
**ACT Team Members’
Responses to Training in
Recovery-Oriented Practices**

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To further our understanding of the consequences of training in recovery principles and practices, this study examined ACT team workers’ responses to a state-wide recovery training initiative. Analysis of trainees’ comments revealed ten themes expressing endorsement of or difficulties with recovery-oriented practices. Trainees’ comments supporting a recovery orientation described service recipients in holistic terms and described using various techniques to attain “client-centered” goals. Recovery-oriented tasks that posed dilemmas for trainees were: reconciling system-centered goals with recipients’ goals, establishing collaborative relationships with recipients, and using a recovery orientation with recipients who are in crisis and/or who “don’t admit to being mentally ill.”

Keywords: ACT services, evidence-based practices, recovery orientation, mental health services training

Introduction

As mental health service systems throughout North America move to a recovery orientation, policy makers are pursuing implementation plans that have training programs as central components. With providers’ lack of technical knowledge and skill a primary barrier to the successful implementation of new practices (Corrigan, Steiner, McCracken, Blaser, & Barr, 2001), in-service training of front-line workers is a vital implementation task—one that faces particularly difficult challenges when the outcome sought is the adoption of a recovery

orientation. Changing to a recovery model often imposes a fundamentally new set of values and requires that most providers make profound changes in their understanding of the basic task they undertake with those they serve (Anthony, 2000, 2004; Deegan, 1988; Jacobson, 2004). Typically, adopting a recovery orientation consists of changing the nature of the relationship between providers and service recipients to enact power-sharing, addressing the need for providers to subscribe to hope in their dealings with recipients, incorporating

individualization in treatment (recovery) planning through recipient goal-setting, and strengthening recipients' autonomy rather than promoting increased dependence (Jacobson, 2004).

At present, controversy exists about whether or not recovery-based practices are fully compatible with evidence-based practices. Those seeing incongruity between the two approaches point to the irreconcilability of evidence-based practice's foundation in medical-model authoritarianism and its reliance on system-derived goals like medication compliance with the recovery model's focus on subjectively defined goals and its provision of hope and belief in each individual's possibilities. Controversy about who is eligible for a recovery approach or, more precisely, whether recovery is as suitable for the most seriously disabled as for those seemingly more obviously headed toward recovery, remains particularly pointed (Anthony, 2000, 2004; Fisher & Ahern, 2002; Frese, Stanley, Kress, & Vogel-Scibilia, 2001; Jacobson, 2004). Anthony (2000, 2004) and others have explained the appearance of conflict between the two types of practices as reconcilable through acceptance of recovery-based values; Solomon and Stanhope (2004) have proposed resolution through a broadened research agenda. Most recently, Farkas, Gagne, Anthony, and Chamberlin (2005) have reconciled a recovery orientation with evidence-based practices by identifying recovery-based interpretations of key program dimensions across services.

Regardless of possibilities for reconciling a recovery approach with evidence-based practices, providers in the field may or may not have the benefit of programmatic or other means for integrating the two and may still experience the approaches as contradictory. Research demonstrates that training

can promote adoption of recovery-oriented practices (e.g., Knight et al., 2003; Moser, Deluca, Bond, & Rollins, 2004) but we know little about the nature of the stumbling blocks providers encounter in their attempt to adopt a recovery orientation. Such stumbling blocks may stem from the perceived contradiction between recovery and evidence-based approaches, such as perceived conflict between professional ethics and recovery values, but can also arise from a lack of skills for reconciling recovery practices with practical dilemmas, and conflicting directives from different administrative sources. This study aimed to extend the field's understanding of the outcomes of recovery implementation efforts by adding process information about providers' experiences during classroom-based training. Knowing what facets of a recovery orientation providers find gratifying and what they find frustrating or difficult should inform us about areas in which training curricula should be further developed, and, possibly, where our knowledge and skill base need to be expanded.

Methods

Training Sessions

The training on which this study was based consisted of sessions on recovery principles and practices given by the New York State ACT Institute as part of the core ACT training curriculum mandated by the New York State Office of Mental Health. Sessions were attended by ACT team members of all disciplines, including psychiatrists, nurses, social workers, substance abuse specialists, family psycho-education specialists, and peer counselors; a total of 212 trainees attended the sessions studied here, with between 5 and 30 trainees representing up to 18 agencies per session. Trainers included nationally-recognized experts

in recovery and illness self-management as well as local peer and non-peer experts.

Recovery training occurred in several segments of ACT team training. Core ACT training included a "recovery module" which introduced models of recovery and described practices such as Deegan's (1990) "key elements in supporting recovery." Other training sessions were devoted to 1) "recovery-centered service planning," describing methods of enacting, through service plans, the recovery principles outlined in Table 1 and to 2) WRAP planning (Copeland, 1997). We considered the two-day introduction to Wellness Management (New York State's term for the evidence-based practice of Illness Management and Recovery) (Meuser et al., 2002) to be recovery-centered, given its use of wellness goals and the collaborative, individually-chosen goal-based practices it involves. The 3- and 6-month follow-up sessions to Wellness Management in which trainees who had begun practicing Wellness Management presented their work for review were also considered recovery-based training in this study.

Data Collection

Researchers attended nineteen training sessions during the months of June to December 2004 in New York City. Observations on the 99.5 hours of training sessions devoted to basic recovery principles, recovery-centered service planning, or wellness management constitute the data for the present study. Two researchers (AB and BF) attended meetings and took detailed notes; after attending 26 hours of meetings together, they checked on the accuracy of each other's notes and refined note-taking procedures to assure consistent and thorough data recording. All research procedures were approved by the appropriate IRB Committee.

Analysis

Researchers used “interface comments” as the fundamental unit of analysis. Interface comments were defined as trainee inputs—with or without comments by trainers and other trainees—that directly challenged a recovery-based principle or practice, or reflected a need for more information about such principles and practices, or gave an example of trainee’s use of or endorsement of recovery-oriented principles and practices. Researchers used the recovery-based principles and procedures in the material presented in training sessions (see Table 1) as the defining template for determining relevance to a recovery orientation. The types of trainee inputs that defined these interface comments included spontaneous statements, answers to trainers’ questions, questions prompted by the training material, and presentations of trainees’ actual work. Overall, applying the study definition of “interface comments” to the 100 hours of observation located 205 such incidents.

Researchers began the interpretive process by identifying, using Kvale’s (1996) procedures, the themes contained in the interface comments; the wording of themes was kept close to the language of the trainees. Following Ware and her colleagues (Ware, Tugenberg, & Dickey, 2003), researchers (BF and AB) began developing categories using broad organizing constructs; the constructs chosen reflected the three basic components of service delivery: views of the service recipient, the recipient-provider relationship, and task definition. Using Atlas.ti to organize the interpretation process, researchers identified categories that were internally consistent and distinct from each other. Sharpening category definitions through an iterative comparison and contrast method, researchers identi-

TABLE 1—BASIC PRINCIPLES OF RECOVERY-CENTERED SERVICE PLANNING IN NEW YORK STATE

1. At every stage of service delivery and support, the individual’s *own stated needs, wants and goals* in their *own language* drive the nature and the development of the service plan.
2. We must very *patiently* develop an honest, trustworthy *partnership-based relationship* that is marked by “*true mutuality*” and “*shared humanity*” which fosters *recovery, respect and responsibility*.
3. Our charge is to foster and “*form a community of hope*” surrounding each individual we serve.
4. Individuals must be afforded the ability to learn from their own mistakes in a supportive atmosphere (*the dignity of risk and the right to failure*).
5. For each self-defined goal, relying on and/or helping to develop each individual’s own skills and capacities should be our first approach (e.g., wellness self-management techniques, self-advocacy).
6. Crisis planning and relapse prevention strategies should be developed as early as the relationship allows that draws upon the individual’s preferences and accounts of what has worked in the past.
7. Determining long-term goals at the outset of the relationship will assist both parties in deciding when *discharge planning* should occur.
8. We should always seek to *favor the use of natural supports* that are available or can be developed in natural community settings. These should include sources of self-help and mutual support.

fied ten interface categories. Fully 97% of interface comments fit into one or another of the ten categories.

While sorting incidents into the ten substantive categories, researchers coded the context in which the incidents arose. Coding identified incidents’ fit with recovery—whether positive, negative, or uncertain. In addition, researchers rated the type of comment, noting, for each, whether it was made in 1) presentations of actual work, 2) in spontaneous comments about any recipient, or 3) reflected general experience; and researchers coded the speaker’s stance toward recovery, that is, whether the trainee was 1) affirming the value of recovery, 2) struggling to work with a recovery idea, 3) objecting to a recovery concept or its applicability, or 4) making a comment that missed a point without the speaker’s being aware of it.

Analyses considered the types of interface comments overall and in these dif-

ferent contexts. In addition, analyses considered whether interface comments emerged 1) in introductory sessions directed toward trainees with widely varying amounts of experience with a recovery orientation, many encountering this approach for the first time, and 2) in follow-up sessions attended exclusively by trainees who had completed introductory training and had implemented—or were supposed to have implemented—wellness management or other recovery practices with specific recipients. Comments made by trainees in these follow-up sessions were based on actual experience and might be expected to have a different range of responses to a recovery orientation.

Tests for Objectivity of Data

Seeking to verify that the study’s categorization system could be objectively evaluated, researchers assessed interrater reliability. Two researchers (BF and AB) separately coded the incidents

from the transcripts of two training sessions into the ten categories. Researchers achieved 80% agreement in coding the first transcript; the reliability of their coding of the second transcript, following some refinement of category definitions, was 87%.

Assurance of validity was sought through two other procedures. One was a comparison of incidents derived from the data here with those that emerged from two days of ACT training meetings in another state. After categorizing those data into this study's ten category system, researchers found that, although the frequency of the categories of interface comments was different, the ten-category system and its code definitions worked well to describe the issues and concerns that faced ACT team members in a different part of the country.

The other validation procedure used a workshop with trainers, peers, peer-trainers, and providers as a forum for getting feedback on preliminary findings. Researchers presented descriptions of the ten categories and asked participants to indicate whether the provider comments fit with their perceptions of trainee reactions, interpret those comments, and recommend indicated training changes. Workshop participants confirmed that the interface commentary generally fit with their experiences. Their recommendations focused on the need for multiple forms of training experiences, given the limitations of classroom-based didactic methods. Much conversation considered trainees' difficulties in understanding the form of the desired recipient-provider relationship.

Results

The ten categories of interface comments formed a three-category grouping that, with one exception,

addressed the questions: 1) Who is eligible for recovery-oriented practice? 2) What is the task to be undertaken? and 3) How do we develop the necessary collaborative relationship? The exceptional category, called "Wellness Works," referred specifically to techniques in Wellness presentations.

A. Who is eligible for recovery-oriented services?

1. "Who is this wellness management for?"

Most trainees understood recovery-oriented ACT practices to be for people with dual diagnoses. A distinct concern arose among a subset of trainees, however, questioning who should be "excluded" from recovery-oriented practice—questions that implicitly suggested, contrary to recovery precepts, that factors such as substance use and illiteracy precluded the application of a recovery orientation. A prime example from the comments in this category is the quote: "Should we exclude substance abusing clients?" Trainees asking these questions expressed either disbelief about the appropriateness of recovery for certain recipients and misunderstandings of it.

2. "Client won't admit to being mentally ill."

Comments in this category described trainees' difficulties in doing recovery oriented treatment planning with recipients who wouldn't "admit" they had "a mental illness," or who did not "believe" or "take seriously" their diagnosis of mental illness. These comments suggested providers were at a loss to figure out how they could use a recovery orientation with those who did not "admit to having a mental illness." One provider posed the problem as a question: "One of the steps in recovery might be recognizing he's mentally ill?" but, by and large, comments by trainees expressed disbelief that recov-

ery could be undertaken when mental illness was not explicitly acknowledged.

3. "Crises prevent us from using recovery practices."

Comments in this category reflected the perception that "crises" prohibited the use of a recovery orientation with ACT service recipients. The recovery-based notion that evictions, hospitalizations and relapse were opportunities to incorporate recovery-oriented service planning was clearly absent: "One of the challenges we face is that all our participants are coming out of state hospitals. It's all we can do to keep them out of the hospital. That's where we're spending much of our time. These are people with acute, acute, symptoms." Another trainee said her team had "wellness on its mind all the time but couldn't often get around to it."

B. What's my task with service recipients?

Comments in this grouping described three different understandings of how to—or whether or not to—use "client-centered goals." In the first category trainees gave examples of successful work with recipients' goals; in the second, they recognized the need for recipient-directed services but struggled with implementation; in the third category, trainee comments reflected either explicit or unrecognized use of systems-derived goals instead of "client-centered" goals.

1. Working with "Client-centered" Goals

In this group of comments, trainees recognized that generation of the goals or direction of treatment planning should be in the hands of the recipient. "You don't have control over them. You must find out what the client wants." Most of these comments, whether presentations of specific individuals or

general mentions of work, reflected the trainee's stance that "recovery works." Some trainees described explicit goals: "One client's goal is to manage his anxiety, to begin to learn more about antiques..." Some emphasized the provider's role as supporting the recipient's choice by linking current behavior to future goals: "What you are doing is the opposite of your goal of becoming a psychologist."

2. Developing the Recipient's Goals

Comments in this category reflected the simultaneous recognition of the need for "client-centered" services and the perception of obstacles to executing this approach. The obstacles mentioned primarily consisted of disparities between provider and recipient definitions of appropriate goals, e.g., the need to manage risk and the perception that the recipient lacked the experience or willingness to direct the nature of their work together. In these comments, trainees, by and large, were not supplanting the goals of the recipient, but rather struggling to decide on goals, especially when the individual seemed unable to do so or had what providers saw as clinically indicated needs: "If a client decides not to take medication you have to deal with your own feelings; It's wrenching when you know how much medication will help." Many of the comments were questions: "Should we suggest a goal?" and "What if the goals are not realistic?" Comments in this cluster were varied in their fit with recovery principles and showed that providers variously believed that recovery works, believed it doesn't work, and found it hard to do.

3. "Whose Goals?"

These comments reflect a "provider knows best" attitude that largely "missed" the recovery-based notion of recipient self-determination. Trainees whose comments fell into this category

were implying that the recipient had to accept as pre-requisites what providers saw as primary, such as ADL mastery and medication compliance, before being given more choice or self-determination. In one example: "We did two sessions (of wellness management) but then the client 'fessed up and said he wasn't compliant with meds so the team moved on to medication management." This category contained the largest proportion of instances in which the trainees' comments revealed that they were unaware of the discrepancy between their views and those of a recovery orientation.

C. How Do We Develop a Collaborative Relationship with Service Recipients?

1. Making a Good Connection

Statements in this category acknowledged that it is necessary but difficult to engage ACT recipients and establish trust. These comments tended to show a positive fit with recovery, describing, for example, providers' recognition of their place in service recipients' lives: "You come as a member of a world that labels the client as mentally ill—you are already in conflict with the person." In many comments, providers described how trust could be established (e.g., by "keeping an open line" and by respecting boundaries around recipients' space). A subset of comments, however, showed providers preoccupied with recipients' delusions, worrying about harming them by "joining," or "reinforcing," or "feeding into" delusions, or worrying about breaking the alliance: "if you speak honestly [about delusions] do you jeopardize the engagement?"

2. "Who—recipient or provider—should do what?"

These comments addressed the relationship between the provider and the recipient in terms of "who does what"

and relate substantially to issues of power. A slim majority of these comments reflected the providers' conviction that "recovery works," such as comments that acknowledged the balance of power that exists between recipient and provider: "The client comes as an expert on himself," "The responsibility is on the client to take their meds." One provider described his pre-recovery orientation practice by saying: "I was keeping them in bondage." Another asked, "Isn't it unacceptable that someone should get hurt in your care?" The fit between recovery principles and the comments in this category was mixed. The negative comments in this category generally referred to obstacles generated by recipients' seeming inability or unwillingness to accept more power in the relationship, e.g., "We become mother and he sees us as mother," and "These are people who have had everything sucked out of them. They're working at a deficit. We are trying to fill them up."

3. Symptom Dominant vs. Holistic Views of the Recipient

These comments reflected a range of views of recipients and the change process, ranging from a recovery oriented view—holistic, contextual, hopeful—to a symptom focused view, relying on a medical model in which diagnosis is presumed to determine behavior. The preponderance of comments in this category were holistic in nature and included comments like: "...introducing some of these [recovery] ideas while they're still in the shelter shows there is something beyond housing," "Depression is often situational, maybe she'll get out of it," and "Take the time to listen to the client. Diagnosis is not informative." Alternately, a "symptoms dominate" view emerged in comments that revealed providers' views of each service recipient as a set of disabilities which

are understood to set limits on what he or she will be able to do, for example, *“He’s manipulative, doesn’t show up, he’s almost borderline”* and *“His insight is poor.”*

D. Wellness Works

This category consists of trainees’ reports of instances in which they used or planned to use the specific tools presented in the Wellness Management training program, such as role playing, journaling, and relaxation and stress management techniques. In the interface incidents in this category, providers reported, *“wellness works,” “it’s great,” “she’s made great progress”* and described changes in their recipients which were positive for them: e.g., going back to school, getting a job, going to a clubhouse, and making friends. Virtually all comments here reflected a positive fit with recovery. The emotional tone of providers’ comments suggested that providers were enjoying the process of utilizing wellness: *“[It] gives the provider something to do with the client”* and *“I like the way wellness helps us to be proactive...work in advance of problems.”*

Follow-up Session Comments

Comparing the commentary of trainees who were reporting on their work with recipients in follow-up sessions with the commentary that emerged in introductory sessions showed several shifts in the relative incidence of comments in three categories. Comments about “who is eligible” were completely absent from the follow-up sessions, probably because the question of eligibility had been answered by the time of follow-up, at least in those examples that trainees chose to present. Concerns about crises, in contrast, appeared only in follow-up sessions with trainees; these comments were largely offered as explanations for why trainees hadn’t been able to initiate recovery-oriented practices with their re-

cipients. Also more prevalent at follow-up (as a percentage of total recovery-relevant statements) were concerns about making and keeping a connection with recipients, with special concern about how to deal with delusional symptoms.

Several categories which had been uniformly positive in their fit with recovery in introductory sessions were more mixed in follow-up where trainees were presenting actual work. Categories that were, in follow-up sessions, less positive in their relationship to recovery and indicative of more struggling on the part of the trainee involved the recipient-provider relationship: comments about keeping the connection with recipients and establishing a mutually acceptable division of labor showed these tasks to be more problematic for those describing actual individuals than for those in introductory training sessions.

Discussion

The current study attempted to extend our knowledge of the impact of training by observing trainees as they sat in training sessions, listening and reacting to presentations of the principles and practices of recovery-oriented practice. A majority of the trainees’ comments fit positively with recovery. The most consistently positive were in trainees’ accounts of their work with participants’ goals using wellness and other strategies and in their descriptions of recipients in holistic terms, that is, in terms of their talents, strengths, and social and emotional concerns. Adopting a “client-centered” definition of the work to be done seems to necessarily invoke a view of recipients that transcends symptoms: when providers undertake to learn what individuals want they concurrently learn about them as whole people. In their comments about working with re-

cipients’ goals, trainees revealed an attitudinal stance and emotional tone suggesting a thorough conversion: the sentiment “It works!” was typical. And these sentiments were even more pronounced among providers reporting on their actual use of the new techniques.

Trainees’ comments about their relationships with recipients reflected more struggle. Most types of relationship difficulties that trainees described reflected their lack of knowledge about how to proceed rather than a rejection or misunderstanding of the desired type of relationships. In speaking about the specific difficulty of developing a working relationship with people who deny having a mental illness, trainees’ stance toward recovery was either discouraged or, in a few cases, oppositional. Denial of illness seemed to rob some providers of a foundation for defining their relationship to recipients, leaving these providers without an alternative basis for connection. Solomon and Stanhope (2004), observing that recovery principles can be complementary to evidence-based practices, in part, by focusing on process rather than structure, note that practice manuals give no guidance about how providers should interact with the consumers in the ACT service environment. Training in this study appeared to have successfully conveyed the value of a power-sharing relationship between provider and recipient. Where trainees did encounter relationship difficulties, their comments suggested the need for tools for developing recovery-oriented recipient-provider relationships, thus indicating an important arena for supervisory follow-up and subsequent on-site training.

One subset of trainees did seem unable to make the fundamental conceptual and value-based shift that providers needed to work exclusively with recipients’ goals; foregoing their

own notions about the primacy of medication compliance and ADL improvement proved difficult for this set of trainees which included providers actively attempting to work in a recovery model. Morrison (2004) surmised that, for providers whose own professional ethics require that they assume responsibility for service recipients, a recovery orientation asks them to abandon an important foundation for their work. Although some workers may use the claim that adopting a recovery orientation violates their ethics as a cover for a more basic difficulty with power sharing (Morrison, 2004), training may need to offer providers explicit help in reconciling the values of a recovery orientation with those they've acquired elsewhere in their professional lives.

Unresolved controversies about the place of a recovery orientation in preferred practices and contradictory messages in the field about specific techniques create challenges for training. In this study, some providers could not overcome the notion that recipient crises prohibited recovery-oriented work, echoing Moser et al.'s (2004) trainees' claim that their "clients are too sick for this model." This blind spot undoubtedly reflects the controversy in the field about whether recovery is, in fact, suitable for the most seriously disabled (Fisher & Ahern, 2002; e.g., Munetz & Frese, 2001) and the concomitant lacuna in training around this issue. Recovery-oriented training must provide more detailed illustrations of how providers can convey hope (e.g., Deegan, 1988) to recipients in the process of being institutionalized or caught in a psychotic episode or otherwise "in crisis" if the conflict about who is eligible for a recovery approach is to be fully resolved.

Providers receive similarly mixed messages from the professional mental

health community about medication. Trainees learn that medication compliance is a "system-determined goal," not an acceptably "client-defined goal," but increasing numbers of adults are required by outpatient commitment laws to take medication. Amidst these contradictory messages, the place of recipient preferences in medication use becomes ambiguous. As the field develops clearer directions for reconciling evidence-based practices with a recovery model, training material and supervision will increasingly help providers negotiate the opposing directives they receive.

Classroom-based training is simply the first step in implementing new practices, with successful training known to require multi-faceted presentations of new information, followed by supervision, follow-up training, and continued feedback to ensure continued adherence to the new practice (e.g., Moser et al., 2004). The questions of why and how the processes of adopting or of being stymied by recovery-oriented practices get put into motion have not been fully answered by this study. The study is cross-sectional and does not locate changes in providers' actual work as they proceed with a recovery orientation. And the trainees studied represent a population of unknown parameters and, in the follow-up sessions, may be biased toward self-selection of those with positive views as providers with successful experiences may have been more likely to show up at training sessions and/or talk. But this study supports and complements other evidence that classroom-based training successfully initiates the process of providers' adoption of a recovery orientation (Knight et al., 2003; Way, Stone, Schwager, Wagoner, & Bassman, 2002). In this study's descriptions of what providers find difficult and/or gratifying, or misunderstand altogether,

we have clues about the issues to which trainers, supervisors, policy makers, and practitioners might fruitfully pay attention. Particularly where providers lack skills—as in developing collaborative recipient-provider relationships and in utilizing recovery notions at points of "crisis"—those charged with implementing a recovery orientation must bolster training and, where necessary, help widen our knowledge base around practicing in a recovery mode.

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