discussed, this can be challenging due to the reality that many service systems still have structures that are hierarchical and separated into different silos depending on the commanding level of staff (Bartholomew, Kensler, 2010). In addition, many positions are filled due to seniority, which can further the resistance to institutional culture changes (Bartholomew, Kensler, 2010). In an effort to continue improving the culture of existing service systems so that the recovery model is embraced and promoted, more attention and support needs to be placed on assisting service systems in the transition to recovery-oriented.

**Conclusion**

Receiving the diagnosis of either a mental health or addiction disorder results in a myriad of obstacles and challenges ranging from stigma within the public and conflicts with navigating the service systems. The recovery movement has offered an avenue for consumers to voice their concerns and share their stories of recovery. In addition, the recovery movement has allowed for the further positive development of services to better meet the needs of consumers. The concept of recovery is now widely known and the recovery model has gained global recognition and support. Research has shown the effectiveness of recovery-oriented services, resulting in positive outcomes for consumers. But more improvement and research is needed to ensure the competency and integration
of the recovery philosophy by service providers, as well as assist service systems in completing the transition to a culture that fosters and supports recovery-oriented practices and services. The recovery movement offers hope for both the mental health and addiction field, but its future will depend on the commitment of all stakeholders in reaching a point where the recovery model is fully integrated and mandated.
Chapter 3

Methodology

This chapter discusses the methodology of the research project, including the study design, sampling procedures, data collection procedures, instruments used within the study, data analysis, and protection of human subjects. The origin, foundation, structure, and practices used will be described in this section as well.

Study Design

This study utilized a descriptive research design. A descriptive research design allows the researcher to draw upon existing findings about the recovery model, while further exploring how mental health and drug and alcohol service providers and staff understand, believe in, and use the recovery model, as well as examining how this upholds the overall agency’s goal of working from the recovery model. Utilizing a descriptive research design further allows the researcher to freely discover the service provider and staff’s perception, utilization, and comprehension of the recovery model within the mental health and drug and alcohol fields. This study utilized a research survey that collected both quantitative and qualitative data. Surveys were first distributed to all county mental health and drug and alcohol service providers and staff’s work emails (N=50). Statistical analysis was completed based on survey responses. Conclusions and suggestions are drawn from survey analysis.

After becoming familiar with the current research and literature on the recovery model, it became apparent that there is a need for an increased understanding about how service providers are learning about, comprehending, integrating, and utilizing the
recovery model within practices with consumers. As discussed earlier, since the initiation of deinstitutionalization in the United States, there has been a progressive movement away from a primarily based medical model, to a slow inclusion of the recovery model. Consequentially, since the President’s New Freedom Commission Report, the delivery of recovery oriented mental health services has become supported at a federal level (Bartholomew, 2010). SAMHSA has further provided evidence and support for recognizing the value of merging AOD and mental health services for consumer needs, as well as unifying the definition of “recovery” within both fields. Since county agencies delivering mental health and drug and alcohol services are supposed to be exemplifying recovery-oriented practices, it is significant to gain greater insight into how these services providers understand, believe in, and implement the recovery model. Therefore this research project asks the questions: how well do mental health and AOD service providers and staff understand the recovery model, how much do mental health and AOD service providers and staff believe in the recovery model, and how much is the recovery model utilized by mental health and AOD service providers and staff?

Since this study focuses on the perspective of service providers and staff, this research examines the clinical side of recovery rather than the consumer side of recovery. Therefore, it is significant to assess how service providers feel about the trainings they may or may not have received on the recovery model, exploring what their suggestions may be for improving the delivery of recovery oriented practices. This research project asked the question, what training mediums are most effective for increasing service
providers’ and staff’s level of competency and implementation of the recovery model? In addition, this research project was also guided by the question, what are the current challenges and successes in the county agency that have contributed to fostering or not fostering a culture that supports the recovery model?

**Sampling Procedures**

This study’s population is mental health and drug and alcohol (AOD) service providers and staff from a Northern California county agency. A mental health and AOD service provider, are individuals that provide direct services to consumers, and are a current county employee. A mental health and AOD staff member is an individual that may or may not provide direct services to consumers, and are currently a county employee. The individuals from this population who voluntarily choose to participate in the online survey, will comprise the study’s sample. Therefore the sample population will meet the following eligibility criteria: a mental health or AOD service provider and/or staff member at the county agency, who may or may not have direct contact with consumers and who voluntarily choose to participate in the study. The current exclusion criteria is: an individual who is not a current county mental health or AOD service provider and/or staff who meet the eligibility criteria or if this individual is an outside mental health or AOD service provider and/or staff that has a contract with the county agency. Given this eligibility criteria, the study uses purposive sampling. All mental health and AOD service providers and staff were asked to participate in the online survey.
This study utilizes purposive sampling given the criteria necessary to participate. Purposive sampling is a non-probability approach, meaning a study’s findings cannot be generalized to the larger population. Given this characteristic, it is important to note that a disadvantage of using the purposive sampling is that this study’s findings concerning a specific county’s mental health and AOD service providers and staff’s level of understanding, belief in, and use of the recovery model cannot be generalized to any county agency, rather it can contribute to the current discussion.

**Data Collection Procedures**

This study collected both quantitative and qualitative data through data collection methods such as an online survey with open and closed ended questions. Before gathering data, this researcher contacted the county agency administration board and received approval to access all mental health and AOD service providers and staff work emails to distribute the online survey. This researcher also received approval from the mental health and AOD departments to speak and introduce the study at each department’s monthly staff meeting. This allowed service providers and staff to ask questions, be aware of the county administration board’s approval and support of participation in the study, and learn about the thesis project. In November 2014, all mental health and AOD service providers and/or staff were then sent an email to their county email address that included a brief description of the study, an informed consent cover page, and the direct link to the online survey (see appendix). The goal was to have 50 survey participants.
Each participant voluntarily completed the online survey through surveymonkey.com. The cover page of the survey describes voluntary participation, anonymity, and confidentiality, as well as that the participant can discontinue the survey at any time. Once the submit button is pushed at the end, this implies the individual giving his/her consent. All names and identifying factors have been kept anonymous throughout the survey. The participant was able to skip any question and still submit the survey. Four reminder emails were sent to participants to complete the survey before the submission date closed.

Throughout this researcher’s internship experience at the county working as a case manager in the adult mental health unit, this researcher will note any worthy observations. In addition, this researcher will collect any fliers and information on trainings or events pertaining to, or in support of the recovery model.

**Instruments**

The only instrument used to collect data throughout this study, was the Recovery Model Survey questionnaire. The questionnaire was developed by this researcher, whom drew upon outside resources throughout the process of its creation. For example, “The Table of Specification” (Yuen, Terao, & Schmidt, 2009) was used while developing the questionnaire to ensure focus, completeness, and balance. Several revisions were completed to develop the final draft of the questionnaire. These revisions allowed for unnecessary, leading, or lengthy questions to be edited and/or thrown out. The questionnaire is structured into the following key domains: trainings (past, current, and suggestions for future trainings), knowledge about the recovery model, belief in the
recovery model, use of the recovery model within practice, and the agency’s culture in regards to creating a supportive recovery based system of care.

SurveyMonkey.com provided the medium through which the questionnaire could be accessed and utilized. The questionnaire distributed through survey monkey can be found in Appendix X. The questionnaire includes an informed consent page, which participants first viewed upon opening the survey link provided through survey monkey. The survey has a total of 15 questions, with an additional comment box per question for participants to add comments if they desire. The survey asked questions concerning previous and future trainings on the recovery model, as well as questions concerning individual’s level of understanding, belief in, and use of the recovery model. The survey took approximately 20 to 30 minutes to complete, with thirteen closed ended questions and two open ended questions.

**Data Analysis**

This descriptive study produces both quantitative and qualitative data. Quantitative data analysis is drawn from the thirteen close-ended questions on the survey. Qualitative data analysis will be drawn from the opened ended additional comments from each question and the two open-ended questions included in the survey. SPSS will be used to enter, code, and run statistical data analysis on the quantitative data collected. Content analysis is used to examine key words and concepts, as well as identify general patterns for the qualitative data. This will allow the researcher to develop categories for the responses, as well as determine any themes or trends within the data. Classic qualitative techniques, such as sorting, categorizing, and coding will be used to organize and
compare responses. Upon completing the content analysis, some data will be coded, entered, and computed for computer analysis using SPSS. Descriptive statistics will be used to determine the frequency distribution and measures of central tendency. Approximately two months will be allotted for the completion of all findings and implications.

All data that is on the researcher's computer will be password protected. No identifying characteristics will be used for the participants and each participant will be assigned a number. Any data that is collected on paper will be kept in a locked drawer, which the researcher will only have access to. Three months after the completion of the study, all data will be destroyed. All data on the computer will be erased and all paper documents will be shredded.

**Protection of Human Subjects**

This study is considered no risk for all voluntary participants. All individuals asked to participate in this study are over the age of 18, and were not asked to state identifying factors/characteristics, asked any questions that may cause them physical or emotional harm, or may jeopardize their employment. In addition, this researcher is an intern at the county agency, but has no authority over any of the respondents. Inherent anonymity and confidentiality in the design of the study further indicate no risk.

Several procedures are taken to ensure the protection of human subjects. This includes a cover letter describing the study, voluntary participation, anonymity, and confidentiality to be included in the questionnaire on survey monkey, prior to the questions beginning. By the participant clicking the "submit" button at the end of the
survey, after being able to view/answer all questions, participants are giving implied consent. All information is confidential and all responses are anonymous. No identifying factors are linked to or stated in the research findings. All information will be destroyed upon completion of the study.

This study presents several benefits. These benefits include the service provider and/or staff member being able to offer their opinion and input regarding what changes could be made or aspects be maintained in order to increase the recovery model level of competency and implantation into practice. In addition, the participant will be able to have access to the research findings. Benefits to society include the potential suggestions on how to improve the overall quality of services through a recovery-oriented perspective, as well as gaining a better understanding of mental health and drug and alcohol service providers understanding and incorporation of the recovery model through a current snap shot of a county behavioral health agency.
Chapter 4

Results and Discussion

This chapter will present the overall findings from the study, as well as specific findings resulting from both the quantitative and qualitative data. Tables and charts will be included in order to help explain the overall and specific findings.

Background

The county agency is considered a rural county, and is situated on an old school campus. This makes it convenient for consumers, as they are easily able to access services for needs ranging from medical clinic, psychiatry, alcohol and drug, mental health, medical, and childcare. The alcohol and drug department building and the mental health buildings are located next to one another. Combined, there is a total of 132 mental health and drug and alcohol staff. Out of the 132 mental health and drug and alcohol staff who received an invitation to voluntarily participate in completing the study’s survey, 50 responses were successfully collected. Due to confidentiality reasons, there is no way to determine how many of the 50 responses were from which department.

Looking at the 50 participants in this study, there are several significant social demographics to discuss. The majority of participants were female, 52%, with 30% of the participants identifying as male. 18% of the participants chose to not identify their gender. Participants were also asked to identify their level of schooling as well as their professional degrees and accreditations. The majority of participants obtained a graduate school level of education, with 50% reporting their highest level of schooling as graduate school. The second highest reported level of schooling was junior college, with 20% of participants
reporting this as their highest level of education. 12% or respondents reported a four year college as their highest level of education and 4% reported post graduate school.

The following are the professional degrees and accreditations that obtained by the participants: AA/AS, BA/BS, MSW, LCSW, MFT, LMFT, Ph.D/Psy.D, AOD certificate, LPN/RN/NP. From this sample population, the professional degree with the highest percentage of respondents was a licensed marriage family therapist. The next two highest percentages of respondents stated having an LCSW and an AOD certificate. It is significant to report that 14% of the participants chose not to answer this question. See the bar graph directly below. It is also important to note that service providers in both the mental health and drug and alcohol departments can be an MFT and/or LCSW. Service providers in the drug and alcohol department may hold just an AOD certificate as their only accreditation, or they may have obtained an AOD certificate while being an MFT or LCSW.

![Bar graph](image)

*Figure 1. Professional degree distribution*
Lastly, participants were asked to report the exact number of years of professional work experience they have obtained. The range of responses were one year to 43 years of professional work experience. The average number of years of work experience from the sample population is 15.37 years. The mode for the number of years of work experience from the sample population is 8 years. See bar graph below.

![Years of Professional Work Experience Distribution](image)

*Figure 2. Years of professional work experience distribution*

**Overall Findings**

This study took a slightly atypical approach to data analysis, allowing the qualitative analysis and findings drive the quantitative analysis and findings. Analyzing the qualitative data first, allowed five main themes to emerge: training and suggestions, agency culture, belief in the recovery model, understanding the recovery model, and implementation of the recovery model. These five main themes were then used to create scales to measure respondents recovery model training that has been received, the overall perception of the agency’s recovery culture, the level of belief in the recovery model, the competency levels
of the recovery model, and the degree to which the recovery model is being implemented. Statistics allowed the researcher to examine how these five main scales are correlated to one another. In addition, running independent t-tests revealed differences among professional degrees in relation to the various scales.

Qualitative data was analyzed and organized into the following five main themes: training and suggestions, understanding the recovery model, belief in the recovery model, implementation of the recovery model, and agency’s recovery culture. For the theme training and suggestions, there were three main findings: 1) most AOD and mental health service providers and staff have not attended any specific recovery model trainings provided by the county agency 2) although some staff and service providers were able to identify trainings that support the recovery perspective, no trainings specifically focused on the recovery model, and 3) clerical staff expressed not knowing about and/or not perceiving the recovery model as useful or necessary for their position.

Under the theme of understanding the recovery model, the main finding was that individuals feel that some coworkers do not know about and are not capable of utilizing recovery-oriented practices. This was supported by main findings under the theme belief in the recovery model. Other main findings under the theme of belief included that AOD and mental health staff and service providers currently have a difficult time believing in the use of the recovery model in various contexts, specifically those where a service provider may have to take a more prominent role. Participants identified several examples for needing to take a prominent role included conservatorship, placing someone on an involuntary hold, and working with children, elderly, or families. Data suggest that there is also a lack of
understanding about how to incorporate a recovery-oriented perspective in specific situations with consumers, which consequentially affects the belief in the recovery model. The main findings under the theme implementing the recovery model are similar to the main findings under the themes of understanding the recovery model and belief in the recovery model. Data suggests that there is still a disconnect between the mental health and AOD departments and that some agency staff and service providers believe that other coworkers do not know about and/or utilize a recovery-oriented perspective.

Looking at the theme agency’s recovery culture, there are some interesting main findings. Data suggests that some AOD and mental health service providers and staff believe that the county does not offer an environment that is conducive to utilizing the recovery model. Like the previous three themes suggested, many AOD and mental health service providers and staff are able to recognize that other coworkers are not comprehending, believing in, or utilizing recovery-oriented practices. This further suggests that there is either a resistance to the recovery model or a lack of awareness about the recovery model. Another main finding concerning the agency’s culture is that AOD and mental health service providers and staff feel there is a current division between AOD services and mental health services in terms of a mutual understanding and/or definition of recovery. An overwhelming majority of participants made the request for more training and support following trainings to ensure that concepts and material discussed in training are being utilized and implemented sufficiently. And lastly, participants expressed the need for the agency to adopt programs that would allow for greater integration of the recovery model.
The overall findings for the quantitative data are drawn from the two tests of correlation, as well as several independent t-tests and a test of reliability. The Pearson’s measure of correlations reveals three main findings. First, there is a very strong, positive relationship between the variables implementation and competency, trainings and competency, and trainings and implementation. Second, there is a moderately strong, positive relationship between the variables belief and competency, belief and implementation, agency culture and implementation, and trainings and belief. Lastly, only weak correlations existed between professional degree and all five scale variables.

Below is the table for Pearson’s measure of correlations. Please refer back to this table throughout the later detailed discussion of these findings.

Table 1

**Pearson’s Measure of Correlations**

<table>
<thead>
<tr>
<th>Measure</th>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
<th>(5)</th>
<th>(6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Belief</td>
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<td></td>
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<td></td>
<td></td>
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<tr>
<td>(2) Competency</td>
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<td>-</td>
<td></td>
<td></td>
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<tr>
<td>(3) Implementation</td>
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<td>.610**</td>
<td>-</td>
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<tr>
<td>(4) Trainings</td>
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<td>.736**</td>
<td>.592**</td>
<td>-</td>
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<tr>
<td>(5) Agency Culture</td>
<td>.072</td>
<td>.246</td>
<td>.439**</td>
<td>.153</td>
<td>-</td>
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<td>(6) Professional Degree</td>
<td>.279</td>
<td>.057</td>
<td>.287</td>
<td>.245</td>
<td>-.038</td>
<td>-</td>
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</table>

Notes. **. Correlation is significant at the 0.01 level (2-tailed).

Spearman’s rho non-parametric correlation measurement is used to test the correlation between the five scale variables and the rank level variable of professional level of schooling. Data suggests that there are only weak positive and negative correlations between schooling level and all five scale variables. Therefore, it cannot be
suggested that the level of schooling dictates a stronger relationship with any of the scale variables. Please see the table for Spearman’s Rho nonparametric correlations below. Refer back to this table during the later detailed discussion of these findings.

Table 2

_Spearman’s Rho Nonparametric Correlations_

<table>
<thead>
<tr>
<th>Measure</th>
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<th>(3)</th>
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</thead>
<tbody>
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<tr>
<td>(2) Competency</td>
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<td>(3) Implementation</td>
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<td>.629**</td>
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<td>(4) Trainings</td>
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<td>.691**</td>
<td>.594**</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(5) Agency Culture</td>
<td>.018</td>
<td>.278</td>
<td>.479**</td>
<td>.254</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>(6) Schooling Level</td>
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<td>-.148</td>
<td>.099</td>
<td>-.114</td>
<td>.132</td>
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_Notes._ *. Correlation is significant at the 0.05 level (2-tailed).

_Notes._ **. Correlation is significant at the 0.01 level (2-tailed).

The independent t-tests reveal that there are few significant differences between the three professional degrees, LCSW, LMFT, and AOD certificate, across the five scale variables. This finding supports previous research that suggests the positive delivery of recovery-oriented services does not vary depending on professional background. Between participants with an LCSW and AOD certificate, there are no differences found. Looking at participants with an LMFT compared to those with an AOD certificate, there are statistically significant differences between the two professional backgrounds in the way they comprehend the recovery model and the trainings they have received on the recovery model. Between participants with an LMFT and an LCSW, data suggests there are
differences in the way participants implement the recovery model and the trainings they have received on the recovery model.

The test of reliability of the five scale variables suggest that the variables all work together well, and correctly measure what was originally intended. Looking at the Cronbach’s Alpha, a value of .778 suggests strong reliability for the five variables combined. The test suggest though, that if the variable agency culture was dropped from the measurement, the Cronbach’s Alpha would increase to .806, therefore increasing the reliability of the measurement.

**Specific Findings**

**Descriptive and inferential statistics.** Utilizing the five scales discussed above, Pearson’s product-moment correlation was used to measure the strength and direction of the relationship between these five variables. Pearson’s correlation allows this measurement to be conducted when there are interval or ratio level variables present, and when it is suspected that there may be a linear relationship between these variables. For this reason, the five scale variables and the professional degree variable were used to run a Pearson’s correlation test. Please see table 1 for a visual display of the P values, which provides evidence for the strength and direction (positive or negative) of correlation between the specified variables. This table can be viewed under the overall findings subsection above. In general, any P values from -1.0 to -0.5 or 1.0 to 0.5 dictates a strong relationship between variables. Any P values from -0.5 to -03 or 0.3 to 0.5 dictates a moderate relationship, -0.3 to -0.1 or 0.1 to 0.3 dictates a weak relationship, and -0.1 to 0.1 dictates a very weak to no relationship.
Looking at table 1, there is a very strong, positive relationship between the variables implementation and competency, trainings and competency, and trainings and implementation. There is a moderately strong, positive relationship between the variables belief and competency, belief and implementation, agency culture and implementation, and trainings and belief. The strongest relationship, with a P value of .736, exists between the variable training and competency. This may suggest that with an increase in trainings about the recovery model, there is a greater level of competency of the recovery model expressed by service providers. The second strongest relationship, with a P value of .610, exists between implementation and competency. This positive relationship suggests that service providers and staff are more likely to utilize the recovery model in practice when they have a greater understanding of the recovery model. The next strongest relationship exists between the variables trainings and implementation, which can therefore suggest that with trainings on the recovery model, service providers and staff are more likely to implement the recovery model in daily involvement with consumers.

Implementation was moderately correlated to belief as well as agency culture, which suggests that if a service provider and/or staff is utilizing the recovery model within their interaction with consumers, their belief in the recovery model may be stronger and consequentially this increases the overall strength of the agency’s recovery culture. Belief was also moderately correlated to competency and trainings, suggesting again that the degree to which a service provider and/or staff believes in the recovery model is related to the degree to which they understand the recovery model and have received trainings about
the recovery model. Lastly, it is important to note that there were only weak correlations between professional degree and all five scale variables.

In order to analyze how the five main scale variables are correlated to the participants’ level of schooling, Spearman’s rho test of correlation was utilized. Spearman’s rho is also known as spearman rank correlation coefficient, which is a non-parametric measure of correlation, using ranks to calculate the relationship between variables; level of school is a rank level variable. The P values for the spearman rho correlation test for the five main scale variables and level of schooling variable can be seen in table 2. Please find table 2 above under the overall findings subheading. As seen in table 2, there were only weak positive and negative correlations between schooling level and all five scale variables. This is interesting, as it cannot be suggested that the level of schooling dictates a stronger relationship with any of the scale variables.

Independent t-tests were completed using the five main scales in relation to several different group clusters. The independent variables were the five main scales: belief in the recovery model, competency of the recovery model, implementation of the recovery model, trainings and suggestions, and agency culture. The dependent variables were the following various group clusters: gender and the three highest reported professional degrees (LMFT, LCSW, and AOD certificate). The independent t-tests reveal that there are few significant differences between the three professional degrees, LCSW, LMFT, and AOD certificate, across the five scale variables. This finding supports previous research that suggests the positive delivery of recovery-oriented services does not vary depending on professional
background. Rather previous research, as does this finding suggest that the proper training and follow-up support allows service providers to better deliver services.

It is interesting to examine the results of the independent t-tests. Between participants with an LCSW and AOD certificate, there are no differences found. Yet, looking at participants with an LMFT compared to those with an AOD certificate, there are statistically significant differences between the two professional backgrounds in the way they comprehend the recovery model and the trainings they have received on the recovery model. For the variable competency, the significant 2-tailed value is .061, with LMFT having a mean score of 50.5556 and AOD certificate having a mean score of 56.7500. For the variable trainings, the significant 2-tailed value is .033, with the LMFT mean score of 28.4444 and an AOD mean score of 35.75000. Between participants with an LMFT and an LCSW, data suggests there are differences in the way participants implement the recovery model and the trainings they have received on the recovery model. For the variable implementation, the significant 2-tailed value is .075, with LMFT having a mean score of 49.1111 and an LCSW having a mean score of 54.0000. For the variable trainings, the significant 2-tailed value is .063, with the LMFT mean score of 28.4444 and the LCSW mean score of 35.1250.

A test of reliability was run, which suggests the appropriateness of the five scale variables in assessing whether the scales correctly measure what they were intended to measure. The Cronbach’s Alpha score tells how reliable a variable and/or measurement is. The test of reliability of the five scale variables suggest that the variables all work together well, and correctly measure what was originally intended. Looking at the Cronbach’s
Alpha, a value of .778 suggests strong reliability for the five variables combined. The test suggests though, that if the variable agency culture is dropped from the measurement, the Cronbach’s Alpha would increase to .806, therefore increasing the reliability of the measurement.

Qualitative data. Qualitative data is drawn from the survey distributed through survey monkey. There are only two open ended questions, question nine and eleven. Question nine asks: what are some situations where the recovery model does not work? And question eleven asks: since the recovery model is the chosen practice model, what else can be done to further the quality of services delivered within the county? Every question in the survey has an additional “any specific comment” box, where participants could leave additional statements concerning the closed-ended questions. Any additional statements were collected and analyzed as qualitative data.

All qualitative data was extracted from survey monkey and transferred to a word document, organized by the sequence of survey questions. Content analysis was utilized to begin identifying repeat words and themes. Repeated words were color coded in order to begin identifying similar themes among responses throughout the questions. From the content analysis, the following main themes emerged: training and suggestions, understanding the recovery model, belief in the recovery model, implementation of the recovery model, and agency culture.
Training and suggestions. For the theme training and suggestions, the main findings include:

- Most AOD and mental health service providers and staff have not attended any specific recovery model trainings provided by the county agency.
- Although some staff and service providers were able to identify trainings that support the recovery perspective, no trainings specifically focused on the recovery model.
- Clerical staff expressed not knowing about and/or not perceiving the recovery model as useful or necessary for their position.

The county requires that all staff and employees, regardless of the department one works in, must attend certain trainings each year. Some of these trainings include diversity and LGBTQ awareness. Therefore, survey participants were asked about the current and past training at the county, which had been on or directed towards the recovery model. As a graduate student intern in the adult mental health case management unit, I had personally not attended any mandatory or voluntary trainings offered by the county agency that discussed the recovery model. Analyzing the “additional comments,” from question two on the survey, which asked participants to please rate the extent to which any provided county provided trainings have been helpful to the individual understanding, developing, and integrating four key core aspects of the recovery model, there are two main results that emerged. The data suggests that most people have not attended any specific recovery model trainings provided by the county agency. Most participants expressed not ever receiving a mandatory county training specifically about the recovery model. One
participant stated: “I haven’t attended any trainings specifically on the recovery model but it is infused in our service philosophy.” It appears that some participants are aware of the recovery model and have therefore been able to identify trainings that support the recovery perspective, but no trainings that have specifically focused on the recovery model. In addition, one participant commented on receiving trainings specific to the recovery model from other county agencies, but not this specific county: “recovery trainings have not been provided in [this county] but other counties I have worked under.”

From the survey questions pertaining to trainings, the data suggests that clerical staff feel that needing to know about or how to utilize the recovery model is not necessary. There were several comments that stated this. For example, one participant stated, “I am clerical staff, therefore I do not practice the recovery model in my work.” Clerical staff are required to attend all the same mandatory trainings as clinicians and have direct client contact. Given that this county serves a rural community, many clerical staff know long-time consumers by his/her first name and have weekly conversations with them. Due to the clerical staff’s direct client contact, it would be important for them to understand and know how to implement a recovery oriented perspective.

**Understanding the recovery model.** Qualitative data suggests the following significant findings under the theme of understanding the recovery model:

- Individuals feel that some coworkers do not know about and are not capable of utilizing recovery-oriented practices.

In order to assess a service provider and staff’s competency and understanding of the recovery model, both question four and question nine are useful measures. Question four
asked participants to rate the level at which an average mental health service provider, AOD service provider, and s/he understands the recovery model. Comments from question four suggest individuals feel that some coworkers do not know about and are not capable of utilizing recovery-oriented practices. For example, one participant stated, “some people working in this field have no recovery based skills.” It can be further be suggested that this implies there is a need for more trainings and supervision, in order to enhance all service providers and staff’s level of competency on the recovery model.

Belief in the recovery model. The main findings under the theme, belief in the recovery model include:

- AOD and mental health staff and service providers currently have a difficult time believing in the use of the recovery model in all contexts, specifically those where a service provider may have to take a more prominent role. Examples for needing to take a prominent role included conservatorship, placing someone on an involuntary hold, and working with children, elderly, or families.

- Appears to be a lack of understanding about how to incorporate a recovery-oriented perspective in specific situations with consumers, which consequentially affects the belief in the recovery model.

Although one may understand the recovery model, it is significant to assess whether an individual believes in the use of it. Question five and nine were targets to measure a service provider and/or staff’s belief in the recovery model. Question five asked participants to rate the extent to which they feel an average mental health service provider, AOD service provider, and his/herself believe in the recovery model. Similar to what data
from question six suggested, comments from question five revealed that some individuals feel that other coworkers do not understand the concept of recovery or practice a recovery-oriented perspective. One participant stated, “most counselors don’t know the difference between treatment and recovery, and most treatment programs fail their client as a result of this ignorance.” From this specific comment, it is suggested that this individual feels that the extent to which one “buys into” the recovery model, translates to the extent to which s/he implements the recovery model in practice.

Question nine, which is one of only two open-ended questions on the survey, asked participants to comment on any situations where the recovery model may not work. This question was created to rate the level of belief in the recovery model; it is suggested that if an individual does not feel the recovery can be utilized, then s/he does not believe in the recovery model within the given context. Many of the situations listed, such as “when an individual’s psychiatric symptoms prohibit them from taking care of themselves and medical interventions are warranted,” “pre-contemplative, antisocial, highly criminalized clients,” and “when a client is in crisis, risk of self-harm or harm to others” suggest that staff and service providers currently have a difficult time believing in the use of the recovery model in all contexts, specifically those where a service provider may have to take a more prominent role. There may further suggest that there is a lack of understanding about how to incorporate a recovery-oriented perspective in specific situations with consumers. Several other participants added that other situations where they believe the recovery model does not work is with “children and families,” “poor medication management,” and “clients with advanced dementia, paranoid clients who prefer the safety
of locked facility, seniors who have medical issues complicating their psychiatric stability.” This suggests that there is a basic understanding of some core characteristics of the recovery model, but service providers may be unclear that working from a recovery-oriented perspective speaks to the manner in which services are delivered. Therefore, the recovery model can be useful in all situations, even when the service provider may not to take a leading role. A good example of this was the only participant whose answer to question nine reflected a true understanding and belief in the recovery model; “Everyone can benefit from this approach even those who are conserved. They still have and should have choices and the ability to decide what they want to some extent, unless in that moment that are a threat to themselves, others or gravely disabled. But again, even then, there are ways to work with a client to have some level of personal choice in their situation.”

**Implementation into practice.** Under the theme, implementing the recovery model, two main findings emerged:

- There is still a disconnect between the mental health and AOD departments.
- Some agency staff and service providers believe that other coworkers do not know about and/or utilize a recovery-oriented perspective. This is similar to predominate findings under both the themes of understanding the recovery model and believing in the recovery model.

Questions six, which asked participants to rate the extent to which they believe the recovery model is utilized in practice by the average mental health service provider, AOD service provider, and themselves. Two main themes emerged from the participants responses. First data suggests that there is still a disconnect between the mental health and
AOD departments. For example, one participant stated, “there still remains a chiasm between both approaches to recovery.” This question brought forth discomfort, causing several participants to make statements regarding his/her inability to rate another service provider, specifically for mental health service providers to rate AOD service providers. Several additional comments included participants stating “I do not have experience with the recovery model as seen by drug and alcohol services” and “I don’t work in the alcohol and drug department, so it is difficult to rate on this topic.” Data suggests that this reluctance stems from a lack of understanding about how service providers in another department may or may not utilize the recovery model. Despite the fact that research shows the need for the mental health and AOD fields to merge in order to better meet the needs of consumers, as well as unify the understanding and definition of the concept of the recovery model, there appears to be a remaining disconnect within this agency.

The second finding that emerged, suggested that some agency staff believe that other coworkers do not know about and/or utilize a recovery-oriented perspective. One participant commented, “a provider may profess to use the model but in my observation, in fact, digress greatly in doing so.” This suggests that further training about the recovery model and how to implement recovery-oriented practices may be helpful to staff at this agency.

**Culture of agency.** Data suggested the following main findings under the theme, culture of agency:

- Some AOD and mental health service providers and staff believe that the county does not offer an environment that is conducive to utilizing the recovery model.
Many AOD and mental health service providers and staff are able to recognize that other coworkers are not comprehending, believing in, or utilizing recovery-oriented practices. This further suggests that there is either a resistance to the recovery model or a lack of awareness about the recovery model.

AOD and mental health service providers and staff feel there is a current division between AOD services and mental health services in terms of a mutual understanding and/or definition of recovery.

An overwhelming majority of participants made the request for more training and support following trainings to ensure that concepts and material discussed in training are being utilized and implemented sufficiently.

Participants expressed the need for the agency to adopt programs that would allow for greater integration of the recovery model.

As the literature review pointed out, the recovery model is both an organic process and outcome. In addition, many consumers of AOD and mental health services comment that they can “feel” and “know” the difference between an environment and/or clinician that works from a medical model versus a recovery model. Therefore, it is various aspects that come together to depict whether the agency’s culture is one that supports the recovery model. Many questions from the survey yielded answers that speak to the current agency’s culture, as well as suggestions for how to improve the agency’s culture in order to further support and exemplify a recovery oriented perspective.

Question seven, which asked survey participants to rate his/her level of agreement to twenty-two various pro or con recovery model statements, had several statements added to
the “additional comments” section. These comments provided evidence to suggest that there are individuals who believe that the county does not offer an environment that is conducive to utilizing the recovery model. For example, one participant made the comment that, “while I believe in the recovery model, there is little opportunity to practice it in the county mental health setting.”

Question nine asked participants to state some situations where the recovery model does not work. From the comments provided by participants, data suggested two main findings. First, it appears that many agency staff are able to recognize that other staff members are not comprehending, believing in, or utilizing recovery-oriented practices. This further suggests that there is either a resistance to the recovery model or a lack of awareness about the recovery model. Resistance to the recovery model is presumably coming from the still predominate medical model approach, as one participant suggests by stating, “when the medical model is entrenched or given precedence in the service delivery system, as it is currently” then it becomes a situation where the recovery model does not work. Another participant stated that they observe a current “resistance of mental health clinicians,” which consequentially results in the recovery model not being utilized or implemented. Other comments revealed participants observing that the recovery model doesn’t work when staff do not understand or utilize the recovery model. For example, one participant commented that the recovery model doesn’t work “when it is not implemented by professionals.”

The second finding drawn from the qualitative analysis of question nine, was that participants feel there is a current division between alcohol and drug services and mental
health services in terms of a mutual understanding and/or definition of recovery. As discussed in the literature review, this division between alcohol and drug, and mental health services in terms of the concept of recovery, as well as how the recovery model is understood and implemented, is a current point of discussion. One of the largest diverging points around the concept of recovery between AOD and mental health, is that within AOD services recovery is not achieved until someone has achieved total abstinence, whereas in mental health services recovery is an on-going process where symptoms of an individual’s mental illness can still be present (Bein, 2014). This diverging point or needing to achieve total abstinence to be seen as “in recovery” within the AOD field can also be quite problematic for individuals who have a dual diagnosis (Bein, 2014; Walsh, 2012). As one participant commented in regards to question nine, “sometimes the recovery model includes total abstinence and some clients need to start with harm reduction.” Harm reduction is a new approach within the AOD field that supports and implements a recovery-oriented perspective. In this regard, this participant is acknowledging the fact that AOD of services in this agency uphold a traditional concept of “recovery,” whereas many efforts are now being made to implement a more modern concept and definition of recovery (SAHMSA, 2012).

Question ten and eleven asked participants to comments on factors that contribute to the recovery model not being utilized in the agency and how improvements can be made to further embrace the recovery model within the county services. An overwhelming majority of comments made the request for more training and support following trainings to make sure that concepts and material discussed in training were being utilized and implemented
sufficiently. One participant stated that “the most critical factor is that there is no follow-up support and training after initial trainings for any type of initiative or service modality that is introduced.” This is also supported by several other comments concerning the perceived need for “more supervision” and “case consultation.” In addition to follow up support, one participant made the request for “more joint training with mental health and drug and alcohol” to further merge these two departments in how they are understanding and implementing the recovery model. In order to better shift the agency’s culture from supporting the traditional medical model, to that of exemplifying the recovery model, staff need to not only be provided with the appropriate trainings, but evidence suggests that staff and clinicians also need additional follow up support and trainings, as well as more access to supervision and case consultation.

The second main finding that emerged from the responses from questions ten and eleven, is that the agency needs to adopt programs that would allow for the greater integration of the recovery model. There were several comments made by participants in regards to the current computer program used to not only document progress notes and assessments, but to also complete the annual wellness recovery plan (WRP). As one participant put it, “the computer program is designed for us, rather than allowing the client to design their own treatment goals/objectives.” This is problematic, given that the recovery model states that recovery is a process and/or journey lead by the consumer him/herself, with the practitioner acting as a “helper” or “guiding force” throughout the recovery process. Participants also added comments suggesting for the implementation of “…specific programs agency-wide with a clear plan for outcome measures and goals.”
This would further allow for both consumer and staff feedback, ensuring that the agency is upholding a recovery-oriented perspective.

**Additional Findings**

As per the suggestion of the agency’s administration, this researcher quickly presented the study to both the mental health and drug and alcohol board meetings. The intention was to introduce and familiarize staff and service providers with the study, and allow them to ask any questions they may have. It was interesting that at the mental health department all staff meeting, no one asked any questions and the presentation concluded rather quickly. The only expressed interest that was received, was when this researcher was later approached by an individual with his LCSW who also offered clinic supervision hours, whom boldly stated that he was very intrigued by the project and curious to see the findings. At the drug and alcohol department all staff meeting, the overall interaction between the staff and this researcher was completely different. Multiple staff asked questions and made statements of praise. Two individuals made direct questions concerning the definition of the recovery model. In general though, the staff from the drug and alcohol department displayed greater interest, communication, and overall vocalized support of promoting the recovery model.

Following the informational presentation of this study at both department’s board meetings, the initial email invitation including the link to surveymonkey.com was sent to all mental health and AOD employees. This researcher received intense feedback from various mental health and AOD employees regarding the concept of “recovery” and “the recovery model.” In total, fifteen individual emails were received by this writer,
specifically asking for a definition for the concept of “recovery” and “recovery model.” Many individuals asked “what do you mean by recovery model,” stating that “without the definition, I cannot understand the context of the concept.” Several individuals made further comments stating that it was “unfair” to not state the definition of “recovery” and “recovery model.” In addition a large majority of individuals expressed confusion, stating they were unsure whether “recovery” and “recovery model” was in reference to AOD or mental health. Since this writer is an intern in the mental health department, several mental health staff and service providers approached this writer, stating their knowledge of “recovery” is strictly from an AOD perspective, they were unaware of a “recovery model” within mental health. After having a small discussion with them highlighting the primary principles for the recovery model, many of these same individuals stated “well that’s what I do anyways.”

From the informal presentations of the study at the board meetings, to the email responses and personal inquiries, there are several suggested conclusions that can be drawn. Purely from observation, it first appeared that AOD employees expressed greater awareness regarding the recovery model than mental health employees, due to a higher rate of questions and interested during the board meeting. From the emails and personal inquiries, it suggests there is still a disconnection between AOD and mental health departments regarding the concept of recovery and the application of the recovery model. It appears that the concept to recovery, without a provider definition, is more commonly associated with AOD consumers rather than mental health consumers. In addition, the email and inquiries suggest that some service providers and staff have had no formal
education or training on the recovery model. It is apparent that there needs to be more discussion and training regarding the recovery model, highlighting the definition of recovery in both AOD and mental health fields and discussing how the recovery model can be implemented by staff and service providers.

**Summary**

Analyzing the qualitative data allowed the researcher to develop five scales, which were used to further analyze the quantitative data. Both the quantitative and qualitative data suggest findings that are conducive to previous research and suggest the need for further research to investigate methods to increase the level of understanding, belief in, and implementation of the recovery model by all service providers and staff.
Chapter 5

Conclusion and Recommendations

This chapter provides a summary of the study and a concluding discussion regarding the major findings. A discussion highlighting the significant findings is provided, commenting on the overall implications of these findings, as well as specifically focusing on the implications for the field of social work. Recommendations based on the study’s findings are presented as well, offering suggestions for future research.

Summary of Study

Recap of study. This study focused on the clinical side of recovery, looking at service providers and staff’s understanding, belief in, and implementation of the recovery model. In addition, this study examined what service providers and staff’s level of schooling, previous trainings for recovery model, and suggestions for improving the level of integration of recovery-oriented services, as well as the agency’s overall recovery culture. Since the concept of recovery is utilized within both the mental health and AOD fields, and recognizing the current movement towards integrating services within these two fields, this study analyzed the perceptions of both mental health and AOD service providers and staff. The study took place at a rural Northern California county agency, where all mental health and AOD service providers and staff were sent email invitations to complete an online questionnaire through surveymonkey.com. In total, there were 50 participants who completed the online survey. Both quantitative data and qualitative data was drawn from the surveys.
This research study was guided by several main questions: how well do mental health and AOD service providers and staff understand the recovery model, how much do mental health and AOD service providers and staff believe in the recovery model, and how much is the recovery model utilized by mental health and AOD service providers and staff? In addition, this research study asked the question, what training mediums are most effective for increasing service providers’ and staff’s level of competency and implementation of the recovery model, as well as what are the current challenges and successes in the county agency that have contributed to fostering or not fostering a culture that supports the recovery model?

Given the study’s guiding research questions, this researcher had hypothesized that the degree to which service providers and staff understood, believed in, and implemented the recovery model would be relatively low. This researcher hypothesized that there would be a higher degree of competency and belief in the concept of recovery among AOD service providers and staff, given the historical prevalence of the concept of recovery within AOD services. In general, this research hypothesized that the majority of AOD and mental health staff at the county agency would have received no formal specific recovery model trainings provided or requested by the county agency. Lastly, this researcher assumed that there would be a slight disconnect between AOD and mental health service providers and staff regarding the definition and use of the term recovery and the recovery model.

**Major findings.** Unlike traditional approaches, the study’s qualitative analysis guided the quantitative analysis. From the qualitative analysis emerged five main
themes: training and suggestions, understanding the recovery model, belief in the recovery model, implementing the recovery model, and agency culture. These five main themes were then utilized to create five measurement scales using quantitative data. Statistical tests of differences and correlations were used to analyze the quantitative data.

Looking first at the major qualitative analysis findings, this researcher’s hypothesis that the majority of AOD and mental health service providers had received no specific recovery model trainings was proven correct. The data suggests that most AOD and mental health services providers and staff have not attended any specific recovery model trainings provided by the county agency. One finding that this research found alarming was that clerical staff expressed not knowing about and/or not perceiving the recovery model as useful or necessary for their position. This is significant given that clerical staff have direct contact with consumers in person and on the phone, and if they are unaware of the recovery model, they may upholding and transmitting negative stereotypes about AOD and mental health consumers. For many consumers, knowing that clerical staff are supportive and respectful of their recovery journey could result in positive transformation and aid in the development of a safety net.

This researcher had hypothesized that the degree to which AOD and mental health service providers and staff understand, believe in, and implement the recovery model would be relatively low. The overall findings for the qualitative theme understanding the recovery model, revealed a large divide between those that do know about and understand the recovery model, and those that do not. For those that did know about and understand the recovery model, it was very apparent that some of their coworkers had no
knowledge about the recovery model and were not capable of utilizing recovery-oriented practices. Looking at the theme of belief in the recovery model, there were indeed very few participants who expressed the belief that a recovery-oriented perspective can be applied to every potential situation and/or client. The majority of participants expressed the belief that the recovery model ended its applicability when a service provider needed to take a more prominent role, such as in conservatorship, placing someone on an involuntary hold, and working with children, elderly, and/or families. Similar to the findings suggested under the theme of understanding the recovery model, the theme implementing the recovery model revealed that a small percentage of AOD and mental health service providers and staff utilize recovery-oriented practices. This researcher’s hypothesis of the existing divide between AOD and mental health field’s definition and use of the term recovery and the recovery model was suggested to be true given the analysis of the participants’ responses regarding the implementation of the recovery model.

The major findings under the theme agency’s recovery culture supported this researcher’s hypothesis that the majority of service providers and staff have a low degree of understanding, belief in, and implementing the recovery model. In addition, this researcher’s hypothesis was in agreement with the data suggesting a current division between AOD and mental health departments regarding the mutual definition and use of the term recovery. What this researcher had not expected, was that a majority of AOD and mental health service providers and staff believe that the county does not offer an environment that is conducive to utilizing the recovery model. Further, participants
expressed the need for the agency to adopt programs that would allow for greater integration of the recovery model. This researcher was impressed by this finding, because service providers and staff were able to identify ways to improve the current agency environment to further support the recovery model. Participants further suggested that having more trainings and follow support trainings, as well as increased supervision, would aid in an increase of competency and integration of the recovery model.

Quantitative data analysis resulted in findings that support this researcher’s hypothesis, but do not directly answer them. The two test of correlation, Pearson’s and Spearman’s rho, identified the strength and direction of relationship between the five measurement scales. Pearson’s measure of correlations suggested that there is a very strong, positive relationship between the variables implementation and competency, trainings and competency, and trainings and implementation. While there is a moderately strong, positive relationship between the variables belief and competency, belief and implementation, agency culture and implementation, and trainings and belief. Although only weak correlations existed between professional degree and all five scale variables, the strong and moderate positive relationships suggest that when there are more trainings available, there is a higher level of belief in the recovery model, understanding of the recovery model, and therefore implementation of the recovery model. Consequently, the overall agency recovery culture is correlated with the other factors as well.

The Spearman’s rho non-parametric correlation measurement suggested that there are only weak positive and negative correlations between schooling level and all five scale variables. Therefore, it cannot be suggested that the level of schooling dictates a
stronger relationship with any of the scale variables. Looking at these results and the 
main findings from the Pearson’s test of correlations, it can be suggested that more 
concentration needs to be placed on examining the recovery model at the agency level. 
Looking at the agency will reveal what necessary trainings, materials, and support is 
needed to ensure that all service providers and staff, regardless of their professional 
experience or educational background, can obtain sufficient knowledge about the 
recovery model so that their belief and use of the recovery model within practice is 
acceptable.

The independent t-tests had interesting findings, in that the data supports previous 
research which shows that there is no significant difference in the delivery of recovery-
oriented services dependent on the professional background of the service provider. It is 
significant to note that participants with an LMFT showed a statistical difference in the 
training they have received on the recovery model compared to participants with an AOD 
certificate and an LCSW. Perhaps due to a general greater acceptance of the recovery 
philosophy by the addiction field and social workers, the data revealed that participants 
with an LMFT comprehended the recovery model differently than those with an AOD 
certificate, yet there was no statistical differences found regarding competency between 
those would hold an AOD certificate and those who hold an LCSW. The data suggests 
that there is also a difference in the way that a service provider with an LMFT and a 
service provider with an LCSW implement the recovery model. This is significant 
because this could cause a disruption in the delivery of recovery-oriented services, and 
therefore change the care a consumer receives.
In general, the findings presented in this study support the research and literature discussed in chapter two. There is still a divide and disconnect between the AOD and mental health fields in regards to a shared definition and use of the term recovery. It can be assumed that this further complicates the lack of integrated services between these two fields, which has shown to be detrimental to consumers (Bein, 2014). Therefore, it can be suggested that further researcher regarding how to better merge the two fields around the definition and use of recovery, could also aid in the development of merging AOD and mental health services for consumers. The findings from this study also support the claim of many other researchers, in that there is still a need for continued research to learn more about how to better improve service provider’s understanding and use of the recovery model. In addition, there needs to be more research on what types of trainings mediums, materials, and programs an agency can adopt and provide to ensure the implementation of recovery-oriented practices.

**Implications for Social Work**

Coming from an ecological perspective, all the issues, pressures, and concerns faced by county consumers lie within a complex web of context. One of the main factors in this given complex web of context are county mental health and AOD service providers and/or staff. For many county consumers, service providers and staff are the main sources of support and reliability. Therefore, it is important to ensure that these main sources of support and reliability are working through a recovery-oriented perspective and upholding the recovery model by attending to the consumer’s well-being and needs with acceptance, humility, and hope. Looking at this context from the
perspective of service providers and staff, gives insight into how services are being delivered, where service providers and staff feel they need more support, and the overall message that may be perceived by county consumers.

The NASW Code of Ethics states that a social worker’s primary responsibility is to provide assistance to those in need, advocating for that individual and addressing existing social problems. This study directly looks at the assistance provided to those in need. Service providers and staff are often the individuals who are advocating for county consumers and providing services. It is essential to ensure that the assistance and services being delivered is in a manner that exemplifies the recovery model. Social work ethics support and embody the recovery model's core characteristics. Both social work ethics and the recovery model exemplify and value strengths based approach, consumer empowerment, the right to self-determination, the acknowledgement of individual worth, and a focus on the individual, personal experience (Carpenter, 2002). To further enhance the social work field and continue seeking social justice for county consumers, this research is essential to gaining a better understanding on the recovery model within the current county agency environment.

The results from this study highlight the current trend of service providers' level of competency, belief in, and implementation of the recovery model, which is significant to understand where improvement is needed. The improvement needed is indicative of the current overall recovery-oriented culture that is emulated by the county. In addition, the study’s findings reveal suggestions for current and future trainings that may be useful to service providers and staff. In general, the findings add to the current recovery model
discourse, which further helps to advance the mental health and drug and alcohol fields for the betterment of services and well-being for county consumers. This is significant within the field of social work, as social workers are key leaders of delivering and improving services provided to those from vulnerable populations and who are in need. The recovery movement began with consumers themselves, who need the continued support of others to strengthen the movement and help project their voices; social workers exemplify this needed continued support and activism. In order to continue improving the effective implementation of the recovery model within, social workers need to take an active stand by educating themselves and others and organizing.

**Recommendations**

In general, I am happy with the turnout rate of participants for this research study. Although I would have liked to have had all AOD and mental health service providers and staff participate in the questionnaire, I was able to collect a sufficient amount of data which yielded some interesting findings. Utilizing surveymonkey.com as a medium to distribute the questionnaire was extremely helpful and I would recommend this to future students and researchers. Designing the questionnaire on my own was difficult and frustrating. In hindsight, I wish I would sought out an already tested recovery model measurement scale, and distributed this to potential participants. It would be interesting for another study to distribute an established recovery model measurement scale to a county agency’s AOD and mental health staff, and then follow up with informal focus group discussions.
Given this study’s suggested findings, it would be interesting to have a group of AOD and mental health service providers go through a training on the recovery model, where there would be a pre and post-test administered. The pre and post-test would aim to determine participants level of understanding of the recovery model, their belief in the recovery model, and their familiarity and comfort level of utilizing the recovery model in practice, to help determine if an intense training would result in high levels of understanding, belief in, and implementation of the recovery model. The pre and post-test could also be administered after a period of increased supervision that focused on discussing the recovery model in relation to practice. These suggestions for further research would produce more information to add to the recovery model discourse. In addition, it may expand the understanding of how to further incorporate, promote, and translate the recovery model within county services from the service provider’s perspective.

Reflecting on the literature review and the findings of this study, there needs to be continued research regarding how to incorporate the recovery model into daily services delivered through county agencies. Politically it has been stated that the recovery model is the chosen model of practice for mental health services, and consumers have gone to great lengths to speak out and organize for the integration of the recovery model and the recognition of the concept of recovery within mental health. But when it boils down to is whether service providers and staff are knowledgeable and capable of providing service that are driven from a recovery-oriented perspective. It comes down to whether staff not only have the education and follow up trainings to draw from, but that they also have the
necessary materials, supervision, support, and agency setting that fosters a recovery oriented model. Therefore, more research is needed to gain a better understanding of just how knowledgeable and capable service providers and staff are, and what specific types of trainings, materials, supervision, support, and agency setting are needed and most effective for allowing the recovery model to fully be implemented. It is unjust to consumers who are left with no other option than to receive services from county agencies, to merely state that the recovery model is the chosen and supported model. There needs to be research and measures in place to ensure that consumers are receiving services and care in a manner that they have already and continue to vocalize works and feels best to them, and that is through the further development and incorporation of recovery-oriented services.

**Limitations**

Understanding that the recovery perspective can be viewed as both a process and an outcome (Walsh, 2013), it is important to understand the boundaries of the problem this research project focused on. This research project did not aim to determine the best way for mental health and drug and alcohol practitioners to understand, believe in, and utilize a recovery perspective. Nor did this research project aim to determine how to improve a current agency’s departments, staff, and overall culture to better fit a recovery-oriented model. Rather, this research project was designed to explore and better understand the current context of one county agency, which yields results that aid in the development of suggestions. Lastly, this research project does not draw upon the voice of the agency’s mental health and drug and alcohol consumers; therefore the results are
only representative of a clinical view of the recovery model, not that of a consumer view of the recovery models.

Current research suggests there is still more to learn about the recovery model, how to train practitioners to work from a recovery-oriented perspective, and how to implement recovery-oriented practices within the overall structure of an agency. Given that the recovery model or a recovery-oriented perspective cannot be achieved through the route memorization or implementation of specific steps, there is on-going debate and research regarding how to best determine practitioner’s competency levels and use of the recovery model. In addition, since the recovery movement began and is sustained through consumer involvement and leadership, further research needs to be conducted to capture the voice and perception of consumers themselves.

Conclusion

“People who gave me grace rather than judgment ultimately made the biggest difference in my life” (VOCAL, 2009, p.63). A consumer seeking services from a county agency’s mental health and/or AOD department has inevitable encountered a myriad of obstacles and hardships. Given this, it can be assumed that the way a consumer is talked to, looked at, and assisted by a service provider and/or staff of the county, can directly impact that individual’s well-being and overall recovery process. Therefore, it is imperative to continue investigating and understanding how to better improve the integration of the recovery model and the delivery of recovery-oriented practices. Research has shown that the recovery model is both effective and useful for mental health and AOD services. And consumers are speaking out to prove that whether a service
provider works from a recovery-oriented perspective really does make a difference. In an
effort to further promote the recovery model, is it essential to ensure service providers
and staff are knowledgeable about the recovery model and how to implement within
practice. This study provides findings that add to the current research proving the need
for more research to investigate how to improve service providers and staff’s
understanding, belief in, and use of the recovery model. In addition, this research
provides evidence to suggest that more work needs to be done to further integrate the
AOD and mental health fields, merging the concept of recovery. County agencies as a
whole need to take a stand, redirect their attention, and place a greater emphasis on
ensuring that their service providers and staff are not passing judgment, but making
differences in the lives of those they serve.
Appendix A

Agency Letter of Support

September 2, 2014

To CSUS IRB,

This letter certifies that I have discussed Ashley Severson’s proposal for her thesis project that is to be carried out at Napa County, and fully support and give permission to conduct the described project. I understand that Ashley is conducting this project as part of her requirements for the Master of Social Work program at California State University Sacramento, and may have the opportunity to present her research findings in other venues.

I understand that the Institutional Review Board for the Use of Human Subject’s in Research (IRB) at the University is concerned with protecting the confidentiality, privacy, and well-being of research participants. Further, it is my understanding that the student will additionally be advised in this project by Professor Yuen.

I do not have concerns about the study that Ashley has proposed based on conversations with the student and after reviewing an outline of the research project proposal. The agency supports this student’s plan and approves of the project, including recruitment of participants and data collection, through our agency.
Should you have additional questions or concerns, you may contact me, Vicki Huezo at 707-299-1760 or virginia.huezo@countyofnapa.org.

Sincerely,

Vicky Huezo, LCSW
Intern Coordinator
Napa County Mental Health Division
Appendix B

Questionnaire

Recovery Model Survey

Informed Consent

You are invited to participate in a research study which will involve an online survey accessed through surveymonkey.com. This survey will ask your opinion about the recovery model. My name is Ashley Severson, and I am a second year MSW student at California State University, Sacramento, Division of Social Work and am currently a second year student intern at Napa County in the adult mental health case management unit. You were selected as a possible participant in this thesis study because you are a mental health or drug and alcohol service provider and/or employee at Napa County. The purpose of this research is to explore the level of understanding, belief in, and use of the recovery model within practice by mental health and drug and alcohol service providers and staff in a county behavioral health agency. In addition, this research will study the agency’s current trainings and support regarding the use of the recovery model, as well as suggestions for further improvement. Your participation in this study will take approximately 20 to 30 minutes and, as approved by the administration, it can be completed during working hours.

There are no risks involved for participants. No personal identifier will be used in this study. All information collected will be treated as confidential and only group data will be reported. Your participation is entirely voluntary and you are free to discontinue
participation at any time. If you feel a question does not apply to you, you may skip the question and still complete the survey. For each question, there is an option to add any specific comments; it is not necessary to add any additional comments. Through this survey, the participant will have the opportunity to anonymously reflect on their perspectives and make suggestions for improved services to consumers. For those who choose to participate in the follow up informal focus groups, they will be able to see preliminary findings and further add to the discussion regarding the recovery model. The final study findings will be disseminated to County service providers in various platforms.

If you are interested in participating, please go to the next page to begin the questionnaire. Completing and submitting this survey by clicking the “submit” button at the end of the questionnaire, indicates that you have read and understand the information provided above, that you willingly agree to participate, that you may withdraw your consent at any time and discontinue participation. Thank you for your support and participation. If you have any questions, please email me at anseverson@ucdavis.edu or my thesis advisor, Dr. Francis Yuen at fyuen@csus.edu.
Recovery Model Questionnaire
(This questionnaire will be imported into the Survey Monkey format)

1. Training on the recovery model:

<table>
<thead>
<tr>
<th>Number of trainings</th>
<th>Approximately how many in service trainings on the recovery model have you attained in the last five years?</th>
<th>Among these trainings attained, how many were offered or required by the county?</th>
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<tbody>
<tr>
<td>Less than 2</td>
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<td>3-5</td>
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<td>6-10</td>
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<td>11-15</td>
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<td>16 or more</td>
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</table>

   Additional Comments: ____________________________________________________________

2. Please rate the extent to which these trainings have been helpful to you in:

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<tr>
<th></th>
<th>None</th>
<th>Very low</th>
<th>Fair amount</th>
<th>Good amount</th>
<th>Perfect!</th>
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<tbody>
<tr>
<td>Understanding of the recovery model</td>
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<tr>
<td>Developing knowledge of the recovery model</td>
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<tr>
<td>Acquiring skills for putting the recovery model into practice</td>
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<tr>
<td>Integrating interventions, treatments, behavior, language, and others into practice that represents the recovery model</td>
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</table>

   Additional Comments: ____________________________________________________________
3. Please rate the importance of the following items in future trainings:

<table>
<thead>
<tr>
<th>Item</th>
<th>Not Important</th>
<th>Somewhat Important</th>
<th>Important</th>
<th>Extremely Important</th>
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<tbody>
<tr>
<td>Gaining a better understanding of what the recovery model is</td>
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<td>Learning techniques to implement the recovery model</td>
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<tr>
<td>Listening to other service providers who currently practice from the recovery model</td>
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<tr>
<td>Hearing from consumers about their perception of the recovery model</td>
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<tr>
<td>Improving knowledge base of recovery model and recovery-oriented practice</td>
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<tr>
<td>Learning skills that enable service provider to work and practice from a recovery-oriented practice</td>
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<tr>
<td>Anything specific that comes to mind</td>
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</tbody>
</table>

4. Please rate the level of understanding of the recovery model:

<table>
<thead>
<tr>
<th>Item</th>
<th>No Knowledge</th>
<th>A Little Knowledge</th>
<th>A Fair Amount of Knowledge</th>
<th>A Good Amount of Knowledge</th>
<th>Very Competent</th>
</tr>
</thead>
<tbody>
<tr>
<td>The average mental health service provider’s recovery</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
model level of understanding

<table>
<thead>
<tr>
<th>The average drug and alcohol service provider’s recovery model level of understanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your own recovery model level of understanding</td>
</tr>
</tbody>
</table>

Any specific comments: ________________________________________________________________

5. Please rate the level of buy-in for the recovery model:

<table>
<thead>
<tr>
<th></th>
<th>No Buy-In</th>
<th>Very Low</th>
<th>Low</th>
<th>Neutral</th>
<th>High</th>
<th>Very High</th>
</tr>
</thead>
<tbody>
<tr>
<td>The average mental health service provider’s level of buy-in for the recovery model</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The average drug and alcohol service provider’s level of buy-in for the recovery model</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your own level of buy-in for the recovery</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
6. Please rate the extent to which the recovery model is utilized in practice:

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Most Of The Time</th>
<th>All The Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>The extent to which the average mental health service provider utilizes the recovery model in practice</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The extent to which the average drug and alcohol service provider utilizes the recovery model in practice</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The extent to which you utilize the recovery model in practice</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Any specific comments: _____________________________________________________________

7. Please rate your level of agreement to the statements:

   strongly disagree (SD), disagree (D), neutral (N), agree (A), strongly agree (SA)

<table>
<thead>
<tr>
<th></th>
<th>SD</th>
<th>D</th>
<th>N</th>
<th>A</th>
<th>SA</th>
</tr>
</thead>
<tbody>
<tr>
<td>All county behavioral services should have a system in place that would assess service providers’ competency of the recovery model</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consumers respond more positively to service providers who understand and incorporate the recovery model into practice.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have been able to successfully apply the recovery model into practice, resulting in positive outcomes for consumers.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>---</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There has been a notable difference in agency support, policy, assessment tools, protocol, and/or trainings since the agency adapted to a recovery-oriented philosophy.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My current working environment incorporates the application of the recovery model.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My current working environment exemplifies the medical model.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The county currently supports and fosters a work environment that is conducive to a recovery-oriented perspective and practice.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A consumer’s ability for positive transformation in his/her life is not dependent on a service provider’s level of understanding of the recovery model.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The medical model is just as useful and effective as the recovery model.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The recovery model is unrealistic to mental health practice within a county behavioral health agency.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A consumer’s ability to reach recovery is independent of the service provider’s belief in and use of the recovery model.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Although the recovery model is good in theory, the medical model is a better approach for practice.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When working with an individual, it is not important to help them see their experiences as a recovery process or journey.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Working from a recovery oriented perspective is clearly reflected in the service provider’s attitude towards the consumer.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My work with a consumer reflects that recovery is a way of approaching the day’s challenges and is a way of life.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>My work with a consumer mostly consists of managing their current symptoms, housing, and</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Setting and working towards goals on a regular basis is not important to an individual’s recovery.

The recovery model is only useful for drug and alcohol services.

Recovery is not a possibility for all consumers.

Peer/consumer led support and counseling can be helpful, but is not that beneficial or essential for a consumer’s well-being and recovery.

When working with an individual with a psychiatric diagnosis, it is essential for the session to be client-directed.

It takes more than just one person’s support and belief in an individual with a psychiatric diagnosis to actually encourage and lead to recovery.

<table>
<thead>
<tr>
<th>Any specific comments:</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>

8. Please rate the effectiveness of the following approaches in treatment outcomes within your practice:

<table>
<thead>
<tr>
<th>Approach</th>
<th>Do not use</th>
<th>Ineffective</th>
<th>Rarely effective</th>
<th>Sometimes effective</th>
<th>Very effective</th>
<th>Always effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have goal directed outcomes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use client centered approach</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Include family and significant others</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use medically</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
driven
treatment

Consider
service
provider as
the gate
keeper and
expert

Any specific comments: ______________________________________

9. What are some situations where the recovery model does not work? Please
specify:

________________________________________________________________

10. Which of the following factors contributed to the above situation? Please check
all that apply:

<table>
<thead>
<tr>
<th>Lack of trainings</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Too large of case load</td>
<td></td>
</tr>
<tr>
<td>Lack of time</td>
<td></td>
</tr>
<tr>
<td>Not enough resources to draw from</td>
<td></td>
</tr>
<tr>
<td>Not enough agency support</td>
<td></td>
</tr>
<tr>
<td>Lack of knowledge of how to implement a recovery-oriented practice</td>
<td></td>
</tr>
<tr>
<td>Client not responding to recovery-oriented practice</td>
<td></td>
</tr>
</tbody>
</table>

Any specific comments: ______________________________________

11. Since the recovery model is the chosen practice model, what else can be done to
further the quality of services delivered within the county? Please specify:

________________________________________________________________

12. Please check all that apply to your academic/professional background:

<table>
<thead>
<tr>
<th>AA/AS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>BA/BS</td>
<td></td>
</tr>
<tr>
<td>ASW</td>
<td></td>
</tr>
</tbody>
</table>
13. Please list the number of years of professional practice that you have: ___

14. When did you first learn about the recovery model? Check all that apply.

<table>
<thead>
<tr>
<th>College</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Post graduate</td>
<td></td>
</tr>
<tr>
<td>Professional school</td>
<td></td>
</tr>
<tr>
<td>In service training</td>
<td></td>
</tr>
<tr>
<td>On my own</td>
<td></td>
</tr>
<tr>
<td>Never learned about it</td>
<td></td>
</tr>
</tbody>
</table>

15. Please specify your gender: ___

Thank you for your participation

“Submit” Button Here
References


Firewalkers: madness, beauty, and mystery: radically rethinking mental illness.
Charlottesville, VA.


