NASMHPD e-Report on Implementing Recovery-Based Care

In seven brief chapters written by consumer-providers, experts in psychiatric rehabilitation, psychometrics researchers, and others, a report from the National Association of State Mental Health Program Directors (NASMHPD) provides encouragement and guidance for transforming state mental health systems. The report builds on the momentum created by the President's New Freedom Commission to develop consumer-driven services that are oriented to recovery. It includes a preview of instruments being developed to measure recovery at the individual, program, and system levels; case studies of successful systems and programs; and a panel discussion on workforce issues for clinicians and administrators.

The introduction to the 43-page report acknowledges that many administrators and clinicians have not "bought into" a recovery orientation, and some may feel that recovery is "too intangible for action." *Implementing Recovery-Based Care: Tangible Guidance for SMHAs* seeks to change their minds. The report cites the definition of recovery presented in the New Freedom Commission's report: "The process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms." In the report, this definition is rounded out with a quotation from a consumer-researcher, "Recovery can be defined as a process of learning to approach each day's challenges, overcome our disabilities, learn skills, live independently, and contribute to society. This process is supported by those who believe in us and give us hope."

In the first chapter, "Overcoming Obstacles to a Recovery-Oriented System," William A. Anthony, Ph.D., cites statewide leadership as the single most important factor in transforming state mental health systems. He calls on state mental health leaders to develop "a recovery vision" and repeatedly communicate this vision through the use of stories, metaphors, anecdotes, and quotations. "The vision of recovery allows the leader to tell an inspiring story," he notes, "rather than the previous broken stories of maintenance and deterioration."

In another chapter, leaders of three psychometric research teams describe the development of recovery-themed measurement tools, all of which reflect substantial input from consumers. The Recovery Measurement Tool is a 91-item self-rated personal measure of recovery developed by a group of consumer leaders. It is designed for use by individuals to measure not only the stage of their recovery but the efforts they take every day to stay on the "recovery journey." The tool has been in the development phase for more than two years, and the research team hopes to test it soon with a variety of groups in order to develop a shorter valid instrument.

The Recovery Enhancing Environment measure (REE), which was created in 1999, was designed not only for consumers to identify and rate personal markers of recovery in their current lives but also for them to rate the recovery orientation of the agency where they receive services. The measure has had two formal pilot tests involving more than 500 consumers and is now available for use. The pilot tests indicated that the instrument is psychometrically sound and that it can be used to identify programs and practices with a strong recovery orientation. The measure is intended to serve as a tool in strategic planning efforts to move agencies toward change.

The team that developed the Recovery Oriented System Indicators (ROSI) measure convened consumer focus groups in nine states and used the methods of grounded theory inquiry to identify person-in-environment factors that help or hinder recovery. Recovery-oriented performance indicators based on these factors were further tested and analyzed by consumers and state mental health administrators. The consumer self-report measure, which has 42 personal assessment items and 23 administrative data items, is targeted for a large-scale pilot test.

System transformation requires a skilled and dedicated workforce that is willing to be flexible while enabling change. The report notes that for administrators and state leaders, the workforce provides both a source of daily challenges and the answers to the system's ills. The final chapter of the NASMHPD e-report is a wide-ranging panel discussion by three experts in recovery-based care. Their detailed answers to a variety of questions provide insights and helpful practical advice. The questions include: What can clinicians and administrators do to become more informed about recovery-based care? How can consumers help professionals facilitate system transformation? What can academia do to instill the philosophy of recovery into the next generation of mental health professionals?

The e-report ends with a suggested-reading list and descriptions of 11 online resources that will help clinicians and administrators implement recovery-based care in the current public mental health system.

The e-report, *Implementing Recovery-Based Care: Tangible Guidance for SMHAs,* is available on NASMHPD's Web site at www.nasmhpd.org.

Two New SAMHSA Reports Focus on Adolescent Substance Use

Two reports from the Substance Abuse and Mental Health Services Administration (SAMHSA) raise concerns about substance use by young people. According to the first report, the number of adolescent admissions to substance abuse treatment increased by 65 percent between 1992 and 2002, from 95,000 admissions to 156,000—a rate nearly three times the overall increase in admissions for substance abuse treatment for that period (23 percent). The surge in

adolescent admissions was attributable mainly to treatment for marijuana use, admissions for which increased from 23 percent of all adolescent admissions in 1992 to 64 percent in 2002. Admissions for alcohol treatment declined from 56 percent of all adolescent admissions in 1992 to 20 percent in 2002.

Adolescent Treatment Admissions: 1992 and 2002 is based on data from the Treatment Episode Data Set (TEDS), an annual compilation of information on the demographic characteristics and substance use problems of individuals admitted for three types of treatment—detoxification, rehabilitation and residential services, and ambulatory services. The information comes primarily from facilities that receive some public funding. Admission information is routinely collected by state administrative systems and then submitted to SAMHSA in a standard format. Approximately 1.9 million records are included in TEDS each year. Admissions of individuals aged 12 to 17 years are categorized as adolescent admissions.

In 2002, more than half—54 percent—of adolescent admissions were the result of referrals to treatment through the criminal justice system, compared with 40 percent in 1992. The number of such referrals increased from 8,500 in 1992, or 9 percent of adolescent admissions, to 52,700 in 2002, or 34 percent of adolescent admissions. The percentage of school referrals decreased from 18 percent in 1992 to 11 percent in 2002, and self-referrals and individual referrals remained stable at around 18 percent.

The rate of admissions of female adolescents declined—from 34 percent of adolescent admissions in 1992 to 30 percent in 2002—whereas the overall rate of admissions for females increased from 28 to 30 percent over the ten-year period. Racial and ethnic characteristics changed somewhat between 1992 and 2002. In 1992 about 68 percent of admissions were for white adolescents, compared with 16 percent for black adolescents and 11 for percent for Hispanic adolescents. The respective rates in 2002 were 60 percent, 19 percent, and 15 percent. Ambulatory services accounted for 78 percent of adolescent admissions in 1992 and 83 percent in 2002. For rehabilitation and residential services the respective rates were 19 and 15 percent, and for detoxification they were 2 and 3 percent.

The second SAMHSA report, *Alcohol Dependence or Abuse and Age of First Use,* provides further evidence that alcohol use in adolescence often leads to abuse and dependence in later life. Adults who first used alcohol before age 15 were found to be more than five times as likely to report past-year alcohol dependence or abuse as adults who first used alcohol at age 21 or older. These findings are from a special analysis of 2003 data from the National Survey on Drug Use and Health, an annual survey of nearly 70,000 persons.

The analysis found that among the 14 million adults aged 21 or older who were classified as having past-year alcohol dependence or abuse, more than 13 million (95 percent) had started using alcohol before age 21. In 2003, 74 percent of adults reported that they had started using alcohol before the age of 21, and 14 percent reported first use at age 21 or older. Among adults who initiated alcohol use before age 15, the rate of past-year dependence or abuse was 16 percent, compared with 9 percent among those whose first use was before age 15 and 3 percent among those whose first use was at age 21 or older.

Men were more likely than women to report having first used alcohol before the age of 15. White adults had the highest rate of alcohol use before age 21 (79 percent) and the highest rate before age 15 (20 percent).

In releasing the report, SAMHSA administrator Charles Curie said, "Research has shown that alcohol dependence, while once thought to be an adult-onset disease, is actually developmental in nature. That is why underage drinking prevention programs are a priority at SAMHSA."

Both reports are available on the SAMHSA Web site at www.samhsa.gov.

Youth Suicide Prevention Law Signed

In late October President Bush signed the first federal law specifically aimed at youth suicide prevention. U.S. Senator Gordon Smith of Oregon, whose son committed suicide last year, introduced the legislation—the Garrett Lee Smith Memorial Act.

The law authorizes $82 million over three years to provide grants to states, Indian tribes, and colleges and universities to develop suicide prevention and intervention programs for young people. It emphasizes screening to identify children with mental illness and training for child care professionals. The law also establishes a federal Suicide Technical Assistance Center that will provide guidance to grantees, establish data collection standards and gather, evaluate, and distribute data. Money for the grants has not been fully appropriated.

According to the Centers for Disease Control and Prevention, more than 3,000 children and young adults take their lives each year, making suicide the third leading cause of death for persons between the ages of ten and 24. Each year, more that 600,000 young people require medical attention for a suicide attempt. Financing for suicide prevention was estimated to be less than $40 million in 2000, although suicide is responsible for about 30,000 deaths a year.