

Words Matter: Recovery-Oriented Systems of Care Language

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Florida Statewide ROSC Workforce Development Initiative
February 9, 2018



This product is supported by Florida Department of Children and Families' Office of Substance Abuse and Mental Health

Webinar Objectives

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- Describe a minimum of 2 recovery-oriented language principles that should shape behavioral health terminology
- Identify examples of traditional behavioral health terms which communicate stigmatizing or demoralizing messages regarding persons in recovery
- Identify strengths-based, recovery-focused alternative terms to be used in both written and verbal communications
- Describe the implications of word choice/language tone on the delivery of behavioral health services and on the experience of persons in recovery



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Florida Recovery-Oriented Systems of Care (ROSC) Language Focus

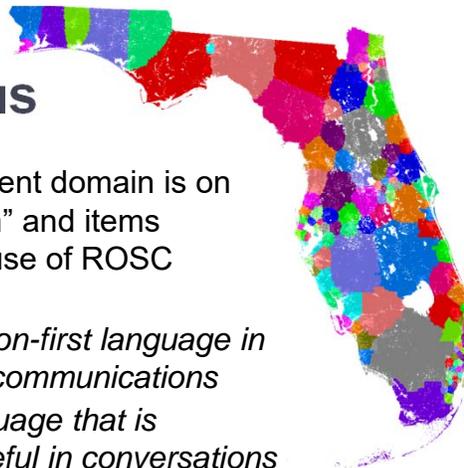
- Self-Assessment/Planning Tool for Implementing Recovery-Oriented Mental Health Services (SAPT)
 - <http://saptrecovery.org/>
- Administrative/Treatment/and Community Integration Domains



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Florida ROSC Language Focus

- One focus of the Treatment domain is on “Validation of the Person” and items specifically explore the use of ROSC language, e.g.,
 - *Agency staff use person-first language in all verbal and written communications*
 - *Agency staff use language that is encouraging and hopeful in conversations with persons who are receiving services*
 - *Agency staff work from a strengths/asset-based model*



A Starting Place



- Why are words important?
- What words do you use on a daily basis at your program?
- What are the messages beyond those words?
- Are they consistent with your belief in RECOVERY?
- If not, why not?
 - Ill intent versus “old habits”

A Preview of Where We Have Been...

- Patient is a 43-year-old schizophrenic Cuban American with a long history of multiple hospitalizations due to med non-compliance in the community. For the last 18 mos., the patient has been compliant with meds and treatment. As a result, she has been clinically stable and has stayed out of the hospital. However, patient has no-showed for her last two visits and the team suspects she may be flushing her meds. The mobile crisis team will be dispatched today to evaluate Sonia as she failed to report to Clozaril clinic this morning for bloodwork.



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And a Glimpse of Where We Want to Be...



- Sonia is a 43-year-old loving grandmother of Cuban-American heritage who has lived with schizophrenia for nearly two decades and experienced multiple psychiatric hospitalizations. For the last 18 months, Sonia has worked with her M.D. to find meds that are highly effective for her, and she has enjoyed her longest period of independent living in the community. She has been active at the clinic and the social club, and she and her team all feel as though she has been doing very well, e.g., returning to work, spending time with friends, and enjoying her new apartment. People have become concerned recently as she has been missed at activities including a bloodwork appointment at today's Clozaril clinic. The mobile outreach team plans to visit her today for a wellness check to see if there is any way the clinic staff can support her.

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“Words are important. The language we use and the stories we tell have great significance to all involved. They carry a sense of hope and possibility or can be associated with a sense of pessimism and low expectations, both of which can influence personal outcomes”.



Devon Partnership Trust and Torbay Care Trust (2008, p. 2). *Putting Recovery at the Heart of All We Do*. <http://www.iris-initiative.org.uk/silo/files/recovery-guide-glenn-roberts.pdf>

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Toward Recovery-Oriented Care

Traditional Approaches	Recovery Model
Self-determination comes <i>after</i> individuals have successfully used treatment and achieved clinical stability	Self-determination is viewed as a fundamental human right of all people
Compliance is valued	Active participation and empowerment is vital
Only professionals have access to information (e.g., plans, assessments, records, etc.)	All parties have full access to the same information – often referred to as “transparency”
Disabilities and deficits drive treatment; focus is on illness	Strengths are celebrated; abilities/choices define supports
Lower expectations	Higher expectations

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Toward Recovery-Oriented Care

Traditional Approaches	Recovery Model
Clinical stability or managing illness	Quality of life/ promotion of recovery
Linear movement through an established continuum of services	Person’s chooses from a flexible array of supports and/or creates new support options with team
Professional services only	Diverse supports (professional services, non-traditional services, and natural supports)
Facility-based settings and professional supporters	Integrated settings and natural supporters are also valued
Absence of risk; protection of person and community	Working collaboratively with person to manage risk as they try new activities necessary for growth/recovery; <u>responsible risk-taking</u>

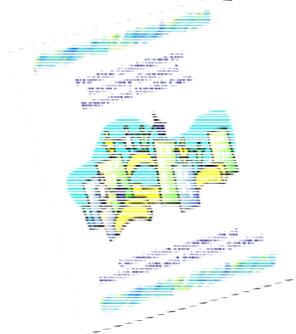
Recovery-Oriented Care... a fuzzy concept?

- *Consumers demand it, public service systems endorse it, medical and professional programs are encouraged to teach it, and researchers investigate it. Yet, people struggle to understand exactly what “it” is and what “it” might look in practice.*



- Tondora, et al., 2005.

The Utility of Practice Guidelines*



- Promote increasing accountability among providers and the system as a whole
- Provide a road-map for trainees/providers who WANT to make changes, but they feel un/under-prepared
- Assist in prioritizing training & consultation objectives
- Educate service users and families re: What they can/should expect from supporters and the system at large, e.g., recovery mentors

[Tandora et al, 2006](#)

Language and the Challenge Before Us

- Recovery-oriented values do not consistently translate into recovery-oriented language
- Despite growing consensus around the importance of a strengths-based approach in a ROSC, the actual language (both written and verbal) routinely used in behavioral health service settings can be pejorative, dehumanizing, and disrespectful.



Language as Micro-aggression?

- Behavioral health service providers have POWER. And language has POWER.
- How we choose to use that POWER is up to each of us every day!
- “Micro-aggressions,” are defined as subtle blows delivered incessantly resulting in small wounds. They result when members of privileged groups—however they might be defined in any one instance—exert their power over the less privileged.”
 - [Pierce, 1995](#)



But Do Words *REALLY* Matter?

- *Words are important. If you want to care for something, you call it a “flower”; if you want to kill something, you call it a “weed”.*

–Don Coyhis as quoted in [William White, 2007](#)



ROSC Language Principles:

Consistently Use Person-First

- The language used is neither stigmatizing nor objectifying. At all times “person first” language is used to acknowledge that the disability is not as important as the person’s individuality and humanity, e.g., “a person with schizophrenia” versus “a schizophrenic” or a “person with an addiction” versus “an addict.”

~~STIGMA~~

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Person First Makes a Difference

Video clip...The Gestalt Project



<http://www.youtube.com/watch?v=QficvVNIxTI&feature=youtu.be>

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Questions for Consideration

- What stood out for you in the clip and why?
- How did you feel emotionally MID-WAY through the clip?
How did you feel at the end?
- What did you learn? And how might this relate to ROSC language and thinking? What if YOU were defined largely by ONE part of yourself – a part you really struggle with...maybe an illness, maybe a difficult experience in your life. What if that was what others focused on most all the time? What would that be like?
- What types of stories do we craft about the people we serve and the lives they live? How can we use language to promote a more hopeful narrative?



ROSC Language Principles:

Solicit and Honor Personal Preferences

- Exceptions to person-first language that are preferred by some persons in recovery are respected, e.g., person-first and 12-step tradition.
- While the majority of people with disabilities prefer to be referred to in first-person language, when in doubt ask the person what he or she prefers!



ROSC Language Principles:

Avoid Sensationalizing and Over-Generalizing

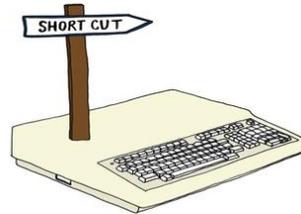
- ROSC language is empowering and avoids making assumptions, overgeneralizing, and sensationalizing mental illness.
- Implication: active versus passive voice
- Words such as “hope” and “recovery” are used frequently in documentation and delivery of services.



ROSC Language Principles:

Avoid “Catch-All” Phrases and Short-Cuts

- Practitioners avoid using labels as “catch-all” phrases as means of describing an individual (e.g., “she’s low-functioning”): Such labels yield minimal information regarding the person’s actual experience or manifestation of their illness or addiction.



- *No one here talks about me or treats me like a label. Just because I have schizophrenia, that doesn't tell you a whole lot. My roommate does too, but we couldn't be more different. Folks here take the time to get to know lots of things about me, not just the things they think go along with my diagnosis.*

▫ Person in Recovery as quoted in CT Recovery Practice Guidelines

RESPECT

[Tandora and Davidson, 2006](#)

It is OK to Be DESCRIPTIVE (Just Avoid Reducing to General “Labels”)

- **Henry is schizophrenic** → Henry says he’s hearing a lot of voices today. We talked about what the voices are saying, how that feels, and what it is interfering with.
- **Jill is depressed** → Jill is having a really hard time getting out of bed lately. She says she just can’t stop crying and feels afraid to leave her house.
- **Margaret is labile** → Margaret went back and forth between crying and laughing several times in our conversation, and couldn’t say why.
- **Mary is a cutter** → Mary sometimes cuts herself, and has explained that it’s a part of how she copes with her emotional pain.

Descriptive Language

Weak Examples

- Anger issues
- Depressive symptoms
- Addiction
- Low-functioning

Strong Examples

- Has had outbursts and interpersonal conflicts with neighbors
- Lacks the energy to take care of basic household tasks
- Frequent substance use at apartment has led to police calls and risk of eviction
- Struggles with X, interfere with the following types of daily activities

ROSC Language Principles:

Maximize Use of Accessible, “Real” Language

- Wherever possible, efforts are made to record the individual’s responses verbatim rather than translating the information into professional language.



What We Hope for “THEM”

- ✓ Compliance with treatment
- ✓ Decreased symptoms/
Clinical stability
- ✓ Better judgment
- ✓ Increased
Insight...Accepts illness
- ✓ Follows team’s
recommendations

What We Value for “US”

- ✓ Life worth living
- ✓ A spiritual connection
to God/others/self
- ✓ A real job, financial
independence
- ✓ Being a good
mom...dad...daughter
- ✓ Friends

What We Hope for "THEM"	What We Value for "US"
<ul style="list-style-type: none"> ✓ Follows team's recommendations ✓ Decreased hospitalization ✓ Abstinent ✓ Motivated ✓ Increased functioning ✓ Residential Stability 	<ul style="list-style-type: none"> ✓ Fun ✓ Nature ✓ Music ✓ Pets ✓ A home to call my own ✓ Love...intimacy...sex

What We Hope for "THEM"	What We Value for "US"
<ul style="list-style-type: none"> ✓ Healthy relationships/ socialization ✓ Use services regularly/engagement ✓ Cognitive functioning ✓ Realistic expectations ✓ Attends the job program/clubhouse, etc. 	<ul style="list-style-type: none"> ✓ Having hope for the future ✓ Music ✓ Joy ✓ Giving back...being needed ✓ Learning

The Implication in Documentation

- We have a history of “bait and switch” in behavioral health recovery plan language
- Plans often are dominated by excessive (and unnecessary) clinical jargon and confusing terms
- WHY does this happen and how does it make people feel?



The Implication in Documentation

- Which Goal Would **YOU** Want to Work in Your Recovery?

Recovery Plan Goal

- “I want to have friends and family back in my life.”



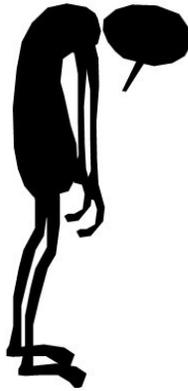
Recovery Plan Goal

- Patient will experience improvements in interpersonal boundaries and socialization, communication, and relational skills



ROSC Language Principles:

Beware False Expectancy And Negation



- Language can contain within it an “expectancy bias.”
- In our context... “Pat’s a high-functioning schizophrenic.”
- And language can include a stigmatizing “negation.”
- “Pat has schizophrenia but has no history of violence or med non-compliance.”

◦ [Seeman, 2005. *Paying Attention to Language*](#)

ROSC Language Principles:

-
- Focusing solely on deficits in a thoughtful analysis of strengths disregards the most critical resources an individual has on which to build in their efforts to adapt to stressful situations, confront environmental challenges, improve their quality of life, and advance in their unique recovery journey.
 - Providers attempt to interpret perceived deficits within a strengths and resilience framework, as this will allow the individual to identify less with any limitations of their behavioral health experience.
 - Strive for “balance,” but put your best foot forward...

It's about what's **STRONG**, not just about what's **WRONG!**



Think about it...



- Ask yourselves about the language, tone, and messages conveyed by the left-hand column on the next several slides:
 - Hopeful vs. gloom and doom?
 - Active agent vs. passive recipient?
 - Past vs. future oriented?
- And ask yourselves:
 - What if you, or a loved one, were described in this manner?
 - Would you feel hopeful about your future or in despair with the present?
 - Would you feel like a partner with your direct supporter or like an outsider in the process?
 - Are there practice implications for our word choices? How does language impact thinking and thinking impact behavior?

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The Glass Half Empty...Half Full

Deficit-based Language

- A schizophrenic, a borderline
- Clinical Case Manager
- Front-line staff in the trenches
- Suffering from
- Treatment Team

Strengths-based, Recovery-oriented Alternative

- A person diagnosed with...living with
- Recovery Coach/Guide
- Direct Support Staff
- Person living with...Substance abuse interferes with
- Recovery Team

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The Glass Half Empty...Half Full

Deficit-based Language

- High-functioning vs. Low Functioning
- Unrealistic
- Resistant/non-compliant
- Weaknesses

Strengths-based, Recovery-oriented Alternative

- A person's symptoms/addiction interferes with the following...
- Idealistic; high expectations
- Disagrees with, chooses alternatives
- Barriers to change; support needs

The Glass Half Empty...Half Full

Deficit-based Language

- Maintaining clinical stability/abstinence
- Puts self/recovery at risk
- Treatment works

Strengths-based, Recovery-oriented Alternative

- Promoting life worth living
- Takes risks to try new things/grow
- Person uses treatment as a tool in recovery

Tondora et al., 2017. Yale University School of Medicine Program for Recovery and Community Health. New Haven, CT.

Practice Implications

Presenting Situation	Deficit-based Perspective		Recovery-oriented, Asset-based Perspective	
	Perceived Deficit	Corresponding Interventions	Perceived Asset	Corresponding Interventions
Person not currently engaging in treatment or using medication	Person is treatment-resistant, noncompliant, lacks insight, or is in denial,	Subtle or overt coercion to promote treatment compliance, e.g., use of medications or participation in services; alternatively, discharge person from care for noncompliance	Consider WHY they may not be finding available treatments useful. They may be ambivalent for various reasons: They may have found past treatments to not meet their needs, goals, cultural values or preferences. They may also be seen as assertive and exercising their right to make treatment decisions and/or to consider alternate	Compliance, and even positive behaviors resulting from it, neither equate nor lead directly to recovery. Attempts are made to understand and "agree to disagree" as needed. Providers value the "spirit of noncompliance" and see it as a sign of the person's energy and vitality, that they haven't given up. Demonstrate how treatment could be useful to the person in achieving their own goals, beginning with addressing their basic needs or expressed needs and

“Through my angry indignation I was affirming that ‘I am more than that, more than a schizophrenic’... My angry indignation was a sign I was alive and well and resilient and intent on fighting for a life that had meaning and hope. What some would have seen as denial and a lack of insight into my illness, I experienced as a turning point in my recovery.”

Deegan, P.E. (1996). [Recovery as a Journey of the Heart](#). [Psychiatric Rehabilitation Journal](#) 19, 3, p. 91–97.

ROSC Language Can Help Forge a New Path...



Practice Implications: Substance Use Focus

- Patient is a 32-year-old white American with a long history of major depression and co-occurring Cocaine Abuse and multiple psychiatric hospitalizations and inpatient detox episodes dating back to his teens. Throughout his 20s, patient refused to acknowledge his addiction or engage in services. However, after developing medical complications secondary to his drug use, he got connected to supported housing and 12-step programs and these enabled him to get clean 2 years ago. He reports continued abstinence, but recent events have the team concerned about relapse. The patient's non-compliance with meds and his tendency to minimize his addiction have led to numerous past treatment failures.
- Patient completed the 12th grade but due to the severity of his illness and addiction, the patient has only been able to hold down part time jobs as a cashier and a shift supervisor. He reports a strong desire to work, but has unrealistic goals in this area and has previously refused referrals to recommended disability entitlement programs.

Practice Implications: Substance Use Focus

Patient has recently become non-compliant with numerous aspects of his treatment program. Three weeks ago, he was discharged from a residential program after breaking house rules and failing to follow programming requirements. Patient was to be out of the house and engaged in productive activity at the local IOP program 20 hours per week. Patient stopped attending (saying he found a part-time job) and was subsequently asked to leave his housing program. He has moved in with a cousin, and reports that this arrangement is "working out fine," however, the apartment is located in an area with high drug activity, and patient fails to see the risk in this situation. At the same time, patient has recently been attending NA only sporadically. Patient reports that he has been busy with the part-time job in order to be able to share living expenses with his cousin, and he is not always able to attend his regular NA meetings. Patient admits to some increase in depression and stress but denies drug use and insists that he wants to continue living with his cousin who he describes as supportive.

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Practice Implications: Substance Use Focus

All-treaters meeting has been called to discuss patient's recent non-compliance with services and to develop treatment recommendations. Team believes patient's mental health has deteriorated and that his risk for substance relapse has increased since his recent return to work and move out of the housing program. Team feels that the patient is demonstrating poor judgment and is putting his recovery at risk by engaging in self-defeating behaviors, e.g., failing to adhere to his programming and 12-step responsibilities. Patient is increasingly symptomatic and unable to follow the recommendations of his treatment team. The following goals and interventions are proposed in order to ensure the patient's clinical stability and abstinence.

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Practice Implications: Substance Use Focus

Problem 1: Substance Abuse: As evidenced by: history of crack addiction; recent withdrawal from 12-Step; putting recovery at risk due to living environment

Treatment Goal: Abstinence

Objectives and Interventions: Patient will resume regular attendance at AA/NA; Patient will submit to random drug testing and will demonstrate clean urines; Intensive Addictions outpatient program, 3 days weekly



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Practice Implications: Substance Use Focus

Problem 2: Housing: As evidenced by: history of homelessness; no stable housing; discharge from housing program due to non-compliance; living in high-risk area

Treatment Goal: Affordable supported housing in drug-free environment



Objectives and Interventions: Patient will express motivation to re-enroll in supported housing program; patient will attend all housing appointments and complete paperwork; patient will sign a behavioral contract to comply with supported housing program rules and procedures. M. Lofthouse to complete housing referral and facilitate re-enrollment in Sober Housing program

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Practice Implications: Substance Use Focus

Problem 3: Financial Hardship: As evidenced by: Patient unable to pay bills; increasing debt; return to work has precipitated decompensation

Treatment Goal: Secure financial stability



Objectives and Interventions: Patient will agree to apply for state/federal disability benefits; Patient will satisfy eligibility criteria for referral to supported employment program, i.e., clinical stability and abstinence for 3 months, compliance with team's recommendations; M. Lofthouse to complete Supported Employment Referral after patient satisfies eligibility criteria

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Practice Implications: Substance Use Focus

- Ryan is a highly motivated, 32-year-old white American man living with depression who recently celebrated 2 years of sobriety following a decade of struggles with co-occurring cocaine use. During his 20s, he did not see the costs of his addiction or the benefits of a drug-free lifestyle, and his ambivalence initially made it difficult for him to benefit from different treatment programs that were offered to him. However, after developing medical problems related to his drug use, he pursued involvement in a 12-step program and started actively working the program.
- While Ryan has continued to experience depression, he actively uses positive coping strategies and reports the depression is now tolerable. In addition to personal wellness strategies (e.g., a WRAP plan), he has effectively used services to help him reduce the impact of symptoms on his daily routine and to avoid resorting to substance use when distressed.



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Practice Implications: Substance Use Focus

Ryan has a strong work ethic and identifies employment as a critical piece of his recovery. He feels he can be successful at a job that is a “good fit” so that he can achieve financial independence and is opposed to the idea of applying for disability benefits. Ryan recently started working part-time as a retail sales clerk at a local athletic shoe store. This builds off of his previous successful part time employment experiences as a cashier and shift supervisor.



The interviewing and part-time job created schedule conflicts for him which have made it necessary for him to reduce the amount of time he spends at the outpatient program. As a result of this conflict, he was discharged from his housing program as he could no longer meet the 20-hour a week programming criteria. While he would like to continue taking advantage of behavioral health services, he is uncertain about how to ask his new boss for occasional time off to attend appointments.

Practice Implications: Substance Use Focus

Upon his recent discharge from the Housing Program, Ryan began living with his cousin. While acknowledging the area has a high amount of drug activity, he reports that things are going well. While his depression and cravings have increased somewhat, he reports continued abstinence. He has not been able to attend NA meetings regularly due to his work schedule. He has learned that keeping busy at work, with his church, or with visits from family and friends to his new apartment is an effective recovery strategy. In summary, Ryan is having difficulty working his original recovery plan.

Ryan and his Recovery Team have met to discuss the situation and to develop an action plan allowing him to maintain employment while also having time for services that he feels are helpful in managing his recovery. The following goals and interventions were developed in the Team Meeting to support Ryan in his recovery:

Practice Implications: Substance Use Focus

Recovery Goal (s): *I want to stay off drugs but I can't always work my life around my home meeting.*

Objectives and Interventions: Ryan and primary clinician, M. Lofthouse, to meet to review evening schedule and activities and to reduce impact on symptoms; Ryan to contact his sponsor for information for alternative 12-Step meeting opportunities that work with his new schedule, e.g., those offered at his parish rather than the weekly group at the intensive outpatient program.

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Practice Implications: Substance Use Focus

Recovery Goal(s): *I don't want to be a charity case. I want to work and pay my own way.*

Objectives and Interventions: Ryan and primary clinician, M. Lofthouse, to complete referral to Supported Employment program; Ryan to attend Protection and Advocacy Seminar: Returning to Work: What You Need to Know to Talk to Your Boss About Accommodations; M. Lofthouse, Primary Clinician, to provide CBT therapy to reduce intrusive thoughts which interfere with job-performance; J. Delphin, Occupational Therapist, to carry out vocational evaluation and consult to Ryan and employer re: accommodations.

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Practice Implications: Final Example

Jason is a 20-year-old African American man suffering from schizophrenia. While he enjoyed some success in high school and had dreams of going to college, he experienced his first psychotic break at the age of 17. Jason's mother brought him to the ER because he was very agitated and yelling at what he describes as "demons" living in his room. He stated that the demons began coming to him while he was living with his aunt Mary, who he moved in with at the age of 16. This occurred after a family financial crisis and the separation of his parents when his father lost his well-paying job in the Silicon Valley. Jason returned home to his mother's house after Aunt Mary said could not manage Jason because he was isolating in his room and spending all of his time in bed, "staring at the walls."

Practice Implications: Final Example

Jason was prescribed Risperidol while in the hospital but he refuses to take it as he has limited insight into his mental health condition and has not been able to accept his diagnosis. It is this writer's opinion that his lack of insight and his inability to adjust his goals and expectations (e.g., he continues to believe he can be an engineer like his father) are preventing him from engaging fully in treatment and adjusting to life with severe mental illness.

Practice Implications: Final Example

Jason would like the demons to go away so that he can get on with his life and go back to college. Team members recognize that this is important to him, but they are concerned that he may be setting himself up for failure with an unrealistic goal given his current clinical instability. However, Jason does seem to do better with structured daily activity and social interactions.

Therefore, a referral to the day program at the local psychosocial clubhouse will be offered. Finally, Jason could benefit from psycho-educational interventions, including medication education to increase med compliance.

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Practice Implications: Final Example

Jason is a 20-year-old man who identifies as African American and Baptist. He grew up in a multicultural environment and feels comfortable in many settings. He has supportive parents and is an only child. Jason is a bright, well spoken man who excelled in high school both academically (he received a prestigious research externship the summer entering his sophomore year) and in sports (he as an all-state basketball player). He states that he has always wanted to become an engineer like his father. His strengths include his strong motivation, spirituality, and family and church supports. Jason has long been active in his parent's Baptist faith community.

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Practice Implications: Final Example

Jason was hospitalized for the first time at the age of 17 after his mother brought him to the ER because he was agitated and yelling at what he describes as "demons" living in his room. He stated that the demons began coming to him while he was living with his Aunt Mary, whom he moved in with when he was 16. This occurred after a family financial crisis when his father lost his well-paying job in the Silicon Valley. His parents separated at the time but remain married and supportive of each other and Jason.

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Practice Implications: Final Example

Jason returned home to his mother's house after his aunt said she could not manage Jason because he was spending all of his time in bed, "staring at the walls". Jason was placed on Risperidol while in the hospital, but he does not want to take the medications because they "dull his mind". In this writer's opinion, Jason has experienced a great loss due to his belief that he is a failure because he was unable to finish college and has lost all contact with his friends from high school. He effectively has lost his future and sees no way to recapture it. He would like the demons to go away so that he can get on with his life and go back to college to get his degree in engineering.

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Practice Implications: Final Example

- **Recommended services include intensive engagement strategies (including peer support) to: explore his feelings of loss and shame; to provide education about recovery; and to discuss potential services to support him in returning to college. Computer classes and research-based information may also be of interest to Jason given his intellectual strengths. It is also recommended that Jason work very closely with his psychiatrist to find a medication that he finds helpful while not "dulling his mind" as he strives to return to an academic setting. Finally, in an effort to reduce feelings of alienation, Jason's recovery coach will meet with Jason and his parents to discuss resuming attendance at Sunday services and exploring a pick-up basketball league.**

Take Home Message



“This is not about superficial political correctness. It is about the future of recovery in America. It is time we embraced a new language that helps us talk about how we heal ourselves, our families and our communities. It is time we abandoned a rhetoric that declares war on our own people.”

[William White, 2007](#)

Closing Q&A Your Thoughts and Ideas...



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