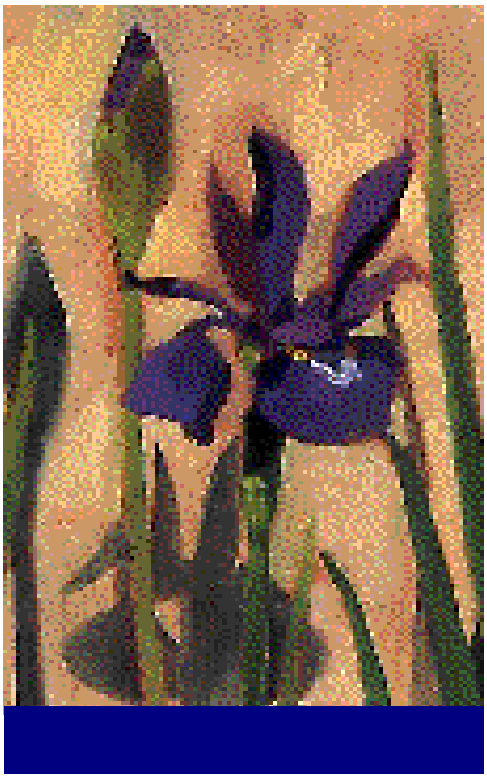
The Department of Mental Health and Addiction Services

RECOVERY RESOURCE GUIDE



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Recovery Resource Guide

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Introduction: The Recovery Resource Guide

The Department of Mental Health and Addiction Services is committed to the development of recovery-oriented services that can be used by people as tools in the pursuit of their recovery. The fact remains, however, that recovery is not what service providers do *to* or *for* people. Rather, recovery is what people experience themselves as they become empowered to manage their mental illness and/or substance use disorder in a manner that allows them to achieve a meaningful life and a positive sense of belonging in their community.

DMHAS believes that *knowledge* about recovery is one way in which people become empowered and begin to feel hopeful about their future. As such, this Recovery Resource Guide was designed to be a useful reference for people in recovery and for those individuals who support them on their path to wellness including service providers, family members, significant others, and community members. The purpose of this Guide is to direct people to a wide variety of resource materials and ways to contact local and national organizations that provide additional information or services that can be used to enhance the lives of individuals with mental illness or substance use disorders. The inclusion of organizations in this Recovery Resource Guide does not imply endorsement or recommendation by the Department of Mental Health and Addiction Services or its co-sponsors in the *Recovery Works* conference. This guide is solely for informational purposes. Just as recovery itself is a deeply personal and unique process, so too are the tools that help one to achieve it. What works for one person may not work for the next. In recognition of this, we have attempted to be liberal in our inclusion of resources but do not intend to imply that all resources will be useful for all people.

A few words about the organization of the Recovery Resource Guide… The Guide begins with the Department of Mental Health and Addiction Services' recently adopted policy on the *Promotion of a Recovery Oriented System of Care*. Next you will find the *Recovery Core Values* which have been developed by people in recovery as represented by **Advocacy Unlimited, Inc. (AU)** and the **Connecticut Community for Addiction Recovery (CCAR)**. These organizations have been integral partners in the planning of this *Recovery Works* conference and in advising the Department of Mental Health and Addiction Services on the development of its recovery policy. Should you require more information regarding a particular area of services or policy development, we have also provided a listing of "Key Contacts" within DMHAS and the State of Connecticut who would be willing to speak with you further.

The majority of this Resource Guide is devoted to an alphabetical listing of various local and national organizations that provide information and/or services regarding recovery from mental illness or substance use disorders. We provide both the contact information and a brief description of what the organization has to offer. For quick reference, each entry is coded in the left-hand column, and these codes denote the specific type of resource that is available, e.g., "B" for "Brochures" and "N" for "Newsletter." The Resource Guide concludes with listings of publications and books which routinely feature recovery-oriented articles and literature as well as first-person accounts of the recovery process.

We hope that you will find this Guide useful and encourage you to share the following material with others. Remember, *Recovery Works!* We hope that this Resource Guide will work for you!

The Department of Mental Health and Addiction Services
Promoting a Recovery-Oriented System of Care

Purpose: The purpose of this policy is to express formal endorsement of the Recovery Premises and Values formulated by the recovery community in Connecticut and to provide a framework for the promotion of a system of care that is based on, embodies, and furthers the vision of recovery encompassed in these premises and values. This policy acknowledges that the system of care that currently exists emerged, for the most part, out of an earlier vision of the goal of mental health and addiction services, and that substantial changes will need to be made in order to bring the system as a whole in accord with a vision of recovery that continues to evolve. In this sense, the policy that follows not only pertains to current practice but also provides guidelines for the future development of the system of care, offering an ideal the system can strive to attain.

Definitions:

Recovery has several different meanings within the mental health and addiction communities. Given these different meanings, there is no one definition of the term that will prove acceptable to all parties involved. For the purposes of this policy, recovery will be defined to include the following meanings: 1. A return to a normal state (e.g., following an episode of depression); 2. A process or period of recovering (e.g., following trauma); 3. A process of gaining or restoring something (such as, e.g., one's sobriety); and 4. An act of obtaining usable resources from unusable sources (such as, e.g., in prolonged psychosis). Taken together, these four meanings suggest a broad vision of recovery that involves a process of shifting in one's orientation and behavior from a focus on a troubling event or condition to the restoration or rebuilding of one's life in the aftermath of this event or condition in a way that makes sense of and integrates, if not actively builds on, elements taken from the event or condition involved.

A recovery-oriented system of care is an integrated network of culturally-responsive mental health and addiction services and supports that first and foremost promotes the recovery of individuals with psychiatric and/or substance use disorders and the community of caring and involved others to which these individuals belong. These services and supports include the full range of hospital and community-based services, acute and non-acute levels of care, active clinical treatment and rehabilitative interventions, and self-help and user-run supports that the Department of Mental Health and Addiction Services funds, facilitates, or fosters.

Policy Statement:

Background: Although a long-standing cornerstone of approaches to addiction and its sequelae, the concept of "recovery" represents a relatively recent advance in mental health services. Based on successful experiences with self-help, twelve-step groups in the addiction community and on psychiatric research documenting a full spectrum of outcomes for serious mental illnesses, recovery within the mental health community has come to represent both the possibility of improvement in a person's condition and the importance of the person assuming an active and responsible role in minimizing the disruptive and destructive impact of the events or illness on his or her life. In both recovery ***from*** trauma and recovery ***in*** prolonged psychiatric disorder, the person becomes engaged in a process of gaining some degree of mastery over the unwanted intrusions of the events or illness, similar to the mastery a person in recovery from substance use

gains over his or her addiction. Managing one's sobriety, one's response to trauma, or the unwanted intrusions of a psychotic or affective disorder then both allows and requires an inter-active process of restoring or rebuilding one's life as a worthwhile and contributing member of a community. Even though a person may continue to have a troubling condition, one can be said to be recovered, recovering, or in recovery to the degree that one has been able to shift in one's orientation and behavior to this task of rebuilding a life despite or within the limitations imposed by the condition. In addition to being hopeful and assuming an active role, recovery in this way finally involves restoring or developing a positive and meaningful sense of identity apart from one's condition and beyond the role of addict, victim of trauma, or mental patient.

Philosophy and Values: The Department of Mental Health and Addiction Services hereby formally endorses the premises and values of recovery formulated by persons in recovery and their loves ones through the combined efforts of the Connecticut Council for Addiction Recovery and Advocacy Unlimited, Inc., and included as an Appendix to this policy statement.

Statement of Policy: Based upon these premises and values, and the definition of recovery above, the Department of Mental Health and Addiction Services accepts as its first and foremost priority promoting the recovery of individuals with psychiatric and/or substance use disorders and the community of caring, involved others to which these individuals belong. A recovery-oriented system of care is envisioned as one that identifies and builds upon each individual's strengths and areas of health in addressing his or her behavioral health needs and concerns across levels of disability and over time so that each person has the opportunities, effective, culturally-responsive treatments, and *in vivo* supports he or she needs in order to achieve a sense of mastery over his or her condition and regain a meaningful, constructive sense of membership in the community. In keeping with this vision, the Department will ensure that existing policies, procedures, programs, and services are revised, and that all new policies, procedures, programs, and services are developed, to be in accordance with the principles of a recovery-oriented system of care. Finally, the Department will ensure that all future strategic planning and resource development efforts build on existing strengths and move the system of care further in the direction of promoting recovery. The core principles for a recovery-oriented system of care are as follows:

- *Focus on people rather than services.* A fundamental component of a recovery-oriented system is the shift in focus from services and programs to the people they are meant to serve. While treatment planning is intended to be individualized, the system continues to be managed programmatically. People do not fit neatly into program boxes, however, no matter how much we try to shove them in. Services need to be redesigned so that people and their recovery, rather than the efforts of providers, are the foci of our attention.

- *Monitor outcomes rather than performance.* As a direct corollary of the first principle, it is no longer enough to demonstrate that services are offered or interventions are delivered if it cannot be shown that they have an effect for the people they serve. Performance indicators only indicate how a program performs, they do not indicate whether or not people get better as a result of receiving such services. As a recovery-oriented system assumes that improvement is possible, services need to be evaluated in terms of the outcomes they produce for individuals, the extent to which they actualize recovery.

- *Emphasize strengths rather than deficits or dysfunction.* To the degree that recipients of service continue to be viewed as 'mental patients,' 'addicts,' or victims (i.e., in terms of their diagnoses or disabilities) the system has yet to shed its institutional mindset of the past. Living in the community rather than a hospital or residential treatment setting involves being a contributing member of society, and thereby having the same rights and

responsibilities as other members of society. The shift to a recovery-oriented system raises the question: How can a person take advantage of these rights and fulfill these responsibilities while she or he has a disability? Within this context, the primary focus remains on exercising one's rights and fulfilling one's responsibilities (i.e., on what the person wants from and has to offer the community in return) rather than on the disability *per se*, and a primary challenge becomes one of making the accommodations needed for the person to function despite the disability.

- *Educate the public to combat stigma.* The primary barrier to recovery is the same as the primary barrier to access: stigma. With rare exceptions, as people improve they gradually leave the public system and are more and more reticent to acknowledge their history of substance use or psychiatric disorder. Although understandable, the fact that people who improve typically conceal their history of disability allows stereotypes of mental illness and addiction to continue, fueled by media accounts of rare but tragic acts of violence perpetrated by people with untreated behavioral health disorders. One challenge for a recovery-oriented system of care is thus to provide a realistic and balanced account of behavioral health disorders that allows for both extremes and for the considerable middle ground in between. To the extent that people avoid accessing care due to stigma they prolong their period of untreated illness, which then worsens the course and outcome of their disorder, further perpetuating the cycle of stigma. Education is the only vehicle for slowing down, and eventually stopping, this destructive cycle.
- *Foster collaboration as an alternative to coercion.* If behavioral health disorders are illnesses like other medical conditions, then people with behavioral health disorders should be treated like people with other medical conditions. Very few people with behavioral health disorders become incapacitated to the degree that they can no longer make their own decisions or act on their own behalf. Current statutes are clear about the criteria for such circumstances. In all other circumstances, people with behavioral health disorders should be accorded the same rights and responsibilities for self-determination as people with diabetes, asthma, or hypertension. This shifts the focus from forcing people into treatment to offering to be of assistance to them as partners in ***their*** recovery.
- *Promote autonomy and decrease reliance on professionals.* A cornerstone of recovery is hope; offering people a sense of the possibility that they can improve their condition and need not be resigned to continuing to be solely the recipient of the care of others. In this sense, progress within a recovery-oriented system of care involves becoming less reliant on the services of providers and becoming inter-dependent with and among one's "natural supports" (i.e., family, friends, neighbors, landlords, employers, grocers, etc.). Essential to this shift are both creating opportunities for self-help/mutual support among peers and also, and equally important, increasing access to opportunities for community integration based on each individual's interests and choice.

Operational Strategy: A key strategy in moving toward a recovery-oriented system of care is to incorporate empirical outcome data and evidence-based practices emerging in the behavioral health field. Outcome studies consistently have documented a full spectrum of outcomes for people with psychiatric and/or substance use disorders ranging from full recovery to extensive and prolonged disability resulting in premature death. Little is known, however, about the factors that would predict full or partial recovery. Given this uncertainty regarding individual outcomes and the increasing availability of new and effective treatments, it is crucial that all individuals be

offered hope and a sense of the possibility that their condition can improve over time. Recovery-oriented systems of care are based on the premises that many people will improve over time, that for some improvement will take a matter of years rather than weeks or months, and that it cannot be predicted ahead of time who will and who will not improve when and at what pace.

As a result, it is incumbent upon a recovery-oriented system of care to ***address people's needs across levels of disability and over time, matching services to needs at each level, in each phase, and in each area, of disability.*** A useful analogy for behavioral health disorders in this sense is cancer, in which earlier detection and intervention also typically lead to better outcomes. With cancer, some people have one episode and recover fully, others need more intensive treatment in order to regain and maintain functioning, and others die and will continue to die until more effective treatments are discovered. While perhaps a harsh reality, this is a current reality nonetheless, and one which will need to be taken into account in the evolution of a system of care. A recovery orientation does not, and cannot, require denial in the face of suffering and significant disability. On the contrary, a recovery-oriented system of care holds out hope and the possibility for improvement in the lives of all those experiencing behavioral health disorders, no matter how severe, prolonged, or disabling any particular condition or combination of conditions may be. In addition, a recovery-oriented system of care acknowledges the barriers to recovery that may undermine or block an individual's efforts to improve including stigma, lack of access to care, and the relative scarcity of culturally-responsive services. In addressing these barriers, the Department will develop services and interventions that are accessible, acceptable, and responsive to the concerns, needs, and aspirations of people with behavioral health disorders across the range of severity, duration, and disability.

Reference: Refer to the attached Appendix for the Core Recovery Premises and Values put forth by the recovery community and endorsed herein by the Department of Mental Health and Addiction Services.

*Recovery Core Values

* As articulated by Advocacy Unlimited, Inc., AU, and the Connecticut Community for Addiction Recovery, CCAR, and endorsed by The Department of Mental Health and Addiction Services.

Recommended new name by the year 2005:
The Department of Mental Health and Addiction Recovery Services

It must be remembered that there is nothing more difficult to plan, more doubtful of success nor more dangerous to manage than the creation of a new system. For the initiator has the enmity of all who profit by the preservation of the old institution and merely lukewarm defenders in those who would gain by the new one." —Machiavelli

RECOVERY BASIC PREMISES

Recovery Premise 1: All individuals are unique and have specific needs, goals, health attitudes and behaviors, and expectations for recovery.

Recovery Premise 2: Persons in recovery with mental illness, alcohol or drug addiction, or both, share some similarities, however, management of their own lives and mastery of their own futures will require different pathways at times.

Recovery Premise 3: All persons shall be offered equal access to treatment and have the opportunity to participate in their recovery process.

Recovery Premise 4: The funding agency shall support a recovery oriented system of care that requires their funded and/or operated treatment programs to treat individuals based on the following recovery based core values:

RECOVERY CORE VALUES REGARDING *DIRECTION*
The Recovery Community is comprised of Persons in Recovery, their family members, significant others and friends, and all people who are dedicated to creating equal opportunities for the health and wellness of Persons in Recovery**.**

- The treatment of an individual must be approached from a total recovery process starting from the acute phase to their return to the community.

- The entire treatment system must support the concept of Recovery, not just in word, but in action.

- Persons in Recovery must have the opportunity to provide input at every level of service provision.

- Persons in Recovery shall be able to provide input in all phases of treatment program planning, staffing, and evaluation.

- The system shall be driven by recovery-based outcomes that Persons in Recovery help to develop.

- A new nomenclature that reflects recovery-based and person-first language (for example, "Recovery Plans" will replace "Treatment Plans", etc.) shall be promoted and used.

- A system-wide training program for all levels of treatment program employees that will address the need for service provision that is rooted in a recovery-based model shall be designed and implemented.

- Every effort shall be made to provide services that are culturally diverse, relevant, and competent, as reflected in the treatment process and staff hiring and promotion practices.

- Persons in Recovery shall participate in all phases of the funding agency's Request for Proposal (RFP) process whenever the process is invoked.

- There shall be a strong commitment to Peer Support and to having Recovery-Operated Services provided by recovering persons.

- Representation by Persons in Recovery on Boards, Task Forces, and Committees remains important, however, there must be an understanding that the voice of the Recovery Community must be strengthened through the powers associated with decision-making roles, voting memberships, and actual oversight responsibilities.

- The time and effort of Persons in Recovery shall be recognized as having a financial value in addition to other benefits in providing the services described in this document. Therefore, applicable travel reimbursement, compensation, wages, education, and other resources should be made available to them in recognition of their commitment for the services provided.

RECOVERY CORE VALUES REGARDING *PARTICIPATION*

There shall be no wrong doors when entering into the treatment system.

- Anyone requesting services cannot be refused without first being offered a full intake interview and being provided with a written explanation if refused.

- An individual may enter any appropriate level of care when needed not just at times of crisis.

- An individual's choice must be respected in matters related to his/her treatment.

- Every person has a right to participate, or not participate in treatment, as he/she sees fit. People from time to time must be able step away from services without receiving threats, given artificial consequences, or experience barriers to re-engagement.

- The treatment goals identified by the Person in Recovery will be valued and will be included as a basis for evaluating outcomes.

RECOVERY CORE VALUES REGARDING *PROGRAMMING*
Programming must be flexible so that services to the Person in Recovery can be individually tailored, as appropriate.

- Programming must represent a full menu of culturally competent services, including access to non-traditional therapies. These full menus must be available across the entire state.

- Recovery specialists and care managers must be fully knowledgeable of ALL the resources and treatment options available so that the Person in Recovery can choose wisely.

RECOVERY CORE VALUES REGARDING *FUNDING/OPERATIONS*
No Outcomes? No Income! Providers shall be reimbursed for services provided, outcomes met, and persons served.

- The treatment system shall be designed so as to allow the marketplace to bear on the provision of services. That is to say that Persons in Recovery can influence service delivery by selecting providers that are responsive to their specific needs.

- A system of Checks and Balances shall be implemented so that neither the funding agency, an Administrative Services Organization (ASO), or an individual provider of service shall exert undue influence on the provision of services.

- Treatment providers must never be put in a position in which they oversee, fund, or direct other treatment providers.

- "Competition *plus* Checks and Balances *plus* Outcome Measurement *equals* an Enhanced Marketplace!" should be a guide when funding treatment providers.

The Department of Mental Health and Addiction Services

Multicultural Behavioral Healthcare Best Standards Practices and Guidelines

The Department of Mental Health and Addiction Services (DMHAS) established the Multicultural Advisory Council (MCAC) in 1998 to be a change agent in the process of meeting the Department's commitment to culturally-competent services throughout our system of healthcare. The MCAC spent a year working with consultants from Temple University to develop needed cultural competence skills and the capability to operate as a change agent for the DMHAS system. Among the many accomplishments of the Council is the work of its Multicultural Clinical Standards committee. With ongoing technical assistance provided by Dr. Laura Finley of Temple University Multicultural Training and Research Institute (MCTRI), the committee enlisted critical input from the MCAC, the DMHAS regional team leaders and the staff of the Office of Multicultural Affairs (OMA). The committee spent many hours to develop a document that could be applicable in both Mental Health Services and Addiction Services.

The DMHAS "Multicultural Best Standard Practices" provide guiding principles for culturally-competent treatment and recovery services to individuals of ethnic/cultural/racial populations living with mental illness and addictive disorders. The "Multicultural Best Standard Practices" reflect the view that multicultural competence is both a value and a set of skills that must be incorporated in every aspect of our system of care. Providers are expected to be sensitive to the cultural values of diverse groups, acknowledge cultural strengths associated with people, their families, significant others, and communities, while recognizing and respecting individual differences. Our prevention, treatment, rehabilitation and recovery services all need to be culturally appropriate for all individuals served. The Department of Mental Health and Addiction Services recognizes that multicultural competence is a developmental process. It occurs along the entire continuum of care and requires the ongoing participation of all stakeholders to bring about a multicultural system of care.

The following are the eight "Best Standard Practices" with the corresponding implementation guidelines as taken from the "Multicultural Behavioral Healthcare Best Practices and Implementation Guidelines" from August 2001.

I. Access and Service Authorization

Access to services shall be made available to persons, their families and/or natural supports(i.e., self-defined family) in a respectful and welcoming manner. Rendered services will be timely, convenient and easily accessible. Bilingual/bi-cultural providers and interpreters trained in clinical and cultural issues will be available across the service continuum. Service availability and service determination will include integrated and holistic approaches in working with people as well as needed support services. This integration includes psychiatric, rehabilitative, medical, social, behavioral, cultural, spiritual, familial and community support models.

Implementation Guidelines

Access to services is culturally appropriate when:

1. Available data establishes the service utilization rates of specific ethnic/cultural/racial groups served in the agency. The services delivered across the service continuum to each ethnic/cultural/racial population of the geographic target community are proportionate to the area's actual demographic breakdown.

2. Persons from diverse cultures who have linguistic differences receive appropriate and comparable quality services.

3. Providers disseminate culturally-relevant and linguistically-appropriate information regarding local mental health and addiction services, as well as non-traditional and self-help resources in a wide variety of formats.

4. Staff has and uses an available list of culturally and linguistically-accessible services within the facilities and throughout the community.

5. The agency's educational materials are made available to individuals served and reflect the language and culture of those persons.

6. Service providers continuously monitor and improve timeliness, access, flexibility of hours, availability of alternative and complementary treatment approaches, engagement and follow-up.

7. A client satisfaction survey for persons served measures satisfaction with timeliness, access, and flexibility of hours and availability of alternative and complementary treatment approaches.

8. The composition of the direct service staff reflects the diversity of the population served.

9. Programs provide, or network to provide for multiculturally and linguistically competent staff to be available 24 hours a day and 7 days per week throughout the service region.

10. The social and physical environment within the agency reflects the diversity and culture of the persons served. Waiting areas and offices display magazines, art, music, etc., reflective of the diversity of persons served.

II. Cultural Assessment

Cultural assessments shall be conducted as part of the treatment planning process within the context of culture, family and community for each person receiving services. The assessments will incorporate a multidimensional strength-based focus. They will include functional, psychiatric and medical areas of inquiry attentive to cultural, social, discriminatory, social status, and economic stress factors, as well as family support.

Implementation Guidelines

Assessments as part of the treatment planning process are culturally appropriate when:

1. The initial and ongoing assessment includes cultural factors which may affect treatment/rehabilitation services. Bilingual/bicultural staff persons are available to assess individuals both in their preferred language and in the context of their cultural heritage.

2. An assessment instrument, which utilizes cultural information and personal preferences, is used to distinguish pathology from cultural factors (e.g. avoiding eye contact with eyes lowered is often a cultural response to respect for the clinician, etc.). Cross-cultural assessment is ongoing throughout the course of treatment and rehabilitation.

3. The assessment instrument forms the basis for a culturally-relevant recovery plan resulting from culturally-appropriate diagnoses, and appropriate rehabilitation/treatment goals.

4. Qualified (in both language and culture) interpreters are used when bilingual staff persons are not available.

5. There are culturally valid and reliable assessment and measurement tools that are administered, scored and interpreted by culturally-competent professionals in each discipline that requires assessment.

6. Involvement of family members, natural supports and significant community supports in the assessment process are documented in client's clinical file.

7. The assessment includes cultural factors that are significant to the treatment process. These may include, but are not limited to, the following:

    - Preferred language of the client
    - History of immigration or migration
    - Description of acculturation and adaption
    - Cultural, social, economic stress factors, discrimination
    - Trauma
    - Learning and cognitive styles
    - Family organizational and relational roles
    - Extent of family support
    - Social network composition
    - Ethnic identity
    - Religious/spiritual identity

- Person's perception/belief of presenting problem and explanation of symptoms
- Person's belief systems regarding mental illness/addictive disorder
- Gender identity and sex role orientation in the cultural group
- Sexual identity/sexual preference
- Coping strategies utilized within the identified cultural group
- Help-seeking behaviors
- Previous attempts at relieving symptoms, including healers, etc.

III. Treatment/Rehabilitation Plan

All persons served are assured a clinically-appropriate treatment plan that incorporates the mutually agreed upon choices of relvant, attainable goals, culturally-compatible treatment/rehabilitation services and alternative treament/rehabilitation strategies when so determined. Strategies may include use of family, community supports, spiritual leaders and non-traditional healers. Plans will be individualized, client centered, based on individual strengths, developed within the context of family and/or social networks in a treament/rehabilitation partnership. Plans will be formulated and reviewed during multiculturally-competent supervision of clinicians.

Implementation Guidelines

Persons served are assured a culturally-appropriate treatment plan when:

1. A comprehensive treatment plan documents the individual's goals and assures that the persons and the families served are satisfied with the goals identified in the treatment plan. Satisfaction with participation in developing the treatment/rehabilitation plan is verified in customer survey documents.

2. In consultation with the clients and their families, culturally-relevant goals (related to family, values, work, spiritual, respect, community cultural resources, etc.) are identified and specified in the treatment/rehabilitation plan.

3. The treatment plan identifies available culturally-compatible treatment/rehabilitation services and strategies. The plan identifies alternative treatment/rehabilitation strategies and culturally-competent services that can be utilized.

4. Persons and their families are satisfied with the degree of participation in developing treatment/rehabilitation plan. Professionals on staff who are multiculturally competent complete or review the plans.

IV. Communication Styles and Linguistic Support

Culturally-appropriate services in the preferred language of the client will be provided to persons, families and natural supports per their request and offered, when deemed necessary, within available agency resources. Access to services in appropriate communication style will be available at each point of entry into the service continuum and continue throughout a person's

course of treatment and rehabilitation. Staff will be knowledgeable in the use of qualified interpreters. Only in crisis situations shall telephone interpreters be utilized. Relevant audio visual, written materials and forms, such as individuals' rights, orientation packets and consents in the person's preferred language shall be the norm for identified populations in the community served and the ideal for individuals from very small populations.

Implementation Guidelines

Services in the individual's preferred language is culturally appropriate when:

1. Cross-cultural communication supports are identified and utilized at each point of entry along the service continuum and throughout treatment. The persons served and their available natural supports are satisfied with the communication resources provided.

2. Staff persons are competent in the communication styles and languages of persons served so as to minimize the use of interpreters.

3. Qualified interpreters are available within one hour for crisis situations and within twenty-four hours for routine situations. Information about qualified interpreters is maintained in the agency and the list of such resources is updated at least annually. The clinical staff is trained and knowledgeable about when and how to utilize interpreters across diverse groups.

4. Data from client surveys document that persons served express satisfaction that communication support is evident and available.

V. Quality of Life

Quality of life is recognized as a holistic integration of symptom reduction, healthy family relationship ("family" is identified by person served, not limited to nuclear or extended family), community support and spirituality, which can be related to the individual's sense of personal meaning, fulfillment and well being in recovery.

Implementation Guidelines

Culturally appropriate quality of life is recognized when:

1. The agency has a mechanism to assess the quality of life for all individuals receiving services. Qualitative data is collected on "pre" and "post" instruments and generated reports regarding quality of life. Facilities will utilize quantitative and qualitative data regarding quality of life to evaluate and improve service delivery.
2. Assessments, treatment/rehabilitation plans, and other services incorporate the preferences, hopes and wishes of persons served.

3. Quantitative data (on standard life functions, e.g., employment, socializing, community involvement, etc.) are collected on "pre" and "post" instruments and reports are generated regarding the person's quality of life.

4. Persons served report increased satisfaction with the quality of life attained.

VI. Case Management

Case managers should be familiar with the values, norms and beliefs of persons from various cultures, as well as the resources available to them within each community. As part of a multidisciplinary team, they engage the person, assess need, assist persons in accessing culturally-competent services and community resources. In the absence of such services, case managers should advocate for the development of services or program adaptations to provide culturally-competent services. Case managers facilitate the coordination of culturally-competent services within the person's living environment and cultural communities while assisting in maximizing a person's independence and support from family and social networks.

Implementation Guidelines

Case managers facilitate the coordination of culturally-competent services when:

1. Case management improves access to a comprehensive array of behavioral healthcare service systems that are compatible with the cultural needs of persons served. Service utilization data indicate increased access, engagement and retention in treatment of underrepresented populations.

2. The agency maintains, as a resource, the descriptions and documentation of culturally-compatible services and resources available to persons served. Identified culturally-competent behavioral healthcare services are provided system-wide.

3. Engagement and retention of persons from under-served and under-represented cultural groups increase.

4. Improved role relationships for familial and social networks of the person's culture show that the individuals receive coordinated services within multiple domains, i.e., vocational, social, educational, residential settings, etc.

5. Services are developed and/or adapted to be culturally-compatible to meet the needs of persons served. Service plans, program changes, and other service adaptation demonstrate inclusion of appropriate cultural factors.

6. Persons achieve a balance between independence and interdependence. The documentation that the person self reports on a prepared instrument indicates the greatest degree of independence possible.

VII. Performance Indicators Continuum of Service/Discharge Planning

Service/discharge planning begins at all points of entry along the service continuum and is provided by multiculturally competent staff, in cooperation and collaboration with the person, family, community supports, and other social networks and is consistent with the values, norms

and beliefs of the persons served. Service/discharge plans shall relate and incorporate pertinent information from the cultural assessment and include service/discharge factors that are culturally relevant and significant to the person's recovery. The plan identifies personal, familial, living environment, social networks and/or cultural resources in the treatment/rehabilitation environment.

Implementation Guidelines

Service/discharge planning is provided by multiculturally competent staff when:

1. A culturally-compatible continuum of service and/or culturally-competent discharge plan includes a summary of accomplishments, resources and services utilized by the persons served. This includes clear goals and recommendations for required services in the post discharge continuum of care and the involvement of the persons, their families and social networks when appropriate.

2. The values, norms and beliefs of the person are documented in the clinical record. Individuals remain connected to treatment, rehabilitation and recovery services as indicated in the record.

3. The description of goals for future treatment and rehabilitation is documented. There is evidence of recommendations regarding personal, familial, living and social networks and cultural resources necessary in the subsequent treatment and rehabilitation setting.

4. Staff establishes confirmed referrals with aftercare services and provides follow-up contacts with persons served and services referred to.

VIII. Recovery and Self-Help

Culturally-compatible recovery, self-help groups and natural supports in the behavioral health service continuum shall be readily available and accessible. These modalities provide an opportunity to engage and support persons and their families in recovery. Recovery, self-help groups and natural supports exist in a variety of community locations including home-based initiatives, community centers, and churches. Multiculturally-competent providers and persons in recovery are enlisted to assist in the creative development of alternative structures, models, and supports compatible with the lifestyles, values and beliefs of persons from different cultures.

Implementation Guidelines

Recovery, self-help groups and natural supports are culturally-appropriate when:

1. Programs identify and refer persons to culturally-appropriate recovery and self-help supports that are available in a variety of settings, including neighborhoods, spiritual communities, educational settings, etc.

2. More persons and their family members from different cultures utilize recovery and natural support activities across cultures.

3. Consultants from community groups, persons in recovery and other natural supports are engaged in the development of recovery and self-help models.

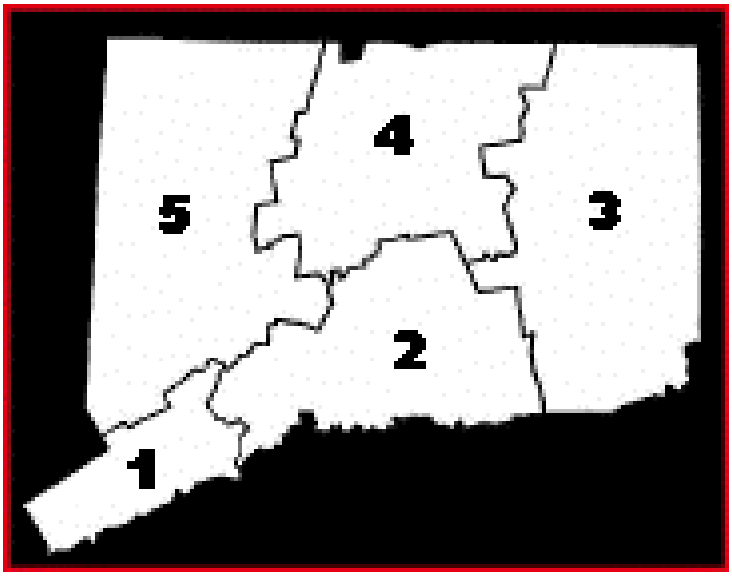
4. Evidence from focus groups comprised of persons served, indicates that culturally-relevant recovery, self-help and natural support program models are available to them.

Glossary of Common Acronyms

Alcoholics Anonymous	AA
Advocacy Unlimited, Inc.	AU
Center for Mental Health Services	CMHS
Center for Substance Abuse Prevention	CSAP
Center for Substance Abuse Treatment	CSAT
Connecticut Bureau of Rehabilitation Services	BRS
Connecticut Community for Addiction Recovery	CCAR
Connecticut Department of Mental Health and Addiction Services	DMHAS
Connecticut Legal Rights Project, Inc.	CLRP
Connecticut Office of Protection and Advocacy for Persons with Disabilities	P&A
The Consultation Center	TCC
Consumer Organization and Networking Technical Assistance Center	CONTAC
International Association of Psychosocial Rehabilitation	IAPSRS
Knowledge Exchange Network	KEN
Mental Health Association of Connecticut, Inc.	MHAC
Narcotics Anonymous	NA
National Alliance for the Mentally Ill	NAMI
National Alliance for the Mentally Ill Connecticut	NAMI CT
National Clearinghouse for Alcohol and Drug Information	NCADI
National Consumer Supporter Technical Assistance Center	NCSTAC
National Empowerment Center	NEC
National Institute on Drug Abuse	NIDA
National Institute for Mental Health	NIMH
National Mental Health Association	NMHA
Substance Abuse and Mental Health Services Administration	SAMHSA

Connecticut Key Contacts

Area of Inquiry	Name of Key Contact	Contact Information
Connecticut Legal Rights Project	Lisa Grandjean-Carlson	860 262-5030 877-402-2299 (toll free)
DMHAS Office of Customer Relations		
Director	Karen Kangas	860 418-6948
Customer Rights and Grievance Specialist	Janet Shepard	860 418-6933
Trauma and Family Specialist	Nancy Kunak	860 418-6928
Veterans Services Specialist	Ed Burke	860 418-6704
DMHAS Employment Services	Ruth Howell	860 418-6821
DMHAS Housing Services	John Doyle	860 418-6903
DMHAS Multicultural Affairs	Jose Ortiz	860 418-6850
DMHAS Regional Contacts (*refer to map below)		
Region 1	Bill Carroll	860 418-6905
Region 2	Mark McAndrew	860 418-6835
Region 3	Sue Tarnish	860 418-6975
Region 4	Rhonda Kincaid	860 418-6886
Region 5	Michael Michaud	860 418-6867



Alphabetical Listing of Recovery Resources

A = Agency
B = Brochures
CT = Consultation & Training
F = Federal
LH = Legal Help
L = Local
M = Media (video tapes, audio tapes, computer software)
N = Newsletter
P= Publications (books, journals, etc.)
SH = Self-help Organization
W = Website

B, L, M, N, SH, W

Alcoholics Anonymous (AA)

Grand Central Station
P.O. Box 459
New York, NY 10163
212 870-3400
Toll free numbers in Connecticut

Litchfield area	800 829-1863
Middletown area	800 530-9511
New Haven area	888 624-6063
New London area	888 268-2067

www.aa.org
www.ct-aa.org Connecticut Region

Alcoholics Anonymous is a 12-step, international fellowship of men and women who have had a drinking problem. It is nonprofessional, self-supporting, nondenominational, multiracial, apolitical, and available almost everywhere. There are no age or education requirements. Membership is open to anyone who wants to do something about his or her drinking problem.

Call one of the toll-free numbers in Connecticut or visit the local website to find out more about locations and meeting times near you.

A, CT, N, SH, W

Advocacy Unlimited, Inc. (AU)

300 Russell Road
Wethersfield, CT 06109
1-800-573-6929 (in Connecticut)
860 667-0460 phone
860 667-2240 fax
www.mindlink.org

Advocacy Unlimited, Inc. is a nationally recognized grassroots, nonprofit consumer–run organization that helps persons with psychiatric disabilities and their families. They believe everyone should be treated equally, regardless of race, gender, or disability.

Knowledge and skills ensure that people play a central role in shaping services and policies that affect their lives. Their primary purpose is to educate persons with psychiatric disabilities in self-advocacy, systems advocacy, and legislative advocacy skills.

AU's advocacy education training might be of particular interest to mental health consumers looking to help themselves and help other people in recovery by learning their rights, realizing their goals and passing information and the belief of hope and recovery on.

They also provide information and referrals, a monthly newsletter, legislative alerts and more.

Advocacy Unlimited was also a key contributor to the "Core Recovery Values" found on page 7.

A,B,P,W

Bazelon Center for Mental Health Law

1101 15th Street, NW, Suite 1212
Washington, DC 20005-5002
Phone: 202-467-5730
Fax: 202-223-0409
TDD: 202-467-4232
www.bazelon.org

The Judge David L. Bazelon Center for Mental Health Law is a nonprofit legal advocacy organization based in Washington D.C. that advocates for the rights of individuals with mental disabilities. The Center's advocacy is based on the principle that every individual is entitled to choice and dignity. For many people with mental disabilities, this means something as basic as having a decent place to live, supportive services, and equality of opportunity. The Bazelon Center has been instrumental in several landmark policy and legislative initiatives to protect the rights of people with disabilities.

Bazelon Center attorneys provide technical support for and co-counsel selected lawsuits with private lawyers, legal services programs, ACLU chapters and state protection and advocacy systems (P&As). The Center collaborates with local, regional and national advocacy and consumer organizations to reform public systems and promote consumer participation in the design and operation of service programs. However, the Bazelon Center does NOT handle individual requests for information or assistance. The Center's website provides an extensive listing of on-line recovery resources, allows you to register to be alerted of critical

mental health legislative initiatives, and provides guidance regarding the best way to become involved in advocacy efforts.

The Bazelon Center also publishes many handbooks, manuals, papers, and reports explaining key legal and policy issues in everyday terms, and many of these resource are available free of charge through the Center's website noted above. Topics covered include such things as: fair housing issues, the preparation of psychiatric advance directives, and legal protections for people with Psychiatric Disabilities. For example, the Center's publication *Mental Health Issues in the Workplace: How the Americans with Disabilities Act Protects You Against Employment Discrimination* may be of particular interest to readers.

A, L, W

Catapult Services, Inc.

40 Stillmeadow Drive
Guilford, CT 06437
203-453-1627
203-458-3628 fax
www.lifelinx.net

Catapult Services, Inc. is a nonprofit corporation coordinating access to treatment, transportation, housing, employment, and training for and by people who are battling alcohol, drugs, addiction to gambling, and homelessness.

B, N, M, P, F, W

Center for Mental Health Services (CMHS)

P.O. Box 42490
Washington, D.C. 20015
800 789-2647
301 443-9006 TTY
www.mentalhealth.org

CMHS leads Federal efforts to treat mental illnesses by promoting mental health and by preventing the development or worsening of mental illness when possible. Congress created CMHS to bring new hope to adults who have serious mental illnesses and to children with serious emotional disorders. CMHS was established under the 1992 ADAMHA Reorganization Act, Public Law 102-321, that mandates CMHS' leadership role in delivering mental health services, generating and applying new knowledge, and establishing national mental health policy. CMHS is a component of the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services.

A, CT, M, P, W

Center for Psychiatric Rehabilitation

Boston University

940 Commonwealth Avenue West
Boston, MA 02215
617 353-3549
617 353-7700 fax
www.bu.edu/sarpsych

The Center for Psychiatric Rehabilitation is a research, training, and service organization dedicated to improving the lives of persons who have psychiatric disabilities by improving the effectiveness of programs and service systems. The work of the Center is guided by the most basic of rehabilitation values that first and foremost, persons with psychiatric disabilities have the same goals and dreams as any other person. They want a decent place to live, suitable work, social activities, and friends to whom to they can turn in times of crisis. The mission of the Center is to increase knowledge in the field of psychiatric rehabilitation and to apply this body of knowledge to train treatment personnel, to develop effective rehabilitation programs, and to assist in organizing both personnel and programs into efficient and coordinated service delivery systems.

The Center for Psychiatric Rehabilitation offers a wide range of recovery-oriented resources including: conferences/workshops on recovery and recovery-oriented services, a newsletter on recovery and rehabilitation, a monthly "e-Cast" providing updates on the Center's events and publications as well as general mental health news items, an extensive listing of recovery resources available via the internet, and several user-friendly on-line publications, e.g., *Handling Your Psychiatric Disability in Work and School*. The Center also has significant experience in providing training and consultation to individual organizations and service systems regarding the delivery of recovery-oriented services. Detailed information regarding these resources is available via the Center's website noted above.

The Center's recently published *Recovery Workbook* may be of particular interest to readers. This workbook can be used by professionals, family members, and consumers/survivors to help people who experience psychiatric disability to begin the process of recovery.

See more on their publications in the select books and workbooks section on page 48.

A, B, F, W

Center for Substance Abuse Prevention (CSAP) SAMHSA

5600 Fishers Lane
Rockville, MD 20857
301 443-0365
www.prevention.samhsa.gov

The Center for Substance Abuse Prevention (CSAP) is a division of Substance Abuse and Mental Health Services Administration (SAMHSA) and is the sole Federal organization with responsibility for improving accessibility and quality of substance abuse prevention services. The Center provides national leadership in the development of policies, programs, and services to prevent the onset of illegal drug use, underage alcohol and tobacco use, and to reduce the negative consequences of using substances.

A, B, F, W

Center for Substance Abuse Treatment (CSAT) SAMHSA

5600 Fishers Lane
Rockville, MD 20857
301 443-5700
www.samhsa.gov/csat

The Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS), was created in October 1992 with a congressional mandate to expand the availability of effective treatment and recovery services for alcohol and drug problems.

CSAT's initiatives and programs are based on research findings and the general consensus of experts in the addiction field that, for most individuals, treatment and recovery work best in a community-based, coordinated system of comprehensive services. Because no single treatment approach is effective for all persons, CSAT supports the nation's effort to provide multiple treatment modalities, evaluate treatment effectiveness, and use evaluation results to enhance treatment and recovery approaches.

A, B, CT, L, W

Connecticut Bureau of Rehabilitation Services (BRS)

3580 Main Street
Hartford, CT
860 723-1400
800 537-2549 vocational rehabilitation, independent living, connect to work
800 772-1213 disability determination services
www.brs.state.ct.us

BRS works to create opportunities that allow individuals with disabilities to live and work independently. This organization has three components: the Vocational Rehabilitation Program, Disability Determination Services and the Independent Living Program.

They are also establishing a Connect to Work Center, aimed at trying to help people with disabilities get back to work by providing key services and benefits information. For more information call the vocational number above.

A, B, M, N, P, L, W

Connecticut Clearinghouse

334 Farmington Avenue
Plainville, CT 06062
800 232-4424
860 793-9791
860 793-9813 fax
www.ctclearinghouse.org

Connecticut Clearinghouse is the state's resource center for information about alcohol, tobacco, other drugs, and related issues affecting mental health and wellness.

This local organization provides pamphlets, posters, books, curricula, a resource library, audio/visual resources as well as links/referrals other agencies.

A, N, L, SH, W

Connecticut Community for Addiction Recovery (CCAR)

465 Silas Deane Highway
Wethersfield, CT 06109
800 708-9145 in Connecticut only
860 571-2985
860 571-2987 fax
www.ccar-recovery.org

Over the past four years, the Connecticut Community for Addiction Recovery (CCAR) has emerged as a well-respected, highly visible and vibrant grassroots organization that includes persons in recovery and their family members, friends, and allies. Simply, we seek to "put a face on recovery". CCAR is an integral part of a new recovery movement that has come to life all across America. Recovering people constitute one of the largest and most invisible communities in America and they are beginning to again assert themselves as a teaching and healing force. The centerpiece of this movement is not the proclamation that "alcoholism is a disease" or that "treatment works", but instead it is the proclamation that "recovery is a reality" in the lives of hundreds of thousands of individuals, families and communities.

CCAR was also a key contributor to the “Core Recovery Values” found on page 7.

A, B, M, P, L, W

Connecticut Department of Mental Health and Addiction Services (DMHAS)

410 Capitol Avenue

4th floor, P.O. Box 341431
Hartford, CT
800 446-7348
860 418-7000
www.dmhas.state.ct.us

The Department of Mental Health and Addiction Services (DMHAS) promotes and administers comprehensive, recovery-oriented services in the areas of mental health treatment and substance abuse prevention and treatment throughout Connecticut.

The Department of Mental Health and Addiction Services is responsible for providing a wide range of treatment services to adults. This includes inpatient hospitalization, outpatient clinical services, 24-hour emergency care, day treatment, psychosocial and vocational rehabilitation, restoration to competency and forensic services (including jail diversion programs), outreach services for persons with serious mental illness who are homeless, and comprehensive, community-based mental health treatment and support services. DMHAS funds and monitors hundreds of community-based treatment programs, and four state inpatient treatment facilities.

A, B, LH, N, L

Connecticut Legal Rights Project Inc. (CLRP)

P.O. Box 351, Silver Street
Middletown, CT 06457
860 262-5030
860 262-5035 fax

Connecticut Legal Rights Project, Inc. (CLRP), is an independent, nonprofit agency which advocates for low income adults who have, or are perceived to have, a psychiatric disability. CLRP is separate from the Department of Mental Health and Addiction Services (DMHAS).

A, LH, N, L

Connecticut Legal Services

62 Washington Street
Middletown, CT 06457
800 453-3320
860 344-0447
860 346-2938 fax
www.connlegalservices.org

Connecticut Legal Services is a not-for-profit law firm dedicated to representing, advising and educating low-income individuals and families in matters relating principally to civil law and thereby helping them secure the protections, privileges, benefits, rights and opportunities this law provides.

They have local offices across the state. Call the toll-free number or look them up on their website for more information and an office near you.

A, B, LH, L, W

Connecticut Office of Protection and Advocacy for Persons with Disabilities

60B Weston Street
Hartford, CT 06120
800 842-7303
860 297-4300
860 566-2102 TDD
860 566-8714 fax
www.state.ct.us/OPAPD

The Office of Protection and Advocacy for Persons with disabilities (better known as "P and A") is an independent state agency created to safeguard and advance the civil and human rights of people with disabilities in Connecticut. They provide information, referral, and advocacy services; pursue legal and administrative remedies on behalf of people with disabilities who experience disability-related discrimination; conduct investigations into complaints from people with disabilities, and into allegations of abuse and neglect with respect to adults who have mental retardation (ages 18-59), and people in psychiatric facilities; and provide public education and training on disability issues and to inform policy makers about issues affecting people with disabilities.

L, SH

Connecticut Region of Narcotics Anonymous

P.O. Box 1817
Meriden, CT 06450
800-627-3543

This is the local affiliate to the worldwide organization. Contact them for upcoming events and group locations and times. The local, toll free Helpline is available for people 24 hours a day, 7 days a week.

A, CT, L, N, W

The Consultation Center (TCC)

389 Whitney Avenue
New Haven, CT 06511
203 789-7645
www.theconsultationcenter.org

The mission of The Consultation Center is to promote the development of individuals and families, prevent mental disorders and problem behaviors, and enhance the effectiveness of mental health and other human services.

Of particular interest may be the Connecticut Self-Help Network. The Connecticut Self-Help Network was organized in 1981 as a volunteer collaboration among mental health/health service providers and self-helpers. The primary goal of the Network is to promote and coordinate

self-help activities across the State. They publish a newsletter, self-help directory and provide self-help information, referrals, workshops and more.

A, CT, F, N, W

Consumer Organization and Networking Technical Assistance Center (CONTAC)
1036 Quarrier Street
Suite 208A
Charleston, WV 25301
888 825-8324
www.contac.org

CONTAC is a resource center for consumers and consumer-run organizations across the United States. Available services and products include informational materials, on-site training and skill-building curricula, electronic and other communication capabilities, networking and customized activities promoting self-help, recovery, leadership, business management, and empowerment. CONTAC provides these services in collaboration, as needed, with other technical assistance centers, consumer-supporters, and its developing western-based office, CONTAC del Oeste.

CT, M, N, P, SH, W

Mary Ellen Copeland, MS, MA
PO Box 301
W. Dummerston, VT 05357
802 254-2092
802 257-7499 fax
www.mentalhealthrecovery.com

Mary Ellen Copeland is a mental health recovery educator and author. Her focus is on self-help. She has learned the concepts, skills and strategies she teaches from her own personal experience with extreme moodswings and from her ongoing studies with people who experience psychiatric symptoms. Her teachings and writings include topics like getting a sense of hope, Wellness Tools, Wellness Recovery Action Planning, Relapse Prevention, Crisis Planning, Developing a Strong Support System, Education, Personal Responsibility, Self-Advocacy, Building Self-Esteem, Healing from the Effects of Trauma, and Relieving Loneliness and Worry.

Find out more details about some of her publications on page 48 or by visiting her website listed above.

B, N, L, SH,W

Dual Recovery Anonymous World Service Central Office
P.O. Box 218232
Nashville, TN 37221
877 883-2332
www.draonline.org

A self-help program for individuals who experience a dual disorder of chemical dependency and a psychiatric or emotional illness. Based on the principles of the 12-steps and the personal experiences of individuals in dual recovery.

Literature, a newsletter, and assistance in starting local groups available.

A, L, SH, W

Infoline

United Way of Connecticut
1344 Silas Deane Highway
Rocky Hill, CT 06067
211 toll free in Connecticut
860 571-7500
860 571-7525 fax
www.infoline.org

Infoline is an integrated system of help via the telephone - a single source for information about community services, referrals to human services, and crisis intervention. It is accessed toll-free from anywhere in Connecticut by simply dialing 2-1-1. It operates 24 hours a day, 365 days a year. Multilingual caseworkers and TDD access is available.

Infoline may be helpful in helping you connect to a local warm line and other self-help resources in your community.

N, P, W

International Association of Psychosocial Rehabilitation Services (IAPSRS)

10025 Governor Warfield Parkway
Suite 301
Columbia, MD 21044-3357
410 730-7190
410 730-1723 TTY
www.iapsrs.org

IAPSRS seeks to help advance the role, scope, and quality of services designed to facilitate the community readjustment of people with psychiatric disabilities. In these times of change and challenge, we in the psychosocial rehabilitation field need a strong and unified voice to achieve the mission and purposes of psychosocial rehabilitation.

IAPSRS continually seeks to improve the quality of psychosocial rehabilitation services and resources, to strengthen the role of community-oriented psychosocial rehabilitation within the mental health service delivery systems, and to facilitate the coordination and continuity of programs.

IAPSRS is the Association that brings together agencies, practitioners, families, and persons with psychiatric disabilities. We serve as advocates

for community-oriented psychosocial rehabilitation and seek to ensure that the best interests of all concerned are effectively supported.

They publish a journal, newsletters, and have a list of publications and educational materials available to order.

A, B, F, M, W

Job Accommodation Network
PO Box 6080
Morgantown, WV 26506-6080
1-800-526-7234 (V/TTY)
1-800-ADA-WORK (V/TTY)
304-293-5407 fax
HTTP://janweb.icdi.wvu.edu/

The Job Accommodation Network (JAN) is a free consulting service that provides information about job accommodations, the Americans with Disabilities Act (ADA), and the employability of people with disabilities.

B, M, N, P, F, W

Knowledge Exchange Network (KEN)
P.O. Box 42490
Washington, D.C. 20015
800 789-2647
301 443-9006 TTY
www.mentalhealth.org

As you realize, knowledge is power. Knowledge can empower us, as mental health consumers/survivors, to gain new resources and to participate meaningfully in planning, implementing, and evaluating the programs and mental health service systems that so greatly affect our lives.

The National Mental Health Services Knowledge Exchange Network (***KEN***), of CMHS, represents a potent tool for consumers/survivors to get the information we need, when we need it. You can order publications or you can download them from ***KEN***'s online sites.

A, B, N, L, SH, W

Mental Health Association of Connecticut, Inc.
20-30 Beaver Road
Wethersfield, CT 06109
800 842-1501 (toll free in CT)
860 529-1970
860 529-6833 fax
www.mhact.org

The Mental Health Association of Connecticut, Inc. (MHAC) is a local affiliate of the National Mental Health Association. This statewide, private, non-profit membership organization and is the oldest organization

in this country's mental health movement. Their mission is to advocate and work for everyone's mental health.

A newsletter, information and referrals are available. MHAC also has a network of support groups across the state.

SH, W

Narcotics Anonymous

World Service Office in Los Angeles
PO Box 9999
Van Nuys, California 91409 USA
818 773-9999
818 700-0700 fax
800 627-3543 local toll free helpline
www.na.org

Narcotics Anonymous is an international, community-based association of people recovering from drug addiction with more than 28,000 weekly meetings in 113 countries.

See the listing for the Connecticut Region of NA to find out about groups in your area.

A, L, W

National Addiction Recovery Organization

P.O. Box 32
Haddam, CT 06438
860 345-8126
www.supportrecovery.org

Through a national, coordinated effort, the National Addiction Recovery Organization supports the empowerment of recovering communities to educate and advocate at the national level.

A, B, CT, M, N, P, SH, W

National Alliance for the Mentally Ill (NAMI)

200 North Glebe Road
Suite 1015
Arlington, VA 22203-3754
800 950 NAMI (Helpline)
www.nami.org

The National Alliance for the Mentally Ill (NAMI) is a nonprofit, grassroots, self-help, support and advocacy organization of consumers, families, and friends of people with severe mental illnesses.

By calling the Helpline you can access referrals and informational brochures, fact sheets, books and videos on various mental illnesses and topics related to family members and consumers.

A, B, CT, L,

National Alliance for the Mentally Ill Connecticut

M, N, P, SH

(NAMI CT)
151 New Park Avenue
Hartford, CT 06106
860 586-2319
800 215-3021 Connecticut only

This is the local affiliate to the National organization listed above. Local information and a newsletter are available through NAMI CT.

B, F, P, W

National Clearinghouse for Alcohol and Drug Information (NCADI)
P.O. Box 2345
Rockville, MD 20847-2345
800 729-6686
800 487-4889 TDD
877 767-8432 Spanish
www.health.org

The world's largest resource for current information and materials concerning alcohol and substance abuse prevention, intervention, and treatment, the *National Clearinghouse for Alcohol and Drug Information (NCADI)* is a service of the Center for Substance Abuse Prevention, which is under the Substance Abuse and Mental Health Services Administration (SAMHSA).

Brochures, publications, information specialists, referrals, literary searches and more are available through NCADI.

B, F, N, P, W

National Consumer Supporter Technical Assistance Center (NCSTAC)
National Mental Health Association
2001 N. Beauregard Street, 12th Floor
Alexandria, Virginia 22311
800 969-6642
703 684-5968 fax
www.ncstac.org

NCSTAC's purpose is to strengthen organizations supporting mental health consumers, survivors and ex-patients by providing technical assistance in the forms of research, informational materials, and financial aid.

A newsletter, booklets, workbooks and other helpful materials and services are available for consumers and consumer run agencies.

A, CT, F, M
N, P, W

National Empowerment Center (NEC)
599 Canal Street
5th floor East

Lawrence, MA 01840
800 POWER2U (800-769-3728)
www.power2u.org

The mission of the National Empowerment Center Inc. is to carry a message of recovery, empowerment, hope and healing to people who have been diagnosed with mental illness.

The NEC has a toll-free information and referral line where you can access information on topics such as advance directives, shock treatment, schizophrenia, self-help groups in your area, legal services in your area, meditation and self-help techniques, coping with depression, etc. If they do not have the information you need, they will work with you to find it. They also publish an award-winning newsletter filled with important and practical news about recovery, advocacy, and self-help.

The NEC keeps updated lists of consumer-run organization and advocacy groups in all 50 states. They are also active in the cross-disability movement and can help you network with independent living centers and disability rights groups across the country.

NEC staff are internationally recognized authors with many publications and books. See page 48 for more information about the NEC publications and materials.

CT, F, N, P, W

National Institute on Drug Abuse (NIDA)

National Institutes of Health
6001 Executive Boulevard, Room 5213
Bethesda, MD 20892-9561
www.nida.nih.gov

NIDA's mission is to lead the Nation in bringing the power of science to bear on drug abuse and addiction. This charge has two critical components: The first is the strategic support and conduct of research across a broad range of disciplines. The second is to ensure the rapid and effective dissemination and use of the results of that research to significantly improve drug abuse and addiction prevention, treatment, and policy.

B, P, F, W

National Institute for Mental Health (NIMH)

Information, Resources & Inquires Branch
5600 Fishers Lane
Rockville, MD 20857
301 443-4513
301 443-8431 TDD
800 421-4211 (Depression/Awareness, Recognition and Treatment Information)
www.nimh.nih.gov

The mission of the National Institute of Mental Health (NIMH) is to diminish the burden of mental illness through research. This public health mandate demands that we harness powerful scientific tools to achieve better understanding, treatment and, eventually prevention of mental illness.

Brochures, fact sheets and other educational materials available.

A, B, N, P, F, W

National Mental Health Association (NMHA)

2001 North Beauregard Street, 12th floor
Arlington, VA 22311
800 969-6642
800 433-5959 TTY
www.nmha.org

The National Mental Health Association (NMHA) is the country's oldest and largest nonprofit organization addressing all aspects of mental health and mental illness. With more than 340 affiliates nationwide, NMHA works to improve the mental health of all Americans, especially the 54 million individuals with mental disorders, through advocacy, education, research and service.

The NMHA offers a variety of low-cost resources including pamphlets, brochures, fact sheets, newsletter and advocacy information and resources available through their website or by calling the toll-free number.

B, M, F, W

National Mental Health Awareness Campaign

1350 Connecticut Avenue, 9th floor
Washington, D.C. 20036
202 207-1334
www.nostigma.org

The National Mental Health Awareness Campaign is a not-for-profit, non-partisan, nationwide public education campaign dedicated to combating the stigma associated with mental illness among youth, adults and seniors. Their goal is to reduce the discrimination that pervades the daily lives of Americans living with mental illness and stimulate help-seeking behavior to substantially increase the number of Americans accessing mental health services.

Brochures, information and referrals are available.

B, CT, F, N, P, SH, W

National Mental Health Consumers' Self-Help Clearinghouse

1211 Chestnut Street, Suite 1207
Philadelphia, PA 19107
800 553-4539
215 636-6312 fax

www.mhselfhelp.org

The National Mental Health Consumers' Self-Help Clearinghouse is a consumer-run national technical assistance center serving the mental health consumer movement. They help connect individuals to self-help and advocacy resources, and offer expertise to self-help groups and other peer-run services for mental health consumers.

F, W

President's New Freedom Commission on Mental Health
5600 Fishers Lane, Room 13C-26
Rockville, Maryland 20857
301 443-1545
301 480-1554
www.mentalhealthcommission.gov

SH, W

Recovery, Inc.
802 North Dearborn Street
Chicago, IL 60610
312 337-5661 phone
312 337-5756 fax
www.recovery-inc.com

Recovery, Inc. is a self-help mental health program based on the work of their founder, the late Abraham A. Low, M.D. It is a non-profit, non sectarian, and completely member-managed organization. Recovery Inc. has been active since 1937 and has groups meeting every week around the world, including Connecticut.

CT

Sangster Associates, Inc.
ysangster@cs.com

Sangster Associates, is a consulting agency, headed by Yvette Sangster, advocate, activist, motivator, organizer, national educator and speaker. Yvette provides guidance, skills training, and trouble-shooting to individuals, groups and agencies that are seeking to gain skills to meet their goals. With more than 18 years of experience of being in recovery and working with others in recovery from psychiatric disabilities, she delivers seminars, lectures and presents workshops on topics related to personal empowerment strategies, skills education, systems re-design, advocacy program development, legislative advocacy, coalition-building, organizing, network development, and more.

CT, N, P, SH, W

Smart Recovery
7537 Mentor Avenue, Suite 306
Mentor, Ohio 44060
440 951-5357
440 951-5358 fax
www.smartrecovery.org

SMART Recovery® is an abstinence-based, not- for-profit organization with a sensible self-help program for people having problems with drinking and using. It includes many ideas and techniques to help you change your life from one that is self- destructive and unhappy to one that is constructive and satisfying. SMART Recovery® is not a spin-off from Alcoholics Anonymous. They teach common sense self-help procedures designed to empower you to abstain and to develop a more positive lifestyle. When you succeed at following our approach, you may graduate from the program, or you may stay around to help others.

L, SH, W

Smart Recovery, Connecticut chapter
Henry Schissler
203 272-0084
http://pages.cthome.net/ctsmart/

This is the local chapter to the Smart Recovery program listed above.

A, B, CT, M, P, F, SH, W

Substance Abuse and Mental Health Services Administration
5600 Fishers Lane
Rockville, MD 20857
www.samhsa.gov

SAMHSA is the main Federal agency charged with improving the quality and availability of prevention, treatment, and rehabilitative services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illnesses.

B, CT, M, P, SH, W

Women for Sobriety, Inc.
P.O. Box 618
Quakertown, PA 18957
215 536-8026
www.womenforsobriety.org

Women For Sobriety, Inc. is a non-profit organization and self-help program dedicated to helping women overcome alcoholism and other addictions. Based upon a Thirteen Statement Program of positivity that encourages emotional and spiritual growth, the "New Life" Program has been extremely effective in helping women to overcome their alcoholism and learn a wholly new lifestyle.

WARM LINES across CONNECTICUT

Warm Lines are telephone services staffed by people with psychiatric disabilities who offer phone support to their peers. These lines are **not** crisis lines and the hours of operation vary at each facility.

Greater Waterbury Mental Health Authority
Waterbury, CT
1-800-314-2680

Inter Community Mental Health Center
East Hartford, CT
860-895-3013

North West Mental Health Authority
Torrington, CT
860-482-1783

Birmingham Group
Ansonia, CT
203-732-2004

River Valley Services
Middletown, CT
1-800-316-9145

Reliance House
Norwich, CT
860-376-2599

Capitol Region Mental Health Center
Hartford, CT
860-297-0920

Connecticut Mental Health Center
New Haven, CT
1-800-258-1528

Greater Danbury Mental Health Authority
Danbury, CT
203-830-0153

Recovery-Oriented Mental Health Journals

The Journal of NAMI California
The JOURNAL
1111 Howe Avenue, Suite 475
Sacramento, CA 95825
916 567-0163
916 567-1757 fax

Psychosocial Rehabilitation Journal
Merged with Innovations and Research in Clinical Practice to form Psychiatric Rehabilitation Journal.

Psychiatric Rehabilitation Journal
Boston University, Department of Rehabilitation Counseling
930 Commonwealth Avenue
Boston, MA 02215 USA
617 353-3549
617 353-9209 fax

Psychiatric Rehabilitation Skills
Recovery Press
The University of Chicago, Center for Psychiatric Rehabilitation
7230 Arbor Drive, Tinley Park, Illinois 60477 USA
708 614-4770
708 614-4780 fax

Schizophrenia Bulletin
For subscription information:
U.S. Public Health Service
National Institute of Mental Health
Superintendent of Documents
Government Printing Office
P.O. Box 371954
Pittsburgh, PA 15250-7954
202 512-1800
202 512-2250 fax

Community Mental Health Journal
For more information on any aspect of this journal contact:
Ms. Sharon Panulla
Senior Editor Behavorial Sciences
Kluwer Academic/Plenum Publishers
233 Spring Street
New York 10013-1578
212 620-8000

212 463-0742 fax
Sharon.Panulla@wkap.com

Journal of Mental Health
Carfax Publishing Limited
C/o Sue Dommett
P.O. Box 25, Abingdon,
Oxford OX14 3UE UK
44-1235-401000
44-1235-401550 fax
www.carfax.co.uk

Psychiatric Services
American Psychiatric Press, Inc.
Journals Division
1400 K Street, NW, Suite 1101
Washington, DC 20005 USA
202 682-6070
202 682-6189
800 368-5777 toll free phone
www.appi.org; www.psychiatryonline.org
Mohanna & Associates
3400 Silverstone Drive North 108
Plano, TX 75023 USA
972 596-8777

Innovations and Research in Clinical Practice
Merged with Psychosocial Rehabilitation Journal to form Psychiatric Rehabilitation Journal.

Addiction Journals

Addiction
Blackwell Science Ltd.
Osney Mead,
Oxford OX2 0EL UK
44-1865-206002 (for online orders)
44-1865-206180 (for print orders)
44-1865-206219 fax
www.blackwellpublishing.com

Alcoholism Treatment Quarterly
Haworth Press, Inc.
10 Alice Street
Binghamton, NY 13904-1580 USA
607 722-5857
607 722-6362 fax
800 429-6784 toll free phone
800 895-0582 toll free fax
www.haworthpress.com

Counselor: The Magazine for Addiction Professionals
Health Communications, Inc.
3201 S.W. 15th Street
Deerfield, FL 33442-8190 USA
954 360-0909
954 360-0034 fax

Substance Abuse
Kluwer Academic / Plenum Publishers
233 Spring St Fl 7
New York, NY 10013-1522 USA
212 620-8000
http://www.wkap.nl

Selected Books & Workbooks Featuring Recovery-Oriented Materials

Publication Catalogues:

Center for Psychiatric Rehabilitation, Boston University, 930 Commonwealth Avenue, Boston MA 02215. 617-353-7700; www.bu.edu/sarpsych. Publication catalog.

Center for Substance Abuse Prevention, SAMHSA, Washington, DC. National Clearinghouse for Alcohol and Drug Information Publications Catalog.

National Empowerment Center, 20 Ballard Road, Lawrence, MA 01843. 800-769-3728. NEC Catalogue and NEC Audio Tape Catalog.

Books:

Beers, C. (1970). A Mind that Found Itself. University of Pittsburgh Press.

Daly, D. and Spear, J. (1989). *A Family Guide to Coping with Dual Disorders: Addiction and Emotional or Psychiatric Illness*. Available from Hazeldon, P.O. Box 176, Center City, MN 55012-0176.

Deveson, A. (1992). *Tell me I'm here: One Family's Experience of Schizophrenia*. NY: Penguin Books.

Fisher, Daniel, M.D., Ph.D. *New Vision of Recovery: You Too Can Recover from "Mental Illness"* National Empowerment Center, Lawrence, MA

Group for the Advancement of Psychiatry (1986*). A Family Affair: Helping Families Cope with Mental Illness*. NY: Brunner/Mazel.

Jamison, K. (1995). *An Unquiet Mind: A Memoir of Moods and Madness.* NY: Knopf.

Kaysen, Susanna. (1994). *Girl Interrupted*. NY: Vintage Books.

Lefley, H. & Wasow, M.Eds. (1994). *Helping Families Cope with Mental Illness*. NY: Harwood Academic Publishers.

Manning, M. (1995). *Undercurrents: A Life Beneath the Surface*. San Francisco, CA: Harper.

Mueser, K. and Giingerich, S. (1994). *Coping with Schizophrenia: A Guide for Families*. Oakland, CA: New Harbinger Publications.

North, Carol S. (1987). *Welcome Silence: My Triumph Over Schizophrenia.* NY: Simon and Schuster.

Papolos, D. and J. (1997). *Overcoming Depression*. (3rd ed.) NY: Harper Perennial.

Schiller, L. and Bennett, A. (1994). *The Quiet Room. A Journey Out of the Torment of Madness*. NY: Putnam.

Simon, Lizzie. (2002). *Detour: My Bipolar Road Trip in 4-D.* NY: Atria Books.

Solomon, Andrew. (2002). *The Noonday Demon: An Atlas of Depression*. NY: Simon and Schuster.

Spaniol, LeRoy, Gagne, Cheryl and Keohler, Martin. (Ed.) (1997). *Psychological and Social Aspects of Psychiatric Disability*. Boston, MA: Center for Psychiatric Rehabilitation.

Spaniol, LeRoy and Keohler, Martin. Ed. (1994). *The Experience of Recovery*. Boston University, Boston, MA: Center for Psychiatric Rehabilitation.

Styron, W. (1990). *Darkness Visible. A Memoir of Madness*. NY: Random House.

Thompson, Tracy. (1996). *The Beast: A Journey Through Depression*. Plume

Workbooks and Handbooks:

Althauser, Doug (1998). *You Can Free Yourself from Alcohol & Drugs: Work a Program that Keeps You in Charge*. Oakland, CA: New Harbinger Publications, Inc.

Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. *Recovering Your Mental Health Series*. 5600 Fishers Lane, Room 15-99, Rockville, MD 20857. (To order your free copies call: 800-789-2647)

Copeland, M.E. *Wellness Recovery Action Plan*. W. Dummerston, VT: Peach Press. (To order, call: 802-254-2092)

Copeland, M.E. (2001*). Wellness Recovery Action Plan for People with Dual Diagnosis*. W. Dummerston, VT: Peach Press. (To order, call: 802-254-2092)

Copeland, M.E. (1999). *Winning Against Relapse*. Oakland, CA: New Harbinger Publications.

Copeland, M.E. (1994). *Living Without Depression and Manic Depression: A Workbook for Maintaining Mood Stability*. Oakland, CA: New Harbinger Publications.

Copeland, M.E. (1992). *The Depression Workbook: A Guide to Living with Depression and Manic depression.* Oakland, CA: New Harbinger Publications.

McDermott, D. and Snyder, C.R. (1999*). Making Hope Happen: A Workbook for Turning Possibilities into Reality*.

Spaniol, LeRoy, Keohler, Martin and Hutchinson, Dori. (2000*). The Recovery Workbook: Leader's Guide*. Boston University, Boston, MA: Center for Psychiatric Rehabilitation.

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NOTES