Serious mental health disorders intersect with other social problems: Issues and intervention models to build inclusive communities

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Abstract

Those at greatest risk of marginalization, stigmatization, and isolation are those with physical and mental health impairments, people who are homeless, immigrants and refugees, and those in the criminal justice system. Women are also at great risk because they often hold positions of lower status and in many cultures are excluded from participation in education, employment, and decision making roles. Women with physical or mental health problems often become homeless, are frequently abused and suffer from extreme trauma, and become caught up in criminal activity. In contrast to a traditional mental health treatment approach that is symptom-focused, a recovery-oriented approach promotes community inclusion and full social participation. Resources are offered toward training and implementation of recovery and rehabilitation interventions.

Keywords: serious mental illness; recovery; mental health.

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Introduction

In most countries of the world, people who are stigmatized are most often socially isolated and excluded from full community participation (Stuart, 2014). Community inclusion implies full participation in all aspects of society (Salzer, Menkir, Shair, Drain, & McClaine, 2006), yet those who are most stigmatized either exclude themselves or are excluded by others from the normal aspects of everyday life. Regular jobs, continuing education, housing options of their choosing, leisure activities, friendships, family life, and civic activities and responsibilities including voting are most often not part of the repertoire of people who are stigmatized and socially excluded (Office of the UK Deputy Prime Minister, 2004).

People who experience serious mental health disorders often encounter environmental and social constraints which dramatically influence their lives in the community and this is true in virtually every country of the world (Morgan, Burns, Firzpatrick, Pinfold, & Priebe, 2007; World Health Organization, 2010). Frequently, they lack access to the supports they need in the community, are shut out of normal community life and are denied housing, avenues for social engagement, and equal employment opportunities, limiting their ability to exercise their full rights of citizenship and be fully integrated members in society (Davidson, Tondora, Lawless, O'Connell, & Rowe, 2009). The literature highlights that individuals with serious mental health disorders experience isolation, loneliness, and loss, and frequently have unsatisfied desires for social connection to others and valued social roles (Davidson, Stayner, Lambert, Smith, & Sledge, 1997). Similarly, the literature highlights that for many individuals who have had serious mental health concerns their life struggles are as much struggles against socio-political experiences like stigma, marginalization, and discrimination, as they are with the effects of mental health conditions themselves (Davidson et al., 2009).

Of particular interest for this paper are people with serious mental health disorders, those who are homeless, immigrants and refugees, those in the criminal justice system, and women. There is frequently considerable overlap between and among these groups of people; the intersecting issues specific to these groups are discussed below.

People with Serious Mental Illnesses

Throughout the world, individuals with serious mental health disorders are among the poorest and most vulnerable members of society (Sayce, 2001; World Health Organization, 2005), adding further to their isolation and stigmatization. They are frequently homeless, some are immigrants or refugees and many are women. These individuals are often rejected by society, leading to a downward spiral of increased isolation, worsening mental health, and loss of social networks (Office of the UK Deputy Prime Minister, 2004). The stigmatization of people with mental health disorders is true is globally (Hopper, Harrison, Janca, & Sartorius, 2007; Lauber & Rossler, 2007; Stuart, 2008; Thornicroft, Brohan, Rose, Sartorius, Leese, & INDIGO Study Group, 2009; World Health Organization, 2010), although in some developing countries individuals are more readily integrated into their communities (Hopper et al., 2007). While being included and given the opportunity for community participation is recognized as an important ingredient for recovery from serious mental illness (Bromley et al., 2013) inclusion is far from the norm in most societies, despite evidence from the World Health Organization showing that acceptance and inclusion are related to better mental health outcomes among people with the most severe forms of mental illness (Jablensky & Sartorius, 2008).

Homeless Individuals

People become homeless for a variety of reasons, some of which are related to mental illness and some of which are related to social or financial reasons. People with serious mental health disorders are often terrified of being confined, are fearful that their belongings will be stolen, are rejected from adequate housing, or are too poor to pay for decent housing. In many communities in the U.S. and Canada, the range of housing options for people with serious mental illnesses is limited as many people need supported housing accommodations, and these are typically in short supply. Similarly, in many developing countries, governments often evict individuals who have few resources and lack the power to defend themselves (Global Urban Research Unit, n.d.). The result is that a large percentage of people with serious mental illnesses are homeless or at risk of becoming homeless (Folsom et al., 2005).

Women also become homeless for a variety of reasons. They may have serious mental health disorders with the attendant concerns mentioned above or they may not have resources to pay for housing. Their lack of resources may stem from simple unemployment to domestic abuse that forced them out of a dangerous situation and onto the streets. Women face additional challenges due to their sexual vulnerability and the fact that they often have children for whom they are responsible. Their vulnerability and need to provide for their children can have dire consequences if they are forced into unsafe prostitution or criminal activity. These experiences of women are common in developed countries (Goodman, Fels, Glenn, & Benitez, 2011) as well as in developing countries (Global Urban Research Unit, undated).

Immigrants and Refugees

Immigrants and refugees who have mental health disorders are particularly vulnerable. Given the large numbers of people moving from one country or continent to another, there are many recent immigrants and refugees that face extreme hardship combined with serious mental health disorders, for which they receive little help.

It is estimated that that in the U.S. 92% of immigrants and refugees in need of mental health services never receive them (Birman et al., 2005; Ellis et al., 2010; Kataoka, Zhang & Wells, 2002). Immigrants and refugees bring the values and beliefs of their country of origin to their new homeland; thus there are many reasons for the failure to seek or receive services. Some of these reasons include the stigma about mental illness that exists in many countries, fear of authority (especially though not exclusively, for refugees) language barriers, and cultural values that preclude receipt of services (Ellis, Miller, Baldwin, & Abdi, 2011). For example, in some cultures, the concept of mental illness is virtually non-existent because behaviors are considered to be under the control of spirits or other forces that can be controlled by indigenous healers or faith based providers (Constantine, Myers, Kindaichi, & Moore, 2004; Malarney, 2002). Even where mental illnesses are seen as true illnesses, stigma may be so great that seeking or accepting mental health services is extremely difficult if not impossible.

There are many cultures in which young people do not ordinarily make decisions or choices for themselves but defer to the wishes of their elders (Ellis et al., 2010; McKay et al., 2004). Similarly, some cultures do not afford women the opportunity to express opinions or make decisions, reserving these for male members of the family (Said-Foqahaa, 2011). In such cultures, it could be very difficult for the person with mental health problems, and particularly with serious mental illness, to access services, participate actively in the planning process, and take part in determining the future direction of his or her life.

Another cultural issue that is not often discussed involves trauma resulting from family perpetrated physical or sexual abuse. Although this occurs in many cultures, it is not officially sanctioned. However, in some cultures women and sometimes children are seen as property to be used as desired (Chaudhuri, 2005; Said-Foqahaa, 2011), and these practices can be overlooked or unofficially sanctioned. This is rarely discussed and leads to tremendous trauma for the victim and sometimes for the perpetrator as well, neither of whom will typically receive any help for the trauma.

The problems of refugees deserve special attention. In addition to the multitude of problems experienced by immigrants and other newcomers, most refugees have endured extreme abuse at the hands of those in authority (Birman et al., 2005; Ellis et al, 2011). This is a defining characteristic of becoming a refugee and can lead to somatic symptoms that may have their origin in the fear, anxiety, and trauma of the person's status as a refugee (Rohlof, Knipscheer, & Kleber, 2014). As a result, refugees generally do not trust people in authority or those who work in institutions or systems where the rules and procedures are determined by someone seen as having power. Refugees typically experience extreme fear of those around them and perceive that they and their families are in imminent danger. When all of these factors are combined (stigma from original background, language barriers, religious beliefs about the origin of mental illness, cultural beliefs or practices related to decision making and or sexual exploitation, trauma from abuse by those in authority) and combined with priority needs for adequate food, shelter, and safety, refugees are frequently very reluctant to engage in mental health services.

Sensitivity to individuals from different backgrounds is essential if steps toward engaging an individual and his or her family are to be successful. In such cases, greater attention to family beliefs and preferences should be considered primary while attempting to involve the individual to the greatest extent possible and facilitate planning, service delivery, and ultimately recovery on the person's and family's terms. Language barriers are a frequent impediment because of the inability to communicate the many important facets of a person's life and background that may have contributed, and may still contribute to the mental health problems experienced. It is essential that services are available in multiple languages and from the cultural perspective of the person represented. Treatment considerations must be tailored to the special needs of those receiving services and trauma informed care must be a part of the mix of services. In all cases, the person's wishes about culturally influenced choices must be respected.

People Involved in the Criminal Justice System

Those involved in the criminal justice system very often have a multitude of co-occurring problems including mental health and substance abuse disorders, homelessness, a history of abuse, victimization, and trauma, and poor physical health (Folsom et al., 2005; Goodman et al., 2001; Greenberg & Rosenheck, 2008; Wenzel, Koegel, & Gelberg, 2000). In the U.S, these individuals receive little treatment for their mental health disorders and often little real help to overcome the myriad of problems that they encounter both within the justice system and after release (Simpson & Penney, 2011). The result is the revolving door of incarceration, release, homelessness, drug abuse, symptom exacerbation, and re-incarceration so often seen in this population. Combined with the highly traumatic experiences of untreated mental illness, homelessness, abuse and victimization, arrest and incarceration, the rejection and isolation experienced by individuals in this population leads to severe and extreme trauma which frequently leads to aggression and other behavioral disorders. This situation is particularly acute in the U.S. where jails, prisons, and some forensic institutions are so overcrowded that many individuals have been released without adequate treatment, supervision, or provision for community integration, often leading to their re-offending and re-incarceration. Unsupervised releases in the U.S. between 1990 and 2012 have increased 119% (Public Safety Performance Project, 2014).

A recent systematic review of studies looked at the prevalence and intersection of mental illness, homelessness, gender, victimization, and involvement with the justice system in the U.S. and found high consistency among the studies reviewed for the prevalence of these variables within a majority of the population. These authors noted the high levels of victimization in this population, especially among women and noted the paucity of literature on victimization contrasted with the much greater literature on perpetration of crime, calling attention to the double stigma surrounding mental illness and involvement with the justice system (Roy, Crocker, Nicholls, Latimer, & Aylion, 2014).

Trauma

A large proportion of those with serious mental illness have experienced trauma. Trauma can be from sources that include physical, sexual, and emotional abuse, combat or war experiences, major illness, witnessing abuse or other traumatic events happening to others, catastrophic events, etc. Many individuals are traumatized by the mental health system itself due to the stigma, lack of respect, uncaring attitudes and sometimes dehumanizing and even abusive practices that are demonstrated even today by some mental health professionals (Jennings, 2008).

Experiencing a psychotic episode for the first time can be highly traumatic and can lead to full PTSD or to PTSD symptoms. The trauma can emanate from terror experienced as a result of the psychotic symptoms themselves or from experiences encountered in the treatment system, or both (Mueser, Lu, Rosenberg, & Wolfe, 2010).

With respect to violence, in the U.S. people with serious mental illnesses are more than twice as likely to be victims of violence than those without mental illness (Kooyman, Dean, Harvey, & Walsh, 2007; Silver, 2002), and are more likely to be victims of violence than to be perpetrators of violence (Brekke et al., 2001). A large majority of people with serious mental illnesses who have been incarcerated have experienced trauma either before being incarcerated, during incarceration, or both (Kooyman et al., 2007).

The rate of exposure to violence and the traumatic effect of this exposure are so high for people involved in the criminal justice system, and in particular for women, that most consider it the norm rather than the exception in the U.S. (Osher & Steadman, 2007). Once inside prison, both men and women with mental health disorders are also often subjected to physical violence and are more likely to be victims of violence than incarcerated persons without mental illnesses (Blitz, Wolff & Shi, 2008). Because jails and prisons (and to a lesser extent forensic psychiatric hospitals) can be highly dangerous environments and particularly so for people with serious mental illnesses, individuals often develop adaptive behaviors that help them survive (Rotter, McQuistion, Broner & Steinbacher, 2005).

Women

Women with mental health disorders who are homeless are poorer, are especially vulnerable and often have children to care for, sometimes causing them to put themselves in situations of great risk, such as selling and using drugs, engaging in prostitution, or conducting other forms of criminal and deviant behavior (Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions, 2006; Elklit & Shevlin, 2011; Harris & Bachrach, 1990). Although some issues specific to women have been mentioned in the sections above, the distinctiveness these have on the mental health and lives of women deserves greater detail.

Worldwide, women are often subjected to physical and sexual abuse, sometimes leading to serious mental health disorders and sometimes occurring after the onset of such disorders. Women in the U.S. who experience serious mental health disorders are also at higher risk for experiences of physical or sexual abuse (Goodman, Dutton, & Harris, 1995), homelessness (Robertson, 1996), incarceration (Becker, Andel, Boaz, & Constantine, 2011), and lower socioeconomic status (Bassuck et al., 1996), which can exacerbate the experience of stigma, marginalization, and prejudice that frequently accompanies having a diagnosis of a serious mental health disorder (Davidson et al., 2009). The literature suggests that gender has been ignored for too long in the research among those with serious mental health disorders and more attention needs to be paid to the unique experiences of women to increase their likelihood of psychological well-being (Cogan, 1998). A review of the literature documents the high prevalence of victimization of women who experience serious mental health disorders and the convergent evidence suggests that in the U.S. these experiences are associated with homelessness, substance abuse, increased symptomatology, and sexual risk behaviors (Goodman, Rosenberg, Mueser, & Drake, 1997). Although there are higher rates of trauma among this population there is paucity in the literature regarding trauma treatment, as well as examination of how trauma affects the course of serious mental health disorders among women (Mueser, Rosenberg, Goodman, & Trumbetta, 2002). The literature points out that there needs to be an increased focus on trauma treatment, residential stability, substance abuse treatment, and safety planning so individuals that experience these challenges and recent victimization can be treated more effectively and feel safe (Goodman et al., 2001). Carr, Greene, and Ponce (in press) also advocate that women's social identities such as race, ethnicity, and socioeconomic status should also be paid attention to in the intersection of serious mental health disorders and sexual objectification, as these intersecting oppressive experiences can have a unique impact on the lives of women with diverse social identities.

Women who experience serious mental health disorders and also are in the role of motherhood report the experience of motherhood as a normalizing experience and protective factor against the experience of marginalization and stigma in culture (Nicholson, Geller, Fisher, & Dion, 1993; Oyserman, Mowbray, Meares,

& Firminger, 2000). Though there are potential benefits for the role of motherhood among women with serious mental health disorders, the lack of supportive environments, while there are a multitude of challenges that are faced, contributes to the life-long fear of being able to maintain custody of children (Oyserman et al., 2000; Nicholson, Sweeney, & Geller, 1998; Sands, 1995). The research in the U.S. among women with these experiences suggests that the normal desire to have children is affected by societal attitudes that they are incompetent to care for their children, inducing a fear that children can be taken away at any time, and they are up against stereotypes from the beginning (Nicholson et al., 1998). Women also report that they have additional stresses from their mental health disorders on top of day-to-day concerns for parenting with limited available supports. The research on programs within North America in public-sector mental health services regarding the provision of parenting supports for mothers indicates there is limited attention to this salient issue and a need for more efforts towards supports, which can empower women and affect positive outcomes for children (Nicholson et al., 1993).

Women in the U.S. who are caregivers of children who experience serious mental health disorders similarly may lack the support that is needed when providing care for an individual that has unique needs. A review of the literature emphasizes the stress caregivers undergo, pointing out frequent experiences of limited assistance from the community and mental health professionals (Saunders, 2003). A qualitative study indicated themes of challenges with stigma and systems issues that can play a major impact on being able to adequately provide the care desired for a loved one with a serious mental health disorder (Veltman, Cameron, & Stewart, 2002). For example, a mother commented on the unique stigma her family experienced which was different than the level of support and coping resources offered other families who were caring for an individual with a brain injury. Other mothers expressed frustration with the lack of supports that could aid their adult children with serious mental health disorders such as the need for appropriate supportive housing or meaningful work. Another qualitative study, similarly, highlighted the experience of stigma among parents who are caregivers of those with serious mental health disorders, as well as experiences of shame and challenges with the mental health system (Pejlert, 2001). This study also expressed how significant it is for mental health professionals to be aware of their own stigma and treatment of families and made a call for professionals to seek to partner with families and offer true support for individuals that are the caregivers.

In the U.S. and Canada, for reasons that are not clear at present, the prevalence of women with serious mental illnesses is higher in forensic populations than that of men, typically estimated to be roughly twice as high, at approximately 31 percent compared to 15 percent for men (Almquist & Dodd, 2009; Blitz, Wolff, Pan, & Pogorzelski, 2005; Ditton, 1999; Sabol, & Minton, 2008; Steadman, Osher, Robbins, Case, & Samuels, 2009). Due to their increased vulnerability, women with serious mental illnesses are at special risk for physical and sexual violence, trauma, risky sexual encounters, and incarceration (Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions, 2006; Darves-Bornoz, Lemperiere, Degiovanni, & Gaillard, 1995; Elklit & Shevlin, 2011). Compared to non-incarcerated women with mental health disorders in the justice system, they have more symptoms related to addiction, anti-social personality disorder, and post-traumatic stress disorder. Incarcerated women are more likely to have had traumatic experiences, including early sexual and physical abuse, than incarcerated men but equally likely to have substance abuse disorders (Lewis, 2006). For example, in the U.S. it has been found that 97% of homeless women with mental illness experienced severe physical and/or sexual abuse; 87% experienced this abuse both as children and as adults (Goodman, Dutton, & Harris, 1997).

Social Rejection

There is still evidence in the literature of persistent and pervasive experiences of social rejection among those who experience serious mental health disorders (Wright, Gronfein, & Owens, 2000; World Health Organization, 2010). Many individuals with serious mental health disorders have to overcome social rejection including rejection from family members, peers, friends, and the community (Davidson, O'Connell, Tondora, Lawless, & Evans, 2005). Surveys still suggest that the public at large holds negative attitudes towards those who experience serious mental health disorders, including employer discrimination (Link, Phelan, Bresnahan, Stueve, & Pescolocido, 1999; Pescosolido, Monahan, Link, Steuve, & Kiluzawa, 1999; Wright, Gronfein, & Owens, 2000). The Independent Living Movement casts a vision that seeks to alter the stigmatized view of the "mental patient" as ostracized and shut out from society (Davidson et al., 2005; Deegan, 1992). This concept offers that individuals with serious mental health disorders self-identify as "normal" people who experience disabilities (Davidson et al., 2001; Deegan, 1993). Most countries recognize the right of all individuals, including those with disabilities, to full community integration (U.N. Convention on the Rights of Persons with Disabilities, 2006). To this end, having a serious mental health disorder should be viewed no differently than other aspects of disability other individuals in society experience and thus, similarly, those with serious mental health disorders should be encouraged and entitled to active engagement in a meaningful life in society.

Community Inclusion and Valued Social Roles

Problems at the society level with lack of basic resources for those with serious mental health disorders present barriers to recovery and community inclusion. Typical barriers that individuals with serious mental health disorders experience are concerns with basic resources and opportunities such as affordable housing, social engagement, employment, and medical care, which is likely impacted by societal deficits in knowledge and skills in fostering and developing inviting and accessible environments for all individuals in society (Davidson et al., 2009). These issues are seen worldwide – the lack of acceptance and inclusion of people with mental health disorders is a global issue (Popay et al., 2008).

To expand, the literature highlights that individuals who experience serious mental health disorders have a notable higher incidence of homelessness and decreased access to affordable housing (Link et al., 1994; Phelan & Link, 1999). Though there has been community organizational progression in North America and many developed countries towards meeting the needs of those who are homeless and have serious mental health disorders, there are still frequent barriers to being housed due to models that delineate housing should occur for individuals only after they have complied with a set list of rules and regulations (Allen, 2003). This type of system sets individuals up for continued community exclusion due to challenges with accessing the much needed basic resource of shelter. The veracity of access to affordable housing is paramount as research indicates better mental health and quality of life for those who have stable housing and also experience serious mental health disorders (Carlsson, Frederiksen, & Gottfries, 2002; Kirkpatrick, Younger, Links, & Saunders, 1996; Shu, Lung, Lu, Chase, & Pan, 2001).

Individuals who are discharged from a hospital have a higher likelihood of being re-hospitalized than returning to work, although the benefits of employment are correlated with social functioning, symptom levels, quality of life, and self-esteem (Anthony, 1994; Mechanic et al., 2002; Marwaha & Johnson, 2003). A qualitative investigation regarding the subjective experience of employment among those with serious mental health disorders advocates that paid employment has personal meaning and promotes recovery, fostering self-esteem and pride, providing financial means, and increased coping strategies for symptoms (Dunn, Wewiorski, & Rogers, 2008). Research indicates most people with serious mental health disorders want to work and educational attainment is a predictor in employment (Mechanic et al., 2002). The literature also suggests that interprofessional relationships and vocational specialists may play a part in enhancing employment, as well as changes in attitudes of mental health and the allocation of resources (Seebohm & Secker, 2003).

The literature espouses the value of increasing social connection to others for those who experience serious mental health disorders (Davidson et al., 2009). As expressed earlier, the experience of stigma and social rejection can impact life experience in a tremendous way (Wright et al., 2000). A large research study of individuals with serious mental health disorders in the U.S. showed that low social support increases the chance of onset of mental health symptoms and decreases chances of recovery (Pevalin & Goldberg, 2003). Social engagement and valued social roles can be realized through avenues such as social clubs, civic involvement, recreational activities, support groups, and peer groups (Davidson et al., 2009). In a similar vein, the development of specific personal meaningful activities can be mechanisms for social connection to the extent that individuals are able to develop in confidence, contribution, and connection, by the acquirement of education, vocation, volunteering, skills, or relationships (Hendryx, Green, & Perrin, 2009; Mancini, Hardiman, & Lawson, 2005; Musick & Wilson, 2003). The literature suggests some positive outcomes from efforts to increase social support and connection via support groups, one-to-one support, or connection to natural supports (Harris, Brown, & Robinson, 1999; Heller, Thompson, Trueba, Hogg, & Vlachos-Weber, 1991; Mittleman et al., 1995).

Individuals with serious mental health disorders frequently experience co-morbid medical concerns and the literature indicates that worldwide, those with serious mental health disorders die, on average, 10 to 25 years earlier than a normal life expectancy (Colton & Manderscheid, 2006; World Health Organization, 2013). The literature demonstrates a multitude of compounding risk factors for this population such as medication side effects, physical inactivity, and use of tobacco or illicit substances, which greatly increase their medical risk (Compton, Daumit, & Druss, 2006). However, this population typically has difficulties with access to medical care and frequently receives substandard care, particularly in the U.S., and to a lesser degree in Canada (Druss, Rosenheck, Desai, & Perlin, 2002; Druss et al., 2000). Models of integrated treatment are catching ground as a method of providing more access to medical care for this at risk and vulnerable population (Druss, Rohrbaugh, Levinson, & Rosenheck, 2001).

Psychological Training and Interventions

Regrettably, most psychologists have not received the specialized training needed to help people with serious mental illnesses and the range of co-occurring disorders and social problems they encounter, recover and achieve their full potential to live a satisfying and productive life. Despite the best intentions of psychology (and other mental health professional) training programs worldwide, most continue to concentrate on traditional methods for helping individuals with mental health disorders. Antipsychotic medications have been documented as effective in treating acute psychotic episodes, in promptly treating psychosis in early stages, and in maintenance therapy to reduce relapse (Fleischhacker et al., 2014). However, these traditional models approach people and their problems from a pathology and deficits perspective that aims to control symptoms or cure the illness whereas newer, recovery and rehabilitation oriented models approach people and their problems from a functional skills model that is strengths based.

A recovery and rehabilitation model is articulated in the American Psychological Association (APA) Resolution on APA Endorsement of the Concept of Recovery for People with Serious Mental Illness (APA, 2009). In this model, treatment paradigms shift from a focus on symptom reduction to emphasizing that people can and do recover from serious mental health disorders, and incorporating empirically supported treatments and strategies which help people build competencies and social capital. Fleischhacker et al. (2014) urged provision of evidence-based, integrated care plans for people with schizophrenia. They listed the following psychosocial therapies which have been shown to improve outcomes in schizophrenia (Evidence-Based approaches): assertive community treatment, cognitive behavioral therapy for psychosis, cognitive remediation, family therapy/psychoeducation, peer support and self-help strategies, social skills training, supported employment, and integrated treatment for coexisting substance abuse disorder. Their list of Promising Approaches included cognitive adaptive therapy, healthy lifestyle intervention, interventions targeting older individuals, prodromal stage intervention, social cognition training, and social rehabilitation (Clubhouse Model). In addition, others have recommended comprehensive community support resources include safe housing; respite care; assistance and support to increase social participation, volunteering, and education; and community wellness centers (Farkas & Anthony, 2010; Tondora, 2011). However, these interventions are underutilized, and are often available only in specialized centers (Fleischhacker et al., 2014).

To provide greater detail of a few clinical interventions which provide incredible forums for the development of empowerment, destigmatization of mental illness, enhanced community inclusion, and self-management of illness, Wellness Recovery Action Plan (WRAP) groups and Illness Management Recovery groups will be highlighted (Copeland, 1997; Gingerich & Mueser, 2005). WRAP groups were initially developed by Mary Ellen Copeland, an individual with her own lived mental health experience, who developed a curriculum for self-management of the experience of mental illness (Copeland, 1997). WRAP groups are peer-led and focus on the development of wellness tools, action plans, daily maintenance recovery plans, personal crisis planning, as well as awareness of triggers, understanding of warning signs, and increased involvement and connection to others. Additionally, WRAP is designed to help decrease and prevent the negative impact of distressing feelings or behaviors, empower individuals in their own ability to seek their own goals and dreams in life, increase quality of life, and increase personal empowerment. Notably, WRAP is also listed as an evidence based program and practice by the U.S. National Substance Abuse and Mental Health Services Administration (SAMSHA, 2010). Research in both the U.S. and Scotland shows that WRAP helps increase self-advocacy, has an impact on hope and recovery-related attitudes, has a positive impact over time, increases greater self-awareness, supports wellness and recovery, as well as connection and mutuality with others, and fosters discussions about mental health experiences in a positive way, reducing the negative impact of the stigmatization of mental illness (Scottish Center for Social Research, 2010; Starnino et al., 2010).

Illness Management Recovery groups (IMR) (Gingerich & Mueser, 2005), similarly have peer elements in many mental health organizations as they are often co-led by a mental health clinician and a peer, who has lived mental health experience. This provides a forum for individuals to both benefit from the expertise of a mental health professional and someone that can understand what it is like to have lived mental health experience. IMR groups are uniquely important in that they target many areas such as recovery strategies, personal goals, education about mental illness, and positive methods of managing mental illness and reducing relapse, but these groups also focus a great deal on dealing with stigma and negative attitudes in culture about mental illness, how to get needs met within mental health systems, and how to build social support and connection within the community. There are also valuable research implications of IMR, including 40 randomized clinical trials, showing that participants have increased knowledge of mental illness, take medications more often as prescribed, show reductions in relapse and hospitalization, experience reductions in severity and distress of persistent symptoms, and have increased hope (Mueser et al., 2002; Mueser et al., 2006).

As shared above, cognitive behavioral therapy (CBT) for psychosis is also a strong clinical intervention that is having implications on a global level (Kingdon & Turkington, 1994). This clinical intervention focuses on the treatment of delusions and hallucinations in those that experience psychosis to reduce distress and disability, while promoting empowerment and recovery. This includes components of helping normalize experiences related to mental illness and symptoms, provision of education about mental illness, and reduction of the negative experience of stigma. CBT is a standard of care in the United Kingdom and is growing in its advancement in the U.S. (Turkington, Kingdon, & Weidon, 2006). Research shows that there are large clinical effects on measures of positive and negative symptoms of schizophrenia, showing promise that this is a noteworthy psychological intervention for those who experience psychosis (Rector & Beck, 2001).

In order to encourage training in these new approaches, the U.S. Substance Abuse and Mental Health Services Administration provided funding to the five largest American mental health associations to develop curricula for their professionals. The American Psychological Association (APA) developed a curriculum designed to train doctoral level psychologists in the specialized approaches they will need to help people with serious mental health disorders and the comorbid conditions they face, recover and achieve their full potential. The curriculum, released in August 2014, consists of 15 modules on a comprehensive range of topics and is entitled *Reframing Psychology for the Emerging Health Care Environment: Recovery Curriculum for People with Serious Mental Illnesses and Behavioral Health Disorders* (American Psychological Association & Jansen, 2014)[1]. If graduate training programs were to incorporate this curriculum into the training of future psychologists (and likewise in the other professional disciplines participating in the curriculum development initiative), we might see broader inclusion of psychosocial interventions in care plans focused on improving functioning and fuller community participation by people with serious mental health concerns.

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[1] The full curriculum is available by contacting APA at www.apa.org/pi/rtp or from the first author of this paper at mjansen@bayviewbehavioral.org.

Conclusions and Recommendations

Stigma and lack of comprehensive recovery-oriented care and community supports inhibit people with serious mental health concerns from realizing their full potential for community participation and membership. Based on their synthesis of research evidence, consultation with stakeholders, and examination of worldwide best practices, Fleischhacker et al. (2014) called for policy changes which could contribute to better lives for people living with schizophrenia. Their recommendations are broadly relevant to people with other serious mental health concerns and their families. First among their recommendations is the provision of evidence-based, integrated care by health professionals, supported by national health care systems. These interventions could include treatments aimed at reducing negative symptoms (apathy and restricted emotional expression), enhancing cognitive impairment, reducing suicide risk, and addressing such major health concerns as stopping smoking and reducing alcohol and substance abuse. As described previously, CBT for Psychosis was shown to be a cost-effective intervention in the UK, as its use was associated with reduced hospitalization costs. Cognitive remediation has shown promising results in promoting the learning of new skills, which enhances other types of psychotherapy.

A second recommendation (Fleischhacker et al., 2014) was the implementation of programs that help people with schizophrenia participate meaningfully in their communities, workplaces, and schools. Assertive Community Treatment (ACT) and supported employment are effective, but often underutilized. In a Canadian review of studies using ACT (use of a multidisciplinary team assisting with medication management, practical support with housing, etc.), reductions of homelessness and hospitalizations were documented, compared to usual care (Latimer, 1999). Research in other countries (including Denmark and the Netherlands) has yielded similar results (Aagaard & Müller-Nielsen, 2011; van Vugt et al., 2011). Studies in the U.S. have documented that ACT is effective in reducing acute psychiatric hospitalization, and increasing housing stability and satisfaction of clients and families. For example, application of ACT (in the context of a recovery-focused client experience) by a large provider in California (Telecare, undated) resulted in ACT clients spending only one-seventh the number of days in institutions compared to other clients, at a net cost savings to the county of U.S.$2,338, 490 over a period of four years.

Housing support is also an important step in recovery. Helping people with serious mental illness obtain a stable residence (whether living independently, or with staff support) can be done in conjunction with ACT models (Nelson, Aubry, & Lafrance, 2010). Supported education for completing high school or postsecondary education assists people to meet their recovery goals and may enhance employment opportunities (Leonare & Bruer, 2007). Supported employment, and interventions to assist in building social capital and increase social connectedness promote recovery. Some communities have used a clubhouse model, such as the Fountain House model, which has been replicated throughout the world. This model includes education for clients and families, along with skills training for functioning at work and in the community, case/care management, medication management, and clinical follow-up (Macias, Rodican, Hargreaves, Jones, Barreira, & Wang, 2006).

Third among the recommendations of Fleischhacker et al. (2014) is the provision of concrete support for families and caregivers. As Lefley (2009) notes, family psychoeducation has been documented as efficacious. She provides background from the U.S. and from European studies that build a case for including family psychodeducation as standardized treatment in mental-health systems, even "obligatory," that it be offered (Bauml, Frobose, Kraemer, Rentropo, & Pitschel-Walz, 2006). Effective psychoeducation programs are not based on the premise that family dysfunction is the cause of serious mental illness, and use of the programs should not be limited to families evaluated as having high levels of "expressed emotion" (highly critical and hostile), and should be made broadly available. Lefley offers examples of model programs, summaries of international and cross-cultural studies, and critical analysis of the complexities of implementation. She also observes that this model is used for early intervention with youth experiencing prodromal signs of developing illness, with families of children and adolescents with serious emotional problems, and with families of persons with co-occurring substance abuse. Guidance for implementation is available in the Family Psychoeducation Evidence-Based practices toolkit, available online from the U.S. Substance Abuse and Mental Health Services Administration (U.S. Department of Health and Human Services, 2010).

The fourth and fifth recommendations of Fleischhacker et al. are regular consultation with relevant stakeholders (health care professionals, organizations, and families) (and we would add, also individuals with serious mental illnesses and concerns), to inform and improve policy and provision of support, research and treatment development that is proportionate to the social and health impact of these conditions. Creating change in large systems, and moving traditional practices toward recovery-oriented care is challenging, but in the U.S. some notable progress has been made in the states of Connecticut, Delaware, New York, Ohio, and the city of Philadelphia (APA & Jansen, 2014). Transformation processes are described at the systems level by Davidson et al. (2007). Essential components include training and education to build competencies of the workforce; revising program, service, and financial structures; and evaluating and adjusting the efforts. A description of successful change at the local level (Omos-Gallo et al., 2011) highlighted the importance of visionary leadership, involving consumers, translating recovery-oriented ideas into practice, and quality improvement based on outcome measurement.

Finally, the sixth recommendation is for the establishment of educational and awareness-raising campaigns that promote understanding, positive attitudes, and reduce discrimination. Finding ways to accomplish this recommendation may be the key to marshalling the research support and impetus for systems change that are needed. A study examining data from 14 European countries determined that persons with mental illness had lower rates of self-stigma and perceived less discrimination when they lived in countries with less stigmatizing attitudes, in which they were more likely to seek treatment, and in which people expressed more comfort talking with people with mental illness (Evans-Lacko, Brohan, Majtabai, & Thornicroft, 2012).

Campaigns in the U.S. have emphasized the theme of “mental illness is an illness like any other.” For example, the National Alliance on Mental Illness (NAMI, 2014) offers this explanation of mental illness: “A mental illness is a medical condition that disrupts a person's thinking, feeling, mood, ability to relate to others and daily functioning. Just as diabetes is a disorder of the pancreas, mental illnesses are medical conditions that often result in a diminished capacity for coping with the ordinary demands of life.” Emphasizing the biological component may communicate less blame toward persons with mental health concerns, but researchers in New Zealand (Read & Harré, 2001) have documented that embracing biological and genetic causal beliefs does not reduce assumptions of dangerousness or desire for social distance. Read and Harré recommend instead, educational campaigns that reduce perceived differences, (increased contact and exposure to people using mental health services). This is in step with the recommendations of Corrigan et al. (2001), who examined strategies of education, contact, and protest. They found that contact produced the most positive changes, especially when participants interacted with persons who mildly disconfirmed the stereotypes held about them.

One vigorous step in challenging stereotypes has been taken by consumers, or persons with lived experience who have moved the concept of recovery beyond clinical improvement and functional recovery to a social transformation perspective. Notably, mental health professionals who have been diagnosed, treated, and are in recovery from schizophrenia and other SMIs have spoken out about their own experiences, and educated about the iatrogenic effects of demeaning treatment. They have advocated for shared decision-making and respectful communication, and emphasized the importance of meaningful work, psychotherapy, intimate and familial relationships, and the salience of hope, “the catalyst of the recovery process” (Freese, Knight, & Saks, 2009). As Freese et al. observed, mental health recovery not only benefits individuals with mental health disabilities by enhancing their working, learning, and fully participating in society, but also enriches the community in which they live, garnering the benefits of their contributions to the strength and health of the nation.

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