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The Journal of BC's Mental Health

Visions

Rehabilitation and Recovery

What do they mean? How do they work together?

GUEST EDITORIAL

Psychosocial Rehabilitation is the way we do what we do

Darrell Burnham

It's appropriate that the BC Division of CMHA has decided to dedicate this edition of BC's Mental Health Journal to Rehabilitation, or as I prefer and will use throughout this article, Psychosocial Rehabilitation (PSR). PSR has become the fundamental service philosophy of the mental health field in British Columbia. It is much more than a fad with roots that go back to the real beginning of the community mental health field in the 1950's.

But what is it? There seem to be many different types of services which call themselves PSR programs. What is the common link among these sometimes disparate services? I've distilled my understanding of this broad field into a few short statements which I hope will convey the fundamentals of this field.

Respect and optimism
Hope and opportunities
Work together through barriers
Cut through the crap

It's that simple.

Darrell Burnham is *Executive Director of Coast Foundation Society in Vancouver BC - a non-profit agency providing housing, employment and others services. He is past president of the BC chapter of IAPSRS (International Association of Psychosocial Rehabilitation Services).*

Respect & Optimism

Underpinning all PSR is a strong belief system. The first part begins with the practitioner and what values he or she brings to their work. This should be a universal value, but, unfortunately, it needs to be stated: **Everyone, particularly those disabled by a mental illness, must be treated with respect and dignity**. The focus must be on the person, not the disease; on abilities, not the disability.

There must be the realization that there is a tremendous capacity to learn and grow in persons living with a mental illness; that people do recover and can and do take important places in society.

This may be self-evident, but it is clear from all the research that the expectations of the practitioner are a critical element in the success of any PSR intervention. You reap what you sow: If you expect failure, more often than not, that's what will happen. On the other hand, the positive power of expectations cannot be underestimated.

Hope and Opportunities

Consumers often speak of hopelessness and despair when describing their experience with a mental illness. The various illnesses seem to sap consumers of their basic sense of worth as a person and cloud any hope they may have for the future. PSR services attempt to help consumers begin to set real goals, create optimism, build on success and overcome despair. Hope is the foundation for the motivation necessary to work through the many challenges faced by PSR programs. Practitioners provide real opportunities for consumers to learn, grow and succeed. They help consumers make informed choices, and to understand and recognize their rights and responsibilities.

Work together through barriers

Consumers find many barriers that impede their recovery. CMHA's Framework for Support offers a good model to help understand the spec-

Continued on opposite page

The Journal of BC's Mental Health **Visions**

is a quarterly publication produced by the Canadian Mental Health Association, BC Division. It is based on and reflects the guiding philosophy of the Canadian Mental Health Association, the "Framework for Support." This philosophy holds that a mental health consumer (someone who has used mental health services) is at the centre of any supportive mental health system. It also advocates and values the involvement and perspectives of friends, family members, service providers and community.

In this journal, we hope to create a place where the many perspectives on mental health issues can be heard.

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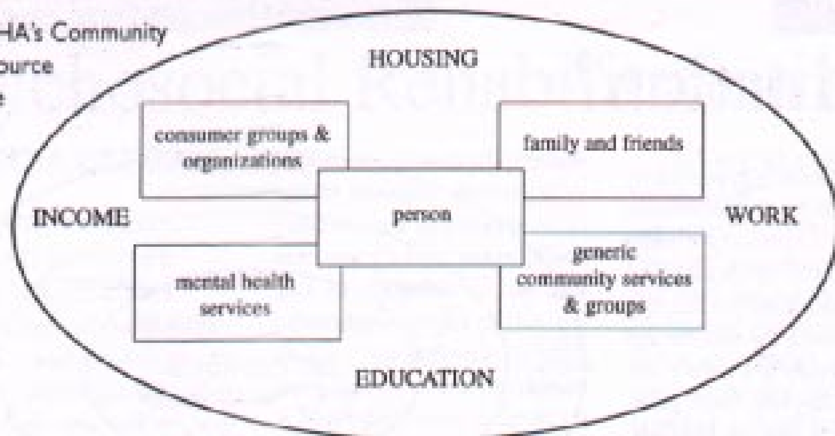

trum of issues that intersect a person's life and may need to be addressed in a consumer's recovery. Clinical Services, Housing, Income Support and Entitlements, Family Support and Involvement, Education, Friends and Social Activities, and on, play critical roles in the recovery of consumers. The Framework also helps to define the broad scope of PSR services.

The relationship between practitioner and consumer is essential to the success of PSR services. Practitioner roles in PSR programs are intentionally informal to minimize the "professional" distance between practitioners and consumers and to help foster trust, communication and understanding.

Though many PSR programs are offered within group contexts, much of PSR work is with the individual. PSR programs respect the individual's unique needs, wants and aspirations and help them define their own goals. The PSR program will then focus its own resources and help broker others to help each consumer reach their own goals.

Cut through the crap

Finally, consumers have enough valid challenges in front of them and it is terribly frustrating when they are faced with the artificial crap that seems to be regularly put in front of them. Their unfortunate dependence on so many systems for their income, housing, clinical support, etc., makes them incredibly vulnerable to policy changes, budget crunches or the worst of the bureaucratic run-a-rounds.

A fertile ground for advocacy is with the current Ministry of Human Resources who, I believe inadvertently, seems to regularly develop policies which entrap and penalize consumers. The recent policy change to Unemployable Benefits (which I hope is permanently shelved) is a clear example of a policy which would hurt mentally ill persons more than any other group. Similarly the elimination of earnings exemptions for Regular and Unemployable categories provides a significant demotivator for consumers interested in a partial return to the workforce. Again, this policy was targeted elsewhere, but consumers were caught up in its wake.

PSR organizations and practitioners must take on this silliness and challenge the bureaucracies and help consumers and families speak up and be heard when these policy changes are being considered. Advocacy is a cornerstone of PSR.

Summary

What does this all mean? Well, for one thing, it is hard to strictly categorize PSR services. They may be designed to address one, some, or all of the above issues. I prefer to consider PSR as a *philosophy* of intervention first and a *means* of intervention second — both which places the needs, wants and desires of consumers first.

As a result, a PSR organization may be dedicated to advocacy; opening doors or challenging the bureaucracy. It may help consumers return to the workforce, help find quality affordable housing, provide recreational and cultural activities, support consumers to return to college or university, offer consumer run self-help groups, provide Multicultural support services, or family support activities, and on and on. This issue of *VISIONS: BC's Mental Health Journal* gives us a picture of some of the ways PSR makes a real difference in people's lives.

Whatever it does and in whatever form, PSR is the present and the future of community mental health services in British Columbia.

Editor's Message

Visions: The Journal of BC's Mental Health reflects the current and future thinking, practice and perspectives on and within BC's mental health system. It is knowledge gathered from many sources, as represented in CMHA's Community Resource Base.

In addition, this journal is about putting theory into practice. We hope to always ask the question, "What does it look like in real life? How will it affect me or my family member? How can I make a difference?"

Please write. Let us hear your perspective. – *Dena Ellery, Editor*

Letter to the Editor

Editor, Visions: I read with interest, and some trepidation, your issue on Early Intervention. I am entirely in support of Dr. Peter Liddle's comment that "for many individuals, over a year passes between onset of symptoms and engagement in treatment." I concur that more precise diagnoses and more effective interventions ought ideally to be done as soon as symptoms manifest. My concern is one that I believe CMHA shares – the problem of stigma. Early intervention has the potential to cause early labelization, and being categorized, and potentially limited in your opportunities by your diagnosis and treatment, and by your own internalization of the label, can lead to not exploring your own capabilities. A sense of self-worth is difficult to maintain, and especially difficult to maintain when you are diagnosed with a debilitating illness. I would caution anyone to take care when labeling people with adult diagnoses when they are children. Also, early intervention requires that supports and treatment be available. We all know the system is strapped. Diagnosing someone without providing the appropriate treatment would be possibly worse than taking more time before diagnosing. Jill Stainsby

What is rehabilitation?

MODELS OF REHABILITATION FOR RECOVERY

Lyse Bissonnette

Rehabilitation (rehab) is an art and a science. Nothing is left to chance in rehab. Rehab is assisting people to develop, maintain, restore and/or improve skills which will enable them to reach chosen goals or overcome identified difficulties. To achieve this, rehab specialists set up or seek out opportunities for people to participate in activities or work where skills can be learned and practiced. The question then becomes, are the skills you have learned useful to you in your life?" I feel this is where the art and science come in.

In order to assist people to formulate and reach their goals, rehabilitation specialists continuously analyze the environment. Consumers looking to develop or improve skills are then introduced to various activities. At some point, rehab staff touch base with the individuals to see if, in fact, they are satisfied with the activities and if they feel they are getting any closer to reaching their goals. Modifications may be required, new goals may be formulated, the individuals may decide to progress to an activity outside of the program and may ask for support to do so. This is rehab.

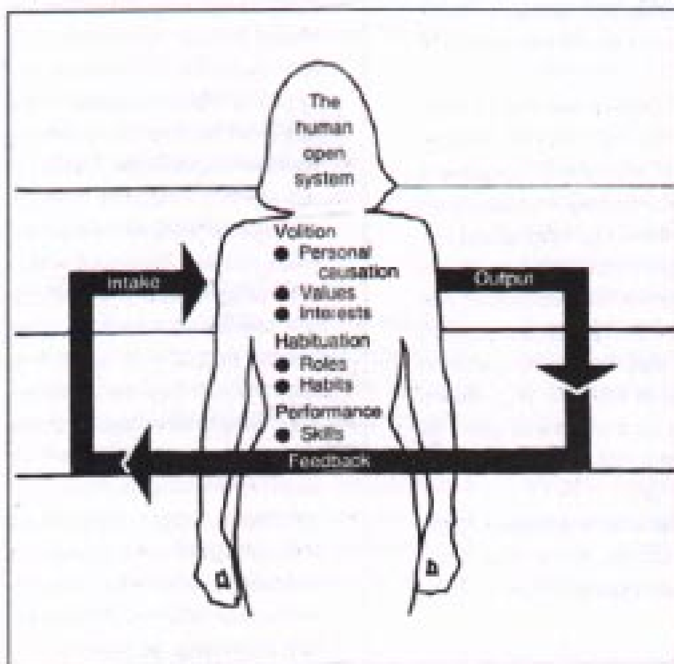

Figure 1: The open system representing human occupation

What guides psychosocial rehabilitation practice?

There are a number of models, including PSR (Psychosocial Rehabilitation) from Boston University which looks at all areas of a person's life, their resources, barriers, and starts from person-centered rehab goals to enhance personal life satisfaction.

In Occupational Therapy, there is the Model of Human Occupation, MOHO (Keilhofner, 1985) (Figure 1). MOHO looks at a person as an Open System, meaning that a person receives input or information from the environment, processes this information according to a set of standards including motivation, awareness, control, values and beliefs, roles and habits, and perceived performance of skills. The person then does some output, which will interact with the environment. This environment in turn provides feedback which will become input, and so on. Keilhofner proposes that motivation and meaningfulness to self are "chief commander" in engaging people in activities which can then become part of their role or routine and lead to self-satisfying performance. Conversely, poor performance will resonate back up to affect motivation and meaningfulness.

The Canadian Occupational Performance Measure, which is an assessment tool also used in Occupational Therapy looks at the whole person in terms of self-care activities, productivity - which includes paid work, home management tasks, volunteer work, and leisure (Figure 2). It considers a person's resources, including spirituality, culture, values, beliefs, family, and supports. This model suggests that a balance between these areas leads to a satisfying life. Goals are identified by the individual and are formulated according to their importance to the individual, and perceived satisfaction with performance.

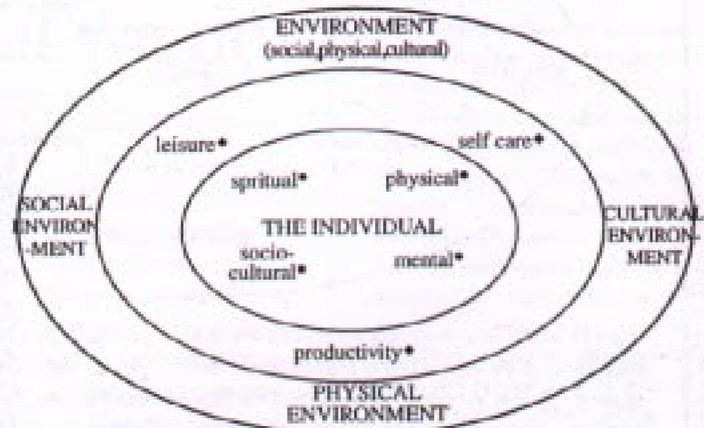

Figure 2: Interacting elements of the individual in a model of occupational performance (adapted from Reed and Sanderson, 1980)

● performance components

▲ areas of occupational performance

The Rehabilitation Guidelines formulated by the Ministry of Health a few years ago provides yet another guide to assist individuals in their rehab planning. It draws our attention to four "domains": personal life, work, education and leisure. These guidelines go one step further, identifying levels of service which include: Rehab readiness, where a person has identified a goal but does not feel ready to begin with the process; Rehab process whereby an individual is actively involved in skill development; and Ongoing support which would occur when an individual has reached a stated goal. These guidelines were developed with Mental Health Centers, club-

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REHABILITATION AND RECOVERY

Psychosocial Rehabilitation as Recovery

PATRICIA DEEGAN

. . . on the difference between recovery and rehabilitation

The application of rehabilitation approaches and technologies to adults with psychiatric disabilities is a relatively new and exciting development in our field. Of significance is the fact that, from the perspective of the rehabilitation approach, it is no longer necessary to isolate persons with psychiatric disabilities as being totally different from other groups of persons with disabilities.

It is important to understand that persons with a disability do not "get rehabilitated" in the sense that cars "get" tuned up or televisions "get repaired." They are not passive recipients of rehabilitation services. Rather, they experience themselves as recovering a new sense of self and of purpose within and beyond the limits of the disability ... the aspiration is to live, work, and love in a community in which one makes a significant contribution.

Rehabilitation refers to the services and technologies that are made available to persons with disabilities so that they might learn to adapt to their world. Recovery refers to the lived or real life experience of persons as they accept and overcome the challenge of the disability. The recovery process is the foundation upon which rehabilitation services build.

. . . on what recovery feels like

Something more than just "good services" is needed, e.g., the person must get out of bed, shake off the mind-numbing exhaustion of the neuroleptics, get dressed, overcome the fear of the crowded and unfriendly bus to arrive at the program, and face the fear of failure in the rehabilitation program. In essence, they must be active and courageous participants in their own rehabilitation project or that project will fail. It is through the process of recovery that persons with disabilities become active and courageous participants in their own rehabilitation project.

It is important to understand that for most of us recovery is not a sudden conversion experience. *Hope* is the turning point that must quickly be followed by the willingness to act. . . in little ways with small triumphs and simple acts of courage.

One day at a time, with multiple setbacks, we [as people with disabilities] rebuilt our lives. **We rebuilt our lives on the three cornerstones of recovery—hope, willingness, and responsible action. This is the process of recovery that is the ground from which springs effective use of rehabilitation services.**

For many of us who have disabilities, recovery is a process, a way of life, an attitude, and a way of approaching the day's challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, re-group and start again.

. . . on recovery-focused rehabilitation

We cannot force recovery to happen in our rehabilitation programs. However, we can create environments in which the recovery process can be nurtured like a tender and precious seedling. To recover, persons with psychiatric disabilities must be willing to try and fail, and try again.

Rehabilitation programs can be environments that nurture recovery if they are structured to embrace, and indeed expect, the approach/avoid, try/fail dynamic that is the recovery process. This means that rehabilitation programs must have very flexible entry criteria and easy accessibility. The design of rehabilitation programming must be nonlinear, with multiple points of entry and levels of entry into programming. The real challenge of rehabilita-

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CMHA's "A New Framework for Support" provides model for recovery and system reform

The CMHA Framework for Support has been used by organizations, individuals and in mental health system reform across North America. A key part of the Framework is called the **Community Resource Base**. *It places the person at the centre of the system. Along with mental health services, it recognizes the other services, supports and relationships which contribute to recovery and to living a fulfilling life in the community.*

Below is an excerpt from "A New Framework for Support for People with Serious Mental Health Problems":

The Community Resource Base is a model for changing how we think about services and support for people with mental illnesses. It takes the perspective of consumers of mental health services and introduces a wide range of factors which influence their lives. While recognizing the importance of mental health services, the Community Resource Base also includes the role of family and friends, generic services and supports, and consumers working together on their own behalf. It also acknowledges some fundamental elements to which every citizen should have access: housing, education, income and work. Taken together, the components of the Community Resource Base comprise the various elements that individuals need in order to live a full life in the community.

In order to be more effective, [mental health] service systems need to:

- fully involve consumers and families in service design and delivery
- reinvest institutional dollars in coordinated and effective community services
- develop services which build access to the basic elements of citizenship such as work, housing, education and income, and
- make generic community services and supports - such as social assistance and public housing - accessible and a part of coordinated service delivery.

Finally, it is necessary to build inclusion in real work, education and other settings by developing strategies for accommodating people with mental illness. This entails adapting the particular setting to people's special needs.

tion programs is to create fail-proof program models. A program is fail-proof when participants are always able to come back, pick-up where they left off, and try again.

Each person's journey of recovery is unique. Therefore, it is important to offer persons in recovery a wide variety of rehabilitation program options from which to choose.

. . . on the gift of hope and relationship in recovery

Creating programs that enhance recovery involves recognition of the gift that people with disabilities have to give to each other. This gift is their hope, strength, and experience as lived in the recovery process. Hope is contagious and that is why it is so important to hire people with disabilities in rehabilitation programs.

If a rehabilitation program is to be a dynamic setting that promotes and nurtures the recovery process, then the rigid walls separating the "world of the disabled" and the "world of the normal" must be torn down. Staff members must be helped to recognize the ways in which they, too, are deeply wounded. Perhaps they have experienced anguish in their lives or perhaps they have known personal tragedy or struggle. To embrace and accept our own woundedness and vulnerability is the first step towards understanding the experience of persons with disabilities. A dynamic rehabilitation environment is one which staff members are vitally involved in their own personal growth and/or recovery.

Patricia Deegan, Ph.D., is Program Director, Northeast Independent Living Program in Lawrence, MA. She works with the National Empowerment Centre in Lawrence, sharing her own story of recovery from mental illness with others, and educating mental health workers about the recovery vision.

Excerpted with permission from "Recovery: The Lived Experience of Rehabilitation" in Psychosocial Rehabilitation Journal, 1988, 11(4), 11-19

Recovery from Mental Illness

Excerpt from RECOVERY FROM MENTAL ILLNESS: The guiding vision of the mental health service system in the 1990s

William Anthony

Recovery is described as 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 with 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.

Recovery from mental illness involves much more than recovering from the illness itself. People with mental illness may have to recover from the stigma they have incorporated into their very being; from the iatrogenic effects of treatment settings; from lack of recent opportunities for self-determination; from the negative side-effects of unemployment; and from crushed dreams. Recovery is often a complex, time-consuming process.

Major recovery may occur without complete symptom relief. That is, a person may still experience major episodes of symptom exacerbation, yet have significantly restored task and role performance and/or removed significant opportunity barriers. For example, a person with paraplegia can recover even though the spinal cord has not. Similarly, a person with mental illness can recover even though the illness is not "cured."

Recovery is a truly unifying human experience. Successful recovery does mean that the person has changed, and that the meaning of facts [relating to the life catastrophe or effects of mental illness] to the person has therefore changed. They are no longer the primary focus of one's life. The person moves on to other interests and activities.

Recovery-oriented system planners see the mental health system as greater than the sum of its parts. In a recovery-oriented mental health system, each essential service is analyzed with respect to its capacity to ameliorate people's impairment, dysfunction, disability, and disadvantage. Recovery outcomes include more subjective outcomes such as self-esteem, empowerment, and self-determination.

For service providers, recovery from mental illness is a vision commensurate with researchers' vision of curing and preventing mental illness. Recovery is a simple yet very powerful vision.

Basic Assumptions of a Recovery-Focused Mental Health System

Recovery can occur without professional intervention. Professionals do not hold the key to recovery: consumers do. The task of professionals is to facilitate recovery. Recovery may be facilitated by the consumer's natural support system ... Self-help groups, families, and friends are the best examples of this phenomenon. Also essential to recovery are non-mental health activities and organizations, e.g., sports, clubs, adult education, and churches. There are many paths to recovery.

A common denominator of recovery is the presence of people who believe in and stand by the person in need of recovery: ... person or persons in whom one can trust to "be there" ... people who believe in them ... who encourage their recovery but do not force it. Recovery is a deeply human experience, facilitated by the deeply human responses of others. Recovery can be everybody's business.

A recovery vision is not a function of one's theory about the causes of mental illness. Recovery may occur whether one views the illness as biological or not.

Recovery can occur even though symptoms reoccur. The episodic nature of severe mental illness does not prevent recovery.

Recovery changes the frequency and duration of symptoms. As one recovers, the symptom frequency and duration appear to have been changed for the better. More of one's life is lived symptom-free.

Recovery does not feel like a linear process. Recovery involves growth and setbacks, periods of rapid change and little change. Periods of insight or growth happen unexpectedly.

Recovery from the consequences of the illness is sometimes more difficult than recovering from the illness itself. An inability to perform valued tasks and roles, and the resultant loss of self-esteem, are significant barriers to recovery. Barriers brought about by being placed in the category of "mentally ill" include loss of rights and equal opportunities, discrimination in employment and housing, lack of opportunities for self-determination,and disempowering treatment practices.

Recovery from mental illness does not mean that one was not "really mentally ill." People who have successfully recovered from severe mental illness have been discounted as not "really" mentally ill. Successful recovery [should be] seen as a model, as a beacon of hope for those beginning the recovery process.

Implications for mental health planning

The mental health system must help sow and nurture the seeds of recovery through creative programming.

For many persons who are recovering from catastrophes other than mental illness, intense emotions of depression, guilt, isolation, suspiciousness, and anger are seen as a normal part of the recovery process. For persons recovering from mental illness, these emotions are too quickly and routinely considered a part of the illness rather than a part of the recovery. The mental health system must allow these emotions to be experienced in a nonstigmatizing and understanding environment.

Previous "visions" that guided the mental health system were not consumer-based. They did not describe how the consumer would ultimately benefit. For example, the deinstitutionalization "vision" described how buildings would function and not how service recipients would function. Similarly, the community support system "vision" described how the service system would function and not the functioning of the service recipients. In contrast, a recovery vision speaks to how the recipients of services would function. Changes in buildings and services are seen in the context of how they might benefit the recovery vision.

William A. Anthony, Ph.D., is Executive Director of the Rehabilitation at Center for Psychiatric Rehabilitation, Boston University, Boston, Massachusetts.

Excerpted with permission from Rehabilitation Journal, *1993, 16(4), 11-23.*

"Raving beauties" combines fun with skill development and friendships

Sharon Chapman

The Living Room Drop-in Centre is a part of Lookout Emergency Aid Society, in Vancouver's downtown eastside. It is an activity centre for people with a mental health history, and provides a safe, supportive, alcohol-and-drug-free environment where members can just hang out or participate in a wide variety of formal and informal activities and programs. There are close to 900 members, or about 150 people daily.

While the LivingRoom has a large female component, the majority of our members are male. In order to make women feel comfortable coming to the Drop-in, we developed Raving Beauties in May of 1995. Held weekly, Beauties is for members who wish to learn how to apply make-up, have facials and manicures. We also do shampoos, hair trims and hair coloring. Raving Beauties is strictly a fun group; we are not there to discuss personal problems but to have light, cheery conversation, to make ourselves look and feel better (if someone has a serious issue they are asked to wait until the end of the group for discussion or another staff member will take them aside for assistance.)

Although the group was initially geared towards female members, the men also quickly showed an interest and some Mondays we have a large contingent of males with mud packs, filed nails and new DO's.

An average of eight members participate, including five or six regulars. Participants say they thoroughly enjoy themselves. They feel it is an esteem builder; they glow when receiving compliments from the other members when they rejoin the larger group. They ask staff to remind them when the group is taking place, and they've told their friends about the sessions. We always enjoy new members joining the group!

Raving Beauties runs mainly on donated items; some participants and staff have donated make-up and shampoo. Funds are limited but we have managed to put together quite a supply of products.

Raving Beauties has proven to be a great success. It is encouraging to see that friendships which have been formed within the group continue to develop outside the program.

Sharon Chapman works with the Lookout Emergency Aid Society as a facilitator at the Living Room.

Recovery through Employment

EMPLOYMENT SERVICES FOR PEOPLE WITH A MENTAL ILLNESS

Cathy Johnson

People with a mental illness comprise a very high percentage of vocational rehabilitation clients, yet the rate of successful rehabilitation for this group is substantially lower than that of all other primary disability categories. Probably the most disconcerting statistic regarding recovery from mental illness is that only 30% of people hospitalized for mental illness have been able to find jobs. Taking into account a further 30% are unable to hold down jobs, this leaves 40% who are capable of working but cannot find work due to the misunderstandings surrounding mental illness.

Involvement in productive work has been identified as a leading component in promoting positive mental health and paves the way for a rich and fulfilling life in the community. Overcoming stigmas and misconceptions surrounding mental illness is the biggest obstacle to securing a job.

Encouragingly, **Coast Foundation Society's Employment Programs** offer a variety of services for people in the Greater Vancouver area who have been challenged by mental illness - from work experience and part-time work to competitive full or contract work. For people who are job-ready, supported employment enhances job placement and is increasingly being offered as a vocational service option for those with a mental illness.

Coast Foundation Society's Employment Programs have a number of opportunities that use the psychosocial rehabilitation model to help individuals choose, get and keep their employment. **PACT Employment Services** offers a Career Assessment workshop to assist an individual choose a satisfying job target. A Job Finding Club develops job search skills. Individual counseling and the employment support group offers a supportive outlet for those seeking work and those in a job. This program is geared towards individuals who are job ready with recent experience and good work references.

A unique opportunity for many of the Coast Foundation Clubhouse members is the **Transitional Employment Program (TEP)** which provides job-ready individuals with a six-month paid work experience (part-time) in a competitive work environment. Shift coverage is guaranteed for TEP participants. On-the-job training is provided by an employment counselor. For the employer this alleviates the problem of staff turnover and the cost of hiring and training. The program provides members with opportunities to rebuild personal and financial independence within a competitive work environment. In addition, the clubhouse offers **Life Skills for Work**, a series of workshops on how to be successful in your chosen job.

Choose-Get-Keep Model

A popular model for job search is the Choose-Get-Keep approach to vocational services developed through research at the Center for Psychiatric Rehabilitation at Boston University.

The three phases, **Choose, Get**, and **Keep**, describe a pre-employment, placement, and training/follow-along. A participant in the **Choose** phase selects the employment goal compatible with their values and qualifications. The **Get** phase includes the job search and concludes with the acceptance of a job offer from an employer in a desired competitive setting. The **Keep** phase continues with supports and skill development, provided as needed, to help the employee be successful and satisfied in his/her chosen job.

Supported Employment for People with Psychiatric Disability (Choose, Get, Keep Model) published in the Journal of Applied Rehabilitation Counseling - Kim. L Macdonald-Wilson (1987)

For more information on Coast Foundation Employment programs or clubhouse contact Cathy Johnson 877-0033 FAX: 872-8783

The ways working contributes to recovery

A PERSONAL PERSPECTIVE

Duncan

I work 10 hours a week and I get to keep a little over $200.00 a month. Prior to working I was living on $771.00. The difference with working aside from having the extra money is that it is healthy to wake up in the morning and go to work especially if it's nice out. I always get up at 7:30 am have coffee, get ready to go to work and go! If I stay home too long, it gets boring and from sheer boredom, it's enough to make anyone ill. You got to occupy your mind and do something physical, every day not just sit around. Usually I get to work 1/2 hour early and have coffee with other employees as they drift in before the day starts.

I work at Liquidation World in Langley. This is a large chain throughout North America. They really look after their employees, Labour Standards Act is posted, the policy manual is right up to date. People seem happy there. At work I perform a number of duties such as bagging goods with the cashiers, stocking shelves, furniture loading and unloading. I like seeing all the people going through the cash, I take stock of what people look like and what they buy; it's a real cross section of population. You don't know who they are, doctors, lawyers, etc... everyone is in there looking for a deal. I see the money that is spent there, especially the furniture. I see young kids come through with their parents and they pay for their own purchases, as though the parents are teaching them how to use their money.

Aside from this I get to talk with the cashiers about regular things like how their week went, what they'll do after work, I'm a staff there! I had never worked in a retail outlet before or with

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Clubhouses as Rehabilitation

FINDINGS FROM PROJECT 2000

Catharine Hume

Project 2000 supported six CMHA clubhouses to examine their role and strengthen their clubhouse. Underlying Project 2000 were the concepts of full member involvement, rehabilitation and community integration. This article explores some initial findings. Key project learnings are highlighted in the side bar.

What We Found

In general, we observed that the title 'clubhouse' was being applied to a variety of different kinds of programs. In two communities, for instance, participating clubhouses were actually being funded as drop-ins and while the term clubhouse was being used, they were operating with little focus on rehabilitation.

In smaller communities where there were no alternative places for people with mental illness to drop-in or become involved in a formal rehabilitation process, we found that clubhouses were attempting to meet both sets of needs. On the other hand, in larger communities with more rehabilitation services, clubhouses were often not recognized as a key part of the rehabilitation system and tended to focus on social/recreational activities and pre-vocational programs.

Purpose

Most people agreed that the clubhouse was a safe place for people with mental illness to come, have meals and get involved in social/recreational activities. The importance and value of having a safe place to socialize was identified by many members through interviews and informal discussions.

People had different opinions about the role of the clubhouse beyond the social/recreational area. Members themselves differed in terms of the purpose they saw the clubhouse playing in their lives: *"some people want a place to go with no expectations"*, while others are interested in developing skills and using the clubhouse as a stepping stone to longer term goals.

Without a clear priority on rehabilitation, we saw a tendency for the drop-in part of the environment to dominate. When this occurred, clubhouses often became low-energy environments, where staff did everything and members dropped-in and out for coffee and meals.

Staff

Although clubhouse staff are often the people who spend the most time with members, their role tends to be undervalued. In three of six clubhouses, staff were not actively involved in the local mental health rehabilitation team and, in the majority of participating clubhouses, there were minimal staff development opportunities.

Members

In general, we found significant room for increased member involvement in decision-making. In three of the participating clubhouses, there were member councils at the beginning of the Project. These councils helped to plan activities and provided a forum for concerns and suggestions. Members of the council, however, were often unclear about their role. In one of these clubhouses, the observation was made by a member of the council that: *"reliance on staff continues, staff still make the main decisions, opinions of members don't hold up too often."* This observation highlights the fact that having mechanisms for member involvement is not, in and of itself, enough to ensure meaningful participation.

Motivation

At the outset of the project, there were concerns expressed by staff

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Project 2000 tips

Tips for a clubhouse development process based on rehabilitation, community integration and member involvement.

- Get a commitment from members, clubhouse staff, the agency's board of directors and funders, to work towards clubhouse development.
- Don't expect to have full commitment from everyone
- Be prepared to work through concerns with people throughout the process.
- Designate a team of people to plan and facilitate the process.
- Free up required staff time.
- Build in, where necessary, staff development opportunities.
- Recognize the membership as a resource and tap into this resource.
- Develop an inventory of member skills, abilities and interests.
- Work through difficult issues in an open and fair way.
- Constantly focus on involving more members of the clubhouse.
- Build formal links between the clubhouse and the agency's Board of Directors to keep them up to date on clubhouse development.
- Develop ongoing ways to evaluate member's experiences of involvement.
- Create multiple ways for people to have input into the development process.
- Follow through on input and make sure people know how their input will be used.
- Recognize and celebrate successes.
- Expect ups and downs as a natural part of development.
- Make sure to build in time to have fun.
- Explore possible clubhouse roles with members, staff, managers and funders by:
  visiting other clubhouses;
  looking at relevant resource materials;
  having ongoing discussions about what people want from the clubhouse.
- Discuss recovery as a real possibility for people.
- Use visioning exercises.
- Develop measurable goals.
- Develop and post a clear plan for reaching the goals.
- Keep people informed of progress.
- Establish clear links between the clubhouse and other local mental health services.
- Establish ongoing links between the clubhouse and non-mental health community agencies, groups and organizations.
- Create ongoing opportunities for clubhouse staff and members from different communities to get together to discuss common issues.

The Role of Income Supports in Recovery

Barbara Bawlf

The importance of income supports in recovery from a mental illness cannot be overestimated. Having sufficient money with which to afford decent housing is crucial to establishing wellness. Being able to afford recreational activities gives one a sense of freedom and belonging. My own experience has been that adequate income helped make my life more pleasurable and heightened my mood.

As someone who was diagnosed with a mental illness ten years ago, but who had suffered many years previous to that, I had found that my working life had often been interrupted. A loss or reduction of income followed, resulting in a loss of self-esteem and an increase in stress. I felt I was unable to participate in the activities of my peers.

From 1993-1996, I received income assistance as I was unable to find employment after completing an ESL diploma. I could find bits and pieces of work here and there, but nothing sustaining. The amount of welfare available to me was just over $500, more than half of which had to be paid toward rent. The rest went mainly for food and bills, leaving little for recreation.

Many people had asked me why I didn't apply for GAIN for Handicapped. The money was better and medical benefits were included. I thought I was too well to receive disability assistance; it seemed to be better suited to people with more severe illness. I was also concerned about being able to work occasionally without being penalized. My impression was that one was not permitted to work while collecting handicapped benefits.

After encouragement from some of my mental health professionals I decided to apply for Disability Benefits. I had learned that the legislation surrounding eligibility had been changed, an important facet being that one did not have to declare themselves permanently unemployable in order to qualify. That issue concerned me; I did not wish to state that I could never work. I saw that as an admission of defeat.

I took my application to my psychiatrist who was very supportive. He filled out his section using few words, but making clear my diagnosis.

For the other part of the form, where one needs a testimony from a professional, I spoke with the social worker of the local psychiatric hospital. She had been my therapist at a day program and knew me well. Basically, she asked me what extra costs I incurred as a result of my mental illness and typed in my answers as we spoke. The types of expenses we came up with were things like recreation, transportation and clothing. These were extras which my budget on social assistance didn't allow for. It was very difficult, for example, to fork out a lot of extra money for bus fare to go to and from medical appointments. With the GAIN for Handicapped program, a yearly transit pass could be obtained for $47.

A month after I sent my application, I learned that I had been accepted as a recipient of Disability Benefits. Shortly thereafter I obtained my first cheque reflecting the increase.

My memories of that time are that I felt very happy and also rich. I went out and bought some new clothes and a pair of shoes. It was amazing how much difference a couple of hundred dollars made to my life. I don't consider myself to be a particularly materialistic person, but I was thrilled to have the extra funds.

Since I have been on Disability Benefits, I have worked both on-call and part-time. When I receive my stub from Social Services, I declare my earnings, providing photocopies of pay cheques. I have had very little problem with any of my assistance, and feel quite pleased that I am still allowed to receive medical and dental benefits as well as collect some money after earnings are deducted.

Income supports can make a huge difference to one's mental health. If you have adequate income you can provide for basic needs such as food, shelter and transportation, while at the same time give yourself a few treats. Everybody is entitled to a decent quality of life, and for [mental health] consumers it is especially true.

Barb Bawlf is president of the CMHA Victoria Branch and also works at A.C.E. Consumer Development.

Individualized funding puts control in consumer's hands

Patricia Wilkinson

Individualized funding is a relatively new concept in the mental health field. In recent years it has been used to help meet the needs of some people with physical disabilities or mental handicaps, although projects in Canada seem to have been few and far between.

The basic concept is simple: funding is calculated based on the individual's particular needs, the person determines for themselves how these needs are best met (in consultation with others as detailed below), and the person then directly contracts for services. This allows individuals to tailor a program and to "hire and fire" until they have the exact mix of service and service providers that works for them. Of course, they must meet their needs within the dollars provided.

Individualized funding is a concept worth investigating for people with mental illness. It may be particularly helpful for those who are having a difficult time getting the types of services they require, or who want to only work with certain service providers. Undoubtedly it will take time to convince funders that people with mental illness are capable of creating their own service system. Well, it never stopped us from making change before!

Patricia Wilkinson is coordinator of consumer Liaison with CMHA, BC Division, and is responsible for planning and facilitating consumer-oriented programs for CMHA, BC Division.

New psychiatry includes rediscovery of fun

Robert Winram

There is a tremendous value to developing an activity program linked to a psychiatric practice. I know because over 10 years ago, my psychiatrist and I worked together to create a consumer club among his patients. Since then I have had the satisfaction of seeing hundreds of his patients enjoy themselves as they were socializing their way to better health.

The improvement in my health could only be described as spectacular. Now I've had 10 years without a hospitalization while in the preceding three years I had over 250 days of hospital care.

How did it happen? The first step was a revision of my medications and a second opinion from my doctor, Dr. Phil Long. He listened carefully to me, and introduced a new mood stabilizer. However, I'm sure without the rebuilding of my confidence, my sense of self worth and usefulness, I might well have continued to flounder even with the new medications.

Our first activity was a soccer game at Sunset Beach. I knew a number of people with the illness because of my lengthy hospital stays. I invited them while Dr. Long invited a number of his patients. He also brought his wife and children. I was particularly impressed at the time that he so freely introduced us to his family. It was really fun.

One activity seemed to encourage another. Soon we had picnic blankets for those who weren't as active and people took turns bringing the snacks. When fall began we moved to a school gym for volleyball. I kept the volleyball so it was essential that I be there every Thursday at 6:30. I also kept the net.

Fulfilling this responsibility was important to me. It was amazing at the time in a slightly manic state how difficult it was for me to be on time on a regular basis. Phoning others to encourage them to come out to one of our events began to take a lot of my time. I would phone two or three reminders to people as close as 15 or 30 minutes before the activity was to start. People responded with a lot of interest. I had been entrusted with all the phone numbers and this encouraged a sense of responsibility and usefulness.

We were always on the lookout for ways to have fun. Where there were activities in the community that had been planned and organized by others, we would just join in like everyone else. The Sun Fun Runs, The Tall Ships, Tuesday night movies, fireworks displays, free tickets to concerts or sporting events. Each time we went out we shared with each other, encouraged each other and began to regain our confidence as we practiced using and developing our social skills.

From the doctor's medical point of view, bringing his patients together at one time was a very efficient way for him to see how people were progressing. At almost every meeting someone would want a few minutes to review a medication requirement or to talk about side effects or a specific concern. In a moment a club member could be reassured and issues could be dealt with on the spot . . .without needing to wait for the next appointment.

Dr. Long bought a 15 passenger van that enabled us to travel together on ski trips, visits to other cities for runs, Long Beach for camping, Whistler, and more. The van also made it possible for Dr. Long to bring along his patients when he was asked to speak. He frequently would ask his patients to speak with him about their experiences. It's flattering to be asked to share your ideas.

We saved and with the help of sponsors, made trips to San Francisco, Disneyland and Hawaii. On our first trip to San Francisco I asked everyone (there were 14) how long it had been since they had had a vacation. The average time was 10 years. No wonder these illnesses can be so difficult to overcome when there often is no relief from the suffering.

Dr Phil Long (#3100) on the finish line with activity group members

Our group brought people together in an informal way. It helped us develop trust in each other and our physician. It certainly has been one of the cornerstones of my recovery.

The relaxed, informal, yet respectful relationship that we all developed with each other is something that is worth encouraging. I hope other physicians will build on the model that worked so well for Dr. Long.

Robert Winram is Executive Director of the Mood Disorders Association of BC - a provincial network of self help groups. He speaks publicly across BC on issues related to mood disorders.

Rehabilitation and Cultural Diversity

Cultural diversity is important to rehabilitation practice in a number of ways. Basic concepts and definitions of health and well-being differ across cultures. This can effect the priority of different rehabilitation needs within a community. It can also effect levels of service use and access because different program approaches may be more or less acceptable to a given community.

In the case of employment issues, people naturally hope that their values, priorities and desired levels of involvement will be acknowledged and accommodated. However, cultural groups differ in their values and expectations about such things as a quick return to full employment. Little attention has been paid to how well the mental health system's employment programs meet the needs of a culturally diverse community.

Likewise, some mental health consumers at some stages (e.g., newcomer refugees) are highly focused on practical survival issues and will have little interest in social-recreational activities. Helping to connect the person with needed financial, legal, educational, and employment services would be the most effective way to engage these individuals in a rehabilitation program. Leisure, which is often a key focus for rehabilitation programs, may not have priority for them at this stage. Also, some cultural communities already have well-developed opportunities for socialization and recreation.

Language ability must also be recognized as a key issue for psychosocial rehabilitation. For recent immigrants and refugees, few things are more necessary and more empowering than mastering basic English. However, many persons with mental disorders find it difficult, if not impossible, to cope with the pace and stress of standard ESL instruction. Some even report that they feel unwelcome in standard classes. The stress of trying to keep up combines with the stress of feeling unwelcome and adds to the stress of not being able to communicate. Strategies certainly exist for other consumers, but the mental health system has done little to explore options for new English-language learners.

In general, awareness of multicultural issues in the mental health field over the past decade has been on the rise, but the impact of this change has been only slightly reflected in the area of rehabilitation programming. Even to a casual observer, the ethnic mix in clubhouses and drop-ins, work-readiness programs, housing programs and other rehabilitation programs can be seen to be low compared with the mix in the general population.

On the positive side, rehabilitation staff are well positioned by their training to take a leadership role in this area. After all, a key tenet of rehabilitation is to always consider the whole person in context. This mind-set, inherent in rehabilitation training, is already closer to the holistic thinking about health and mental health found in many newcomer communities than it is in the Western medical or psychiatric model. Rehabilitation workers should take advantage of this and build on the opportunities such a convergence in thinking provides.

Ron Peters is Director of Planning and Evaluation at Greater Vancouver Mental Health Service

Voices of Diversity

The following voices are self helpers and family members from Chinese-speaking support groups. These groups meet regularly through Greater Vancouver Mental Health Service's Broadway South team. Interpretation kindly offerred by team worker Raymond Li.

I lived with my wife for almost ten years and faced daily problems with her. Yet I did not know she has "schizophrenia". Since she started treatment with the mental team my life is becoming more "normal" and a little bit more enjoyable.

I benefit a lot from the monthly support group meeting:

1. I realize that I am not the only one with such problem.
2. I meet a lot of friends who are able to share their experiences on how to look after their mentally ill family members.
3. The group invites professionals to speak to us. They provide us with good ideas and instill confidence in us as being the most significant persons in helping our loved ones to recover at home.
4. The group gives me a chance to express my daily frustrations I can contribute my own experiences and I can also listen to those from other family members and workers at the team.

I am grateful to the team and the support group for their advice and information on various aspects of mental health. I am thankful for the enlightenment of life for myself and for my entire family. – *John Wu*

I have been participating in the support group for almost three years and I still get a surprised reaction from many new members, particularly family members, when they find out that I am a client of the team.

I am comfortable in sharing my view on mental health with other members. Speaking from my own experience, I urge others to stress on recovery, to focus on a day at a time and not to dwell on negative thoughts. It is important for me to make my life meaningful and to remain in treatment. – *Mary (a pseudonym) is a client-participant of the support group*

Reaching out: Making psychiatric services more culturally accessible

The first practical step in making improvements is to open the lines of communication to the ethnocultural communities at large. Different communities have different resources and different avenues of communication available. Be flexible and creative:

- Take advantage of local radio or cable television programs, newspapers or magazines.
- Phone a local immigrant-serving agency or cultural association and start a dialogue about issues of mutual concern.
- If there is no such agency in your area see if there is an ESL class, or an ethnic seniors drop-in, or a moms-and-tots group. Approach the group leader and see if you can talk to the group about your services at the end of their next regular meeting.
- Approach your Health Board and see if you can help with whatever planning activity they already have underway, or tell them you are willing to help them organize such an activity.

Rehabilitation in a community setting

GREENWAYS PROGRAM AT PROVIDENCE FARM

Christine Winter

Greenways is one of several rehabilitation programs run at the Horticulture Centre at Providence Farm, a 400 acre farm located 5 km east of Duncan on Vancouver Island. The Horticultural Centre includes of a 3 acre market garden, an orchard, unheated greenhouses, a wheelchair accessible greenhouse, a classroom, a coffee room, a small engine workshop, and a livestock barn that houses sheep, donkeys and chickens. There is also a sales area for a wide variety of nursery stock, and pesticide free produce. There are two permanent staff, a summer student and 9 active volunteers who work with 18 employees - all consumers of mental health services.

The mandate of Greenways is to provide employment for mental health consumers. The employment opportunities include greenhouse and nursery work, field crop production, customer service, computer skills, small engine maintenance, agricultural and horticultural equipment operation, livestock management, value added product manufacturing, marketing and advertising. Greenways is run as a small business. It is only interested in an employee's abilities; not their disabilities.

If a person has existing skills - welding, for example - the idea is to see how that person's talents can be incorporated into the business. If a person wishes to attain new skills, they can start training in their selected area. A person may not know what they can do, or want to do, so they can try a variety of jobs until the employer or the employee discovers their talents.

For some employees, Greenways is a short-term opportunity for work experience and training as a transition towards working in the regular work force. For others, Greenways offers a stable working environment where they can gradually learn new skills, gain confidence and be part of working team. A wide age range participates in this program and there is a working balance between staff, volunteer, and paid employees. This diversity leads to a matching of the motivated

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Horticultural therapy builds holistic health: body, mind and spirit

Mary Davis

Everyone, including the afflicted, needs the opportunity to work and earn a living, and is deserving of a job. Greenways is an excellent start in the right direction.

Greenways, to me, is very transitional, therapeutic, and most importantly, rehabilitative - whether it be mentally, physically, or emotionally. As a child, and later as an adult, I have experienced many strong horticultural interests, especially flowers and vegetables. These interests left me when I became ill and have since returned due to my placement on Providence Farm. I feel I have become well again because of the nurturing that one experiences with the plants as well as nature in general and of course from the people around me.

Because of a lack of assertiveness, a sense of failure, and a lack of activity, I felt I had no existence. The benefits of working have given me a sense of self-worth, self-esteem, self confidence, and most importantly a sense of pride and vitality. I have learned some new skills to teach others such as demonstrations of moss hanging baskets at a local garden outlet. I have been encouraged and praised by staff to develop a sense of direction

Employment at Greenways creates social contacts which are very beneficial and important, especially if one becomes isolated or lonely. Employment provides a camaraderie and fellowship. There is rarely a problem with everyday employment, as there is a sense of belonging with a spirit of cooperation. We are treated with respect. We even have our birthdays recognized complete with a birthday candle and cake.

One can be healed and helped by horticultural therapy when one's mental outlook is improved by way of being more physical. One has a purpose to get out of bed in the morning. I firmly believe that in order to recuperate from any kind of illness, one has to exercise. You have to become active again. The more active you are, the better you feel physically. If one allows this process to happen, one becomes well again and can overcome illness..

Staff at Greenways are exceptional. They create a healing environment. They praise and encourage us, they focus on the positive. We all possess special talents and abilities. There are no limitations towards our personal growth with our employment.

We are also kept informed with a business meeting once a month. We are informed of sales figures and administrative costs. We are meant to feel important. This creates encouragement and mutual respect. We are contributing towards the economy and the community with our hard industrious work. It is a slow and gentle process with rewarding results.

There is a sense of accomplishment and a pride of product when you spend the entire summer watering a crop of green peppers, only to see the vegetables harvested and sold. They have depended on you to control their lives. One feels the encouragement of the acceptance of responsibility of caring for a living plant.

I have been given the pleasure and opportunity of employment which has given me a restored faith in myself and in my abilities. That is why it is so important to have a Providence Farm in every community.

Mary Davis is a nursery technician at Providence Farm's Horticultural Centre, and was also responsible for customer service and sales.

Rehabilitation in a community setting

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with unmotivated, the outgoing people teaming up with the insular. The result is a successful, exciting program.

Greenways is rehabilitative, prevocational and vocational training program. Horticulture is used to create the environment where social and physical benefits lead to emotional benefit and employment opportunities. Because the Greenways program can adapt and adjust working conditions as necessary or as a participant requires, horticulture serves as a unique mechanism for facilitating growth and change in people.

As therapy, the Greenways program enables a person to:

- focus in on the job in order to gain some control of his/her illness
- extend active time over sleeptime or withdrawal time to alleviate depression
- focus energies on anger into physical labour
- socialize with more motivated individuals to help prevent isolation
- shift responsibilities onto themselves
- provide a reason to get up in the morning

Horticulture enables us to move from an isolated and artificial style of living to one that includes shared and natural benefits. Serving customers, friends and relatives, providing tours, winning prize ribbons from the fall fair, a sense of pride in a product and a sense of belonging are all social benefits. Employees feel the impact of their actions on self and other, the impact of their thinking and creativity, the increase of a sense of potency and an increased sense of effectiveness. They are reminded daily of their impact on their environment and gain personal power through actively participating in the management of the operation of Greenways through our monthly business meetings.

People need the opportunity to earn income, to make choices and to have real economic opportunity. Greenways is a start in that direction.

Christine Winter, H.T.M., is a horticultural therapist. Horticultural therapy programs are rare in Canada, and Christine Winter is the only woman horticultural therapist in Canada.

The ways working contributes to recovery

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the public. I find that my observation skills are getting better. I only used to work in production areas, repetition, lots of it; really boring.

I spent many years not working, occasionally finding odd jobs a day here or there. You have to be resourceful when you're short of cash. Even next week, we'll be helping a store move; one of the guys spotted the sign in the window. We'll get a week's worth of work there! I always wanted to work, I tried to upgrade myself in school, it was all too much pressure with the voices. They associate everything I'm doing; if I'm home watching TV, they seem to watch it with me, they seem to know what's on the radio, they seem to know what I'm talking about. At work they try to confuse me, speed me up or slow me down, they use sounds, create sensations, all this kind of knocks you off balance. Usually I put up with them, I keep working. I've only had to go home once. My employers are very supportive.

When I went through the Vocational Directions Program through Delta Recycling, all this information was shared first hand with the employer. I felt I had to keep it in the open. They were giving me a break, why not come clean with them. My supervisor is a woman, I have found women to be more understanding about these things. I have a good rapport with many of the workers there. I want to keep this job, they seem to want to keep me.

Working has done many things for me. It's giving me something to look forward to, a new group of people to socialize, a little more money which has made a big difference to me, and I feel great.

Models of Rehabilitation for Recovery

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houses, community living support and supported work programs in mind.

One other model is CMHA's Framework for Support (see page 4-5). I feel that level of access an individual has to various supports is extremely relevant when we talk about recovery and rehabilitation. This framework became even more significant to me after a recent seminar I attended on Hope and Recovery. In her discussion, Corinne Huddart talked about how all of us have teams of support and how these teams change as our needs change. Similarly, for a consumer who is stable, his/her team might include family, friends, volunteer work, significant others. If this same consumer was going through a psychiatric crisis, his/her team would likely change to include a GP, psychiatrist, the Mental Health Center or even the hospital, and it may not include some other members of the team at that moment in time.

An overall guiding philosophy of rehabilitation

I find that frames of reference are important in developing a personal philosophy, guiding practice and in providing check points, but what really matters is what we do with that information. I believe that rehabilitation is not only about formally teaching skills but has to do with a process and a relationship. Rehabilitation happens at all stages, whether it be in supportive activities or in skill development activities. Every interaction we have within our environment effects some change in us, however small. I believe that rehabilitation has to do with helping people achieve their goals, optimize their quality of life and become independent. I believe that what we can do as rehab workers, clinicians, professionals, etc., is to teach people about supports and how to access them. We can then help people develop and maintain their own teams of support which may or may not include us. Our programs must strive to be a means to an end and not an end in themselves.

I also believe that in order to perform this extremely demanding job rehab workers at all levels need to have skills and knowledge and need to be supported to pursue ongoing education. My approach is eclectic. I take from these models what seems to work for the consumers I work with.

To help me explain rehabilitation, I often refer to a saying from Steven Covey's *The Seven Habits of Highly Effective People*: "Start with the end in mind"; always know what you're doing, why you're doing it, who you're doing it with or for, and what will happen when you've done it!

Lyse Bissonnette is an Occupational Therapist currently employed at Langley Stepping Stone Rehabilitative Society. She teaches part-time at Kwantlen University College in Langley with the Human Services Faculty and works privately in the community.

Findings from Project 2000

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and members about being able to "motivate" and involve members in the Project. As we discussed this issue, a number of reasons for low motivation were identified.

Members in one clubhouse noted that people are not always encouraged to participate and take ownership in other mental health programs. This reduces their confidence and experience in taking on meaningful roles in service settings. In another clubhouse, some members who were living in family care homes were being dropped off at the clubhouse in the morning and picked up at the end of the day, with little or no say. Although clubhouse membership is supposed to be voluntary, it stands to reason that if people are being forced to attend it is unlikely that they will be motivated to get involved.

The clubhouse environment itself can be unmotivating as can ineffective structures for member involvement. Asking for people's input through member councils or in other ways without having a process to put people's suggestions into effect can reduce people's interest in getting involved.

While low motivation may be a barrier to participation for some people, other factors that clubhouses can address may underlie what appears to be low motivation in others.

Project Impact

By expanding people's ideas of what was possible and by developing achievable one year goals in each clubhouse, the project attempted to support clubhouse development.

In the clubhouses that took the time and energy needed to focus on clubhouse development, relationships were strengthened and new possibilities opened up. As concrete things started to happen, momentum was created and more members became involved in specific areas that were of interest to them. However, progress was not linear and both members and staff experienced ups and downs as they attempted to meet their goals.

Near the end of the Project, seven of the fifteen clubhouse goals were completed, seven were in progress and only one had been abandoned. These accomplishments are a testament to the hard work and commitment of staff and members in participating clubhouses.

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Resources for rehabilitation and recovery

BOOKS, BOOKLETS and VIDEOS

Community Support Systems: Lessons for Managed Care A guide for planners , administrators, practitioners and consumers. Centre for Psychiatric Rehabilitation, Boston University (1996), 50 pages. $18.95 US

Consumers as Providers in Psychiatric Rehabilitation. Collection of consumers' experiences in the mental health field and beyond. International Association of Psychosocial Rehabilitation Services (1997) 525 pages.

Introduction to Psychiatric Rehabilitation. From the publications editors of the International Association of Psychosocial Rehabilitation Services (1995). $39.95 US

Psychiatric Rehabilitation. William Anthony, Mikal Cohen and Marianne Farkas collaborate on this comprehensive, practical text. Centre for Psychiatric Rehabilitation, Boston University (1990), 283 pages. $139.95 US

Psychological and Social Aspects of Psychiatric Disability Comprehensively covers issues from stigma to full employment, issues from consumer, provider, family perspectives. Centre for Psychiatric Rehabilitation, Boston University (1997), 584 pages. $44.95 US

Readings in Psychiatric Rehabilitation. Edited by William Anthony and Leroy Spaniol, provides current thinking, research and practice. Centre for Psychiatric Rehabilitation, Boston University (1994), 538 pages $34.95 US

The Recovery Workbook: Practical coping and Empowerment Strategies for people with Psychiatric Disability. Leroy Spaniol, Martin Koehler and Dori Hutchinson's resource for professionals, family and consumers/survivors. Centre for Psychiatric Rehabilitation, Boston University (1994) $29.95 US

Leader's Guide to the Recovery Workbook. Authors as above. $4.95 US

The Experience of Recovery. Edited by LeRoy Spaniol and Martin Koehler. book gives personal accounts from people who have experienced psychiatric disability. Centre for Psychiatric Rehabilitation, Boston University (1997) $10 US

Toward a Vision of Recovery for Mental Health and Psychiatric Rehabilitation Services. William Anthony's video, booklet and resource list on recovery. Centre for Psychiatric Rehabilitation, Boston University (1997) $85 US

Return to Community: Building Support Systems for People with Psychiatric Disabilities The Guildford Press, (1995) (price not available)

Toward a Vision of Recovery for Mental Health and Psychiatric Rehabilitation Services. Video and readings on the vision of recovery. Centre for Psychiatric Rehabilitation, Boston University (1994), video: 30 min. + 24-page booklet. $85 US

Voices of Experience: Five tales of community economic development in Toronto. Video and booklet outlining the experiences of consumer initiatives. CED/Health Research Project (1995) (price not available)

BOOKS AVAILABLE THROUGH CMHA, BC DIVISION

A New Framework for Support. Outlines the philosophy of rehabilitation and system reform adopted by the Canadian Mental Health Association (1994) $18.50

Diversity Works. How to make workplace accommodations work for employer and employee. Canadian Mental Health Association (1994) $12.00

Learning Diversity. Making accommodations for individuals with mental illness in university and college settings. Canadian Mental Health Association (1994) $9.50

Moments. A coffee-table book with stories of hope and moments of recovery, from consumers across BC. Canadian Mental Health Association, BC Division (1995) $14.95

Steps to Employment: A Workbook for people who have experienced mental health problems. Mental health consumer's hands-on guide to getting and keeping real work. Canadian Mental Health Association (1997) $15.00

JOURNALS

Psychiatric Rehabilitation Journal. Up-to-date information on research, practice, publications, job opportunities and more. Centre for Psychiatric Rehabilitation, Boston University. Quarterly, $45/$80/$26 individual/institutional/consumer-survivor or IAPSRS member

ARTICLES

Assessing the Community Support Services Needs Women with Psychiatric Disabilities May Have Regarding Relationships. J Cogan, Centre for Change through Housing and Support (1993), 139 pages. $18.00 US

Consumer and Ex-Patient Roles in Supported Housing Services: A Technical Assistance Report. Wilson, Mahler and Tanzman, Centre for Community Change through Housing and Support (1990), 100 pages. $20.00 US

Crazy Folks Guide to Reasonable Accommodation and "Psychiatric Disability" Howie the Harp, Oakland Independence Support Centre (1991), 9 pages. $2.50 US

Reasonable Accommodations in the Work Place for Persons with Psychiatric Disabilities. Paul Carling, Centre for Change through Housing and Support (1993) $10.00 US

Working with a Psychiatric Disability. M. Downs, Centre for Change through Housing and Support (1989), 102 pages. $14.00 US

To order, or for a complete listing of all the above organizations' publications, write to the following addresses:

Centre for Psychiatric Rehabilitation, Boston University
930 Commonwealth Avenue
Boston, MA 02215 USA
Tel: 617/353-3549
Fax: 617/353-9209
web site: http://web.bu.edu/SARPSYCH

International Association of Psychosocial Rehabilitation Services
10025 Gov Warfield Parkway, #301
Columbia, MD 21044-3357
USA
Tel: 410/730-7190
Fax: 410/730-5965

The Centre for Community Change through Housing and Support
Institute for Program Development
Trinity College of Vermont
208 Colchester Avenue
Burlington, VT 05401
USA
Tel: 802/658-0000
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