Wellness & Recovery Centers

An Evolution of Essential Community Resources

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The balancing act that counties have to perform to maintain minimum service levels while the state reduces funding is constant and exhausting. As part of the mission of the California Mental Health Planning Council to promote promising and best practices, the Adult System of Care Subcommittee has identified Wellness and Recovery Centers (WRCs) as an example of truly doing more for less. It is a cost-effective option for counties that more often than not meets the needs of consumers more meaningfully than most of the traditional and more costly clinical services. The Mental Health Services Act provided the perfect opportunity for counties to test the concept of Wellness and Recovery Centers using the Community Services and Supports (CSS) component of funding. In order to receive CSS funding, each community must determine what best suits their needs through a stakeholder process, so each WRC is organic to its surroundings.

Recovery and Wellness Centers are places that consumers can go to learn coping mechanisms and living skills in a non-judgmental environment that focuses on one's strengths. Once a person begins the process of recovery, the Center provides supports and services that reinforce Wellness and prevent relapse.

The essential role of Wellness and Recovery Centers in community-based care cannot be overstated. They work in an environment of inclusion and acceptance, and more often than not, are peer-run. First-time visitors are welcomed by people who have walked the same path and understand that the route to recovery is highly personal and individualized. They can either function as an entry-point into a full service partnership or as a step-down for FSP graduates. The "no-wrong door" access point is an important conduit for keeping engagement with the community while re-learning life skills or integrating back into the community. Wellness and Recovery Centers – particularly peer-run- are an underappreciated and under-utilized resource for communities to draw upon.

Mark Ragins, MD, a long time champion of the Recovery and Wellness model, has identified the four cornerstones of recovery for both clients and partners as being Hope, Empowerment, Self-Responsibility, and Meaningful Roles. In the initial 2005 MHSA CSS Program and Expenditure plan, which guided counties through the program planning process, the DMH defined recovery:

> *"Recovery refers to the process in which people who are diagnosed with a mental illness are able to live, work, learn, and participate fully in their communities. For some individuals, recovery means recovering certain aspects of their lives and the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or elimination of symptoms. Focusing on recovery in service planning encourages and supports hope."*

The CMHPC has heard presentations from several providers and counties through the years on the value of Wellness and Recovery Centers. Los Angeles maintains a fluid, yet structured support system that relies heavily on WRCs. Many Full Service Partnership (FSP) graduates utilize the WRCs for step-down services as they progress in their recovery, which opens up the slots to people in higher need of more intensive services. In Kern County, an entirely peer-run Wellness and Recovery Center was established using MHSA Innovation funds.

Program design might vary slightly from county to county, but most initially started as a conduit for outreach and engagement to hard to reach populations. They started as drop-in centers with no limits or expectations made of the consumers. Their main intent was to establish trust and persuade them to accept services. Several of the "drop-in" models evolved into models that required consumers to be actively engaged in their recovery rather than just a place to "hang out and watch TV". In the 2009 "MHSA Implementation Study: Community Services and Supports Successes and Challenges", reviewers focused on consumer driven Wellness and Recovery centers in seven early-adopter California counties (2007) and found the following common threads:[1]

All nine centers were operated by contract agencies.

Over 80% of the staff was consumers and family members, largely consumers.

The philosophy and orientation of the centers had much in common, but their roles in the county's system of care differed.

Two of the counties (4 centers) required a current or prior connection with the mental health system.

The "drop-in" aspect of the centers differed and was not always clearly articulated.

All the centers had formal schedules with group activities offered for the majority of the hours the center was open.

Using these observations and information from presenters as a starting point, the Adult System of Care committee wanted to understand how Wellness and Recovery Centers have evolved and adapted in recent years. Had they changed much from the initial observations?

The 2011 review of Recovery and Wellness Centers focused on five main areas:

- Funding – How the program is sustained
- Program Design – Self-identified purpose or function in the community
- Menu of Services – What services are offered and how are they accessed?
- Community Partnership – To what extent are the Centers included in the community safety net?
- Staffing/Organization - Contractor or County, Consumer and family member involvement

1 El Dorado, Los Angeles, Madera, Monterey, Riverside, San Mateo, and Stanislaus counties

METHODOLOGY:

Information was collected via a questionnaire distributed through Working Well Together coordinators at California Institutes for Mental Health to the people most closely aligned with running the WRC. A request was also sent out through the MHSA coordinators. However, the ASOC staff received feedback that there was an element of brain fatigue on the part of MHSA staff in regard to answering questionnaires. Reporting requirements for MHSA programs are so numerous and feel so repetitive that a majority of the MHSA program staff are understandably tired of providing information. The outcomes they are required to report are not widely disseminated, creating a perceived dearth of information for outside observers, which leads to more requests for information that in turn unfairly impacts the MHSA staff. The responses that *were* received covered a broad swath of the state but the highest number came from small, rural counties in Northern and Central California.

County	Region	Rural	Urban	Small	Large
Fresno	Central	X			X
Modoc	North	X		X	
Tulare	Central	X			X
Colusa	North	X		X	
Humboldt	North	X		X	
Kings	Central	X		X	
Mendocino (2)	North	X		X	
Mariposa	Central	X		X	
Marin	Central/Bay		X		X (medium)
Tri-City	South		X		X
San Diego (3)	South		X		X

BACKGROUND INFORMATION:

One of the issues that arose in the initial MHSA reports was NIMBYism. Some counties reported difficulties in locating spaces they could open or in contending with harassment once they established themselves. Although the questionnaire did not specifically request information on bias or stigma, they were asked to report on their longevity and stability. All of the WRCs were asked to describe the length of time the center had been open, if there were others in the county, and whether any had relocated since opening. Two of the counties reported that there were more than one WRC in the county. San Diego has 13 county-contracted Wellness and Recovery Centers, and sent responses from three centers that best represented different models within their system. One was based on and certified by a national model, one was bilingual, and the 3rd specialized with the homeless population; thus had a significant outreach thrust in addition to site-based services.

Of the 14 responses, the majority had opened in 2008, with a few having started much earlier and a few coming in later. All reported that they had been in continuous operation since first established. Three were located on county campuses, and a few relocated to save money or gain space, but with the exception of one organization, nobody moved due to neighborhood pressure. This appears to indicate that they are usually considered good neighbors and an accepted part of their respective communities.

	Modoc	Tulare	Colusa	Humboldt	Kings	Mendocino	Mariposa	Marin	Tri-City	Fresno	San Diego 1	San Diego 2	San Diego 3
HISTORY/BACKGROUND													
Yr. Established	*2008	2011	2008	2007	1996	2008	2009	c. 1990	2009	2008	1990	2004	1985
Operated continuously?	Yes	N/A	Yes	Yes	†Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Ever Relocated?	*Yes	No	No	No	Yes		No	‡Yes	No	No	^Yes	No	>Yes

* Started as a socialization group hosted at Health Services, relocated to save money and have more opened up space/offices
† Started as a drop-in center in 1996, relocated due to fiscal and accessibility issues
‡ Moved for purposes of expansion
^ Moved for more operating space and acquisition of on-site housing units
> Lost lease in 2007 after 22 years and relocated

FUNDING:

With all of the uncertainty and volatility of program funding affecting counties, the ASOC wondered if any WRCs could maintain themselves independent from the county. It found that most WRCs have consistently been funded or had their original funding enhanced by MHSA dollars. Some started on Community Services and Supports (CSS) dollars, and shifted to Prevention and Early Intervention (PEI) and Workforce Education and Training (WET) dollars later. Kings County started out funded with SAMHSA dollars, but later shifted to MHSA. One county mentioned that it had a grant writer on staff but had so far not obtained any grant funding, and another county mentioned that its WRC established its own non-profit status in order to do fundraising for art supplies and other “extras”. None of the WRCs responding to this survey provided any type of Medi-Cal billable services. Legally, if they were established through any type of federal funding such as SAMHSA, they cannot draw down any Medi-Cal or Medicaid dollars.

		Modoc	Tulare	Colusa	Humboldt	Kings	Mendocino	Mariposa	Marin	Tri-City	Fresno	San Diego 1	San Diego 2	San Diego 3
FUNDING														
MHSA		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	^Yes	Yes	Yes
Always MHSA?		Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	No	No	No
±	CSS	X	X	X						X		X	X	X
	PEI									X				
	WET	X												
SAMHSA?		Yes	No	No		†No	No	No	No	No	No	No	No	Yes
Receive Public /Private Grant ?		No	No	*Not yet	No	No	No	No	‡Yes	No	No	Yes	No	Yes
Medi-Cal		No	No	No	No	No	No	No	No	No	No	No	No	No
M/C Admin Activity (MAA)												Yes	N/A	Yes

± Not all counties specified which component of MHSA funding was used
* Has applied for, and received non-profit 501C3 status to aid fundraising activities and be eligible for grant funding.
† Started out with SAMHSA funding, converted to MHSA
‡Base contract funds from county plus private donations
^ Partially MHSA funded – also generates revenue through rental income, donations, and grants

PROGRAM DESIGN:

This area, along with services offered, was one of the most interesting to learn about, and what prompted the ASOC to conduct this study. The ASOC wanted to know how WRCs see themselves today, what type of internal adjustments they have made, and how programs are guided and staffed. As noted earlier, many started off as simply drop-in centers to help the county staff connect with the hard to reach, but evolved into places where people actively worked on their recovery and learned social and independent living skills. In San Diego County, The Meeting Place Clubhouse is structured and certified as an International Center for Clubhouse Development (ICCD) model.[2] It is based on the strong belief that people who are productive recover more quickly and maintain wellness more easily, and bases its structure on work-ordered days. Club Members can select from one of two work unit options – administrative (office oriented) or day–to-day functionality (home oriented). The Casa del Sol Clubhouse, also in San Diego County, is fully bilingual, majority peer staffed and run, and offers a full complement of wellness-based, recovery oriented classes and skill building along with an independent (outside) employment program. The following thumbnail profiles represent the models of a small, rural Northern County, a large, rural Central County, a large, urban Southern county, and a mid-size Bay Area county. Each segment starts with their response when asked how the organization defined itself or to provide its Mission statement.

> *"To Provide a platform for Mental Health clients to work towards recovery without discrimination or stigma and to provide educational outreach to the community, to help being accepted for who we are without discrimination" (Sunrays of Hope, Inc.- Modoc)*

In Modoc County, the doors of Sunrays of Hope, Inc. are only open part of the day, but phone access is 24/7, and the phone duty is rotated weekly among a group of volunteers. Membership is automatically conferred upon initial use of the center, but, if abused, the center revokes the membership. It operates under a structured environment of scheduled activities that are voted on by the membership and a van picks up members three times a week. The Board of Directors, maintenance, and socialization staff are all consumers, and the one county employee is also a consumer. Legal, fiscal, and administrative advice is pursued on an ad hoc basis from professional providers.

> *"Blue Sky Wellness Center is focused on wellness, recovery and self empowerment for mental health consumers. Blue Sky is a consumer-driven wellness and recovery environment that creates a sense of "place" by welcoming and nurturing the consumer's individual choices in their recovery journey." (Blue Sky Wellness Center, Fresno County)*

Fresno County's Wellness Center started out from Kings View Behavioral Health System but contracted out through Blue Sky as a separate entity in May 2008. It absorbs and reflects all activities and services through a wellness lens that is very motivating to its members. Blue Sky

[2] ICCD is an offshoot of Fountain House, which was established in New York City in 1947 by former psychiatric patients banding together for mutual support. Initially calling themselves the WANAs (We Are Not Alone) they based their club on the radical premise that recovery from serious mental illness must involve the whole person in a vital and culturally sensitive community. It eventually formalized as the ICCD in 1994 as a national organization that provides direction to groups wishing to establish wellness centers in their communities both in the US and abroad. The San Diego Meeting Place Club House is the first officially ICCD certified site in California.

provides orientations to newcomers, not assessments. It does not have a membership policy other than requiring consumers to be Fresno County residents with a mental health disorder diagnosis at some point of their lives. The environment is structured but the activities are voluntary. Consumers are encouraged to design their own wellness plan each month based on weekly activity offerings. Its staff is 100% contractors with a high ratio of consumers to family members (8:1) for Peer support specialists and 2:1 for Mental Health Specialists /Supervisors. The Peer Advisory council is similarly comprised and meets bimonthly.

> *"Full Service Partnership with Community Mental Health Services. Also, The Wellness Center is a Community Based Organization" (Enterprise/Linda Reed Center, Marin)*

Although currently funded solely through MHSA funding, the Enterprise/Linda Reed Center of Marin had its first iteration over twenty years ago. Working as contractors for Marin County Behavioral Health, Community Action, a Community Based Organization, runs the program though base funding from the county contract, but the program is occasionally augmented with private donations. It is co-located on a county campus with other programs and is 100% consumer administered and operated, with an Advisory Council that is comprised of staff. It offers services to anybody who wants them and does not require a membership. Although not a 24 hour operation, it is open 7 days a week and offers day and evening programs and services.

> *"To provide first class, culturally competent mental health services to the cities of Claremont, LaVerne and Pomona" (Tri-City Wellness Center, Tri-City JPA Los Angeles)*

The Tri-City Wellness Center was established in Spring of 2009 using MHSA funding. It is presently located on-site with the outpatient clinic but hopes to move sometime in 2011. It is 100% staffed by county employees, of which 20% have disclosed as being consumers. The Center funds a Family Wellbeing Specialist through a combination of PEI and CSS funding. Other than requiring that participants be county residents, there is no membership requirement, and the center is open to everybody. Open Monday through Friday until early evening, it offers a full calendar of structured support groups, some in Spanish, covering both wellness and life skills areas.

None of the Centers operate as 24 hour centers, but one was open 7 days a week, another was open six days a week and all holidays, and another maintained 24/7 access by phone. All of those who responded either shared the following qualities or stood out from the others in one significant way:

- All of them operated as a structured environment, meaning activities or services were regularly planned out –often by consumers- on a set schedule and consistently offered. The types of services and activities are discussed in more depth in the following section.
- All of them either had an active Advisory Council, were in the process of putting one together, or had to recently scale back or disband it, and for most, the majority of the Council were consumers.
- With the exception of one, all of the Centers have paid consumers and family members on staff. The exception was fully staffed by C/FM volunteer staff, with one paid county staff.

- For one county, the one paid county staff was also a direct consumer.
- For most of the centers, the ratio of county or contract employee to C/FM was extremely low. The smaller the county, the higher the percentage of C/FM staff.[3]
- In some instances, the contractor was 100% consumer operators, so the answer was yes to both questions (percentage of consumer staff, and percentage of contract staff).

The following matrix summarizes the responses received from the responders.

	Modoc	Tulare	Colusa	Humboldt	Kings	Mendocino	Mariposa	Marin	Tri-City	Fresno	San Diego 1	San Diego 2	San Diego 3
PROGRAM DESIGN													
24 hour?	*No	No	No	No	No	No	No	No	No	No	^No	No	No
Membership based?	Yes	No	No	‡No	Yes	No	No	No	No	‡‡No	No	Yes	Yes
Structured Environment?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Advisory Council?	Yes	Not Yet	Yes	No	Yes	**No	Yes	Yes	Yes	Yes	^No	Yes	>Yes
C/FM Staff?	Yes	†No	Unk.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
County employees?	1	1	Yes	Yes	No	No	Yes	No	Yes	No	No	No	No
Contract Employees?	No	No	No	No	Yes	No	No	No	No	Yes	Yes	Yes	Yes

*Doors not open 24 hours, but 24 hour phone access available. Membership is automatic upon initial access but rescinded if services are abused. Advisory Council is the Board of Directors, who are all direct consumers.
† Center is run by consumer volunteers from the onsite TLC and ETAC programs (99%) + 1 county employee.
‡ Looking at making it membership based, in process of creating Advisory Council
**Advisory Council was in continuous existence until Jan 2011, lost due to funding cuts.
‡‡ Does not require a membership but does require a mental health disorder diagnosis made at one time in consumer's life.
^ Open every Saturday and holiday, requires mental health disorder diagnosis and county residency to participate, workday activities until 4:00, followed by social. Advisory council is membership at large, but two consumers sit on Board of Directors.
> Advisory Council is 100% consumer operated

TYPES OF SERVICES/ACTIVITIES OFFERED:

This category was an extension of the program design questions. Providers were asked to describe how their services were Wellness/Recovery oriented, whether there was a drop-in component for people wishing to shower or do laundry, and how it fit in with the overall dynamic of wellness and recovery. A description of the types and extent of education, employment, and life skill training offered was also requested, as well as descriptions of any peer-run and crisis intervention activities.

One thing that consistently stood out in the WRCs' operation plan was the distinction made between WRC and a drop-in center. There were no hybrid models. None of them offered up showers or laundry facilities as amenities. For some, it appeared to be a matter of resources, but

3 Marin County was an exception to this rule, being a medium sized, semi-urban county with a 100% consumer run wellness center.

for others it was a conscious decision. Blue Sky Wellness Center's response to 'drop-in for showers?' question was an unequivocal *"No – we discourage the "drop-in" attitude – Blue Sky is for healing, a world of possibilities….We continually encourage self-sufficiency, making our own choices and reminding consumers the difference between a Wellness Center and Drop-In Center."* Others responded that previously there were problems with people cleaning up after themselves after showering/laundering, or that even the act of offering up computers and internet access can create serious issues and *"…a constant struggle with not allowing the Center to become a "flop house" mentality."*

All descriptions of how their WRC's services were Recovery/Wellness oriented shared common themes of inclusiveness, self-sufficiency, social integration, organic, responsive to needs of consumers at the time of need, strength-based, consumer directed, and consensus oriented. All emphasized quality of life as the most important outcome and all responded that their services were self-directed. The Centers offered services that were planned by consumer-led advisory councils or members and the consumers selected which ones they would employ at any given time. The single most unifying element in all of them was the essential nature and roles of peers in the success of the Centers. One responder wrote "*through the Peer Advisory Council and Consumer Volunteer Peer training consumers become aware of wellness, empowerment, healing, and hope*." Another wrote "*Our groups are requested by consumers and … are changed as needed to benefit the current consumers' needs. At any time a consumer may request a specific groups or activities that they feel the Center may need*."

	Modoc	**Tulare**	**Colusa**	**Humboldt**	**Kings**	**Mendocino**	**Mariposa**	**Marin**	**Tri-City**	**Fresno**	**San Diego 1**	**San Diego 2**	**San Diego 3**
TYPES OF SERVICES/ACTIVITIES OFFERED													
Services Self-Directed?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Peer-Run?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	‡‡ Yes	Yes	^Yes	Yes	Yes
Drop-Ins for shower/laundry?	*No	No	No	No	No	No	No	No	No	No	No	No	No
Crisis Intervention Component?	*Yes	No	Referral Only	††No	‡ No	No	No	Yes	No	No	No	No	Yes
Employment development?	Yes	**TBD	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	>Yes
GED/College?	No	No	†No	No	No	No	No	No	Yes	Yes	Yes	Yes	Yes
Independent Living Skills?	Yes	TBD	Off site	Yes	Yes	No	Yes	No	Yes	Yes	Yes	Yes	Yes

*Used to be at previous location, now vouchers and assistance are provided
** At the time of the survey, Tulare was still working on opening, developing its menu of services, etc.
† Did offer GED program but funding was exhausted.
†† Center shares site with county Mental Health, Crisis intervention is referred to them; GED services discontinued, in process of seeking reinstatement; also working on increasing the life skills training options.
‡ Shares space with local MH clinic, crisis services are referred to it.
‡‡ Currently training peers and consumers to facilitate support groups; crisis services offered through main outpatient clinic
^ Staff and members work side by side, members are expected to take leadership roles, independent living skills taught on individual basis.
>Job development, job coaching, resource/computer lab, supportive employment program assistance, referrals to education or training Programs. Independent living skills are provided as one-to-one services if consumer requests them.

Sunray's of Hope in Modoc County offers an extremely comprehensive array of consumer training and services that are 100% peer-run. Life skills training is based on a 10 module program that builds a holistic wellness plan that covers baseline self-assessment, support systems, budgeting, nutrition, personal hygiene, medication education, physical exercise, spirituality and ongoing Wellness, Recovery, Action Plans (WRAP). It provides in-house training in order to fill any openings with center members. An attempt to liaison with the local community college for additional classes at no cost/low cost to the student/consumer fell through. The crisis intervention component gradually intensifies, starting at the lowest level with a peer staff-member of the consumer's choosing for an advocate, and gradually continues through a written referral to their county counselor if a resolution is not reached and a higher level of intervention is needed. One San Diego center trains staff to use Nonviolent Crisis Intervention techniques. The majority of the other centers did not offer any type of direct intervention, although most of them did provide support if consumers were referred to clinicians, who were more often than not, either co-located on site or very near by.

All of the centers recognized the intrinsic need to work as a foundation for wellness. The question of whether employment training or opportunities were offered or brokered was answered affirmatively by all, but it did not always carry the same meaning. Nearly all mentioned some type of in-house training for peer support specialists or facilitators, but not all mentioned job placement in outside employment. The Tri-City facility mentioned having an Employment/Vocational counselor for coordinating education and training services with outside entities. Blue Sky trains in-house for peer support and volunteer services as well as offering a "prep" class for consumers contemplating obtaining their GED. In San Diego, The Meeting Place Clubhouse has a very strong employment component – Transitional Employment Placements- which works with outside employers for limited term "regular" jobs that gradually introduce, or re-introduce consumers to the workplace. The Friend-to-Friend program, also in San Diego, offers several employment-development activities, including supportive employment program support and college referrals. San Diego's Casa Del Sol program has a job developer and offers vocational training through PETCO Park's (San Diego Padre's baseball stadium) fund-raising opportunity for non-profits through their concession stands..

COMMUNITY PARTNERSHIP

One of the last areas to be queried surrounded the Center's relationship to the rest of the service community. Community trust and acceptance is a vital part of effective linkage for a strong local support system. Referrals from community safety net providers to Wellness and Recovery Centers is an expression of their confidence in the effectiveness of WRCs in addressing the wellbeing of community residents. Without exception, each center responded that they would accept or did accept referrals from the outside entities listed – law enforcement, emergency rooms, county mental health, private providers, other Community Benefit Organizations, veterans' services, primary care, family/significant others, mental health organizations (NAMI, CNMHC). The main limitations cited were that the county was too small to sponsor a particular organization (NAMI, veteran's services office) or that it had never happened so far but they would if they were asked.

Blue Sky, which is fast becoming the standard-bearer for the Wellness and Recovery Center model, accepts referrals from Fresno County Behavioral Health and refers consumers to them if needed, has an understanding with law enforcement regarding the types of referrals they can accept, and is articulating an understanding with the local emergency room. It formalized its relationship with the local Veterans' hospital and has accepted referrals over the past two years and also works through NAMI, SEES, and Mental Health America to promote their services and availability.

BIGGEST OBSTACLES TO SUSTAINING OR EXPANDING SERVICES:

Predictably, the main area that hindered security and growth was money, closely followed by staffing. This was described both as loss of funding and lack of sufficient funding. It affected location and adequate space as much as it affected remaining operational and staying afloat. It impacted initial hiring of staff, but also on retaining competent staff at the current funding level, suggesting lack of incentive pay or advancement.

For non-fiscal dynamics, one comment centered on the lack of resolution or follow-through on the part of staff and others mentioned waiting for County Board of Supervisor approval to approve funding for a new building or requiring special zoning requirements in order to offer expanded services or hours. The data collection requirements on the part of funders was mentioned by one responder as a barrier to providing more staff time to consumers. Two others mentioned the difficulty in maintaining consumer motivation.

Lastly, despite all indicators that WRCs could be considered good neighbors, one respondent who was forced to relocate did mention community stigma and the reluctance of most neighborhoods to tolerate homeless persons in their neighborhoods. Another responder cited a need for a more organized and unified presence on the part of consumers in order to fight stigma. While the longevity and stability of the WRCs is promising, it does not appear that NIMBYism has completely abated.

OUTLOOK:

All in all, the common denominator for all of the responses was that hope and effort combine to make a powerful, effective force for recovery in their community. Each responder expressed pride and enthusiasm for their center, even when acknowledging operational difficulties. This paper was intended to describe how the centers evolved from drop-ins centers to Wellness and Recovery models, but the change was so rapid, it was more of a revolution than an evolution. No matter how small or large the county, each of the centers "walked the walk and talked the talk". All of them held higher hopes and expectations for their consumers and the drop-in center model was effectively a distant memory.

As counties acquire more discretion in designing their mental health systems and assume greater determination of their funding streams, the Wellness and Recovery model should place high on their priority list and be replicated throughout their community.