Implementing recovery in mental health – a US perspective

By Gene Johnson, President of Recovery Innovations, in Phoenix, Arizona

[video - part 1]

Introduction, what is recovery?

Thank you, Jed and Angela.

It's an honour and a thrill to see many people that have also come all the way over to Arizona and made the journey the other way. But, esteemed friends and colleagues, it's really a privilege to be here with you. Welcome from the US, where, for some reason, they seem to think they can solve issues in a town meeting, but I'm not so sure that's the solution, but maybe we can have something of a discussion and a dialogue here, about what recovery looks like. I don't want you to be confused by me standing up here behind the lectern, and you get some idea that I'm some kind of an expert. I'd just like to say that really we all have some kind of expertise. And we can all contribute to something wonderful, I think, that is emerging, together, and that's how we're going to do this. So I honour what you're creating and know that, in many ways, there's so much that we'll be able to learn from you, so I'm thrilled with the partnership.

'Making Recovery a Reality' – I think Jed was telling us a little bit about changing the name. We really do believe that it is possible to put recovery into practice but to do that, we're really going to create the future. And I think that's the theme of what my remarks are about – that it's up to us. It's up to us to create something new and wonderful in the future.

And we know it starts with a vision, doesn't it? So whether we're working with an individual that's come to us for services, whether we're an organisation, whether we're a community, whether we're a country or wherever we're coming from, we start with a dream. We start with some hopes, and it's a vision that is different from where we've been. So, this other subtitle here - 'We changed our mind' – I was sitting, interviewing someone for a management position, a couple of weeks ago, in a new project that we're about to get started in Washington State. And I was a bit triggered because his language didn't resonate with me. You could imagine where he was coming from and I think he was doing this because I would be impressed by how clever and smart he was. But he was talking about brains and chemistry and illness and disease and I had to interrupt him, because it wasn't working for me, and I said "Well, we changed our mind. We have another point of view."

Now, there was a guy who changed his mind and thought it was a good idea to spend four years of his life lying on a scaffold, painting a ceiling. And Michelangelo said, 'I hope that I always desire more than I can accomplish.' He also said this – 'The greater danger, for most of us, lies not in setting our aim too high and falling short, but in setting our aim too low and achieving our mark'. We've had low expectations. We can change our mind and raise the bar.

Now, in the US, we were given a vision, a few years ago, in a report that the federal government did, called, Transforming Mental Health Services in America: Achieving the Promise. And there was a vision statement in this report, and when I read it, I was amazed, and a bit perplexed, actually, because the vision was really a big, big vision, and this is what they said: 'We envision a future where everyone with a mental illness will recover.' How big is that? Everyone! Not 90%, but everyone.

And we have to understand what this word 'recover' means. And we've had a lot of discussion about that, Sainsbury centre has been trying to detail and flesh that out. For us, what we've come to understand 'recovery' to mean is simply this: remembering who you are and using your strengths to be all you were meant to be. What happens to so many people when they get labelled with a mental illness is they forget who they are and, in fact, many times, become that label. And, so, we hear people say 'I'm a schizophrenic, I'm a bipolar', and our task is to help people remember who they really are, who they were born to be, if you will, and use those strengths, those gifts that they have to become all they were meant to be, and that's what we understand recovery to be.

Now, the other thing I wanted to say about recovery, that I didn't know when we first started having this discussion, back in Arizona, in our organisation, about what recovery did mean, about ten years ago, is that recovery is also for us. Recovery is also for me. Because there were certain beliefs I had that didn't support people becoming all they were meant to be, and certain practices that we engaged in that, in fact, held people back, and in some cases, even traumatised people. I was the chairman of a provider organisation that was responsible for all of the crisis and emergency services for our county of 3.5 million people. And when I started to listen to people and what they said about what it was like to be served by my services, sometimes what I heard didn't make me feel good. They talked about being traumatised, they talked about violence, they talked about abuse. And, in fact, sometimes, the things that we did were something else that they said they had to recover from. So I needed to recover too, from some of the things that I believed to be true and thought were necessary.

I think our system needs to recover as well, and I believe that it can. I believe that there's hope for all of us. Now, we're in the midst of very tough times, financially. I know for the last year, in the States, there have been tremendous, tremendous cuts, reductions, budget challenges, and it's put our whole mental health system in a real crisis. We provide services in about five or six different communities in North Carolina, and due to the budget crisis, the state decided they had to right-size their budget and they had to reduce the mental health funding and they completely eliminated one of the important community service codes that we were billing under, called Community Support. They have AC [?] teams, Community Support teams and Community Support. $200 million worth of services gone that were supporting 36,000 people in the community. How do you deal with something like that? What's the solution to something like that?

We were awarded a little opportunity in the city of Philadelphia, and I was talking with the Philadelphia leaders because the funding wasn't what we needed it to be, and they were explaining their situation, that the State was in such a budget crisis because of the economic challenges they were having that none of their provider organisations were getting paid, period. One large, major organisation in Philadelphia had, just last week, when I was talking with them, cut everybody's salary by 30% in order to stay in business. We got a funding cut in Arizona programmes of $0.5million which represents 10% of the outpatient and peer services that we deliver there and I had to reduce executive salaries by 20%. We cut people's hours, we tried to do it in a way that was responsible, but these are tough times, you know. We provide services in California, and the State of California, you may have heard about their budget crisis, is sending out IOUs instead of cheques. What do we do? What's the solution? What's the answer?

I have hope because the kinds of things we're talking about now are the future, and can offer a solution that can create real opportunity, I think, for recovery to grow.

[video – part 2]

Culture – changing beliefs

So, this is a simple paradigm that I like to use, because it says something about how the results in our culture are created, and it starts first with what we believe to be true. What we think, in our minds. The world is flat – no, it's round. So we change our mind. In this case, the results are produced by the actions that we engage in, which create an experience that further validates our belief. So, in our system, oftentimes, we've had non-recovery results show up because we didn't believe recovery was possible. We didn't believe that people could take on their life, we didn't believe that people could take care of themselves and make decisions, and that we had to take care of them. And so we engaged in actions and created programs that were built on maintenance and stabilisation and care-taking, and so forth. And of course, the experience then was not recovery, because we didn't believe it was possible. So, again, we have to change our mind, to produce recovery results first by believing that everybody can recover. If we really embrace that, if we really believe that, it has huge implications for the actions that we engage in, and it's been my experience that then people have the experience of recovery in their lives. What we believe, creating actions, creating experience that reinforces the belief. So, we changed our mind, and ten years ago, we were a traditional mental health provider in our mental health system with the usual kinds of staff and the usual kinds of services and treatment and so forth. As we started to listen to people about their experiences of having received services from us, they told us that our mission statement, which was to be the premier provider of crisis stabilisation services, wasn't very inspiring.

I thought it was great to be the best, you know, but the best at what? Stabilisation? People said they wanted more than that, that our expectations were way too low, and that they were capable of so much more. And so we began to explore how to raise our expectations and see what showed up.

So the first thing we had to do was that we had to re-create our purpose. We had to figure out what our mission really was. And our mission wasn't really to recover people. We can't do that – that's up to people themselves, right? And we realised that our mission, our purpose was to create an opportunity, and create and environment so people could get the power to recover. And, of course, we wanted to have some success. We wanted to see people thriving; we wanted to see people achieving their goals, their hopes and dreams. And realised that we had to do this in connection, together. And we had to be connected to ourselves, who we really are, what our purpose is, the people around us. And finally, what it all means, our meaning and purpose, what are we here for. So we changed our mind about what our mission was.

So with the passion and the hope of our new recovery mission, we began to expect great things. And great things began to show up. The first experience that perhaps we had that caused us to start to think differently was discovering the Wellness Recovery Action Plan (WRAP). And this is how we did this. We didn't have somebody come to us and say, 'you should do this'. We didn't have somebody come to us and say, 'we've got money for you to do this'. It seemed that it was the right thing to do. And so we got busy doing it, and we began to have WRAP classes. And after about 6 weeks, we had 12 or 15 people that had completed their WRAP plans and we decided to do something else that we'd never done before, to have a celebration. Usually we'd do something we'd call discharge, sometimes under circumstances we're perhaps not as proud of as we'd like to be. But let's have a graduation, let's celebrate people's accomplishments. And so we did, and we got together and we heard stories, and you know the most amazing thing was, that there were several people who had been in our services, perhaps briefly in the crisis services, something like that, that we didn't recognise. They were transformed people. And the most amazing thing that

changed our minds, was they did it themselves. They did it without us. And we thought we were necessary for their recovery. But once they got the tools, once they got a dose of hope, once they heard that someone else had recovered and heard their story, they did it themselves.

And what we did, and I can't say that this was deliberate and strategic, we did something really hard. And I think when we're going to take something on that's a recovery challenge, we should do something that's really challenging, and maybe that we think is impossible. I know each one of us sitting here today can think of a few things – 'Oh, that'll never happen'. Well, guess what? Then it won't. So take on something that seems to be impossible. One of the areas we were really concerned about was the way we treated people in our crisis and emergency service. And, what now seems so disrespectful, the seclusion, the restraint techniques, in some cases, the take-downs, the forced medication, the forced treatment that people said was one of the worst things they'd experience in their life. But we did not know how to do this any differently, because we were convinced that this was necessary to keep people safe. And so we got busy with that and we started to work on that. And we made a declaration that we were not going to engage in violent practices with people and we were not going to use force. And we were able to achieve that because of that declaration and a belief that somehow we could find a way to be with people that was more respectful.

[video – part 3]

Using and training peers

We changed our mind about the potential of people who were receiving services with us, folks that had only been in a role with us as a mental patient. We had over the years a strong belief and supported consumer-run services. In fact, we'd started a few organisations that are still going today. But what I believed about that was that it was a good start because there was good work being done there, and there was tremendous value there. But what I noticed was that it was kind of over here on the side. It wasn't part of the mainstream of the service system, and oftentimes poorly funded, many times at risk, sometimes without appropriate infrastructure to really grow the service.

So I began to wonder what it would be like if we could come together - if we could bring those consumer-operated programs into the mainstream of our services. We said that it seems like that could have value and we could learn from that. But frankly, I had no idea, no idea what was going to show up as a result of that. People began to step up. When I first thought about it, I thought where in the world would we find people with serious mental illness who could work with us. So we took some risk, we stepped out, and we created a training program. And people began to graduate from the training program and people began to become employed.

It's really important, I want to say that we have a large number of peers that have graduated from our training program in 16 states in the US, even in Scotland and over 100 folks in New Zealand and here in England. The important thing is that it does start with training, but training has got to be for real jobs. We're not going to train people if there's no work. So we've slowed down the training right now in many places because there are no jobs. We're laying people off. Where we have opportunities, is when we create a new service and there, like we're doing in Washington State now, where we're converting the county-run crisis triage unit into our living room approach, which we can talk a little bit about, half of the staff there will be people in recovery, will be peers. So there, where we have jobs, we're going to do training.

Just a bit about the outcomes of the training itself. Sometimes people say 'I want to come to the training, because I've heard it's personal enrichment'. Well, it is that, but it is training for real work. So the first year we did this, in 2000, 66 people graduated from the training and we hired them all. Because, by this time, the news had gotten out about WRAP, the news had gotten out about some of the other recovery education things that we were doing, and so we had work. So 66 people graduated and they were all hired.

Our evaluation partner, Bill Anthony, and his team at the Center for Psych Rehab at Boston University, did a study of the first cohort of peers that we employed and administered a series of standardised tests and first of all, on the vocational outcomes, 89% were still working after a year. That's a phenomenal statistic. Across our workforce, if we had that kind of retention rate, that would be fantastic. And this has sustained itself over the years. And you see an increase, just from the training, in empowerment, in recovery attitudes, in self-concept, because what's happening here is people are really beginning to get a hold of what recovery means. Part of the training is understanding myself and how to give my gifts, my life experience in a way that can help others recover.

So we changed our mind about the role of people with a serious mental illness. We created a new discipline, in fact, that we call Peer Support Specialist. We didn't know how to label this in the beginning, but that's what we landed on. And we began to create a new workforce. So today I would say that this has pretty much become a global movement. And in the US, at least 20 states recognise Peer Support as a benefit or a covered service in their Medicaid program. The Center for Medicare / Medicaid Services that funds the Medicaid program, in 2007, endorsed Peer Support as a best practice and encouraged states to move forward with creating Peer Support as a service in the mental health system.

So what did we start to notice that showed up when we started to bring peers onto our teams. First thing, people's recovery grows by leaps and bounds. And it's not just about having a paycheck, although that's a good thing, you know, to improve people's quality of life. But it's also being valued, making a contribution that's important, giving back to other people. And people began to grow in their recovery. And we saw amazing things happening with people who were receiving Peer Support, grow in their recovery. Now, we haven't done very well in our system at engaging people who say no. We've got our ways, right, of bringing people in. But what we noticed with the peers is that they were much better at being able to engage people in services that previously had not been willing to be engaged with us. Part of that is the natural credibility, the natural credential of life experience that they bring, they've been there. We encourage our peer staff to use the credential ITE after their names – I'm the evidence. It's me, I'm a real person and yes, I was in your shoes.

The concepts of peer support are grounded in mutuality, grounded in relationships, not fixing, but rather 'being-with'. It's a powerful thing to be with someone at a distressing moment on their life, not having to do anything but bear witness to their experience. That connection between us is very healing. And the other thing that we did not intend or know would show up is that it helped our organisation become more of a recovery-based organisation. A re-definition of our roles together – someone that has been exclusively in the role of patient becoming my colleague. Now that didn't happen by flipping a switch, and in some cases it didn't happen easily, but I can tell you that quickly, it happened. We know that the beliefs that we often bring may be grounded in biases, past experiences and sometimes even stigma. The way we overcome that is through getting to know each other. And as we got to know people in a different way, in a complete way, it redefined what we thought was real, our reality.

If you work in a hospital, if you see people in crisis and emergency services, you're seeing people when they're at their most difficult times. What I found with the staff when I started having the discussion about

recovery values, was that we got stuck right away on the first value of hope. They didn't have it. There wasn't much hope anywhere. But, when Tommy showed up, who, six months ago, had been a patient in the hospital, and he was looking good and had a smile on his face, and he was participating as an equal member of the team, suddenly it changed how I felt about what was possible, and I got a burst of hope, a dose of hope myself.

[video – part 4]

So, once we saw what our peer staff could do, we realised we'd set the bar way too low. Their capabilities and their effectiveness began to make a big difference throughout our organisation and even the entire system. Our peer staff helped us shift from focusing on problems to seeing the possibilities because they knew it from first-hand experience. And this is profound, because, we were talking earlier this afternoon about how, too often, when people come to us, we have to diagnose the problem and, by golly, if it's not pretty big when they come in the office, it's pretty big when they leave. The peer staff aren't trained in problems. We don't train them in diagnoses. We've got that down. They're trained in possibilities, they're trained in potential. They helped us begin to shift our conversation. They had higher expectations than we did. They believed that people could recover. And they were more apt to say, 'I know what you mean', and do that with credibility. They would say, 'I've been there'. They would say, 'We can get over this'. The message of hope.

So as this began to grow, we were thrilled and excited and just busy, busy, busy doing all this stuff and sometimes we were too busy even to count the numbers, but all of a sudden, we realised that, over the years, in Maricopa county, which is the Phoenix area, there had been roughly 850 people that had graduated from the training program but that 75% of them had been employed as Peer Specialists. For some, this became a new career, others chose to move on to some other field of interest. They began to have some success in their life and in their work.

Since we started, till June 2009, 546 Peer Specialists have been employed in our Arizona program. And this has grown now to other programs that we're delivering in other states. 100 have been employed with other organisations, so we're not training them just to work with us, but throughout the mental health system. Today, 247 Peers are currently employed in the Arizona program, which represents 72% of our workforce. Many of them are in full-time jobs. Now, I didn't set out to do this, deliberately, strategically, but it's what showed up because it's what was working and it's what was making a difference, and every time there was an opportunity to re-direct some funds, or some new funds became available, this is what was funded. So we had more opportunities to continue to grow the Peer Support work. The other people, the other professionals, the other mental health staff didn't go away, but we continued to grow the Peer workforce.

Again, 91% of the 247 Peers in the current workforce have been employed for at least a year and over 50% have been employed for over three years, and that's much higher than that because they hadn't started working prior to three years ago. 73% of this group are in leadership positions, a couple of them as CEOs of other organisations in our community. These were people that had been told they would never work again, and had spent years lying on their sofa in their living room. In fact, our Regional Vice-President, Lisa, of our California programs, is someone who was told exactly that. She had no life, no life whatsoever. But now she's working at a very responsible level, making a real contribution to the Southern California system.

Another thing that was so exciting is that $4million of salary was being paid to this group of employees that was previously going into mental health treatment, these were mental health dollars that were now going into their paychecks to improve the quality of their life, I think that's really cool.

So, some tips from what we've learned over the years.

- First of all, you have to have real commitment. That has to be commitment from the organisation, a commitment from the leadership to really make this work. Because this does challenge many things. We've had rules that get in the way of this being able to work. One organisation I'm thinking of in Tucson literally had in their HR policies that somebody with a mental health problem couldn't be employed, and I've heard rumours of similar things in other places. Employed in their organisation.

- We've got to have quality training, I've been talking about that, we also got to have training for all staff so that everybody understands what we're doing and why we're doing it, to really embed this new discipline of peer support. We've had to do supervisor and leadership training. Now, this is really interesting, because we were asked by the state of Pennsylvania to be a vendor throughout the state as they implemented their peer support initiative, and one of the things they required was that anybody who was going to supervise a Peer Specialist employee had to go through special training for that. So, we kind of scratched our heads and said 'what is that like?', and said, 'yeah there are some things we need to talk about, for sure'. But what we started to realise was that is just needed to be good supervision and good coaching across the board, that there was nothing special or unique for the peer staff that didn't apply to everybody else. So the nature of the workshop, the two-day workshop, we do, that we call Leading and Coaching, is really a very good workshop for anybody supporting any employee.

- Create job-specific, peer support roles. This is really important. One of the things that has happened in some states in the US that have implemented peer support is they've added it in as a service to existing teams. Now this is a good thing, if you're a Peer Support Specialist working on an AC team. The question is, what distinguishes what you do from the Case Manager or the Rehab Specialist, or the other members of the team. And in some places, it looks the same. Now this is a pitfall, because if it looks the same, we're going to lose the value of peer support on that team, and the challenge, the conversation that the peers bring is fundamentally different. We were talking earlier this afternoon about some of the conversations that go on in the break room or in the staff meetings that are conversations about people we're serving that sometimes aren't so nice. If I'm a peer on your team, I may have been there two days ago, or two weeks ago, and I've seen so many of our peer staff be so disturbed and distressed and we support them to have that conversation. But we want peer support to really be peer support, so we create a job-specific role and tasks for the peers.

- We also need to reach a tipping point. And, I would say, it's a transformation tipping point, because, for us, the most powerful thing we've done in terms of creating recovery-oriented services has been changing our workforce and hiring peers. A critical mass of peer support workers. And we need to do this as quickly as we can. We put one peer out in an organisation or in a team that has many, many, many other employees and, guess what?, they suddenly have to adapt themselves to that culture. We want to create a peer presence in the culture so let's get a critical mass as quickly as we can.

- We also want a career ladder. What's started to happen with us, is that as our Peer Support Specialists gain more confidence, and more comfort in their job role, they wanted to take on more responsibility. So if we didn't have that opportunity, they would go down the street and become and Case Manager,

where all that they learned about the peer culture would be not as valued. So we created a career ladder where we have team leaders, we have program managers and administrators that are peers that are supervising peer staff.

- Parity for peer support workers. This is really, really important. So supervision and support, performance expectations, pay, promotions, ethics, it's the same across the organisation. We don't make a distinction between peer staff, we don't do anything special. We expect the same things in terms of what we say is service productivity, direct service hours, attendance, documentation, ethics and boundaries, the same rules apply to everybody and we've always got to remember that it's because this is real work. And we had to learn this in the beginning because we wanted to cut them some slack, and we did that and what we found was the peer staff didn't want it and they didn't like it, and they said, 'Stop that, we're real employees making a real contribution, so why don't you treat us like everybody else around here?'.

- Another key thing to our transformation to create recovery practices was developing an education approach. We believed that education was more compatible with a recovery approach because it's about learning and growing. And it's certainly much more acceptable in society to be a student than a mental patient, there's a valued role that goes along with it. So in 2000 we created what we call the Recovery Education Center and we began to offer classes. We didn't know what to call them, is it groups, is it meetings, and we started listening to people and they said, 'Well, we'd like to come to a class, we've had enough groups'. So we created classes and then we wanted to figure out a way that they could have value. So we started talking with our local college system and we began to form a collaboration where these classes actually could be completed and people could get college credit for taking the class. Eventually this moved to a degree program in recovery, where people could get something on their resume that had great value and improve their employability.

[video – part 5]

Housing

We changed our mind about housing. This was a very challenging area, because, at least in the States, if you are an individual and you a determined to have what is called a Permanent and Total Disability, you must have something like that, which means you have a lifelong chronic illness that you won't recover from, there are certain entitlements that go along with that. Financial support, housing support, and this is good, people need that, but if we're really going to embrace the idea of recovery, they don't need it forever. So it's a temporary situation of support to get somebody to a point where they can take it on themselves.

So when I was approached by our funder, who said, 'Gene, this peer support stuff is really fabulous, we can't believe it, it's really wonderful, it's making such a difference, could you do a peer-operated housing program? And I thought, 'OK, I know what's being delivered now that you call housing, you know, group homes, residential treatment, caretaking and so forth. OK, let's take it on but really have recovery be the goal, rather than housing be the goal. So we invited people to join in this initiative, and we asked them to enrol in the school, in the Recovery Education Center, to learn something about recovery. We created a special class there, called Housing for Success, where they would learn everything about what they needed to know to be able to have an apartment, a place of their own choice in the community.

Then we got busy with them and they were working with a peer, a recovery coach, to help them find an apartment of their own choice and get a lease in their own name. And this was kind of a radical concept

because nobody thought that people with serious mental illness could even get a lease, you know. Criminal backgrounds, evictions, poor credit history, all those things that were said. But it wasn't a problem. We teamed up with someone who does this kind of thing for the general community, apartment finders, or something, they call themselves. And they said, 'We do this all the time with people'. I guess there are other people besides those with a serious mental illness who also have poor credit or have been evicted and so forth. 95% of the people that enrolled in the program got a lease in their own name.

Now these were people that were stuck in the hospital, these were people that were in jail or homeless, all with a label of serious mental illness. We set the goal together with them, of being able to become self-sufficient, which to us meant paying for their own rent, within 12 months. Now that was really a very high expectation. And I would say that it was causing me some anxiety and we were running on thin ice. But it has been absolutely amazing what happens when you change your mind about what's possible. What showed up, after two years, was that we had enrolled 120 people in the program and 77% of them achieved this result of no longer needing the subsidy for their rent. They did this themselves. They did this sometimes through employment, improving their income, some found room-mates, some got reunited with family or friends. An amazing outcome. And I think the other thing that is so relevant in our environment, is that the cost is so much less, compared to the group home, which was fairly highly staffed. And then the cost ended because people graduated from the program.

Hospitalisation

We changed our mind about hospitalisation. Listening to people who said, 'That was not a place where I got well'. In fact, hospitalisation has the same root, I understand, as the word hospitality, which means something like 'a loving blessing'. So we began to wonder whether we could create a loving blessing instead of a hospital. We had an opportunity to create something we called the 'Living Room'. As we were sitting in this very overcrowded, very unhappy space that was our crisis and emergency service, we had an opportunity to take a little additional adjoining space. We were sitting in this space, and we thought, 'You know, if you're really having a hard time, you need a place where you're going to feel comfortable. You need a place you would choose to go to. Most of us have places like that, when we're getting a little crispy, a little ragged.

But what if we created something that was kind of like a living room where people could be treated as a guest. And maybe we could have someone who'd been there before appear there, in the living room, and share their experience and the message of hope and recovery. So we did that. And we began to have a different experience. Our language began to change. So instead of assessments, we'd do something called a 'getting to know you meeting'. Instead of a therapy session, we'd have a recovery partnership. And we were engaging people as we would treat them in our own home.

Now what showed up – this is another, very dramatic, outcome – is that 15 months later the impact on hospitalisation was dramatic. We had had about a 25% rate of hospitalisation at the one centre. That dropped to below 10% in that first 15 month period. That represented in our system a saving of roughly $10 million. That was money that got re-directed to fund more, recovery-based services. Very exciting, it is possible.

We changed our mind about what would really help people if they did have to end up in the hospital. So finally we convinced our county hospital system to have our peer staff on every unit in the hospital. It made a huge shift in the outcomes that occurred from the nine units at the hospital. They reported, after one year, a 56% reduction in re-hospitalisations. Now, this wasn't a scientific study, but the only thing we could

identify that was different was that the peer staff were there on the units. Part of the reason for that was that one of the things that peers developed as their unique contribution was something they called a discharge recovery plan. And this was not like a discharge plan that I was used to seeing. It wasn't a clinical plan, although we had to get people connected to continue, so it was a very practical plan – 'what about my mail and my mailbox, and where am I going to get my medicine and who's taking me home from the hospital', and all of those life issues that get people stressed out and back in the hospital. Also, the reduction of forced interventions in the hospital, because the peers brought their lens of personal experience that created a new kind of accountability.

System structure

We changed our mind about the entire structure of the system. The old belief that we've lived with for so long is, frankly, that it's an entitlement system – 'Because of my disability, I am entitled to treatment, I am entitled to support, financial aid, and so forth'. What people get, in the entitlement belief system is being a victim. And we've got a whole bunch of stuff about how they can complain and file grievances, and all kinds of things happen. So we've had to change our mind about the fundamental beliefs of the system to create a system, a way of being, that is a based on empowerment beliefs. Empowerment, simply, is the ability as opposed to the disability, to perform and produce the results I want. This is very challenging for all of us. It's challenging for us in our work, it's challenging to our employees, It's challenging to those people that we serve to take it on and be accountable for producing the results that I want in my life. But we discover a sense of enlightenment when we do that – is that I can, my gifts, my strengths, my possibilities, we can take on our life. If it's in our work, if it's in our system or if it's in our healthcare. The more personal responsibility, the more accountability I can take on, the less of a victim I'm going to be.

Now I put these two slides up here as a bit of a challenge, if you will. Because personal responsibility, to me, is simply a willingness to be the source of the results I want, the results that show in my life. Personal accountability is the willingness to own those results. It's mine, I did it, it was a mess, I own it, I learned from it, hopefully, or, isn't it great, celebrate it with me. In these hard times, in these tough times, economically, financially, funding-wise, we have to take it on. We really do. It's up to us. We have to take responsibility for creating the future, we have to be accountable for producing the results that we want to see show up, instead of being victimised by what's happening. It's up to us.

So, I say we need to be courageous, that means taking risks, seeing it as an opportunity, really, to create the future. I think it was Eleanor Roosevelt, I love this little quote, who said, 'Do one thing, every day, that scares you.' Are we awake in our life? Sometimes we have to scare ourselves awake. So, have the courage to step out and try something that hasn't been done before. And we need to be generous. We can be driven by fear, and that will shut us down. Then we will simply be reacting to what's coming at us, trying to protect ourselves, hold on to what we think is ours. Or we can give our gifts, we can be generous, and we can do that with great passion and enthusiasm. We've got to create hope, you know, that simple message that we've heard recently. 'Yes we can.' We can, we can do this. There is hope, there's lots of hope. And we've got to stay connected because it's together that we're going to create the future. We've got to do this as a community, we've got to do this as a partnership. We won't do this if we're competing and fighting with each other. We're going to create cooperative working partnerships to create the future. So let's step up, and create the future.

Thank you.