

***Recovery in DEPTH: Transforming Mental Health Care  
in the United States and Canada***

***Remarks by***  
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*Attached is the text prepared for delivery; however, some material may have been added or omitted at the time of delivery.*

Thank you, Michael (Michael Kirby is Chairman of the MHCC) for your kind introduction and for the invitation to join you this evening. Under your dedicated leadership, the Standing Senate Committee on Social Affairs, Science and Technology produced the seminal document *Out of the Shadows at Last*, Canada's first-ever national report on mental health, mental illness, and addiction. As Chair of the Mental Health Commission, you oversaw development of a draft framework for a mental health strategy for Canada. In reviewing the wonderful work you have done around mental health transformation and recovery, I'm reminded of the words of civil rights leader Martin Luther King, Jr., who said, "*We all may have come in different ships, but we're in the same boat now.*"

Indeed, we share more than a common border. We share a deeply held belief and a common vision in the fundamental right of individuals who have mental health conditions to live healthy, satisfying, and productive lives in their communities.

And we are not alone. Recently, the Center for Mental Health Services in the Substance Abuse and Mental Health Services Administration, part of the U.S. Department of Health and Human Services, funded a project that studied national mental health system reform movements in seven countries. In addition to Canada and the United States, the countries included Australia, England, Italy, New Zealand, and Scotland. An analysis of policy documents and reports from these seven countries reveals a striking national-level policy consensus about the need for substantial if not radical change of their respective mental health systems.

Each country must deal with unique fiscal, political, and clinical considerations. However, three common concepts that transcend international borders have emerged as pivotal in forming the basis for consensus. They are:

- First, **the emergence of the recovery framework**. Each of these countries believes that the hopeful expectation of recovery should underlie the design and practice of mental health care services.
- Second, **the rise of consumer activism**. Consumers are no longer content to be at the margins of the mental health care system, and rightly so. They are the reason the system exists and they must be at the center of everything we do.
- And finally, **a trend toward a more holistic and integrated view of mental and physical health**. I'm reminded that no less an authority than Hippocrates, widely credited as the father of medicine, believed that the mind and the body are one. We must attend to both as good stewards of public health in both of our countries and around the world.

Each of the seven countries has individually established priorities for reform. But a review of their activities reveals a perhaps surprising consensus on six international priorities.

Moreover, I think you'll see a significant convergence between these international priorities, the eight goals highlighted in your proposed framework, and the six goals of our New Freedom Commission on Mental Health. And the New Freedom Commission's goals are closely aligned with the six priority areas for reform cited by the Institute of Medicine, which has called for health care for mental and substance use conditions to be safe, effective, patient-centered, timely, efficient, and equitable. These goals and principles are driving transformation of the mental health system in the United States.

I think it's clear that in the United States and Canada—and around the world—we are all working to develop a mental health care system that is based on a belief in recovery, centered on

consumer needs and preferences, grounded in evidence-based practice, and led by a culturally competent, technologically savvy workforce.

In the United States, the work of the New Freedom Commission on Mental Health set in motion a series of events that we believe will have *a profound impact* on the ability of individuals of all ages to live, work, learn, and participate fully in their communities. The Commission's final report, called *Achieving the Promise: Transforming Mental Health Care in America*, was groundbreaking in its emphasis on building a system that is evidence based, recovery focused, and consumer and family driven.

The New Freedom Commission made clear that simple reforms no longer are adequate to respond to the needs of children and their parents, adults, and older adults with mental illnesses.

Instead, the Commission called for wholesale and fundamental

transformation of the mental health system. We must transform the mental health system from one dictated by outmoded bureaucratic and financial incentives to one driven by consumer and family needs that focuses on building resilience and facilitating recovery.

The New Freedom Commission's vision statement makes this clear. The Commission said:

We envision a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports—essentials for living, working, learning, and participating fully in the community.

To accomplish its vision, The New Freedom Commission called for immediate and significant changes and our Federal Government—in partnership with States, communities, consumers, families, and the private sector—is responding. Soon after the release of the Commission’s final report in 2003, the Substance Abuse and Mental Health Services Administration—or SAMHSA—was charged with leading efforts to transform the mental health system in this country. That same year, Charles Curie, then SAMHSA administrator, asked me to head up the agency’s Center for Mental Health Services—or CMHS—to guide the transformation of the mental health system at the Federal level. I continue to be humbled and gratified by this important work.

Together with my colleagues at SAMHSA, we organized an unprecedented, collaborative effort among more than 20 Federal agencies and offices to help ensure that people with mental health conditions have every opportunity for recovery. Our efforts

are not codified in law and they receive no special funding. We meet together as concerned citizens, mental health and social service professionals, and stewards of public resources to transform the delivery of health care in the United States.

Together, the Federal partners created a specific and affirmative agenda for wholesale transformation of the mental health system. *Transforming Mental Health Care in America: The Federal Action Agenda* was released in 2005 and updated in 2008. The Action Agenda is both a vision and a plan. It is a vision of the attainability of recovery for people with mental health conditions. Our Action Agenda is also a living document that charts both initial and ongoing steps for altering the form and function of the mental health service delivery system in the United States. I'm pleased to say that we are making significant progress in a number of key areas, which I will share with you in my remarks this evening.

In particular, I want to focus in DEPTH about the concept and practice of mental health recovery. In DEPTH is a shorthand way for me to describe what it means to transform the delivery of mental health services to be person centered, recovery focused, and evidence based. We must:

- **Define** recovery and all its dimensions;
- **Eliminate** practices and beliefs that work against recovery;
- **Promote** healthy behaviors that support recovery;
- **Train** health care providers to understand, embrace, and expect recovery; and
- **Hold** ourselves and others accountable for transforming systems and services that make recovery possible.

## Define recovery

The New Freedom Commission concluded that the U.S. mental health system is not oriented to the single most important goal of the people it serves—the hope of recovery. In order to better address what noted recovery researcher William Anthony has called the “simple yet powerful vision” of recovery, we first had to define what recovery means.

In 2006, SAMHSA unveiled a consensus definition of recovery that I think you will recognize as very similar to your own. The statement was developed through the deliberations of more than 110 expert panelists who came together to examine topics like recovery across the lifespan and recovery in different cultural contexts. We considered how recovery applied at individual, family, community, provider, organizational, and system levels. We also identified 10 key components that are essential elements of the recovery process.

Like you, we consider mental health recovery to be a journey, not necessarily a destination. The process of recovery builds on the strengths of each individual. It is nonlinear and self-directed.

Recovery is holistic and person-centered and it involves personal and community respect and responsibility. It empowers consumers to make decisions that impact their lives and to support and encourage one another.

Perhaps most important, recovery involves hope, which even science tells us is essential to the process.

In his book *The Anatomy of Hope*, Dr. Jerome Groopman of Harvard Medical School explores the essential relationship between hope and healing. He writes:

Without hope, recovery can seem like an elusive goal, a quest that demands too much of our body, our minds, and our spirit. But hope gives us the strength to fight for that better life. Hope helps us overcome hurdles that we

otherwise could not scale and it moves us forward to a place where healing and recovery can begin.

Resilience is a related concept to recovery. Resilient individuals are those that bend rather than break during stressful conditions. They are most likely to have a positive outlook and a sense of personal mastery and to find meaning even in difficult circumstances.

The most important thing to know about resilience is the fact that it is not a static trait. Rather, resilience in an individual is dynamic and varies across time and life domains. Individuals do not develop resilience by “pulling themselves up by their bootstraps” when faced with life’s challenges.

Instead, resilient adaptation to adversity comes about as a result of characteristics of an individual interacting with resources in the environment. This means that we can, in fact, help build resilience in the individuals we serve.

## Eliminate practices and beliefs that work against recovery

To build resilience and facilitate recovery, which is our mission at SAMHSA, we must eliminate those outmoded practices and beliefs that work against it.

To do so, we must recognize the significant impact that trauma has on the lives of men, women, and children in our countries. I began work in the mental health field as a rape crisis counselor and later served as a victim services advocate. I learned again and again that a woman's searing exposure to the raw trauma of physical or sexual assault put her overall emotional health at very high risk for both the short and long term. I heard women say that they needed time and support to recover from the traumas of rape, incest, and domestic violence.

I have never forgotten those voices during the past 30 years. They have inspired me to work tirelessly to help open our Nation's eyes to the impacts of trauma. We must promote emotional

health and recovery for every man, woman, and child who has been affected by traumatic events, including criminal violence, disasters, terrorism, or wars.

In the 15 years since CMHS held a groundbreaking conference called “Dare to Vision,” we have focused national attention on the effects of physical and sexual abuse on the lives of women who are diagnosed with mental illnesses. Sadly, studies reveal the startling facts that from 55 to 99 percent of women in substance use treatment and from 85 to 95 percent of women in the public mental health system report a history of trauma. The abuse most commonly occurs in childhood.

Yet we have also learned the individuals have an enormous potential to recover from trauma when practitioners acknowledge the underlying effects of abuse and work with women and men toward hope and recovery.

Perhaps one of the most important things we can do in this regard is to stop re-traumatizing individuals by using the outdated and dangerous practices of seclusion and restraint. I'm reminded of the Hippocratic oath, "First, do no harm."

When our National Council on Disabilities held a hearing to collect the testimony of people with psychiatric disabilities, they heard loud and clear that involuntary commitment and forced treatment were among the most painful and difficult experiences of individuals' lives. One of the participants noted that individuals who are admitted to the hospital for a physical health problem, in her words, "wouldn't dream of allowing the doctors, nurses, or nursing aides to lock them up, shock them up, tie them up, or drug them up, and the staff wouldn't do it to them."

She's right. Seclusion and restraint aren't treatment options; they are treatment failures that have no place in a transformed system of care. They keep consumers at the margins, not the center of

care. Individuals can't learn to manage their illnesses and their lives when they are under external control—either physical or chemical.

SAMHSA has taken a leadership role in eliminating seclusion and restraint through a number of activities, including the award of 16 Seclusion and Restraint State Incentive Grants. We also developed a *Roadmap to Seclusion and Restraint Free Mental Health Services*, a consumer-based staff training manual that includes best practices. We plan to release a video on alternatives to seclusion and restraint later this year. You can learn more about these activities on our Web site at [www.samhsa.gov](http://www.samhsa.gov).

In addition to not doing the wrong things, we also must do the right things for people with mental health conditions. I particularly like this statement in your recovery framework: *“At the core, when it comes to mental health and well-being, we are all the*

*same – whether we are currently experiencing a mental health problem or illness or not. **There is no ‘us’ and ‘them.’***”

Unfortunately, we know that discrimination, fear, and bias continue to separate individuals with mental health conditions from the rest of society. Inaccurate and hurtful perceptions lead others to avoid living, socializing or working with, renting to, or employing individuals with mental health conditions.

These misperceptions lead to low self-esteem, learned helplessness, and hopelessness on the part of individuals and deter the public from wanting to pay for care.

Worst of all, the fear of discrimination often causes individuals, young people, and whole families with mental illnesses to become so embarrassed or ashamed that they conceal symptoms. As a result, they may avoid seeking the very treatment, services, and supports they need and deserve.

In response to the New Freedom Commission's call for a national public education campaign to combat these stereotypes and prejudices, SAMHSA launched the National Campaign for Mental Health Recovery. We've begun with a focus on teaching young adults how to reach out to their friends who may be having a mental health crisis.

The Campaign includes radio and TV ads and has been enormously successful. We've distributed more than half a million copies of the Campaign brochure nationwide and created and disseminated materials specifically for colleges and universities. We are currently developing multicultural materials based on the "What a Difference a Friend Makes" theme targeting 18 to 25 year olds who are African American, Asian American, Native American, and Hispanic American. I encourage you to visit [www.whatadifference.org](http://www.whatadifference.org) for more information.

Finally, we have a special responsibility to reach out to those individuals who may be struggling with fear, uncertainty, and loss. This might be a veteran who is having trouble readjusting to civilian life, a widow who is overcome with grief and loss, a victim of a natural disaster who is trying to pick up the pieces, or a recent immigrant who is having trouble adjusting to a new life.

At these critical life junctures, vulnerable individuals without appropriate support may be at increased risk for suicide. In 2005, the most recent year for which we have national data, suicide resulted in more than 32,000 deaths in the U.S., according to our Centers for Disease Control and Prevention. Sadly, suicide is the third leading cause of death among young people age 15 to 24.

Suicide also is a significant problem among older adults and increasingly among veterans and active duty military.

SAMHSA's National Suicide Prevention Lifeline, at 1-800-273-TALK, averages 1,500 calls every day. Over the past year, the

Lifeline has experienced a 30 percent increase in calls, with crisis centers reporting a significant number of people who are calling because of economic fears. Many individuals have lost their job or their home or are afraid they will.

To help our Nation's veterans, SAMHSA and the U.S. Department of Veterans Affairs created a special feature that allows Lifeline callers who are veterans to be connected to VA Suicide Prevention Coordinators. In its first year of operation, calls from veterans led to more than 6,000 referrals to VA Suicide Prevention Coordinators. These calls also resulted in more than 1,700 rescues—calls to police or emergency medical personnel for immediate responses for individuals judged to be at imminent risk. This is mental health transformation in action!

### Promote healthy behaviors that support recovery

Helping to prevent suicides and other adverse consequences of untreated mental illnesses is only part of the equation. We also

must promote health and wellness. We must understand, acknowledge, and act on our belief that there is no health without mental health. This is a simple yet profound concept that underlies a public health approach to health care.

Indeed, the World Health Organization has noted, “The goals and traditions of public health and health promotion can be applied just as usefully in the field of mental health as they have been in the prevention of infectious or cardiovascular diseases...”

Public health is a community approach to preventing and treating illnesses. Its premise is that caring for the health of the individual protects the community, while—in turn—caring for the health of a community protects the individual. As such, health promotion is a primary focus of a public health approach.

Think about Type 2 diabetes. We now know that diet, physical activity, and even modest weight loss can forestall or prevent the onset of Type 2 diabetes in at-risk individuals.

In the same vein, we are learning that if we intervene early, we may be able to prevent the onset of some mental disorders, lessen their impact, or preclude co-morbid conditions and long-term disability.

In March, the Institute of Medicine of the U.S. National Academy of Sciences released a much anticipated report, *Preventing Mental, Emotional, and Behavioral Disorders among Young People: Progress and Possibilities*. CMHS was pleased to support this update to the seminal 1994 report, *Reducing Risks for Mental Disorders*. That report provided the basis for understanding the science of prevention, examined early research in the field, and proposed areas for further study.

This new report focuses on our Nation's young people. We know that half of all diagnosable lifetime cases of mental illness begin by age 14, and three-fourths of all lifetime cases start by age 24. We also know that first symptoms occur 2 to 4 years prior to the

development of a diagnosable disorder, which means we have an important window of opportunity in which to respond.

Unfortunately, data show a significant lack of access to services for both mental health and substance use problems for our Nation's youth.

I'm pleased to be able to share with you two key findings from the new report. First, the 2009 update reveals concrete evidence that an increasing number of mental, emotional, and behavioral disorders are, in fact, preventable. Second, and equally important, this groundbreaking report goes beyond the 1994 report by recommending the inclusion of mental health promotion in the full spectrum of mental health interventions.

The authors conclude, "*The nation is now well positioned to equip young people with the skills, interests, assets, and health habits needed to live healthy, happy, and productive lives in caring*

*relationships that strengthen the social fabric.” What a wonderful vision for health care reform.*

The notion that mental health is essential for overall health represents a sea change in our thinking. In fact, I believe we have reached the “tipping point” where it is no longer appropriate to consider the mind and the body separately. We must “create the neck,” as CMHS Medical Director Dr. Ken Thompson is fond of saying.

Increasingly, the concept of integrated care for mental health and general health conditions is seen as both a financial and an ethical imperative.

In the United States, the newly enacted Mental Health Parity and Addiction Equity Act requires insurance coverage for mental and substance use disorders to be equivalent to that offered for other medical conditions. This hard-won legislation is testament to the

growing recognition of the need to integrate care for mental health and general health problems.

And at SAMSHA, we are now accepting grant applications for the Primary and Behavioral Health Care Integration program. We hope to improve the physical health status of people with serious mental illnesses by supporting communities to coordinate and integrate primary care services into publicly funded community mental health agencies. We expect the services we fund will incorporate a prevention and wellness approach and show cooperation and collaboration across community mental health and primary care.

The push to integrate mental health and general health care is more than a philosophical exercise, however. It is a matter of life and death. We know that the top three leading causes of disability worldwide are behavioral health disorders, as reported in the World Health Report of 2001.

We also know that people with serious mental illnesses die, on average, 25 years earlier than the general population. More important, we know they die from treatable medical conditions that are caused by modifiable risk factors, including smoking, obesity, substance abuse, and inadequate access to medical care. This is a public health crisis that must be addressed.

To help address this issue, SAMSHA sponsored a wellness summit that attracted a wide range of stakeholders, including mental health and primary care providers, researchers, consumers, family members, and advocates. The heart of the summit was the enunciation of a national call to action to reduce the life expectancy disparity by 10 years within the next 10 years, or what we call the “10 by 10” program. Summit participants developed a National Wellness Action Plan for People with Mental Illnesses built on the following vision:

We envision a future in which people with mental illnesses pursue optimal health, happiness, recovery, and a full and satisfying life in the community via access to a range of effective services, supports, and resources.

Effective, person-centered services and supports require the individual to be a full participant in his or her own treatment. The right of individuals to have full power over their lives is often referred to as self-determination.

One promising approach for self-determination is called self-directed care, which gives consumers greater economic say in how their medical dollars are spent.

Research on self-directed care for people with developmental disabilities reveals that participants do as well or better than those who take part in traditional programming. They receive more services than those in traditional programs and are significantly

more satisfied with these services. Self-directed care programs don't cost more than traditional services.

To promote this practice, we've held trainings with consumers on ways to control finances, such as setting up individualized budgets and using a broker or finance coach to guide decisions. Our Self-Direction Education Project includes training Web casts available on DVDs and fact sheets on mental health self-direction approaches.

Another important tool for self-determination is the practice of shared decision-making, which gives consumers a greater voice by encouraging them to partner with their health care providers to make treatment decisions. It combines the provider's medical expertise with the consumer's knowledge of what gives his or her life meaning and value.

Shared decision-making is not a new concept in health care, but it is not widely practiced or accepted in mental health care. In part,

this is because many providers mistakenly believe—despite evidence to the contrary—that people with mental illnesses are not competent to participate in treatment decisions or don't wish to do so. This simply is not the case.

We recently awarded a contract for the development and testing of shared decision-making aids in mental health care. The tools we develop will help empower individuals with mental health conditions to take charge of their health and their lives. This is mental health transformation in action!

### Train the workforce that provides care

Building resilience, facilitating recovery, and promoting self-determination for mental health consumers requires that we train, educate, and support the workforce that delivers care—not only in behavioral health care, but across the health care professions.

“The people who deliver care are the health system’s most

important resource,” noted the Institute of Medicine in its report, *A New Health System for the 21<sup>st</sup> Century*.

The complexities we face in reinventing the behavioral health workforce are numerous. Among other challenges, we know that:

- There are severe shortages of mental health workers to meet the needs, particularly of children, older adults, communities of color, and other growing populations.
- Workforce shortages are particularly acute in rural areas of the U.S., many of which have no practicing psychiatrists, psychologists, or social workers.
- Current education and training often are not consistent with evidence-based practice.
- And there are no national core competency standards to ensure that minimum requirements are met.

SAMHSA has undertaken a major Behavioral Health Workforce Development Initiative to meet this challenge.

The centerpiece of our efforts is a Behavioral Health Workforce Development Resource Center to serve as a comprehensive Web portal for mental health and substance abuse treatment providers and the programs that employ them. When we launch the site later this year, it will contain a wealth of information on such cutting-edge issues as licensing, credentialing, education, and employment, as well as recruitment, retention, supervision, and leadership training.

Behavioral health providers will be able to search for a job and build a resume. They will also have access to state-of-the-art education and training resources on such topics as recovery, consumer-directed care, and integration with general health care.

Employers will find information on how to recruit qualified, well-trained staff and help staff succeed both in serving their clients and in meeting their own personal and professional goals.

We will use the Resource Center Web portal to host webinars on topics in behavioral health workforce development, and we'll have an "ask the expert" feature. Information on the site will be updated daily.

As part of this project, we are also developing core competencies for behavioral health care providers who work with a full range of clients—from adults and older adults to women, children and families, and various ethnic and cultural minority groups. The Resource Center Web portal allows us to extend SAMHSA's resources for workforce development to the most people, with the most current information, and in the most readily accessible manner. This is mental health transformation in action!

Hold ourselves accountable

Finally, if we are going to transform our services and systems around the hope of mental health recovery, in both the United States and Canada, we must hold ourselves accountable for doing so.

Rick Smyre, President of the international consulting group Communities of the Future, points out that “as long as things stay the same or change occurs slowly, it is appropriate to use traditional ideas and only reform basic approaches.”

However, he continues, “when the very concept of how things are done begins to change, reforming old ideas is no longer enough. We must begin to think about experimenting with totally new approaches.”

Transformation is such an approach. It is a deep, profound, and ongoing process along a continuum of innovation. It is a way of creating something possible from the perceived impossible.

Transformation implies profound change—not at the margins of the system, but at its very core. In a transformed Nation, new sources of power emerge and new competencies develop.

Opportunities and challenges are looked at with a new perspective.

John Kao—psychiatrist, educator, and author of *Innovation Nation*—identifies how transformation occurs. He says we must “move beyond old, established ways of thinking. We [have] to be able to entertain ‘impossible’ possibilities.”

“Impossible possibilities” sounds like an oxymoron, but I have a good way to explain what it means. Two of my favorite thinkers, Rosamund Stone Zander and Benjamin Zander, tell this story in their bestselling book, *The Art of Possibility: Transforming Professional and Personal Life*.

*A shoe factory sends two marketing scouts to a region of Africa to study the prospects for expanding business. One sends back a telegram saying,*

*SITUATION HOPELESS\_ STOP\_ NO ONE WEARS SHOES*

*The other writes back triumphantly,*

*GLORIOUS BUSINESS OPPORTUNITY\_ STOP\_ THEY HAVE NO SHOES*

Innovative, transformative leaders articulate possibilities. Instead of predicting failure, they sense opportunity. When others ask “why,” they ask “why not?”

Each and every one of you in this room this evening is a transformative leader. In the language of my favorite sport, you have stepped up the plate and have swung for the fence. You

know the status quo is no longer acceptable. In fact, transformational leaders recognize that maintaining the status quo is actually moving the organization—or the country—backwards. Transformative leaders understand that when you are doing things well, it is time to make them better.

In the United States, we are growing transformation and developing transformative leaders as part of our Mental Health Transformation State Incentive Grant or T-SIG program. We have a decentralized mental health system, with services provided by States and providers within those States. Nine States were awarded T-SIG grants, which are unique in that they are supporting new and expanded planning and development to promote transformation of systems explicitly designed to foster recovery and meet the multiple needs of consumers.

We are beginning to collect data that will help us determine whether infrastructure changes lead to service changes and

whether service changes lead eventually to client outcome changes, though we know we may not see these changes in client outcomes during the life of the grants. Our evaluation will also document factors that contribute to successful transformation in order to inform current and future transformation efforts of other States and SAMHSA.

We have our first set of data available. They reveal that the first group of 7 States have:

- Made more than 150 significant policy changes, including more than 35 regarding the financing of mental health-related services;
- Trained more than 20,000 providers in best mental health practices;
- Made 65 significant organizational changes to support transformation;

- Expanded data accountability systems across 450 organizations; and
- Implemented state-of-the-art mental health practices in more than 1,000 programs.

This is mental health transformation in action!

### Social inclusion—a vision for the future

At SAMHSA, we are proud of what we have done, but we know we still have much to do. Recently, CMHS developed a 5-year strategic forecast to guide the Center's work in formulating policy and directing resources. We want to be well prepared to be key players in health care reform discussions in the United States.

Among our most important goals is to focus on the broad personal, social, economic, and environmental factors that impact

health and wellbeing. You said it well in your proposed framework: “The context of people’s lives matters.”

Indeed it does. As the World Health Organization notes, “Increasing and persisting socioeconomic disadvantages for individuals and for communities are recognized risks to mental health.” In fact, in its recent prevention report, the Institute of Medicine concluded about the United States, *“the future mental health of the Nation depends crucially on how...the costly legacy of poverty is dealt with.”*

The World Health Organization also points to hopelessness as an important risk factor for poor mental health. And hopelessness is bred when people feel excluded from relationships, from jobs, and from the life of the community.

Writing in the April 2007 issue of *Psychiatric Services*, Norma Ware and her colleagues note that even when people with mental illnesses live in neighborhoods alongside people without

disabilities, many of them “lack socially valued activity, adequate income, personal relationships, recognition and respect from others, and a political voice. They remain, in a very real sense, socially excluded.”

We have excluded people with mental illnesses from the social fabric of our lives for far too long. We know that social exclusion increases the likelihood of significant psychological distress and psychiatric illness, including substance abuse.

On the other hand, social inclusion means that we adopt policies and activities that are not necessarily planned as mental health interventions, but—because they improve access to a wide variety of resources—have important mental health effects. We include all members of a community when we have safe schools, stores that sell healthy foods, and places to gather for recreation and relaxation.

But I'd like to go one step further and propose that it's no longer enough for us to talk about the importance of individuals with mental health conditions living IN the community. Instead, they must be OF the community. They should be able to flourish, not merely function. To help them do so, we must remove attitudinal barriers and establish appropriate supports to make this possible.

Individuals with mental health conditions need affordable, accessible, and appropriate housing—the same kind of housing you or I might live in—in neighborhoods of their choice. Recent research in the U.S. confirms earlier studies which show that permanent supportive housing is both effective at helping individuals with mental health conditions remain stably housed and is cost-effective.

Individuals with mental health conditions want and need to work. Yet despite their desire and ability to work, individuals with mental

illnesses in the United States have the highest rate of unemployment of any group with disabilities. Supported employment is an evidence-based practice that helps individuals choose, get, and keep competitive jobs. SAMHSA has toolkits on supportive housing, supported employment, and a range of other evidence-based practices that you can access from our Web site.

Most of all, individuals with mental health conditions want to be accepted for who they are. Perhaps Roy Muike said this best, in *Out of the Shadows at Last*, when he remarked:

To the people of Canada, I say welcome us into society as full partners. We are not to be feared or pitied. Remember, we are your mothers and fathers, sisters and brothers, your friends, co-workers and children. Join hands with us and travel together with us on our road to recovery.

We must walk this road together with Roy and with all individuals and family members whose lives have been affected by mental illnesses. Ultimately, without access to housing, health care, meaningful activities, social support, and community relationships, individuals of all ages are excluded from all that it means to be healthy in today's society.

### Wrap-up and Conclusion

In closing this evening, I want to thank you again for inviting me to join you and extend my support and my gratitude for the work you are doing. We have much to learn from one another.

Hubert Humphrey, the 38<sup>th</sup> Vice President of the United States, remarked, *"It was once said that the moral test of government is how government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those*

*who are in the shadows of life, the sick, the needy and the handicapped.”*

The hard work you are doing in Canada and that we are doing in the United States is designed, as you have so eloquently stated, to bring individuals with mental health conditions out of the shadows forever.

We must bring them out of the shadows by supporting their recovery and eliminating practices and beliefs that are impediments to recovery.

We must bring them out of the shadows by promoting health and wellness across the full spectrum of mental health and general health care.

We must bring them out the shadows by educating, training, and supporting qualified practitioners, including mental health consumers and family members.

And we must bring them out of the shadows by holding ourselves accountable for transforming the way we do business. The status quo is no longer acceptable.

Then and only then can we say that individuals with mental health conditions are full, productive, and healthy members OF our communities. They deserve nothing less. Thank you.