Vermont Recovery Education Project

Vermont Psychiatric Survivors, Inc., and the Vermont Department of Developmental and Mental Health Services

Introduction

In August of 1995, the Commissioner of the Department of Developmental and Mental Health Services (DDMHS) established a programmatic priority for the development of recovery-oriented services in the adult mental health service system. One of the major strategies of this programmatic priority was the establishment of a Recovery Education Project. After one year of piloting recovery education activities, Vermont Psychiatric Survivors (VPS), with the assistance of DDMHS, received a generous grant from the Henry van Ameringen Foundation to implement the Vermont Recovery Education Project from July 1st, 1997 to June 30th, 1999. This document summarizes the major activities and results of an evaluation of the Vermont Recovery Education Project.

The Vermont Recovery Education Project

For the Vermont Recovery Education Project, recovery has meant finding hope, developing a personal understanding of the experience of mental illness in one's life, and developing the skills and knowledge to support one's own wellness, and, in some cases, full recovery. Over the past two-and-a-half years, the Vermont Recovery Education Project has designed and implemented a program to teach recovery skills and practices to citizens with psychiatric disabilities, their family members, and professional support providers. Using three educational formats (Recovery Education Cycles, Recovery Education Events, and Training of Recovery Educators), this project has provided a statewide focus on hope, personal responsibility, self-advocacy, education and support.

Designed by Mary Ellen Copeland in coordination with other people who have experienced psychiatric symptoms as well as health care professionals and related organizations, the educational program has maintained two objectives:

To teach individuals who experience psychiatric symptoms, their family members, supporters and health care professionals how to reduce or eliminate psychiatric symptoms safely, simply, and effectively on a daily basis, and how to get well and stay well. These skills are taught complementary to, and not exclusive of, other treatments, including medication and rehabilitation supports.

To teach peers (others who have experienced mental illness) who have attended a Recovery Education Cycle to become "Recovery Educators" using a variety of formats to network and teach recovery skills intensively to people in their region using a variety of formats.

As of January 31st, 2000, the Vermont Recovery Education Project has completed twenty-three recovery education cycles, trained thirty-eight peers, family members and professionals as Recovery Educators, and completed fifty-two educational events about recovery. Over four hundred peers, family members and providers have participated in a recovery education cycle. This document will focus on the evaluation of the recovery education cycles.

Recovery Education Cycles

Each Recovery Education Cycle involved forty hours of training using a curriculum developed by Mary Ellen Copeland. Between fifteen and twenty consumers (individuals with psychiatric disabilities), family members, community members, and mental health staff participated as learners in each cycle. Typically, two Recovery Educators taught each cycle: one individual with a psychiatric disability and one community mental health staff member. In some instances the community mental health staff was also someone who had experienced mental illness. The forty hours of class were structured in various blocks of time. For instance,

some cycles were two hours a week for twenty weeks or one six-hour day per week for seven weeks, or even one hour a week for forty weeks. The various formats were developed based on the preferences of attendees and the educators, as well as feedback from previous participants.

Each cycle covered the following topics: essential recovery concepts such as hope, responsibility, self advocacy, education and support; medical care and health management; how to develop and use various support systems; developing a healthy lifestyle; suicide prevention; beginning steps to dealing with trauma; and the development of a personal Wellness Recovery Action Plan™, or WRAP (see Appendix A for outline). The WRAP, developed by Mary Ellen Copeland as a component of the Recovery Cycle, is a personal monitoring system in which an individual documents techniques and strategies for reducing symptoms as well as for ongoing management and prevention of symptoms. Components of the WRAP include:

- a plan for daily maintenance
- identification of situations that trigger symptoms and strategies to address these
- identification of early warning signs and what to do when they appear
- a plan for how to deal with pre-crisis and crisis situations

Participants received a WRAP workbook at the start of each cycle and were encouraged to complete sections of the workbook during the cycle.

The Vermont Recovery Education Project completed twenty-one cycles during the period from July 1997 to January 2000. Two pilot cycles were completed prior to the grant period in November of 1996 and February of 1997. Four hundred and thirty-five peers, family members, community members and providers attended a Recovery Education Cycle during the time period from July 1997 through January 2000.

The planning and development of cycles were coordinated by the designated Recovery Education Project Coordinator with guidance from the Recovery Workgroup, a statewide recovery planning group, formed in the summer of 1996 by peers, family members, providers, administrators and other interested stakeholders to promote and develop new recovery activities in the state of Vermont.

Methods

Instrument Development

The survey to evaluate the Recovery Education Cycles was designed by the Recovery Workgroup with assistance from a student intern from the University of Vermont's Masters in Social Work program. The survey questions were created by the Recovery Workgroup and edited by the intern. The survey was piloted at two cycles prior to the grant period and, based on the results, re-edited for evaluation of the twenty-one remaining cycles. Questions focused on:

- identifying early warning signs and using coping skills to prevent a worsening of symptoms,
- developing a crisis plan,
- asking about medications,
- getting information about support services,
- identifying supporters,
- advocating for oneself,
- using wellness tools, and
- feeling hopeful about one's own recovery.

The survey also asked participants to identify their roles as they related to the recovery process:

- consumer of mental health services/survivor of a psychiatric disability,
- provider of mental health services (paid),
- peer supporter,

- family member of someone with a psychiatric disability

Survey Implementation

The survey was administered at the first session of a forty-hour education cycle, and then again at the last session using the same questions to measure changes in attitudes, feelings, knowledge, and skill development (see Appendix B for the survey).
The Recovery Educators teaching the cycle administered the survey and explained its purpose. Participants were assured that their names would not be used.

Of the 435 individuals who participated in a Recovery Education Cycle, 225 completed at least one survey, and 193 completed both the pretest and the post-test, giving a response rate of 44 percent. Only the individuals who completed both a pretest and a posttest are represented in this report.

Analysis

Once the pre and post surveys were collected for a given cycle, DDMHS staff entered the responses to the fixed-alternative questions and the open-ended/qualitative questions into an Excel spread sheet. Responses to the pretest questions were linked to posttest questions using an identification code assigned by the Recovery Education Coordinator. Responses to the fixed-alternative questions were translated into SPSS format and analyzed by the DDMHS Research and Statistic unit. Change between pre- and posttest responses was analyzed using a paired two-tailed t-test for difference of means.

Participants

Participants for the cycles were recruited in various ways. Clients of community mental health Community Rehabilitation and Treatment (CRT) programs were encouraged to attend, as well as participants in local VPS self-help groups. Most of these participants were individuals identified as having a psychiatric disability. In many CRT programs, administrators and supervisors encouraged direct service staff to attend also. In many parts of the state, cycles were advertised locally and thus attracted family members and some community members. Participation was voluntary for all participants. There was no screening process that eliminated any individual who expressed an interest in attending.

Of the 225 individuals who completed at least one survey:

- 147 (65%) identified themselves as consumers/survivors of psychiatric services,
- 95 (42%) identified themselves as providers of mental health services (paid)
- 70 (31%) identified themselves as peer supporters, and
- 60 (27%) identified themselves as family members of someone with a mental disability.

Because participants could select more than one role, many individuals identified themselves in dual roles:

- 25 (17%) identified themselves as both consumers and providers,
- 48 (33%) identified themselves as both consumers and peer supporters,
- 37 (25%) identified themselves as both consumers and family members,
- 34 (36%) identified themselves as both providers and family members,

There were also a number of individuals who identified themselves in three or four roles:

- 16 (7%) individuals identified themselves as consumers, providers and family members,
- 13 (6%) individuals identified themselves as consumers, providers and supporters,
- 24 (11%) individuals identified themselves as consumers, family members and supporters, and
- 10 (4%) individuals identified themselves in all four roles.

Results

There was a significant positive change in response to thirteen of the seventeen survey questions (see Appendix C for full results). A positive change indicated that the participant perceived an improvement in attitude, understanding, lifestyle or a specific skill relating to recovery. Participants reported a significant perceived increase in their:

- knowledge of their own early warning signs/symptoms (t (192)=4.089, p=.000)
- knowledge of skills/tools for coping with early warning signs (t (192)=6.009, p=.000)

Preference for using natural/community supports:

- friends/neighbors (t (187)=2.05, p=.042)
- other individuals who have experienced mental illness (t (172)=2.29, p=.023)
- support groups (t (180)=3.12, p=.002)
- use of wellness tools in their daily routine (t (197)=5.71, p=.000)
- level of hope regarding their own recovery process (t (193)=5.13, p=.000).

Regarding the development of crisis plans, participants reported a significant perceived increase in their understanding of how to create a crisis plan that:

- listed their supporters and people to contact (t (224)=7.62, p=.000)
- expressed their needs and wishes (t (224)=8.22, p=.000)
- explained their symptoms and early warning signs (t (224)=8.50, p=.000)
- and fewer participants reported feeling unsure of how to create a crisis plan (t (224)=7.56, p=.000).

In addition, a significant number of participants reported feeling more comfortable about:

- asking questions and getting information about community services (t (197)=5.06, p=.000)
- advocating for themselves (t (194)=4.39, p=.000).
- participants did not report a significant change in:
- feeling comfortable asking a doctor/psychiatrist questions about medications

Their preference for using mental health providers, other services providers (doctors, et alia) or family/partner for support.

Analysis of Consumer Participants

Among the 147 participants who identified themselves as consumers, the results were very similar; the analysis showed a significant positive change in response to the same thirteen survey questions (see Appendix D for full results). Consumer participants reported a significant perceived increase in their:

- knowledge of their own early warning signs/symptoms (t (118)=3.07, p=.003)
- knowledge of skills/tools for coping with early warning signs (t (119)=4.19, p=.000)

Preference for using natural/community supports:

- friends/neighbors (t (118)=2.48, p=.015)
- other individuals who have experienced mental illness (t (110)=2.90, p=.004)
- support groups (t (113)=3.90, p=.000)
- use of wellness tools in their daily routine (t (124)=4.92, p=.000)
- level of hope regarding their own recovery process (t (125)=4.37, p=.000)

Regarding the development of crisis plans, consumer participants reported a significant perceived increase in their understanding of how to create a crisis plan that:

- listed their supporters and people to contact (t (146)=5.72, p=.000)
- expressed their needs and wishes (t (146)=5.81, p=.000)
- explained their symptoms and early warning signs (t (146)=6.26, p=.000),
- and fewer consumer participants reported feeling unsure of how to create a crisis plan (t (146)=5.69, p=.000).

A significant number of consumer participants reported feeling more comfortable about:

- asking questions and getting information about community services (t (123)=4.61, p=.000)
- advocating for themselves (t (120)=3.87, p=.000).
- consumer participants did not report a significant change in:
- feeling comfortable asking a doctor/psychiatrist questions about medications
- their preference for using mental health providers, other services providers (doctors, et alia) or family/partner for support.

Detailed Findings on Selected Items

While the responses to each of the questions yielded valuable information, specific items and sets of items conveyed essential elements of the Recovery Education Project: developing the skills and knowledge to manage one's own symptoms, education and advocacy, developing a support system, and finding hope.

Developing Skills And Knowledge To Manage One's Own Symptoms

Responses to questions 1,2,3 and 8 (see Appendix C and D) indicated that participants gained skills and knowledge in anticipating, managing and even preventing the debilitating symptoms of their illness. The Recovery curriculum teaches that disabling symptoms of mental illness can be anticipated and avoided or alleviated using specific skills, tools and support. In some instances, this can lead to a full recovery from one's illness. In traditional mental health services, consumers have typically been placed in a passive stance of receiving treatment for their symptoms from professionals. In the Recovery cycles, participants began to take an active part in controlling how their mental illness affects their life. Participants in the recovery cycles learned how to:

- recognize their own early warning signs/symptoms
- identify specific skills and tools to cope with these symptoms
- create a crisis plan (WRAP) that listed their supporters, expressed their needs and wishes, and explained their symptoms and early warning signs
- incorporate tools for staying well into their daily routine

Through the development of an individualized Wellness Recovery Action Plan™, participants developed an understanding of the entire spectrum of their illness, identified potential skills to maintain wellness and manage symptoms, and began to incorporate these wellness tools into their daily routine. Through this process, participants learned new ways to take responsibility for their own recovery process. Several participants commented on the value of this educational component:

"[The Recovery cycle] has kept me out of crisis. This course reminded me that I did have a choice and I could use what I learned here to relieve my symptoms."

"Due to the WRAP plan this is the first June I've gotten through without either hospitalization or home intervention [crisis bed]."

"I feel I can take control over my life after drawing up a WRAP and putting it to use."

"I have struggles with symptoms still. I feel I am beginning to understand how to manage the symptoms of depression and mania through this system--recognizing the early warning signs and strategies for dealing with them."

"[It] reinforced very much my belief that I can manage my symptoms and my life. The WRAP I think is going to be a very valuable tool for me. It will be something I can look at, refer to and use as a guide as I am trying to proceed with my recovery. [It will be] especially useful to have when I am not able to remember what helps and what I need to do."

"I feel I am on the way to healing my emotional problems, [and that] I am able to deal better with symptoms so I do not go into a serious crisis."

"[The course] has given me tools to use on a daily basis to improve my life."

"It is a new outlook, and I think, a healthier one. I am the one responsible for my mental health and with the help of the course I think I can manage it!"

Education and Advocacy

"I have learned to stand up for myself." (quote from cycle participant).

Responses to questions 5 and 7 (see Appendix C and D) indicated that participants felt more comfortable:

asking questions and getting information about community services and treatment alternatives; and advocating for themselves regarding services, resources and assistance.

The Recovery Education curriculum stresses the importance of education and self-advocacy as part of the recovery process. By learning about mental illness and the services, supports and treatment alternatives that are available, individuals can make better decisions about how to manage their illness and enhance their life. As individuals gain confidence in their ability to advocate for themselves, learn about their rights, and understand the types of treatment and support which are available, they are more capable of expressing and receiving the support they need.

Developing A Support System

The responses to questions 2 and 6a-6f indicated that a significant number of participants perceived an increase in their:

understanding of how to create a crisis plan which listed their supporters; and preference for using friends, neighbors, other individuals who have experienced mental illness, and support groups for support.

Developing and using a strong support system is another key component of the Recovery curriculum. The Recovery curriculum stresses that support from family, friends and health-care professionals is essential, and that effective support can help to prevent and relieve symptoms. In addition, supporters can also be used when individuals feel their symptoms are too severe and someone else needs to make decisions or follow predetermined plans on their behalf. In this manner, individuals proactively plan their support system for those times "when things are breaking down" (taken from the WRAP Workbook).

A preference for friends, neighbors, other individuals who have experienced mental illness, and support groups for support represents a preference for natural supports. By seeking out natural supports, individuals reduce their isolation and reliance on artificial (professional) support, which may be stigmatizing and is limited by resources. In contrast, natural supports tend to be normalizing and not limited by resources. In addition, by using peers and support groups comprised of people who have experienced a mental illness firsthand and are on the road to recovery, individuals gain a better understanding of their own illness, see how others have developed wellness in their lives, and gain hope by seeing how others can recover from mental illness.

Participants did not report a significant change in their preference for using mental health providers or other service providers for support. While not anticipated, this response certainly makes sense within the context of the curriculum. Typically, clients of mental health agencies rely on professionals for the majority of support services and are often very isolated and without other types of support. Because the Recovery curriculum explores the many different types of natural support available and the ways in which these types of supporters can help, it makes sense that participants would begin to think about using natural supporters to replace some of their professional support services. As evidenced by the following comments, many participants recognized the value of support, especially from someone else who has a mental illness:

"This course has helped me see that there are options for me in how I live my life with my problems, and that recovery and health happen by degrees, with steady effort; that supporting and being supported by friends, etc. is really just one of the most integral parts of anyone's life."

"I was living in a group home and I was invited to go to a cycle in my community. The third week my dad from New York died. The recovery coordinator supported me through the grief and I made friends. Now I'm working in a local store bagging groceries. I feel like I am part of the community and my years of isolation are diminishing."

"When the cycle came to town I had just returned from a short hospitalization. The cycle gave me support and was an extra program to assist me in staying in the community. Holidays are hard for me this year but we discussed alternatives and support. I went to lunch with another in the group and [we] gave each other peer support for the day. It was wonderful."

"I realize that I am not the only one out there having to cope with problems similar to mine. I have met people I would like to stay in contact with. I have an action plan. I now know about the resources that are available."

"It has given me support and a place to go to interact with people who have also suffered illnesses and get guidelines and assistance on how to recover."

Finding Hope

A significant number of participants reported feeling more hopeful about their own recovery process. Hope is perhaps the most important of concept of recovery. Recovery has been described as a process, an attitude, and a way of life in which the goal "is to meet the challenge of the disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration to live, work, and love in a community in which one makes a significant contribution" (Hatfield AB: Recovery from Mental Illness. The Journal of the California Alliance for the Mentally Ill 6(3):6-7, 1995). Without the belief that one can achieve these aspirations, that people do get better and even recover from mental illness, the recovery process cannot occur. As Mary Ellen Copeland has said many times, "Those of us with psychiatric illnesses need to know that there are many, many people who get well, stay well, and lead rich, rewarding and valuable lives." Here are some quotes about hope taken from the post-surveys:

"I can now see that recovery is possible."

"[The Recovery Cycle] totally changed my belief about mental illness in terms of getting better from it."

"It has helped me realize that I am not alone in my illness."

"This recovery group has saved my life. I was very suicidal at the start of the group. I am still here [and] OK."

"I feel this workshop has made me hopeful that I will someday live without depression and I will be able to use it in my job to help others."

"This course gave me positive proof I am getting better. Hope is possible."

"[I feel] a lot more hopeful than I did 10 years ago. I have lots of hope and faith in my recovery process and the professionals I've chosen, support team and other tools of recovery."

"With recovery I have found a reason to live. My hospitalizations have decreased and when one occurs it's for a shorter period. For the past six years, I've lived on the streets. I was afraid, alone and suicidal. When I heard the recovery cycle was going to be in my area, the recovery coordinator encouraged me to go and I found acceptance. A week before Christmas I moved into my apartment. I had three recovery participants over for Christmas dinner. I felt belonging and found hope. Thanks to recovery I'm alive today."

Discussion

The goal of this evaluation was to measure change in attitudes, knowledge and skill development occurring during the education cycle. A significant number of the participants who completed both the pre and post surveys perceived an improvement in their attitude, understanding, lifestyle or a specific skill relating to recovery. Based on these results, we feel that the Recovery Project was successful in teaching the core elements of Recovery Education to consumers, professionals, peer supporters and family members.

While these evaluation results were promising, they cannot provide a full picture of the positive changes that have occurred as a result of implementing Recovery Education in Vermont. We have learned a great deal from implementing and continually evaluating the development of the Recovery Education Project, and Vermont has experienced a number of qualitative shifts in the mental-health system on all levels.

Development of Consumer Leaders and Teachers

Of the 435 individuals who participated in a Recovery Cycle, thirty-eight have attended the training for Recovery Educators. Two-thirds of these individuals have gone on to participate in teaching a Recovery Cycle. Over half of these educators are individuals who have a mental illness and would identify themselves as a consumer. Many of these consumers were clients at a community mental health agency at the start of the Recovery Education Project and began by taking a Recovery Cycle in their region. Through encouragement and support, these individuals went on to become trained as recovery educators. From that experience, many have emerged as leaders and teachers within their community: teaching cycles, running ongoing recovery support groups, giving presentations on recovery to providers and community members, presenting recovery workshops at conferences, and advocating for recovery services at their local mental health agency and hospital. In the past two years, four recovery educators have gotten masters degrees, and four more are pursuing further education. For several of the consumer educators, teaching a cycle is the first paid work they have done in many years. Two different agencies have begun to pay consumer recovery educators to develop and coordinate recovery activities for their staff and clients in addition to regular cycles. Many participants and educators have also become consumer representatives on agency boards and advisory committees

The development of these consumer leaders and teachers has been remarkable. They have created a presence that did not exist in Vermont two-and-a-half years ago. Today, individuals with a mental illness can learn about recovery and be inspired by other individuals who have learned to manage their illness and work towards recovery.
The presence of these consumer teachers and leaders has caused a shift in which more and more providers and consumers are realizing that people with mental illness can lead, teach and train us in invaluable ways. Providers, family members and community members are hearing the message that people can manage and recover from their mental illness from people who are actually managing and recovering from their illnesses. Providers are learning about the experience of mental illness from people who actually have a mental illness, and this has led to a much richer communication and understanding between providers and consumers. In many situations, providers and consumers are teaching Recovery Cycles side-by-side as equals, learning from each other and learning from the participants. Because of this, we feel the field of mental health is becoming more considerate of the need to include consumers as trainers, teachers, advocates and stakeholders whenever the subject of understanding and improving mental-health services in Vermont is discussed. We anticipate that, as more consumers take part in Recovery Cycles, more will be inspired in their own recovery and will develop leadership skills. As the numbers of these consumer leaders and teachers grow, the unique learning and understanding occurring within Vermont will grow exponentially.

"....learning from Mary Ellen [Copeland], who has had the courage to learn how to manage her symptoms and now the courage to share that experience with others, is a unique and profound experience. No one can tell it like someone who's been through it." (quote from cycle participant).

A Fundamental Paradigm Shift

"It's like going from the world is flat to the world is round."
-(quote from cycle participant).

The Recovery Education Project has caused a major shift in how people think about mental illness in Vermont. Within the provider system, professionals have traditionally focused on treating the symptoms of mental illness. Providers have been so busy trying to eliminate these symptoms with medication and professional support, those people with a mental illness have remained in a passive stance of receiving treatment. Despite an ideological commitment to empowerment over the past decade, Recovery Education has been one of the first hands-on models in which consumers can actually take an active role in their own recovery process. This represents a major shift in how professionals think about their role. Instead of applying treatment to their clients, their clients actually learn the skills and knowledge to understand and manage their own symptoms and make decisions about the support they receive. With the development of the Wellness Recovery Action Plan™, consumers can make decisions about their care and support in times when they might not be able to make those decisions for themselves. With these changes, consumers are now becoming equal participants in managing their own recovery process.

Within the provider system, many professionals have also shifted their thinking about what the future holds for people with mental illnesses. Mental illness is no longer being seen as a chronic illness that lasts a lifetime. Providers are attending Recovery Cycles, public presentations, and conference workshops taught by people who are living proof of the ability to manage and even recover from their mental illness. This has helped many providers learn new ways to assist their clients and gain a new sense of hope about the possibility of their clients getting better. As one provider who participated in a cycle said:

"In my job, working with people with psychiatric symptoms, I was beginning to lose hope, seeing the same clients over and over. Hearing and seeing everyone share and all I've learned has totally changed my view back to being excited about going to work, looking forward to helping people on their road to recovery."

Bringing Consumers, Providers, and Family Members Together

Perhaps one of the most valuable outcomes of the Recovery Education Project is that it has brought consumers, family members and providers together in a way that no other Vermont initiative has done. In a time when the various stakeholders in our state and elsewhere are contentiously debating subjects like involuntary medication, Recovery has been the one initiative in which all the stakeholders have been able to come together, learn and work side-by-side, collaborate, and avoid controversy. Providers and family members have learned firsthand about the lived experience of mental illness, and consumers have learned from other consumers. Having a mix of consumers, family members and providers as both educators and participants has brought these traditionally separate groups together and facilitated a process in which a remarkable level of communication and learning has occurred.

In addition to bringing these groups together, the Recovery Education Project has highlighted the fact that many people do not fit into any one category or role. As outlined above, ninety-five (42 percent) of the participants identified themselves in multiple roles of consumer, family member, provider, and/or peer supporter of someone with a mental illness. This in itself has brought everyone a little closer and increased people's awareness that we often have more in common than not.

Limitations To The Evaluation

In this evaluation, a significant number of participants reported a perceived improvement in their attitudes, feelings, knowledge, and skills as they related to the recovery curriculum taught through the Recovery Project. We do not have data on the long-term effect of this change, however. The participants reported learning the core elements of recovery education, but there was no formal evaluation of the benefits of having learned these elements. The evaluation did not measure whether people's lives actually got better

after having taken a cycle. Anecdotal and qualitative feedback would suggest that many individuals' lives have improved, but no statistical data on outcomes exist. In the future, we would recommend a more controlled study in which participants in cycles were followed over a longer period and specific outcome measures (housing, employment, use of crisis services, psychiatric hospital use, perceived quality of life, for example) were measured. With the implementation of a new Managed Care Information System, the Department of Developmental and Mental Health Services anticipates that it will have the capacity to undertake such a study in the future.

In addition, this evaluation did not collect any information on those participants who dropped out of a cycle or did not complete both a pre and post survey. Because of this, we know little about the positive or negative experiences and outcomes of those who did not complete a cycle.

Future Directions and Challenges

Through the procurement of federal grant funds, state block grant funds, and state funds, Vermont Psychiatric Survivors and DDMHS has been able to secure resources to continue the Vermont Recovery Education Project into the future. In many ways, the Vermont Recovery Education Project is still in the beginning stages of development. As outlined above, further evaluation is needed to understand the long-term benefits of the curriculum and provide feedback for further curriculum development and improvement. Further work is also needed to understand how to support participants in their recovery process once they have completed a cycle. Many different consumer and professional educators in different parts of the state are experimenting with ongoing recovery support groups, follow-up training and support for consumers and staff, and changes in how related services are structured to assist consumers and their support network in maintaining a focus on recovery. Given the ever-expanding number of educators and cycles being offered, the Vermont Recovery Education Project has also begun examining how to ensure a level of quality and consistency among educators and the cycles they teach.

Both Vermont Psychiatric Survivors and the Department of Developmental and Mental Health Services are committed to continuing and expanding the Vermont Recovery Education Project. We feel that this project represents the future of the public mental-health system in Vermont: consumers taking an active role in understanding and managing their illness; the dissolution of traditional barriers and relationships between consumers and professionals; a quantum leap in the understanding and learning that occurs among consumers, family members, providers and community members; the ever-growing presence of consumer leaders and teachers; and the overarching belief that people can and do recover from mental illness.

Appendix A: Wellness Recovery Action Plan™
Appendix E: Additional Quotes from Survey Participants