



Published in final edited form as:

*Hum Organ.* 2011 ; 70(2): 107–117.

## “An Old Way to Solve an Old Problem”: Provider Perspectives on Recovery-Oriented Services and Consumer Capabilities in New Mexico

**Marnie K. Watson, Caroline A. Bonham, Cathleen E. Willging, and Richard L. Hough**

Marnie Watson, Cathleen Willging, and Richard Hough are affiliated with the Behavioral Health Research Center of the Southwest. Watson and Willging are further affiliated with the Anthropology Department at the University of New Mexico (UNM). Hough and Bonham have affiliations with the Center for Rural and Community Behavioral Health at UNM

### Abstract

The goal of recovery has emerged as a core value in the reformation of public and private mental health services in the last twenty years. However, definitions of recovery remain as varied as methods of implementation. Through an ethnographic lens, we examine meanings of recovery in the context of a major statewide reform of mental health services in New Mexico, focusing specifically on provider-voiced concerns regarding recovery and recovery-oriented care. We argue that the concept of recovery functions as a symbol that seemingly reconciles the long-standing tension between biological and social explanations of mental illness. Drawing upon provider perspectives, we also discuss concerns that popular rhetoric about recovery may mask some needed fundamental changes to transform the mental health system to a recovery orientation. Finally, we consider recovery from a capabilities standpoint and discuss how this view lends itself to addressing both individual and social components of mental illness.

### Keywords

recovery; serious mental illness; health care reform; New Mexico

### Introduction

In July 2005, the State of New Mexico launched a major 10-year overhaul of its ailing public mental health system. To reduce costs and increase efficiency and consistency in services, the state initiated a process to “blend” and “braid” all public funding for mental health and substance abuse treatment.<sup>1</sup> The fifteen state agencies that had administered these funds agreed to work collaboratively to plan and oversee an integrated system. Rather than only including the largest purchasers of mental health care, New Mexico also involved state agencies that could play vital roles in delivery of other relevant services, such as those specializing in employment, housing, and transportation. A single managed care company, ValueOptions, was then selected to administer services. In response to federal calls for recovery-oriented care and outcomes, the architects of this reform stated that services in the transformed system would focus explicitly on consumer recovery (Hyde 2004).<sup>2</sup>

---

Corresponding Author: Cathleen E. Willging Pacific Institute for Research and Evaluation Behavioral Health Research Center of the Southwest 612 Encino Place, NE Albuquerque, NM 87102.

<sup>1</sup>“Blended” funding refers to the process of pooling money from multiple sources to pay for services. “Braided” funding similarly allows for flexibility in paying for services from multiple sources. However, each source must be kept separate for accounting and reporting purposes (Aron et al. 2009).

During the early stages of reform, the emphasis on recovery was enthusiastically embraced by consumers, advocates, managed care employees, and state government officials. The optimistic language of “hope,” “fulfillment,” and “empowerment” associated with recovery both in New Mexico and throughout the nation united such diverse stakeholders behind the goal of societal integration for individuals with serious mental illness (SMI), including schizophrenia, major depression, and bipolar disorder.

We conducted in-depth interviews with mental health providers in New Mexico, a predominantly rural and economically-challenged state that has undergone three major shifts in the delivery of publicly funded services since 1997 (Willging, Waitzkin, and Nicdao 2008; Willging, Waitzkin, and Wagner 2005). Each shift extended the penetration of managed care within the public sector. The first two shifts promoted the free-market goals of competition, efficiency, and cost cutting through the privatization of Medicaid services. Here, the state government contracted with multiple managed care companies to contain costs and oversee service delivery to low-income individuals. The move to managed care resulted in several adverse impacts for providers, i.e., administrative burdens and payment problems, and contributed to the closing of mental health programs throughout the state. The most recent reform has extended the purview of managed care to all publicly funded mental health services. In contrast to the two previous shifts, in which the logics of neoliberalism were enthusiastically embraced by state officials, the current reform departs from the earlier of narrative of privatization and cost containment and has instead heralded the development of a system of care that will support “recovery” and “resiliency” among persons with debilitating psychiatric illnesses.

In 1997 – years prior to the initiation of the most recent reform in New Mexico – the State of Wisconsin launched its own ambitious initiative to introduce managed care and simultaneously transform the public mental health system toward a recovery orientation. In her ethnographic account of this transformation, Nora Jacobson (2004) suggests that the Wisconsin reform was not only motivated by a genuine interest among state bureaucrats and other relevant stakeholders in recovery, but also by the desire to incorporate a humanitarian aspect within the new system of service financing and delivery under managed care. This reform was fraught with challenges, including a malleable yet elusive definition of the very phenomenon (recovery) the system was intended to champion, a lack of familiarity with the basic concept among providers, and insufficient mechanisms to bill for recovery-oriented care.

In this paper, we build upon Jacobson's state-specific account by problematizing provider perspectives on recovery within the context of the New Mexico reform. Our interviews with providers reveal widespread skepticism regarding the state government's interest in creating a recovery-oriented system of care. In these interviews, providers commonly expressed ambivalence about this new direction and confusion over what the term “recovery” means. Emphasizing their daily experiences as practitioners, they also questioned the premise that recovery was possible for the chronically ill represented in their caseloads.

We argue that the concept of recovery functions as a multivocal or polysemous symbol (Turner 1967, 1968) within the New Mexico reform, in that it circumscribes a range of concepts and, as such, seemingly reconciles longstanding tensions between explanations for

---

<sup>2</sup>As employed in this paper, the term “consumer” represents an emic category used by state officials, mental health system administrators, providers, and laypersons who participated in our study to identify individuals who utilize mental health services. Historically, this term, evolved with the “consumer movement” in the 1960s, which focused on increasing public power and autonomy in various social arenas, including education, product safety, law, and social welfare. In the health care context, the term emerged in reaction against physician hegemony and toward more patient input and autonomy (Reeder 1972). More recently, it has been used to frame health care services in economic and marketing discourses (Pellegrino 1999).

SMI that are influenced by medical models of disease and those explanations that relate SMI to broader societal factors. Symbolic language, however, can be falsely reassuring and quell unwanted protest and criticism regarding new reforms and policies (Edelman 1964). We argue that while the popular, optimistic language of recovery serves as an important rallying point for stakeholders with disparate goals and backgrounds to coalesce and support system reform in New Mexico, such language may also obfuscate concern for fundamental structural changes needed to promote the health and well-being of individuals with SMI. Finally, we discuss our findings from the grounded perspective of a capabilities approach, which may offer some substance to address the potential pitfalls inherent in symbolic language.

Health capabilities refer to a person's biological capacity to achieve wellness within a broader social context. Societal expectations for health and structures for resource allocation also influence wellbeing. Increasingly, researchers are pointing to the relevance of this model for recovery in mental health, suggesting that the capabilities approach can inform a new paradigm for promoting, assessing, and measuring recovery (Davidson et al. 2009; Davidson, Rakfeldt, and Strauss 2010; Hopper 2007; Ware et al. 2007). This approach integrates both individual and social dimensions of mental health and has the potential to address provider concerns about incorporating recovery-oriented treatment into clinical care.

### National calls for recovery

The movement to establish recovery-oriented service systems can be traced to the early 1990s and coincided with the rise of managed care in the public sector (Jacobson 2004). By the late 1990s and into the 2000s, major mental health documents on the national level enthusiastically embraced the idea of recovery. In *Mental Health: A Report of the Surgeon General*, recovery conveyed the message that hope and a meaningful life were possible for all Americans, including those struggling with SMI (United States Department of Health and Human Services 1999). The President's New Freedom Commission on Mental Health (United States Department of Health and Human Services 2003) also backed the notion of recovery. A major report issued by this commission juxtaposed the concepts of recovery, cure, and prevention, implying that these three concepts rested side-by-side within a single continuum. In the report's conclusion, the commission did not just recommend a few adjustments, but rather "a fundamental transformation of the Nation's approach to mental health care" with a new orientation toward recovery (United States Department of Health and Human Services 2003:1). In response, The Substance Abuse and Mental Health Services Administration set aside \$92,500,000 for states to "transform" their mental health systems. New Mexico was among the first seven states to receive this funding.

In national documents, recovery is generally defined as the "the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms" (United States Department of Health and Human Services 2003:5). The State of New Mexico has adopted this definition of recovery. The original concept paper that outlined the goals and objectives of the New Mexico reform included a clear commitment on the part of the state to values associated with recovery. These values were to be enacted through several mechanisms, i.e., increased education, provision of consumer input into reform processes, and the creation of a peer certification program (New Mexico Interagency Behavioral Health Purchasing Collaborative 2004).

## A Few Words on Recovery Models: The Individual and the Social

In many respects, contemporary discourses of recovery both within New Mexico and throughout the country are reminiscent of debates surrounding the transition from the state hospital system to community mental health treatment in the 1960s and 1970s. When President John F. Kennedy (1963) introduced legislation to encourage this shift, he described a vision in which people would no longer be warehoused in oppressive institutional settings. Articles in the mental health literature at this time called for the establishment of community-based outpatient programs, special outreach to local education and social service agencies that could potentially play a role in providing services to the mentally ill (Dancy 1972), and greater collaboration between mental health professionals and their patients (Borus and Klerman 1976).

Many providers and consumers within the community mental health movement struggled to integrate models of mental illness that located explanations for disease within the body and behaviors of the individual and those that focused on the social etiology of SMI. Critics worried that community-based treatment overemphasized preventive care and short-term counseling thereby gearing services towards people who were relatively well at the expense of those with more chronically debilitating mental illnesses who would benefit from ongoing care and more intensive forms of treatment, i.e., psychotropic medications (Grob and Goldman 2006; Langsley 1980). At the time, medical insurance companies and federal government programs, such as Medicaid and Medicare, were reluctant to pay for mental health interventions considered “non-medical” (Sharfstein 1978). Contemporary discourses of recovery echo these past discussions about community mental health treatment. Today, concern largely centers on whether dominant recovery philosophies overemphasize individual freedom, choice, and responsibility at the risk of underestimating the biological etiology of mental illness (Peyser 2001).

Competing definitions and models of recovery from mental illness have been extensively reviewed in the broader literature (Andresen, Oades, and Caputi 2003; Bellack 2006; Davidson et al. 2005; Gagne, White, and Anthony 2007; Onken et al. 2007; see Slade, Amering, and Oades 2008 for a discussion of cross-cultural approaches to recovery-oriented services). They are also the subject of vigorous contestation among “psychiatric survivors” (Mental Health “Recovery” Study Working Group 2009).

The controversy surrounding these definitions and models has typically centered on the struggle of conceptualizing recovery as a measurable outcome versus an ongoing process. Much of this struggle is attributable to philosophical and disciplinary differences in belief as to whether the roots of mental illness are to be found within the individual or within society. For example, psychological and medical models of recovery tend to regard mental illness as syndromes of individual symptoms resulting from biological deficits and including impairments in thought processes, cognition, and coping strategies (Andreasen et al. 2005). Hence, improvement (or recovery) in these domains can be helped by clinical interventions, such as therapy or medication, and can be measured as an outcome (Kopelowicz et al. 2005). Conversely, the empowerment model of recovery, which has its origins in the civil rights movement, characterizes mental illness as a response to external factors, such as social stress and discrimination. This model holds that policies on health care, housing, and education are as influential, if not more so, than medical interventions for helping individuals to experience recovery (Carpenter 2002; Frese and Davis 1997; McLean 1995; Tomes 2006).

Recently, proponents have called for the development of a more comprehensive theory of recovery that reconciles the competing definitions and models (Onken et al. 2007; Resnick,

Rosenheck, and Lehman 2004). Rooted in the capabilities approach, the theory of social integration explains how individuals with SMI “develop and increasingly exercise capacities for interpersonal connectedness and citizenship” (Ware et al. 2008:27). This theory, for example, accounts for factors on the individual level and the realities of service systems and wider social environments. While maintaining the elements of hope, fulfillment, and empowerment, this capabilities-centered approach remains grounded in its assessment of community-based barriers that shape the experience of those struggling to find recovery in SMI.

## Research Design

As part of a long-term study of the New Mexico reform, we carried out semi-structured interviews with 109 frontline service providers (e.g., psychiatrists, psychologists, social workers, counselors, case managers, and psychosocial rehabilitation coordinators) in 14 community-based agencies between April and December 2006, prior to the onset of major changes in the service delivery system.<sup>3</sup> Located in six counties chosen for specific demographic characteristics, the selected agencies included those specializing in providing mental health and/or substance abuse services to adults.<sup>4</sup> Six agencies were community mental health centers, three were substance abuse treatment centers that delivered residential and outpatient services, two agencies specialized in outpatient services for homeless adults with co-occurring disorders, and three agencies represented small group practices.

We implemented a purposive sampling approach to recruit participants at each agency. The aim of samples in qualitative research is to represent the range of views and values related to the issues under study, such as local experiences under the statewide reform. Such samples include individuals who can discuss most issues under investigation (Johnson 1990). We first met with a lead administrator who then referred direct service providers for participation. We generally interviewed all providers specifically involved in delivering services to adult patients. Table 1 includes an overview of provider demographics.

We conducted interviews using a semi-structured protocol that included prompts for providers to share their thoughts and attitudes about official calls for recovery-oriented services. Interviews, approximately 45 to 60 minutes long, were audiotaped, transcribed, and coded. To analyze semi-structured interviews, we developed a descriptive coding scheme from transcripts based on the specific questions and broader domains that made up the interviews. We utilized the well-respected qualitative data analysis software, NVivo 7 (Gibbs 2007), to organize and index data and to identify emergent categories and themes (Miles and Huberman 1994). Coding proceeded iteratively; the first and second authors coded sets of transcripts, created detailed memos linking codes to emergent themes, and then passed their work to the third and fourth authors for review. Discrepancies in coding and analysis were identified during the review process and resolved during research team meetings.

<sup>3</sup>In this paper, we report baseline findings from a five-year study of the New Mexico reform. While this paper focuses specifically on the perceptions and experiences of direct service providers, the larger study combines quantitative and qualitative approaches to examine the process of introducing the reform within a rural and multi-ethnic state and the degree to which the reform enhances access and quality of care for low-income individuals with SMI. The overall research design consists of the following elements: (1) a six-county set of structured and semi-structured interviews with consumers, their social supports (i.e., family and close friends), and the mental health agency personnel who serve them at baseline and then again at 18 and 36 months into the reform; (2) a statewide survey of clinical directors and chief executive officers of agencies that provide treatment to individuals with SMI at baseline and 36 months; (3) semi-structured interviews with key policymakers and community leaders at baseline and 36 months; (4) examination of statewide administrative data; and (5) document review.

<sup>4</sup>This research took place in three low-income rural counties (population less than 50,000 persons) and three counties with metropolitan areas (populations greater than 50,000 persons). These counties were chosen to facilitate eventual comparisons of reform impacts across geographical settings as well as between the largest racial and ethnic groups in New Mexico. These racial and ethnic groups (Anglo or White, Hispanic, and Native American) were well represented in the counties selected for participation.

## Findings

In order of their significance, the major themes generated by our analytic process include: (1) lack of clarity about meaning and implementation, (2) conflation of recovery with full symptomatic remission and skepticism that the latter is indeed possible, (3) recovery as a rhetorical device that draws attention from necessary infrastructure changes and profit motives that underlie privatized managed care systems, (4) personal experience as a form of expertise in clinical settings, and (5) stigma and discrimination as barriers to recovery.

The five themes suggest that providers maintain different interpretations of what “recovery” means within the context of the reform and struggle with how the language of recovery favored by the state government and its managed care contractor meshes with their daily experience of caring for individuals with SMI. While elucidating factors affecting the integration of recovery philosophies into clinical practice, the findings also point to social and economic interventions that might be needed to advance the development of what the majority of our study participants would characterize as a recovery-oriented mental health system.

### Lack of clarity about meaning and implementation

Given the multiple models of recovery from mental illness, providers were perplexed by what exactly was expected of them as publicly funded caregivers, as well as of the consumers they serve. Did recovery represent an outcome or a process? Many providers requested a concrete definition of recovery from our interviewees and said it would be helpful for the state government or ValueOptions to provide them with measures to chart progress related to recovery among consumers. One provider commented:

If [the state government and ValueOptions] are going to push for something...then they have to have a standard.... At this point in time, I do not think there is an appropriate standard...[therefore] you cannot succeed at [delivering recovery-oriented services] because there is no level to say “this is when you have achieved recovery.”

Familiar with service authorization and reimbursement procedures under managed care, this provider suggested that the notion of recovery needed to be tied to clinical outcomes that could be measured and documented. Other providers also took for granted that recovery would be reduced to a quantifiable individual outcome for administrative purposes under the reform.

The lack of an implementation plan to transform the mental health system toward a recovery model also contributed to suspicions and led providers to speculate about implications for treatment. One provider, who worked in a psychosocial rehabilitation (PSR) program,<sup>5</sup> expressed concern about the lack of clear direction. His frustration was fueled by the state government's decision to reduce provision of services traditionally offered by PSR programs, while simultaneously celebrating the system's focus on recovery:

Recovery, okay. When you say that, it sounds more like, “Let's fix them.” I think that [the state and] ValueOptions don't see the need for these people that have these severely disabling mental illnesses to continue to go to psychosocial

---

<sup>5</sup>Psychosocial rehabilitation or psychiatric rehabilitation (PSR) programs offer multiple services which focus on enhancing skills, capacity, and social support for independent living in a natural environment. The field of PSR traces its roots as a specialty to the era of deinstitutionalization in the 1970s and many of the leaders within this field have been active proponents of recovery-oriented services (Ellison et al. 2002).

rehabilitation.... They don't see how that's where they get to socialize and be a part of the community....

This provider emphasized social participation as an important component of consumer health and valued the flexible format of the PSR program as a key element to promoting social interaction and community involvement. His resistance to the official recovery discourse was based in the fear that consumers deemed “recovered” would be considered ineligible for such programs and face the risk of isolation in the future.

### **Skepticism about the possibility of recovery**

In keeping with a view of mental illness as an individual deficiency, many providers suggested that full recovery would not be possible for consumers with the most serious and persistent mental illnesses, particularly bipolar disorder and schizophrenia. One provider cited her experience in the service delivery system to illustrate the basis for her suspicion that recovery was not always possible for consumers with SMI:

My personal belief is that not everybody can find recovery, and I'd probably get shot for saying that.... I know these people.... I've seen some success stories. And then I've seen people that have been sick, sick, sick and aren't going to get better.... But maybe you just lose that perspective after awhile that they're going to actually recover.

This provider revealed that her lack of faith in recovery-oriented services had situated her as an outsider within her own agency, one who would “probably get shot” for voicing her concerns and skepticism. She also argued that mental illness occurred in severity along a continuum, and that not everyone with a mental illness could achieve a full abatement of symptoms or full integration into their communities. Other providers expressed similar views, underscoring the profound disability that consumers could experience as a result of their SMI. The intensity with which they repeated these thoughts suggests they felt that the serious, biological nature of disease was being minimized by an overly optimistic emphasis in reform-related policy on remission.

Other providers postulated that a recovery-oriented system would not serve consumers, but add more stress to their lives. One provider observed:

To call [the public mental health system] recovery-based adds a layer of bureaucracy onto enough problems that mental patients already have got. Instead of just being mentally ill, they need to recover.... That's like telling somebody with cancer, they have to recover, or they've got heart disease and they need to recover, or they've got diabetes and they need to recover. You know, I think in some cases it's possible, but it's pretty rare. I think these are chronic conditions that require treatment or at least some kind of contact for most of one's life.

This provider underscored the need to empathize with consumers regarding the struggles they face, yet such compassion also entailed lowering expectations, which, in turn, could lead consumers to lower expectations of themselves. On the one hand, the perceived advantage of traditional medical explanations for SMI included the recognition that its consequences could be just as painful as those from serious physical illness. On the other hand, this emphasis on suffering and impairment simultaneously implied futility and resignation about future prospects.

### **Recovery as rhetorical device**

There was considerable concern that the emphasis on recovery was only a “name change event;” or as one provider put it, “an old way to solve an old problem.” One administrator

expressed suspicion toward the stated aims of the reform and ambivalence about the reality of recovery for those with SMI:

Recovery is just another name change event. We changed our mission statement to include the new verbiage. And I said, “Why do we have to change our mission statement every time everyone decides to change the name of everything?” The people that [I see] are so in need, I don't really think they would ever recover. If they haven't recovered by now, I don't think the new word “recovery” is going to make them recover. They've been here 19 years, as long as I've been here.

When asked about recovery, another provider expressed his exasperation with a term denoting a nebulous concept that administrators aiming to align program goals with the reform had imposed on him and his colleagues:

Recovery? I don't think it means that much. It's a buzzword.... I think that most people with severe mental illness, they are trying to get better.... If I never heard the word again, it would be great.

This skepticism about “new words” or “buzzwords” reflected a frustration with recovery's sometimes slippery, polysemous symbolic nature and signaled a potential barrier to acceptance and implementation of recovery-oriented services on the local level.

New Mexico's public mental health system has also undergone dramatic shifts over the course of many providers' careers. Some providers complained of reform fatigue and were cautious about jumping on the bandwagon for what might turn out to be short-lived, rather than an enduring change. One provider – who sighed and described herself as, “Stressed. And just wondering when the next change is going to be” – embodied this sentiment.

When discussing the reform, providers suggested that profit motives associated with managed care drove the push for recovery-oriented services rather than a genuine interest in identifying and mobilizing strengths so that consumers might release their own potential and live independently within the community. Many providers were suspicious of the reform process and whether the state government's emphasis on recovery sufficiently addressed the roots of stigma and other social and economic barriers that made it hard for consumers to achieve social integration. Several providers alluded to a covert agenda to reduce the intensity and length of service delivery in order to cut costs. One provider explained, “[Recovery is] a managed care friendly thing. It's like the minute you come in, what are we doing to get you out?”

Conversely, providers argued that the documentation they were required to produce under managed care to ensure continued authorization and funding for services was, ironically, at odds with the goal of recovery-oriented care. Documentation requirements, they suggested, encouraged a clinical emphasis on impairment rather than recovery. One provider explained:

To be determined seriously mentally ill – to get case management or housing assistance or psychiatric medications – you had to have a specific diagnosis and you had to have a specific level of functional impairment because of your psychiatric issues.... The reality is that the more that [managed care] comes in, [companies are] going to deny payment.... And it's a whole different way of thinking. You have to think of how the managed care company is going to do it.... You are working for your client. You want to do the best you can for your client so that's why you have to learn how to play the games.... And every level of care has to be justified.... It's all based on the medical model [and] your documentation needs to be based on the medical model.



In light of the dominant medical paradigm that shaped clinical work, many providers were reluctant to adopt a recovery perspective, which they largely perceived as opaque as well as susceptible to cooptation under managed care.

Despite their misgivings, providers generally supported several of the ideas associated with recovery discourse, i.e., integration into communities. Yet, they argued, the public sector was preoccupied with clinical-level interventions, giving short shrift to larger-scale social and economic reforms that would ultimately improve the lives of persons with SMI. Many providers advocated for broader fundamental changes, describing barriers, i.e., lack of basic resources such as housing and employment, which would require substantial investments in state and community infrastructure development. One provider commented:

I think [recovery] is an excellent idea. I think it's going to take a lot of funding that we don't have right now.... You see [people] living on the streets and not accessing services.... If we don't provide the help then there [are] more street people and a lot more casualties.

Other providers lamented the apparent lack of funding needed for recovery-oriented services while expressing enthusiasm for the concept. The providers suggested that both the state and ValueOptions had underestimated the practical resources necessary to enact this transformation. Providers frequently mentioned that employment, housing, and transportation must be addressed as part of a recovery orientation. They also indicated that their own agencies were commonly short staffed and more providers were necessary for sustainable system change to occur.

### Personal experience as expertise

A key recovery-oriented innovation in the state reform is to institutionalize the position of certified peer specialists as recognized providers within the mental health system. Peer specialists are consumers who are considered to be in recovery and have undergone training and a series of examinations to obtain certification (Salzer, Schwenk, and Brusilovskiy 2010). Once certified, their duties could encompass tasks ranging from counseling to support services to program development, although more commonly the peer specialists found themselves assisting with clerical duties, such as reception, enrollment, and even billing, during the early stages of reform. The promotion of this position and the formalization of the certification process were explicit validations of the idea that personal experience of recovery was an important achievement. Nearly all the providers interviewed were enthusiastic in their support of the peer-specialist role. In one provider's words, peer specialists were the “best things about the recovery movement.” Another praised a new colleague who helped open her “...eyes to be hopeful for recovery, [and] to see her as an example and as a leader.”

Despite the vocal enthusiasm for these new positions, there was some resistance tied to the financial realities affecting agencies. The system reform had yet to institute mechanisms to ensure that peer-provided services were reimbursable. The few agencies that employed peer specialists had to locate funds from non-state sources to subsidize these positions. One provider indicated that although administrators at her agency paid “lip-service” to these new positions, they were not willing to use funds from their own agency to hire someone in this role but instead would only accept such a provider if the salary came directly from the state government or ValueOptions.

Other providers alluded to new concerns regarding confidentiality and boundaries between providers and consumers that challenged traditional mental health practice. One provider pondered:

We've thrown out some questions to people in our administration about how our roles change with a peer specialist. They're not able to answer that. A lot of the policies say “no contact with anyone who's been a client for four years after their last date of service.” Well that doesn't work when you have a staff member who is also a consumer.

This provider observed that policies and procedures within clinics as well as training for mental health professionals had not yet “caught up with the times and the whole consumer empowerment movement.”

Only one provider expressed direct criticism of the concept of certified peer specialists. He also mentioned the concern for boundaries:

[The state government and ValueOptions] were interested in us employing people with mental illness as peer counselors. We came back really convinced that wasn't going to work here, and we just dug in our heels and said it's not going work here. It's too small a town, and we're not going to be coworkers with our patients. It's just too much of a conflict of interest. The boundary violations are just too volatile. Yeah, so we kind of put an end to that.

This provider admitted to the interviewer that he was a firm believer in medical interventions for persons with SMI. He viewed the emphasis on peer specialists and empowerment under the reform as an unfortunate legacy of the antipsychiatry movement and an uncritical rejection of the medical model:

They were beating up on psychiatrists and on medication.... There was this underlying feeling of psychiatry as being bad and medications being bad, and I felt kind of lousy by the end.

Although his responses did not represent most providers, he did articulate concerns to which others had alluded more indirectly, suggesting that challenges to current structures of status and authority could be unsettling.

The role of stigma and secrecy about mental health diagnoses also arose when providers described the perceived difficulties of integrating certified peer specialists into clinical settings. Another provider reflected:

What's interesting is that there's this idea of peer support and community-driven, client-driven access to treatment. There's still a stigma about having mental illness, and if you are a provider and you have a mental illness, unless it's causing disability to you, I don't think people disclose that, you know? So there's this movement towards peer support system, but there's also this hesitation to disclose, you know? And would it be used against you, and would you be looked at any differently? Would you be less professional?

As we discuss below, many providers argued that stigma comprised a key barrier that must be overcome in order to establish a “true” recovery orientation within the mental health system.

## Stigma and discrimination

Providers most often discussed stigma and discrimination directed against individuals with mental illness in relation to barriers to recovery-oriented services in community settings. For example, providers frequently identified employment as an important component of recovery; however, they felt that the presence of stigma prevented many consumers from securing regular work. One provider commented on this challenge:

Connecting them up with DVR [Department of Vocational Rehabilitation] to get a job or go back to school [is] sort of frustrating because I don't think DVR really helps out with anything.... They don't have job coaches. When it comes to try and get somebody to hire a mentally ill person, that stigma stays with them. It's just a lot of stigma behind mental illness and everybody [here] knows everybody.

This provider argued that stigma was unlikely to subside naturally and pointed to the need for anti-discrimination policies and more financial investment in DVR and job coaches as practical steps to address this problem.

Issues around stigma also arose when providers mentioned the need for transportation, one of the most significant barriers to access and utilization of mental health services in New Mexico. In one of the six study counties, research participants reported that the local ambulance service refused to transport consumers if they carried a diagnosis of SMI out of fear that those struggling with mental health issues might suddenly display aggressive, uncontrollable behavior.

In addition to employment and transportation, stigma surrounding SMI created difficulties for consumers in need of safe and affordable housing. Several providers noted that landlords were reluctant to rent apartments and houses to such individuals and clarified that options for low-income individuals with SMI were virtually non-existent or took years to access.

## Discussion

Within the context of the New Mexico reform, the term “recovery” functions as a powerful symbol of the type Turner (1967, 1968) described as polysemous or multivocal, capable of “condensing” several meanings or attributes in one symbol. Edelman (1964) observed that condensation symbols have a political utility in evoking and distilling multiple disparate emotions and meanings associated with a broad field of thought and action. Alternately, Hopper (2007:872) argued that the notion of recovery represents a “floating signifier” that can metamorphose depending on the desired agenda. Symbols serve crucial political needs by reconciling tensions and uniting groups with different priorities. Yet the power of a symbol can be diluted if it is overused or invoked gratuitously. Conversely, compelling symbols can effectively suggest that lingering tensions are prematurely resolved and can halt critical discussion. Awareness of the highly symbolic nature of the recovery concept reminds us of the differing perspectives and agendas of various stakeholders.

This qualitative research helps clarify relationships between provider attitudes and beliefs and policy change regarding recovery-oriented services. Mental health providers are trained to work with individuals and to offer medication and therapy, which are commonly viewed as vital components of recovery-oriented treatment (Resnick, Rosenheck, and Lehman 2004). Some of the frustration about recovery expressed by the providers appears to stem from their recognition that comprehensive recovery also entails larger systemic and societal changes. While appreciating the need for such changes, providers are unsure how to relate the calls to adopt and implement a recovery perspective within service delivery settings to their own clinical work without ultimately compromising care for the consumer.

While this study focuses only on the perceptions and experiences of a subset of providers in New Mexico during the early stages of the reform, the in-depth nature of this qualitative research offers important insight into a range of contextual issues that could impede the adoption and implementation of recovery philosophies and models of care within real world practice settings. In particular, provider resistance emerged as the most significant potential barrier to the delivery of recovery-oriented services. This resistance was rooted in three of the themes outlined above: (1) the ambiguous and insufficient understanding of what the

state government and its managed care contractor meant by the very term recovery, (2) conflation of recovery and cure and the pervasive doubt that consumers can actually recover from SMI, and (3) widespread fears that the use of recovery language in clinical documentation might result in service denials for consumers in need of care (cf. Jacobson 2004).

Despite skepticism regarding the statewide move to a recovery-oriented delivery system, some providers were open to new approaches intended to foster consumer self-determination, to equalize asymmetrical power relations between providers and consumers, and to maximize consumer involvement in mental health care. For example, although a few providers expressed concern over the introduction of the peer-specialist position, others were receptive to this innovation and the role it might play in transforming services within their own agencies and the encompassing system. Yet, providers still cautioned that stigma, especially within rural areas, might prevent persons grappling with SMI from taking on the public role of peer specialist. In general, providers argued that non-clinic-based factors – particularly stigma and discrimination in communities and the insidious effects of economic deprivation on the everyday lives of consumers – comprised the greatest obstacles to the pursuit of recovery.

When promoting recovery-oriented services within the context of policy reform, states must wrestle with putting forth a simple definition of recovery that captures the essential components of dominant philosophies and the deployment of more complex definitions that address the needs and priorities of a very diverse population. This dilemma may contribute to provider suggestions that New Mexico's definition of recovery does not adequately tend to larger societal structures that prevent persons with SMI from living, working, and participating fully in their communities (United States Department of Health and Human Services 2003).

The nature and scope of recovery-oriented services may depend precisely on the definition of recovery adopted in system reform (Ware et al. 2007). If recovery is considered purely at the individual level, preferred services will most likely encompass psychological and rehabilitative interventions offered to a given consumer. However, learning from the lessons of the community mental health movement, if a very broad interpretation of recovery is used, then the multitude of non-medical community-level interventions that can be subsumed under this umbrella may risk overwhelming any specific medical services that might be offered to those who are most severely disabled from SMI.

The capabilities approach provides a helpful structure in resolving this problem. The political economist Amartya Sen (1980, 1999, 2002) originally developed this approach to define and measure objects of value between communities or countries. This approach first focuses on the individual, inquiring into the capabilities that are possible for this person. Barriers to these capabilities, such as racial prejudice, poverty, disability, and stigma, are subsequently identified. Fundamentally grounded in a concern for human rights, the capabilities approach draws attention to the fact that due to the uneven distribution of barriers and possibilities, different individuals do not possess equal capabilities for health, happiness, and achievement of life goals. This approach acknowledges that decisions are made at multiple levels of influence that, in turn, impact a person's capacity to achieve health. While individuals make some choices, society exerts an influence on others. Sen's original economic model has since been expanded to address a variety of problems, i.e., gender inequality and other issues related to social justice (Carpenter 2009; Harcourt 2001; Nussbaum 2000).

More recently, the capabilities approach has been incorporated into the theory of social integration, a promising framework for more carefully considering the goals of mental health treatment. For this theory, capabilities are defined as individual attributes such as the capacity for imagination or empathy. Individual capacities are most likely to flourish when matched with societal resources. Mental health treatment can help individuals cultivate their capabilities with the awareness that full capacity may be determined by the availability of social resources (Ware et al. 2008). This approach to recovery provides a structure for considering the contributions of both individual and social domains. By reconciling this false dichotomy, the capabilities approach can function productively as a model for providers to orient their work towards recovery. The emphasis on health potential as opposed to retrospective measurements of achieved health is also compatible with the messages of optimism and hope that are such attractive features of dominant recovery philosophies.

The structured nature of the capabilities approach may reassure providers who are searching for tangible tools to use in order to incorporate recovery perspectives into their own work in a meaningful manner. From the vantage point of providers participating in our study, a recovery-oriented system would ideally consider multiple contexts at the level of the state, community, clinic, and individual. For example, a consumer's capability for health might be influenced by access to resources such as housing and employment. Simultaneously, that same person's capability for health might also be influenced by the availability of clinic-level interventions that promote collaborative care or address stigma. The focus on the individual level will always be important because it ensures that the system is consumer-centered and that the medical and biological aspects of SMI are not ignored or minimized. The ecological framework of the capabilities approach can capitalize on the role of recovery as a dense and multivocal symbol in reconciling these conflicting foci. This kind of systematic and understandable model for conceptualizing recovery may help address provider concerns that the state sanctioned language of recovery is rhetorical and may harm consumers by undermining appropriate clinical practice.

The capabilities framework, with its emphasis on agency, choice, and expectations for health also provides a format to address the power differentials that quietly shape relationships between providers and consumers. As Smith and Bartholomew (2006) observe, many psychiatric hospitals use rhetorical language compatible with recovery models when proclaiming their mission statements, yet the daily reality of interactions reflects a more paternalistic approach to service delivery. They note that providers must make an uncomfortable adjustment to recovery philosophies that challenge their professional status. In our interviews, relatively few providers acknowledged personal discomfort with this process, and it appeared that these adjustments were beginning to take place. Views of recovery as simply stabilization of symptoms or as an unlikely outcome may reflect existing power dynamics and a residual paternalism that perpetuates low expectations for consumers. In New Mexico, the institutionalization of certified peer specialists may be the most direct challenge to existing power structures. The general willingness among providers to accept the idea of expertise gained by experience is a hopeful sign that these patterns are not intractable. Ethnographic work with consumers in recovery confirms that stigma continues to be pervasive and shapes their participation in society (Jenkins and Carpenter-Song 2008). As the relationships between traditional and peer providers mature, it will remain important to be attuned to the presence and nature of stigma within and between these roles.

Finally, in an editorial published shortly after the announcement of the transformation grants, noted psychiatric rehabilitation specialist Kenneth Gill (2006:7) reminded readers that “real jobs, real housing, and overall health and wellness” are essential ingredients of recovery. He called on states to consider creative initiatives to integrate employment,

housing, and primary care services within mental health systems in order to aspire towards a recovery orientation. New Mexico's vision of braided funding has afforded a unique opportunity to address housing and employment through infrastructural investments.

In keeping with this argument, the State of Tennessee interpreted a recovery-oriented system as one that begins with housing. In 2001, under the auspices of the Division of Recovery Services, Tennessee launched the Creating Homes Initiative to develop affordable housing for consumers. By 2008, over 4,000 permanent housing units were developed. The creation of new infrastructure was expensive. This project began with an initial \$2.5 million investment, and over \$100 million had been allocated toward this initiative over the seven-year period (Tennessee Department of Mental Health and Developmental Disabilities 2008).

As New Mexico deepens its reform efforts, the state government plans to capitalize on the collaboration afforded by the creation of braided and blended funding streams. The participation of the Departments of Labor and Transportation and the Mortgage Financing Authority provides an exciting avenue to enact infrastructure change in response to Kenneth Gill's challenge to provide "real jobs" and "real housing." Since our interviews were conducted, the state has announced a long-term plan to increase the availability of supported housing (Technical Assistance Collaborative 2007). However, New Mexico is a state with serious economic challenges and a long history of an underfunded mental health system. Substantial investment in housing and employment will take time. Therefore, it is important to address this economic reality directly and acknowledge these basic needs as goals that will be addressed within a long-term plan for system transformation. The capabilities approach offers a framework for acknowledging these competing priorities in an open dialogue with providers. If providers find that their concerns are acknowledged, as outlined in the themes above, they may start to shake the feeling that New Mexico's system transformation is only symbolic and the concern that substance is being sacrificed for the sake of rhetoric.

## Acknowledgments

This study was funded by the National Institute of Mental Health (R01 MH076084) and the Substance Abuse and Mental Health Services Administration. The methods, observations, and interpretations put forth in this study do not necessarily represent those of the funding agencies. The authors wish to thank their ethnographic team – Elizabeth England Kennedy, Miria Kano, Louise Lamphere, Jill Reichman, Gwen Saul, and Paula Seanez – for their contributions to this study. They also wish to express appreciation to their research participants for their generous assistance and cooperation.

## References Cited

- Andreasen, Nancy C.; Carpenter, William T., Jr.; Kane, John M.; Lasser, Robert A.; Marder, Stephen R.; Weinberger, Daniel R. Remission in Schizophrenia: Proposed Criteria and Rationale for Consensus. *American Journal of Psychiatry*. 2005; 162(3):441–449. [PubMed: 15741458]
- Andresen, Retta; Oades, Lindsay; Caputi, Peter. The Experience of Recovery From Schizophrenia: Towards an Empirically Validated Stage Model. *Australian and New Zealand Journal of Psychiatry*. 2003; 37(5):586–594. [PubMed: 14511087]
- Aron, Laudan; Honberg, Ron; Duckworth, Ken, et al. *Grading the States 2009: A Report on America's Health Care System for Adults with Serious Mental Illness*. National Alliance on Mental Illness; Arlington, VA: 2009.
- Bellack, Alan S. Scientific and Consumer Models of Recovery in Schizophrenia: Concordance, Contrasts, and Implications. *Schizophrenia Bulletin*. 2006; 32(3):432–442. [PubMed: 16461575]
- Borus, Jonathan F.; Klerman, Gerald L. Consumer-Professional Collaboration for Evaluation in Neighborhood Mental Health Programs. *Hospital and Community Psychiatry*. 1976; 27(6):401–404. [PubMed: 950227]

- Carpenter, Jenneth. Mental Health Recovery Paradigm: Implications for Social Work. *Health and Social Work*. 2002; 27(2):86–94. [PubMed: 12079172]
- Carpenter, Mick. The Capabilities Approach and Critical Social Policy: Lessons From the Majority World? *Critical Social Policy*. 2009; 29(3):351–373.
- Dancy, Ricky R. The Broker: A New Specialist for the Community Mental Health Center. *Hospital and Community Psychiatry*. 1972; 23(7):221–223. [PubMed: 5036118]
- Davidson, Larry; O'Connell, Maria J.; Tondora, Janis; Lawless, Martha; Evans, Arthur C. Recovery in Serious Mental Illness: A New Wine or Just a New Bottle? *Professional Psychology: Research and Practice*. 2005; 36(5):480–487.
- Davidson, Larry; Ridgway, Priscilla; Wieland, Melissa; O'Connell, Maria. A Capabilities Approach to Mental Health Transformation: A Conceptual Framework for the Recovery Era. *Canadian Journal of Community Mental Health*. 2009; 28(2):35–46.
- Davidson, Larry; Rakfeldt, Jaak; Strauss, John. *The Roots of the Recovery Movement in Psychiatry: Lessons Learned*. Wiley-Blackwell; Oxford, United Kingdom: 2010.
- Edelman, Murray. *The Symbolic Uses of Politics*. University of Illinois Press; Chicago: 1964.
- Ellison, Marsha L.; Anthony, William A.; Sheets, John L.; Dodds, William; Barker, William J.; Massaro, Joseph; Wewiorski, Nancy J. The integration of psychiatric rehabilitation services in behavioral health care structures: A state example. *The Journal of Behavioral Health Services and Research*. 2002; 29(4):381–393.
- Frese, Frederik J.; Davis, Wendy W. The Consumer-Survivor Movement, Recovery, and Consumer Professionals. *Professional Psychology: Research and Practice*. 1997; 28(3):243–245.
- Gagne, Cheryl; White, William; Anthony, William A. Recovery: A Common Vision for the Fields of Mental Health and Addictions. *Psychiatric Rehabilitation Journal*. 2007; 31(1):32–37. [PubMed: 17694713]
- Gibbs, Graham R. *Qualitative Data Analysis: Explorations with NVivo*. Open University Press; New York: 2007.
- Gill, Kenneth. With Recovery Now In Our Public Policy, Is Recovery In Danger? *Psychiatric Rehabilitation Journal*. 2006; 30(1):7–8. [PubMed: 16881238]
- Grob, Gerald N.; Goldman, Howard H. *The Dilemma of Federal Mental Health Policy: Radical Reform or Incremental Change?*. Rutgers University Press; Piscataway, N.J.: 2006.
- Harcourt, Wendy. *The Capabilities Approach for Poor Women: Empowerment Strategies Towards Gender Equality, Health, and Well-being*. 2001.  
URL:<<http://www.stedmunds.cam.ac.uk/vhi/sen/papers/harcourt.pdf>> (January 18, 2010)
- Hopper, Kim. Rethinking Social Recovery In Schizophrenia: What a Capabilities Approach Might Offer. *Social Science and Medicine*. 2007; 65(5):868–879. [PubMed: 17499900]
- Hyde, Pamela S. State Mental Health Policy: A Unique Approach to Designing a Comprehensive Mental Health System in New Mexico. *Psychiatric Services*. 2004; 55(9):983–985. [PubMed: 15345757]
- Jacobson, Nora. In *Recovery: The Making of Mental Health Policy*. Vanderbilt University Press; Nashville, Tenn.: 2004.
- Jenkins, Janis H.; Carpenter-Song, Elizabeth A. Stigma Despite Recovery: Strategies for Living in the Aftermath of Psychosis. *Medical Anthropology Quarterly*. 2008; 22(4):381–409. [PubMed: 19189724]
- Johnson, Jeffrey C. *Selecting Ethnographic Informants*. Sage Publications; Newbury Park, Calif.: 1990.
- Kopelowicz, Alex; Liberman, Robert; Ventura, Joseph; Zarate, Roberto; Mintz, Jim. Neurocognitive Correlates of Recovery From Schizophrenia. *Psychological Medicine*. 2005; 35(8):1165–1173. [PubMed: 16116942]
- Kennedy, John. F. Message From the President of the United States to the 88th Congress Relative to Mental Illness and Mental Retardation. Washington, D.C.: 1963. Document No. 58February 5, 1963. [2]
- Langsley, Donald G. The Community Mental Health Center: Does It Treat Patients? *Hospital and Community Psychiatry*. 1980; 31(12):815–819. [PubMed: 7203401]

- McLean, Athena. Empowerment and the Psychiatric Consumer/Ex-Patient Movement in the United States: Contradictions, Crisis, and Change. *Social Science and Medicine*. 1995; 40(8):1053–1071. [PubMed: 7597459]
- Mental Health “Recovery” Study Working Group. What Do Psychiatric Survivors in Toronto Think About Mental Health “Recovery?”. Wellesley Institute; Toronto, Canada: 2009. Mental Health “Recovery”: Users and Refusers.
- Miles, Matthew B.; Huberman, A. Michael *Qualitative Data Analysis: An Expanded Sourcebook*. Sage Publications; Thousand Oaks, Calif.: 1994.
- New Mexico Interagency Behavioral Health Purchasing Collaborative. Concept Paper: For Public Comment and Discussion: A Work in Progress. State of New Mexico; Santa Fe: 2004.
- Nussbaum, Martha. Working Paper for Beijing +5 Review. United National Research Institute for Social Development; Geneva, Switzerland: 2000. Women's Capabilities and Social Justice.
- Onken, Steven; Craig, Catherine; Ridgway, Priscilla; Ralph, Ruth O.; Cook, Judith A. An Analysis of the Definitions and Elements of Recovery: A Review of the Literature. *Psychiatric Rehabilitation Journal*. 2007; 31(1):9–22. [PubMed: 17694711]
- Pellegrino, Edmund D. The Commodification of Medical and Healthcare: The Moral Consequences of a Paradigm Shift from a Professional to a Market Ethic. *The Journal of Medicine and Philosophy*. 1999; 24(3):243–266. [PubMed: 10472814]
- Peysner, Herbert. What is Recovery: A Commentary. *Psychiatric Services*. 2001; 52(4):486–487. [PubMed: 11274494]
- Reeder, Leo G. The Patient-Client as a Consumer: Some Observations on the Changing Professional-Client Relationship. *Journal of Health and Social Behavior*. 1972; 13(4):406–412. [PubMed: 4648896]
- Resnick, Sandra; Rosenheck, Robert; Lehman, Anthony F. An Exploratory Analysis of Correlates of Recovery. *Psychiatric Services*. 2004; 55(5):540–547. [PubMed: 15128962]
- Salzer, Mark; Schwenk, Edward; Brusilovskiy, Eugene. Certified Peer Specialist Roles and Activities: Results From a National Survey. *Psychiatric Services*. 2010; 61(5):520–523. [PubMed: 20439376]
- Sen, Amartya. *Tanner Lectures on Human Values*. University of Utah Press; Salt Lake City: 1980. Equality of What?.
- Sen, Amartya. *Development As Freedom*. Oxford University Press; Oxford, United Kingdom: 1999.
- Sen, Amartya. Why Health Equity? *Health Economics*. 2002; 11(8):659–666. [PubMed: 12457367]
- Sharfstein, Steven S. Will Community Mental Health Survive in the 1980s? *American Journal of Psychiatry*. 1978; 135(11):1363–1365. [PubMed: 707636]
- Slade, Mike; Amering, Michaela; Oades, Lindsay. Recovery: An International Perspective. *Epidemiologia e psichiatria sociale*. 2008; 17(2):128–137. [PubMed: 18589629]
- Smith, Russell C.; Bartholomew, Thomas. Will Hospitals Recover?: The Implications of a Recovery-Oriented Orientation. *American Journal of Psychiatric Rehabilitation*. 2006; 9(2):85–100.
- Technical Assistance Collaborative. *New Mexico Behavioral Health Purchasing Collaborative Long Range Supportive Housing Plan*. State of New Mexico Department of Health; Santa Fe: 2007.
- Tennessee Department of Mental Health and Developmental Disabilities. *Creating Homes Initiative*. 2008. URL: <://state.tn.us/mental/recovery/CHIpage.html> (October 10, 2008)
- Tomes, Nancy. The Patient as a Policy Factor: A Historical Case Study of the Consumer/Survivor Movement in Mental Health. *Health Affairs*. 2006; 25(3):720–729. [PubMed: 16684736]
- Turner, Victor. *The Forest of Symbols: Aspects of Ndembu Ritual*. Cornell University Press; Ithaca, N.Y.: 1967.
- Turner, Victor. *The Drums of Affliction: A Study of Religious Processes Among the Ndembu of Zambia*. Clarendon Press; Oxford, United Kingdom: 1968.
- United States Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, and National Institute of Mental Health; Rockville, Md.: 1999.
- United States Department of Health and Human Services. *Achieving the Promise: Transforming Mental Healthcare in America*. United States Department of Health and Human Services and



President's New Freedom Commission on Mental Health; Rockville, Md.: 2003. Publication number SMA-03-3832

Ware, Norma C.; Hopper, Kim; Tugenberg, Toni; Dickey, Barbara; Fisher, Daniel. Connectedness and Citizenship: Redefining Social Integration. *Psychiatric Services*. 2007; 58(4):469–474. [PubMed: 17412847]

Ware, Norma C.; Hopper, Kim; Tugenberg, Toni; Dickey, Barbara; Fisher, Daniel. A Theory of Social Integration as Quality of Life. *Psychiatric Services*. 2008; 59(1):27–33. [PubMed: 18182536]

Willging, Cathleen E.; Waitzkin, Howard; Nicdao, Ethel. Medicaid Managed Care for Mental Health Services: The Survival of Safety Net Institutions in Rural Settings. *Qualitative Health Research*. 2008; 18(9):1231–1246. [PubMed: 18689536]

Willging, Cathleen E.; Waitzkin, Howard; Wagner, William. Medicaid Managed Care for Mental Health Services in a Rural State. *Journal of Health Care for the Poor and Underserved*. 2005; 16(3):497–514. [PubMed: 16118839]