



Te Kaitiaki Oranga  
**MentalHealth**  
**COMMISSION**

October

2011

## Recovery meanings and measures

A scan of the literature

## **Abbreviations used in this document**

DHB	district health board
IROSS	Indicators of Recovery-Oriented Service System
ROSE	Recovery-Oriented Services Evaluation
ROSI	Recovery-Oriented System Indicators Measures
RSA	Recovery Self-Assessment
SIRI	South Island of New Zealand Recovery Indicator Draft
SRI	Scottish Recovery Indicator

Prepared for the Mental Health Commission by Case consulting Ltd

October 2011

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PO Box 12479, Wellington, New Zealand

ISBN 978-0-478-29235-0

This document is available on the Mental Health Commission's website:  
<http://www.mhc.govt.nz>



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# 1 Introduction

In its Statement of Intent 2009-2012 the Mental Health Commission (the Commission) identified that one of its 2009/10 projects would be to develop a 'DHB Recovery Report Card'. In the first year views of services user, family and professional groups were to be incorporated into the development of a recovery report card. The card was to be piloted in 2010/11 and implemented in 2011/12.

This report is part of the initial work to clarify the concept of recovery and describe different systemic recovery measures.

We hope it is a useful resource for those working in mental health and addiction to help them clarify the concept of recovery and give them ideas of how to ensure that the services they provide are focussed on recovery.

## 2 The evolving concept of recovery

### 2.1 Ordinary usage

In ordinary English usage, the term 'recovery' is most commonly used in relation to health or the economy. It is either expressed as:

- an outcome – a retrieval or a return to a better or former state
- a process – the act of retrieving, returning or improving.

The online dictionary.com defines recovery in the following ways:

- An act of recovering.
- The regaining of or possibility of regaining something lost or taken away.
- Restoration or return to health from sickness.
- Restoration or return to any former and better state or condition.
- Time required for recovering.
- Something that is gained in recovering.
- An improvement in the economy marking the end of a recession or decline.
- The regaining of substances in usable form, as from refuse material or waste products.
- (*Law*) The obtaining of right to something by verdict or judgment of a court of law.
- (*Football*) An act or instance of recovering a fumble.
- (*Fencing*) The movement to the position of guard after a lunge.
- (*Rowing*) A return to a former position for making the next stroke.

### 2.2 A brief history of 'recovery' in addictions and mental health

In medical language, 'recovery' is used to mean a return to a former state of health after an illness, and it has been traditionally used this way in mental health for people who were expected to get better, usually with the higher prevalence milder mental illnesses. However, the advent of the asylum era in the late 18th century, was associated with moral treatment – an approach that emphasised optimism, psychological interventions, the minimisation of coercion and comfortable, healthy environments for people with serious mental health problems (Tuke, 1813; Jacobson 2004). Hope for recovery was high in the early asylums, and some reported a recovery rate of around 50 percent (Jacobson, 2004). The early asylums defined recovery, in the traditional medical sense, as the abatement of symptoms. By the beginning of the 20th century, the asylums were overcrowded, and initial work on the formal classification of mental disorders by Kraepelin and Bleuler suggested a deteriorating course in people diagnosed with schizophrenia (Ralph & Corrigan, 2006). The early idealism gave way to pessimism about recovery that lasted well into the 20th century.

During the 20th century, however, the term 'recovery; in the area of mental health and wellbeing expanded its meaning beyond clinical recovery or the abatement of symptoms. A generic recovery or self-help movement centred in North America developed over the 20th century. One of its earliest and most lasting manifestations was the 12-step groups for people with addictions, starting with Alcoholics Anonymous in 1937. These 12-step groups provide "a program designed to assist in the recovery from addiction or compulsive behavior, especially a spiritually-oriented

program based on the principles of acknowledging one's personal insufficiency and accepting help from a higher power" ([www.answers.com/topic/twelve-step](http://www.answers.com/topic/twelve-step)).

In the late 20th century, the notion of recovery re-entered the mental health arena. Several longitudinal studies completed in the 1970s and 80s reported that a majority of people with a diagnosis of schizophrenia experienced partial or full recovery in the clinical sense (Harding, 1988; Koehler, 2006). But the psychiatric rehabilitation and the user/survivor movement gave recovery new meanings in the late 1980s and the 1990s. Unlike clinical understandings, recovery did not necessarily mean an abatement of symptoms but a renewed sense of self and the self-directed return to a meaningful life (Deegan, 1988; Anthony, 1993; Davidson, O'Connell, Tondora, Staeheli & Evans, n.d.). This marked a distinction between clinical recovery and personal recovery that has not always been understood by mental health practitioners (Slade, 2009).

Psychiatric rehabilitation and the user/survivor movement, however, tend to emphasise different elements within their shared fundamental understanding of personal recovery (O'Hagan, 2008, 2009; Wikipedia, 2010). Psychiatric rehabilitation is not a term in common use in New Zealand but its purpose is to assist people overcome their functional limitations. Although the professional groups that practice psychiatric rehabilitation claim to be more multidimensional and optimistic than their acute services colleagues in mental health, their practice is grounded upon the personal deficits of people with a diagnosis (Ralph & Corrigan, 2006, p.26). The user/survivor movement on the other hand, is grounded on the notion of self-determination. Consequently the recovery literature coming out of the user/survivor movement is more likely to question the basic drivers of the mental health system such as the concept of mental illness, compulsory treatment and deficits thinking (Slade, 2009; O'Hagan, 2008, 2009). If anything, user and survivor literature on recovery tends to focus on the deficits external to the individual with a diagnosis, in services and in wider society, more than in the individual themselves. As a result, user/survivor literature has been quick to acknowledge the environmental barriers and contributors to recovery (O'Hagan, 2002; Onken, Dumont, Ridgway, Dorman & Ralph, 2002; Wallcraft, n.d.).

The user/survivor movement has been deeply influenced by the social model of disability that has come out of the disability movement. The social model asserts that it is society that disables, not the impairments of individuals; it is society that doesn't accommodate the diverse needs of disabled people to allow them physical and social access to the opportunities others take for granted (Oliver, 1990). The social model has obvious resonance with recovery.

These differences in emphasis have added complexity to the meaning of recovery in mental health (Jacobson & Greenley, 2001; Davidson et al., n.d.). The traditional medical professional view of recovery is the abatement of symptoms. Psychiatric rehabilitation views recovery at least in part as an improvement in functioning but also recognises the renewed sense of self and the self-directed return to a meaningful life, as does the user/survivor movement. But the user/survivor movement also emphasises freedom from multiple oppressions in its understanding of recovery. These different emphases need not always be seen as a source of tension and can be regarded as complementary.

Recovery is not universally accepted as a term or as an underlying concept. Service users have objected to the term with statements like:

- “Recovery takes you back to where you were, but my experience transformed me.”
- “I’ll always have mental health problems so I’ll never recover.”
- “I don’t believe I had an illness but recovery implies I did have one.”
- “I don’t see my madness as undesirable, so what is it I need to recover from?”
- “To recover means to cover up again, but I don’t want to cover up my distress.” (O’Hagan, 2002)

Some population groups, particularly children and young people, do not like the term (Friesen, 2005). Other people have had concerns about recovery that go deeper than semantics – that recovery is an import from America and that it has been overtaken by professionals (Wallcraft, n.d.). Some mental health professionals have described recovery as ‘esoteric nonsense and lacking an evidence base’ (Davidson, O’Connell, Tondora, Styron & Kangas, 2006).



### **3 The current meanings of recovery**

The initial literature on recovery in mental health focused on personal recovery (Deegan, 1988), but the recognition that recovery happens in a context led to a broadening of the literature, which subsequently began to define recovery-based services and systems and recovery-friendly societies (Anthony, 1993).

#### **3.1 Clinical recovery**

Clinical recovery is the abatement of symptoms and improvement in functioning. Clinical recovery is an objective outcome-oriented view of recovery that tends to view the individual in terms of their pathology, as passive recipients and in isolation from their context (Frese, Stanley, Kress & Vogel-Scibilia, 2001). This meaning of recovery is too narrow to encompass the recovery approach.

#### **3.2 Personal recovery**

Personal recovery is a person's renewed sense of self and the self-directed return to a meaningful life, which may or may not include the abatement of symptoms. It is a more subjective process-oriented view of recovery than clinical recovery. It views the individual as possessing strengths, as an active agent and in relation to their whole known context (Frese et al., 2001; Slade, 2009). Some of the better known definitions of recovery bear this out:

Recovery is happening when people can live well in the presence or absence of mental illness. (Mental Health Commission, 1998)

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, regroup again... The need is to meet the challenge of the disability and to re-establish a new and valued sense of integrity and 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 (Deegan, 1988, p.15).

Recovery is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness (Anthony, 1993).

...mental health recovery was defined as an ongoing dynamic interactional process between a person's strengths, vulnerabilities, resources and the environment involving a personal journey of actively self-managing psychiatric disorder while reclaiming, gaining and maintaining a positive sense of self, roles and life beyond the mental health system (in spite of the challenge of psychiatric disability) (Onken et al., 2002, p.2–3).

In people's accounts of personal recovery (Tooth, Kalyanansundaram & Glover, 1997; Lapsley, Nikora & Black, 2002; Onken et al., 2002) hope is of overarching importance. People also talk about the importance of:

- self-esteem, including emotional growth, confidence and living without internalised stigma
- resourcefulness, including personal determination, self-management, learning and making choices
- relationships that are respectful, strengths-based, supportive and reciprocal
- income to cover basic living needs, housing and transport
- activity, such as work, education or leisure
- transitions, such as making life changes to one's identity, personal circumstances or place.

The concept of personal recovery has much broader implications for the role of individuals, services and society than clinical recovery. It implies the need for self-direction and a broad range of services, resources and opportunities for people to facilitate their return to a meaningful life.

### **3.3 Recovery-based services and systems**

In response to the call for services to facilitate personal recovery rather than just clinical recovery, various attempts have been made to define a recovery-based service system. Recovery is central to mental health policy in all the English-speaking countries. A comparative analysis of policy directions in seven countries (New Zealand, Australia, Canada, England, Scotland, USA and Italy) notes a good deal of convergence in their priorities (Compagni, Adams & Daniels, 2006):

- Making the promotion of wellbeing and anti-discrimination a public priority.
- Improving access and enhancing the range of services.
- Ensuring an adequate, competent and skilled workforce.
- Focusing on service user participation, responsiveness and recovery.
- Integrating and linking health and social sectors.
- Promoting evidence-based, measurable and accountable responses.

The literature on systemic responses to the recovery philosophy has evolved since the early 1990s (Anthony, 1993; Jacobson and Curtis, 2000; Happell, 2008a,b). Recent vision statements on the future of mental health from New Zealand (Mental Health Commission, 2007; Mental Health Advocacy Coalition, 2008) and Britain (The Future Vision Coalition, 2008) stress the need for a recognition of the social and economic determinants and consequences of mental health problems and an investment in a broad range of integrated responses that address these determinants and consequences, including

- a whole-of-government commitment to wellbeing promotion, prevention, early intervention and anti-discrimination
- holistic responses for people with mental illness that provide them with the support and opportunities to be self-directed, regain meaning in their lives and take on valued roles in the community – these responses include service navigation, talking therapies, drug therapies, peer support, recovery education, support in crisis, support in housing, support in education and employment, and advocacy.

### **3.4 Recovery-friendly societies**

In order for people to achieve personal recovery and for recovery-based services to facilitate meaning and valued roles, discrimination against people with a diagnosis of mental illness needs be reduced. People with a diagnosis often come up against social barriers to full participation that hinder their recovery, particularly in families, social networks, housing, education, employment, financial services and citizen engagement. The above descriptions of recovery-oriented systems include anti-discrimination and social inclusion programmes. In the last 15 years, several countries have launched anti-discrimination campaigns, such as Like Minds, Like Mine in New Zealand, See Me in Scotland and Time to Change in England. Mental health services are also developing social inclusion programmes that are conceptually and practically linked to recovery (Repper & Perkins, 2003; South London and Maudsley Mental Health NHS Trust, 2007; South West London and St George's Mental Health NHS Trust, 2007; Wallcraft, n.d.).

## 4 Recovery and different populations

### 4.1 Recovery and addiction

It has been argued that recovery in mental health and addiction are essentially the same process (Davidson & White, 2007) – a process where people regain control of their lives that have been controlled by their condition or other people’s responses to it. People in recovery from addictions, especially those influenced by 12-step approaches, are likely to focus on overcoming their addiction rather than others’ responses to it. In contrast, the user/survivor movement in mental health has focused at least in part on overcoming other people’s responses through its advocacy on forced treatment and discrimination (for example, Borchard, 2010). Personal recovery and harm reduction in addictions have in common the notion that people can live well in the presence of some of their symptoms or addictions (Davidson & White, 2007). Abstinence and harm reduction are both considered relevant to recovery (Ministry of Health, 2010a).

### 4.2 Recovery and Māori – whānau ora

Whānau ora has evolved as a concept. It was first mentioned in official documents as the overall aim of Māori health policy and was defined as, “Māori families supported to achieve their maximum health and wellbeing” (Ministry of Health, 2002). It is now the name given to a new government programme for multi-agency service provision to whānau, delivered in partnership with them, with the aim of strengthening their capabilities. Recovery comes from a western individualistic perspective, whereas whānau ora is grounded in the collective perspective. However, whānau ora resonates closely with elements of recovery, with its focus on whānau strengths and aspirations, working in partnership with whānau and offering whānau a broad range of integrated services (Durie, Cooper, Grennel, Snively & Tuaine, 2010). Whānau ora could be viewed as an expression of a recovery approach for Māori.

Te whare tapa whā model of health, commonly used to explain the Māori concept of health to non-Māori, uses the metaphor of four walls of a house to illustrate the interrelated dimensions of holistic health:

- Taha tinana (the physical domain)
- Taha hinengaro (the domain of thoughts and feelings)
- Taha whānau (the social domain)
- Taha wairua (the sacred or spiritual domain).

This model, and other similar models such as Te Wheke (Ministry of Health, 2010b), resonate well with the recognition of multiple determinants and consequences of mental health problems inherent in the recovery approach.

### 4.3 Recovery and Asian people

Asians are the fastest growing immigrant group in New Zealand (Ho, Au, Bedford & Cooper, 2003). A paper on Asian people and recovery (Yee, 2003) depicts them as an extremely diverse group who nevertheless share a collectivist rather than an individualist world view.

An Asian recovery approach means “additional attention being paid to family connectedness and spirituality and less emphasis on independence and personal responsibility” (Yee, 2003, pp.4–5).

#### **4.4 Recovery and Pacific people**

There is very little literature on what recovery means for Pacific people though it appears that Pacific people, like Māori and Asian people have a more collectivist than individualistic view of recovery. “The family is a key concept in Pacific Island cultures... this is why families can have such a large impact on recovery” (Malo, 2000, pp.8–9). The popao model of recovery and strengths has been proposed by two Tongan writers (Fotu & Tafa, 2009). The popao is an outrigger canoe and serves as a metaphor for the recovery journey. The objectives of the popao model are to strengthen the connection to people’s cultural heritage, to provide an encouraging environment where people can connect to their family and community and to allow people to increase their self-esteem and skills.

The fonofale model of health is a Pacific model of health, similar to te whare tapa whā model. This model also resonates well with the recovery approach.

#### **4.5 Recovery and children and youth – resilience**

Mental health services for children and youth often prefer to use the term ‘resilience’ instead of recovery. Resilience has been defined as “a dynamic process encompassing positive adaptation within the context of significant adversity” (Friesen, 2005). Child and youth services have a different history and identity to adult services, and they serve a broader population than those served by adult mental health services, which focus on people diagnosed with so-called serious mental illness.

Some believe that recovery, as in returning to a former state, is not a suitable concept for the developmental stages of children and youth. Others question the meaning of the individualism and self-determination of the recovery approach when it comes to children and their families (Friesen, 2007). Despite these objections, resilience and recovery are largely overlapping, compatible concepts. In a consultation with children, youth and their families in the United States, “the aspects of recovery which sparked the most interest and excitement were the hope, optimism and positive orientation to the future...” (Friesen, 2005).

#### **4.6 Recovery and older people**

Very little attention has been given to the meaning or application of recovery for older people, either with a diagnosis of mental illness or with dementia. Recovery concepts can and should be applied to older people (Read & Sole, n.d.). Although people in the later stages of dementia may not be able to experience personal recovery in the sense of “a renewed sense of self and the self-directed return to a meaningful life”, there needs to be consideration of the elements of recovery that are relevant to this group. No literature on recovery for people with-late stage dementia could be identified.

## **4.7 Recovery and forensic service users**

There is very little literature on recovery in the institutional forensic setting, although a book has recently been published (Alred & Drennan, 2010). Achieving the standards of a recovery-based service is a challenge in a place of detention and compulsory treatment. The physical security and the institutional environment can strip people of their independence, autonomy and valued social roles, despite valiant efforts to minimise these consequences. Despite these challenges and perhaps because of them, a recovery approach is vital for forensic service users to minimise the limitations imposed by detention and compulsion and prepare people for life beyond these restrictions (Mental Health Commission, 2000).

## **4.8 Recovery and disability**

The social model of disability has resonance with the recovery philosophy because it locates at least some of the barriers to a meaningful life outside the individual, in society. But people with intellectual, sensory or physical disabilities do not use the concept of recovery in relation to these impairments. They are often fixed ways of being, unlike mental health problems and addictions that fluctuate and may eventually dissipate.

## **4.9 A universal philosophy**

Recovery is a philosophy, not a specific model of practice. Its cornerstones are self-determination, a broad range of responses and a return to socially valued roles. Some models of practice fit the recovery philosophy well, such as the strengths model (Rapp, 1998), the tidal model (Barker & Buchanan-Barker, 2005), WRAP (Copeland, 1997) and intentional peer support (Mead, 2005), though these could be delivered in a way that is not true to their values and does not fit the recovery philosophy. Recovery is a large enough concept to accommodate the needs and world views of different populations, such as resilience for children and youth, whānau ora for Māori and recovery from addictions. Implementing the recovery philosophy is a challenge for some populations such as people in an acute crisis, people with dementia and people in locked forensic services, but it is applicable to everyone within the constraints that cannot be changed. Nevertheless, recovery as a concept has been dominated by working-age white people. Although its principles are universal, they need to be adapted for different population groups. These adaptations, in turn, can enrich the discourse and understanding of recovery for all populations.

## 5 Recovery measures

Various attempts have been made to measure recovery (Campbell-Orde, Chamberlin, Carpenter & Leff, 2005). These measures need to be contrasted with measures of clinical recovery such as the Health of the Nations Outcome Scale (HONOS) (Royal College of Psychiatrists, 2010) in use in New Zealand and other countries. HONOS measures clinical recovery.

Recovery measures generally fall into three categories:

- Individual and family measures where individuals rate their own recovery.
- Provider measures where providers or others rate their performance in providing a recovery-based service.
- Systemic measures where managers or evaluators rate service statistics or trends that indicate the services provided are recovery-oriented for service users.

### 5.1 Systemic recovery indicator tools

Systemic recovery indicator tools measure aspects of the systems that are believed to correlate with recovery. The literature search did not locate any systemic outcomes tools but it did locate six sets of systemic recovery indicator tools:

#### **IROSS**

Indicators of Recovery-Oriented Service System (Pennsylvania Department of Public Welfare, Office of Mental Health and Substance Abuse Services, 2005).

#### **ROSE**

Recovery-Oriented Services Evaluation (American Association of Community Psychiatrists, 2009).

#### **ROSI**

Recovery-Oriented System Indicators Measures (Dumont et al., 2005).

#### **RSA**

Recovery Self-Assessment (O'Connell et al, 2005).

#### **SIRI**

South Island of New Zealand Recovery Indicator Draft (South Island Shared Services Agency, 2010).

#### **SRI**

Scottish Recovery Indicator (Scottish Recovery Network, 2007).

Further information on the tools (descriptions, domains and testing) can be found in Appendix 1.

As expected, the indicators in the tools reflected the literature on recovery-based systems, and there was much overlap in the indicators used in each of the tools.

Domains 1 to 10 are shared by a majority of the systemic recovery indicator tools:

Domains	IROSS	ROSE	ROSI	RSA	SIRI	SRI
1. Access to a broad range of services	x	x	x	x	x	x
2. Individual service user participation	x	x	x	x	x	x
3. Systemic/service level service user participation	x	x	x	x	x	x
4. Employment of service users in mental health services	x	x	x	x	x	x
5. Staff training on recovery	x	x	x	x	x	x
6. Advance directives and crisis planning	x	x	x		x	x
7. Minimisation of coercion or its effects	x	x	x		x	x
8. Family support, education and participation	x	x		x	x	x
9. Cultural responsiveness		x	x	x	x	
10. Information for service users	x	x			x	x
11. Recovery-oriented mission statement		x	x			
12. Service user access to clinical files		x		x		
13. Welcoming processes		x		x		
14. Reduction of discrimination in community	x					
15. Right to change clinician/worker				x		
16. High staff to client ratio			x			
17. Service user-led evaluation				x		

## 5.2 Further details on the top 10 domains

### 1. Access to a broad range of services

All the tools mentioned a broad or comprehensive range of services as a recovery indicator. Some also specified what those services are:

Domains (range of services)	IROSS	ROSE	ROSI	RSA	SIRI	SRI
Peer-run initiatives	x	x	x	x		x
Employment	x	x		x	x	x
Integrated MH/AOD services	x	x			x	x
Trauma/abuse services	x		x	x		x
Talking therapies	x			x	x	x
Recovery education – service users	x			x	x	x
Physical healthcare	x			x	x	x
Housing	x	x			x	x
Drug therapy	x				x	x
Basic material needs	x				x	x
Jail diversion services	x		x			
Alternatives to hospital	x					

### 2. Individual service user participation

The different tools emphasised the strengths approach and involving service users in their own assessments and recovery plans. The plans need to be holistic and based on the individual's aspirations. A collaborative process needs to be used, and the individual should be the author of their own plan. Plans should have an exit strategy, and there should be variation across recovery plans.



### **3. Systemic/service level service user participation**

Service users need to be actively involved at governance and management levels and in planning, funding, delivery and evaluation. They need to be paid for their involvement, and their input needs to lead to demonstrable change.

### **4. Employment of service users in mental health services**

Mental health services should have targets for the percentage of the workforce who have lived experience of mental health problems. They can be employed in either traditional roles or roles specifically for service users. They need equal pay and responsibilities to employees without lived experience.

### **5. Staff training on recovery**

All staff need routine training on recovery that is delivered or co-delivered by people with lived experience. The training needs to reflect lived experience. Staff also need routine recovery supervision.

### **6. Advance directives and crisis planning**

All people using the service should be offered the opportunity to create a plan to prevent and deal with relapse. This includes advance directives that, in New Zealand law, indicate the treatments a person consents to or doesn't consent to if they are unable to communicate their wishes. Crisis planning has a broader application, beyond just treatment consent. Both are necessary. Relapse prevention strategies also need to be blended into crisis planning.

### **7. Minimisation of coercion and its effects**

Inpatient treatment orders and community treatment orders need to be minimised, and people under these orders need the maximum possible input into their treatment. Seclusion and restraint also need to be minimised, and people involved in these events need debriefing.

### **8. Family support, education and participation**

Families need peer support and education. They also need to be involved in the assessment and recovery planning of their family member and at the systemic and service levels.

### **9. Cultural responsiveness**

Culture is defined broadly beyond just one's ethnic group to lifestyle groups such as gay and lesbian people. Staff should be culturally competent, and it is an advantage if the ethnic/lifestyle mix of the staff roughly matches that of the service user population they are serving.

### **10. Information for service users**

Service users need information on available treatments, services and community resources and opportunities. They also need information on their rights.

## **5.3 Discussion on the indicator tools**

An example of each tool, on its coverage of peer support (as one of the broader range of services), is in the appendix.

These examples show considerable variation between the tools, which may offer a useful guide to developing a DHB tool:

- Variation in the formats – ROSE, RSA and SRI grade responses into Likert scales.
- Variation in the levels of the system the tool is aimed at – IROSS and ROSI are the highest-level tools.
- Variation in the detail required to complete the tools – IROSS and ROSI require the most detail.
- Variation in the level or type of evidence required – IROSS, ROSI and SRI require quantitative evidence.

Another useful guide may be the SMART acronym. The recovery indicators need to be:

- specific enough to measure
- measurable through current information collection systems
- achievable or partially achievable for DHBs
- relevant to recovery and to current policy directions, plans and standards
- timely to the current or emerging environment.

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# Appendix 1: Information on the systemic tools

## IROSS

**Full name:** Indicators of Recovery-Orientated Service System

**Author/s:** Pennsylvania Department of Public Welfare – Office of Mental Health and Substance Abuse Services

**Available from:**

[http://www.paproviders.org/Pages/MH\\_Archive/Call\\_for\\_Change\\_110505.pdf](http://www.paproviders.org/Pages/MH_Archive/Call_for_Change_110505.pdf) (pp.36–53)

**Description:** IROSS has three versions of the indicators for service users, services and systems. The service version has 106 items, and the others have a similar number. There is no response facility. It describes recovery indicators followed by the ways the indicators can be demonstrated at the individual, service and system levels.

**Domains:**

- Validated personhood
- Person-centred decision-making and choice
- Connection – community integration, social relationships
- Basic life resources
- Self-care, wellness and meaning
- Rights and informed consent
- Peer support and self-help
- Participation, voice, governance and advocacy
- Treatment services
- Worker availability, attitude and competency
- Addressing coercive practices
- Outcome evaluation and accountability

**Testing:** IROSS is a preliminary set of indicators taken from focus group information and other sets of recovery indicators and intended for discussion and further development. The tool had not been tested or used at the time of publication.

## ROSE

**Full name:** Recovery-Orientated Services Evaluation

**Author/s:** American Association of Community Psychiatrists

**Available from:** <http://www.comm.psych.pitt.edu/finds/AACPROSEIII.pdf>

**Description:** ROSE comprises of 46 statements that are ranked on a Likert scale with a 1 to 5 agreement response from 'strongly agree' to 'strongly disagree' and can be filled in by any stakeholders.



**Domains:**

- Administration (management)
- Treatment
- Supports
- Organisational culture

**Testing:** As at 2005, ROSE had not been formally tested. No subsequent literature on ROSE could be found.

**ROSI**

**Full name:** Recovery Orientated System Indicators

**Author/s:** J.M. Dumont, P. Ridgway, S.J. Onken, D.H. Dornan & R.O. Ralph

**Available from:** [www.power2u.org/downloads/pn-55.pdf](http://www.power2u.org/downloads/pn-55.pdf) (pp. 81–90, 229–243)

**Description:** ROSI has two versions – one for service users and one for system-level administrators or managers. The service user version has 42 statements, written in the first person, which are ranked on a Likert scale with a 1 to 5 agreement response from ‘strongly agree’ to ‘strongly disagree’. The administrator version has 16 performance indicators, which are converted into quantitative information requests for system-level administrators, then for service-level administrators.

**Domains:**

Service user version:

- Decision-making and choice
- Self-care and wellness
- Basic life resources
- Meaningful activities and roles
- Peer advocacy
- Staff treatment knowledge
- Access

Administrator (system) version:

- Peer support
- Choice
- Staffing ratios
- System culture and orientation
- Consumer inclusion in governance
- Coercion

**Testing:** As at 2005, ROSI had face validity (items were derived from extensive literature and focus groups) but no others types of validity had been tested. Tests for reliability were waiting for funding. A search for subsequent literature on testing yielded nothing.

## RSA

**Full name:** Recovery Self Assessment

**Author/s:** M. O'Connell, J. Tondora, G. Crog, A. Evans & L. Davidson

**Available from:** <http://www.ct.gov/dmhas/LIB/dmhas/Recovery/RSAprovider.pdf>  
(original version only). An update of RSA, named RSA-R has just been released and is available in Appendix 5. It is not available to download at this stage.

**Description:** RSA has four versions of the measure for services users, families/advocates, staff and CEOs. It has 36 statements written in the first person (only for the service user version). which are ranked on a Likert scale with a 1 to 5 agreement response from 'strongly agree' to 'strongly disagree'.

### Domains:

- Life goals
- Involvement
- Diversity of treatment options
- Choice
- Individually tailored services

**Testing:** As at 2005, RSA had been field tested, had face validity (items were derived from extensive literature and focus groups) and had been tested for internal consistency (where similar items come up with similar ratings). It had not been tested for inter-rater reliability (the degree of agreement between raters). Further testing was planned, but details of this testing could not be found. Since 2005, a revised version of RSA has been developed.

## SIRI

**Full name:** South Island of New Zealand Recovery Indicator Draft

**Author/s:** South Island Shared Services Agency, 2010

**Available from:** <http://www.sissal.govt.nz/sissalinternal/contactus.htm>

**Description:** Modelled on Scottish Recovery Indicator (see below). A measure on cultural relevance has been added to the domain on meeting basic needs.

## SRI

**Full name:** Scottish Recovery Indicator

**Author/s:** Scottish Recovery Network

**Available from:** <http://www.scottishrecoveryindicator.net>

**Description:** SRI has one version of the measure that can be filled in by any stakeholders. It has 20 statements that set a standard and are ranked on a 1 to 5

scale, each describing the degree to which the standard is being met. The SRI is based on ROPI (Recovery Oriented Practices Index, developed in New York).

**Domains:**

- Meeting basic needs
- Personalisation and choice
- Strengths-based approach
- Comprehensive service
- Service user involvement/participation
- Involving support networks and promoting social inclusion and community integration
- Service user control and active participation even when subject to compulsion
- Recovery focus

**Testing:** SRI has been evaluated. The main findings were:

- it has good potential to influence change
- the level of detail in the tool enabled people to pinpoint where change is needed
- it was time-consuming to fill in, and the scoring processes were a little confusing
- it requires further refinement and instructions on its administration
- it is sensitive to recovery and social inclusion, though not quite so much to equality
- it could be used across different types of services but would need to be less medically focused
- the tool can be used in a variety of ways.

## Appendix 2: Examples from each tool on peer support

### IROSS

(See top row and see columns headed 'By Programs/Services' and 'By County, Regional or Statewide')

<b>RECOVERY DOMAIN 7: Peer Support &amp; Self-Help</b>			
Elements of a recovery-oriented system	Ways this indicator can be demonstrated		
<i>Indicator</i>	<i>Individual Indicator/Outcome</i>	<i>By Program/Services</i>	<i>By County, Regional, or Statewide</i>
Availability and support for self-help, peer support, consumer-operated services	<ul style="list-style-type: none"> <li>I have access to other consumers who act as role models.</li> <li>There is a consumer advocate to turn to when I need one.</li> <li>I am encouraged to use consumer-run programs.</li> </ul>	<ul style="list-style-type: none"> <li>At least 1% of total mental health budget set aside for development and operation of peer services.</li> <li>Training and education programs available to educate and prepare consumers for employment in human service arena.</li> <li>At least one independent (501-c-3) consumer operated service in each locality.</li> <li>Evidence that workers are knowledgeable about peer support, self help, and consumer operated services available locally.</li> <li>Evidence that workers support and promote consumer participation in these services.</li> <li>Evidence of collaborative agreements and positive working relationships between consumer operated and traditional services.</li> </ul>	<ul style="list-style-type: none"> <li>There is at least one free standing peer consumer operated service in each service area.</li> <li>At least 1% of the total mental health budget is allocated for the development, operation, support, and evaluation of peer services.</li> </ul>
Employment of consumers as workers in traditional and non-traditional service & administrative/ policy organizations	<ul style="list-style-type: none"> <li>I personally know consumers who are working as paid staff in the mental health services.</li> </ul>	<ul style="list-style-type: none"> <li>Evidence of workers at all levels of traditional and non-traditional organizations who are consumers – and “out” as personal experiences with mental illness.</li> <li>Career paths open to individuals within traditional organizations.</li> <li>Mechanisms for dialogue regarding challenges presented by and faced by consumer workers.</li> <li>Attention to agency ethics policies and practices in light of impact of consumer workers.</li> <li>Evidence of affirmative action program within organizations.</li> <li>At least 5% of all staff in mental health agency are individuals who receive or received services.</li> </ul>	<ul style="list-style-type: none"> <li>Evidence of affirmative action program for hiring C/S/X into regular positions.</li> <li>Evidence of advocacy for or use of Medicaid as source of funding for peer delivered services.</li> </ul>

## ROSE

(See 30 and 31 for peer support)

<b>AACP ROSE- Recovery Oriented Services Evaluation</b>	<b>Strongly disagree</b>	<b>Modly disagree</b>	<b>Somewhat</b>	<b>Modly agree</b>	<b>Strongly agree</b>
	0	1	2	3	4
26. Organization has program to reduce or eliminate the use of coercive treatment					
27. Attempts are made to engage and empower persons on involuntary treatment status					
28. Staff has been adequately trained to de-escalate volatile situations and to avoid seclusion and restraint					
29. Debriefing occurs following all episodes of seclusion or restraint if it must be used.					
<b>Supports</b>					
30. Organization facilitates service user participation and leadership in advocacy and peer support efforts/organizations					
31. Organization has an active liaison with local advocacy and peer support groups					
32. Service users consistently indicate satisfaction with access to services.					
33. Family members are engaged and educated to support recovery efforts.					
34. Opportunities exist for family members to be involved in treatment planning and organizational development					
35. Family members are represented on committees and are involved in staff training					
36. Service users are encouraged and supported in pursuit of employment and vocational skills.					
37. Development of educational and employment goals are emphasized in recovery plans					
38. Individualized placement and support guides vocational activities					
39. Tolerant housing is available to those who cannot maintain sobriety or stable recovery.					
40. Service users are satisfied with housing options available.					

## ROSI

**Directions:** Please respond to each item as thoroughly as possible. Please report data for your current activities or your most recently completed fiscal year. When the available data does not fully meet the specified item definition, please define the data used for that item on the form and continue to the next item. When data is not available, please indicate this on the form and continue to the next item.

### 1. Independent Peer/Consumer Operated Programs

- 1a. Numerator: The total number of mental health catchment or service areas as responding that have independent peer/consumer operated programs:

1a. \_\_\_\_\_

- 1b. Denominator: The total number of mental health catchment or service areas as responding:

1b. \_\_\_\_\_

- 1c. Indicator: The percentage of mental health catchment or service areas as responding that have independent peer/consumer operated programs.  
(Numerator 1a. divided by denominator 1b.)

1c. \_\_\_\_\_ %

### 2. Peer/Consumer Delivered Service Funding

- 2a. Numerator: For the reporting period, the amount of program funds in the state mental health budget allocated for peer/consumer delivered services:

2a. \_\_\_\_\_

- 2b. Denominator: For the reporting period, the total amount of program funds in the state mental health budget:

2b. \_\_\_\_\_

- 2c. Indicator: For the reporting period, the percentage of state program funds allocated for peer/consumer delivered services.  
(Numerator 2a. divided by denominator 2b.)

2c. \_\_\_\_\_ %

## RSA

(See 21 for peer support)

1 = strongly agree

5 = strongly disagree

N/A = not applicable

D/K = don't know

17. Staff routinely assist program participants with getting jobs.	1	2	3	4	5	N/A	D/K
18. Staff actively help program participants to get involved in non-mental health related activities, such as church groups, adult education, sports, or hobbies.	1	2	3	4	5	N/A	D/K
19. Staff work hard to help program participants to include people who are important to them in their recovery/treatment planning (such as family, friends, clergy, or an employer).	1	2	3	4	5	N/A	D/K
20. Staff actively introduce program participants to persons in recovery who can serve as role models or mentors.	1	2	3	4	5	N/A	D/K
21. Staff actively connect program participants with self-help, peer support, or consumer advocacy groups and programs.	1	2	3	4	5	N/A	D/K
22. Staff actively help people find ways to give back to their community (i.e., volunteering, community services, neighborhood watch/role group).	1	2	3	4	5	N/A	D/K
23. People in recovery are encouraged to help staff with the development of new groups, programs, or services.	1	2	3	4	5	N/A	D/K

## SRI

(See text by heading 'Self-help')

Note: SIRI is modelled on SRI but it does not mention self-help and collective advocacy groups.

<b>6. Involving support networks and promoting social inclusion and community integration</b>					
<p>Indicating that there should be active efforts in the planning and delivery of services to involve service user's social support networks (families, partners, friends, named persons, work colleagues, spiritual advisers, community leaders etc) in care and treatment. Also indicating efforts to promote social inclusion and community integration.</p>					
	1	2	3	4	5
6a. Service makes active efforts to involve service user's support system in care and treatment.	Fewer than 10% of service users have some member of their support network involved in their care and treatment	11-20% of service users have a member of their support network involved in their care and treatment	21-30% of service users have a member of their support network involved in their care and treatment	31-40% of service users have a member of their support network involved in their care and treatment	> 41% of service users have a member of their support network involved in their care and treatment
<p>Services to promote social inclusion and community integration include:</p> <ol style="list-style-type: none"> <li>1. <b>Self-help</b> - service makes routine referrals to self-help and collective advocacy groups. (A list or detailed knowledge of self-help and collective advocacy groups in team's immediate area should be readily available).</li> <li>2. <b>Non-mental health activities</b> - Service routinely facilitates service user's participation in non-mental health activities. (Should be able to identify significant instances in which service users were given assistance to participate in a desired activity, including educational, recreational, voluntary work or other pursuits. Group outings should not be counted toward this indicator).</li> <li>3. <b>Vocational/employment services</b> - service provides or facilitates referral to a range of proactive employment services for those able and wishing to work, including job assessment, development, placement, coaching, and ongoing supports. (Assessing job needs and providing some coaching does not pass for this indicator; there should be evidence of active job assistance).</li> </ol>					
	1	2	3	4	5
6b. Service provides a range of responses designed to promote service user's inclusion and integration into the community.	Service provides no responses related to community integration		Service provides 1 response related to community integration	Service provides 2 responses related to community integration	Service provides all 3 responses related to community integration