Transforming Systems of Care: Translation of Recovery to Mental Health Treatment Settings

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Introduction

Concepts of "Recovery" have recently gained momentum in their trajectory toward becoming the predominant means for organizing and delivering behavioral health services. (New Freedom Commission on Mental Health 2003; Office of the Surgeon General 1999; Inglehart 2004; Jacobson, Curtis 2000) While the value of these ideas have only recently been broadly recognized within our systems of care, many aspects of currently recognized recovery principles have been with us for sometime.

Historical Perspective

The idea of recovery has been a mainstay of the addiction community for many years. It has its roots in the 12-step movement that began in the 1930's (White 1998; Alcoholics Anonymous World Service 1976). It became clear to the founders of Alcoholics Anonymous that overcoming the disease of addiction was much more than establishing abstinence. They recognized that addictive disorders create thought processes and conditioned responses that are far more powerful than the physiological manifestations of dependence. The 12 steps and the various slogans related to thought processes common in persons with addictions are all related to current concepts about recovery.

Although recovery has had a less prominent role in the mental health community in the past, it has been part of the scene for nearly as long as it has been part of the addiction field. Abraham Low, MD, a psychiatrist, began developing recovery-enhancing techniques in 1937, and by 1952, Recovery, Inc was established (Sachs 1997; Low 1950). Recovery, Inc. is an organization run by MH consumers that employs many of the ideas developed by Dr. Low. It offers a peer assisted healing program that focuses on changing thought processes, developing autonomy, and regaining productive and satisfying lives. Like the twelve step approach, it attempts to empower people to take responsibility for managing their illness or disability. Recovery, Inc. has recognized the value of developing a partnership with helping professionals and has promoted this model (Murray 1996; Galanter 1988).

Recent Developments

Recovery has grown in its breadth and stature over the last 15 years. Contributing to its ascension has been the consumer-survivor movement (Fisher 1994; Chamberlain 1984; Chamberlain 1990), the development of psychiatric rehabilitation (Munich, Lang 1993; Anthony et al 1986; Anthony, Liberman 1986), and an improved understanding of how change occurs (Diclemente et al 2004; Miller, Rolnick 1991; Linehan 1993; Sowers 1997). Research has indicated that majority of people with severe BH disabilities do have success in

establishing recovery, many of them without professional assistance (Harding et al 1987; Harding 1987). With this broadening of the understanding of the recovery process, there has been growing recognition of its value and power for individuals and for systems that serve people attempting to overcome significant problems. As the treatment community becomes more aware of the myth of chronicity, the need for a transformation of service systems is more apparent. This was pointed out most prominently with the release of the President's New Freedom Commission Report in 2003. It clearly indicates the need to move toward consumer and family driven services that offer hope and dignity to persons struggling with behavioral health disorders (New Freedom Commission on Mental Health 2003; Onken et al 2002).

Transformation to Recovery Based Services

Recovery has often been described as a universal process; its principles can be applied by virtually anyone attempting to change. Although it has been variably defined, most conceptualizations recognize that recovery is a highly personal process and one that may continue throughout a person's life. Persons who receive services in the public mental health system are challenging the status quo and informing new definitions of recovery from the individual and system perspective (Mead & Copeland, 2004). Generally accepted definitions of recovery share common characteristics including describing value driven and conceptual shifts in service provisions that moves everyone "... out of the old, comfortable roles and begins to talk about mutuality, boundaries, risk and who gets to define and decide on treatment" (Ibid, p. 4). The concept of power is also of importance when seeking to define recovery from an individual or systemic perspective. Defining the role of power and authority, who has it and who wants it, and how to negotiate decisions without resorting to coercion will be of significant importance in operationalizing recovery in systems of care.

Most definitions of recovery include several of the following elements (Fisher 1994; Allen et al 2003; Deegan 1998; Mead, Copeland 2000; White 1998):

- hope and faith
- self-management and autonomy
- restoration and personal growth
- tolerance and forgiveness
- adaptability and capacity to change
- personal responsibility and productivity
- peer support and community life
- dignity and self-respect
- acceptance and self awareness
- honesty, humility and trust

The consumer movement has created a demand for recovery oriented services in many areas of the country, and this has often been critical in creating an impetus for system change (Jacobson, Curtis 2000; Curtis et al 1991; Roth et al 1997; New Mexico Human Services Department 2004). Despite these inroads, the majority of services in our country continue to practice more traditional models of service delivery, and many of the consumers of behavioral health services remain unaware of the promise of recovery and its potential for improving the quality of their lives.

The movement toward recovery models provides an opportunity for service systems to discard practices that may inadvertently impede their constituent's ability to realize their potential (Anthony 2000; Anthony 1993). The transformation of systems from a paternalistic, illness oriented perspective to collaborative, autonomy enhancing approaches represents a major cultural shift in service delivery. Traditional professional training has

developed a workforce that has seen its role as a benign authority providing care for persons with severe, unremitting illnesses, unable to make rational decisions independently. It has viewed their illnesses categorically, rather than individually, and as a result, services have been designed with rigid rules and treatment regimes to meet the needs of a group, into which individuals must fit. Professionals have been trained to have limited expectations for lasting improvement and therefore, hope has not been given to service users to establish a productive and satisfying life. Training has often emphasized avoidance of personal involvement and self-disclosure and maintenance of fairly rigid boundaries in professional and non-professional roles. These traits have tended to divide professionals from persons seeking assistance and have hindered collaboration, mutuality, and reality based relationships (McCubbin, Cohen 1966; Fisher 1994). Recent research has yielded the identification of "themes" that are being used to develop measures with which to assess the performance of mental health systems and providers (Onken, Dumont, Ridgeway, Dornan, & Ralph, 2002).

Guidelines for Transformation to Recovery Focused Services

The remainder of the paper presents a set of guidelines that will facilitate the planning and evaluation of services that are focused on recovery. These guidelines are based on the Guidelines for Recovery Oriented Services which were developed by the American Association of Community Psychiatrists (AACP 2003). They should be useful to systems that have only started to thinks about this process, but also to organizations that have already made significant progress in creating services that promote recovery. They provide a systematic way of thinking about continuous quality improvement and management for these services. The guidelines are organized in three domains of service systems: administration, treatment and supports. Each domain is composed of several elements and recovery-enhancing characteristics for each of these elements are described. Indicators included with each element are intended to provide a template for systems wishing to develop measurement processes, and may be customized to meet specific circumstances unique to localities. In many cases, however, further refinement or quantification will not be necessary.

Recovery Oriented Services Quality Domains

ADMINISTRATION

Leadership

Leadership may be the most important element in any change process and is one variable that has tremendous significance in planning, implementation and sustainability of transformation to ROS. Leadership must facilitate the creation of a shared vision, communicate that vision, put organizational values into operation, empower all constituents, create an open forum and support for those constituents, use information to guide organizational decisions, and recognize and value exceptional accomplishment. (Anthony, 2004)

Indicators:

A) Leadership facilitates inclusion and empowers all constituents.
B) Leadership behaves in a manner that is consistent with values and vision of the ROS system.

C) Outstanding accomplishment is encouraged, facilitated, and rewarded in a consistent manner.

Mission and Vision - Strategic Plan

Commitment to processes fostering recovery must be clearly articulated for organizations to successfully pursue and maintain recovery-oriented services (ROS). The organizational mission must commit to the vision that individuals with mental illness can recover and find a life in the community. Organizational strategic planning must include articulated values, principles, and goals that focus on developing the community of recovering persons (Schmook undated, Anthony 1993).

Indicators:

A) Development of mission and vision statements articulating organizational commitment to recovery and a process for achieving recovery oriented services.
B) Organizational review and strategic planning process that incorporates diverse viewpoints from the community of service users.
C) Organizational values are clearly articulated

Organizational Culture and Resources

Organizational structures responsible for oversight of recovery oriented services must be empowered and supported through the highest levels of the organization to create a political environment that is conducive to the development of these services. This should be manifest at least in part, through the provision of adequate financial resources to meet the requirements of such programming. This would include funding to ensure ample consumer participation in administrative processes governing the organization (i.e., by providing appropriate compensation for their expert contributions) and creating employment opportunities for consumers to enhance ROS (Mueser et al 2002; Simpson, House 2002). Systems of care should develop operational guidelines, polices and procedures in keeping with mission statements, vision statements, and organizational values that are congruent with recovery concepts. (Ashcraft, 2004).

Indicators:

A) Annual budget insures adequate resources to support consumer participation in administrative processes and committees.
B) Significant representation of persons in recovery in organization's clinical and support staff.
C) Policies are accessible to all stakeholders, easy to understand, avoid professional jargon, and are easy to remember.

Training- Continuing Education

Adequate understanding of recovery concepts and of consumer perspectives and aspirations, by professionals working in service delivery systems is essential to the implementation of ROS. Ensuring that professionals have adequate exposure to recovering consumers in non-clinical settings should be a significant goal of orientation, training, and continuing education programming. Professionals must have exposure to effective recovery models in their

Continuing Education programs. Training standards and competency requirements should reflect these values and outcomes (Fisher 1994; Onken et al 2002; Roe et al 2002).

Indicators:

A) Processes developed for interactions and/or communications between consumer and providers in non-clinical settings.
B) Establishment of core competency standards regarding knowledge of recovery values and principles.

Continuous Quality Improvement (CQI)

CQI programming assumes that those most intimately involved with the activities and services of the organization are in the best position to identify improvement opportunities and to develop, implement, monitor and evaluate plans to take advantage of them. ROS providers that incorporate users of services into the governance of their agency/organization will naturally integrate consumers into quality improvement processes at all levels. Consumer involvement in CQI projects as equal partners should be supported through adequate compensation of consumer participants for the services they provide, just as it is for professional participants. This approach provides an important way to empower individuals and to foster investment in the services they receive by recognizing the value of collaboration in establishing stable recovery environments (Simpson, House 2002; Chowanec 1994; Torrey, Wyzik 2000).

Indicators:

A) Processes in place to ensure that consumers are included in CQI activities as equal partners with professionals.
B) Agency budgets will reflect compensation for consumer involvement in CQI activities.

Outcome Assessment

As behavioral health services become more accountable to the outcomes they produce, recovery oriented services will develop indicators that relate not only to objective measures of function, but also to variables related to an individual's progress in recovery and personal growth. These somewhat qualitative and often abstract aspects of experience will be translated into quantifiable and measurable constructs that will provide evidence for quality of life, as defined by persons in recovery, as a valid aspect of service outcome (Roth et al 1999; Mueser et al 2002; Simpson, House 2002; Bigelow et al 1990; Resnick et al 2004; Friese et al 2001).

Indicators:

A) Outcome indicators will include items related to quality of life, self-management and hope.
B) Identification and use of standardized quantified and subjective scales for recovery facilitating processes and outcomes.
C) Established process for consumer participation in developing process and outcome indicators for progress in recovery.
D) Process and outcome measurement processes are used to improve services and programs

TREATMENT

Service Arrays

A variety of services that support consumer self-sufficiency and decision-making will be available in comprehensive recovery-oriented service systems. Available services will embrace a consumer locus of control and include flexible, individualized options for individual and group psychotherapy; rehabilitation and skills building opportunities; various intensities of empowering case management; crisis management and hospital diversion plans; and participatory psychiatric medication management. Prevention, health maintenance, and disease self-management principles will provide the guiding philosophy for all clinical services (Roth et al 1999; Mueser et al 2002; Macias et al 2001).

Indicators:

A) Integration of consumer, family and peer supports, disease management education and crisis management/safety planning will be reflected in policy and procedure documents.
B) Establishment of services supportive of recovery processes and which incorporate illness self management principles
C) Recovery oriented service design will be reflected in policy and procedure documents, including financial structures that encourage such service development
D) Consumers and family members are enlisted to participate in the decisions regarding resource allocation and service development.

Advance Directives/Safety Plans

Encouraging and facilitating the completion and utilization of advance directives/safety plans by service users is an important process in creating a recovery-oriented environment. Advance directives and inpatient safety plans provide a method to respect the wishes of consumers should they become incapacitated at some future time. Providing adequate information for consumers to make informed decisions when they are capable of doing so is a critical aspect of the process (Allen et al 2003; Srebnik et al 2003; NMHA News Release 2002).

Indicators:

A) Established process for obtaining informed advance directives from consumers during periods of relatively healthy function.
B) Established process for review of advance directives during periods of relapse/incapacitation.
C) Common development and use of individualized safety pans upon admission to inpatient facilities, regardless of existence of advance directives.

Cultural Competence

Culturally sensitive treatment and services indicate respect for individuals and recognition that beliefs and customs are diverse and impact the outcomes of recovery efforts. Access to service providers with similar cultural backgrounds and communication skills supports consumer empowerment, autonomy, self-respect, and community integration (Dixon et al 1994; Felton et al 1995; Westermeyer 1999; Smith et al 1993; Onken et al 2002). Full knowledge and understanding by staff of universal approaches that respect individual needs, communication patterns, choices, and situational issues that provide hope.

Indicators:

A) Development of treatment staff with an ethnic/racial profile representative of the community being served
B) Established cultural competency standards for organization's staff.
C) Staff training and development to include expertise in universal methods to ascertain individual needs, choice, desires and to instill hope of recovery.
D) All aspects of the organization's operation are sensitive to cultural issues.

Planning Processes

Respect for consumer participation and efforts to obtain meaningful input will be a hallmark for ROS. This input should be solicited even when consumers are most debilitated and opportunities to make choices should be provided whenever possible. The use of healthcare surrogates will be explored and supported as appropriate. ROS will emphasize consumer choice in all types of planning processes including, but not limited to treatment, service, transition and recovery plans. ROS will emphasize the identification and use of a person's strengths to design a plan to overcome their difficulties (Kaufman et al 1989; Copeland 1997; AAAP/AACP Joint Task Force 2002; AACP 2001).

Indicators:

A) Development of collaborative process for developing continuous comprehensive service/recovery plans between consumers and providers.
B) Efforts to engage all consumers in planning processes are reflected in agency records
C) Processes are in place to inform service users of treatment/service options and to discuss pros and cons of each during every planning process.

Integration – Addiction and Mental Health

ROS will value and promote holistic approaches to health maintenance and recovery development that recognize the impact and interaction of co-occurring illnesses and the need to address them concurrently. Principles of recovery can be applied to diverse processes that disrupt health and can provide a common thread by which the return to health may be orchestrated (Mueser 2002; Drake et al 2001; AACP 2000; Sowers 1997).

Indicators:

A) Integration of mental health and substance abuse programming is reflected in agency activities.
B) Establishment of recovery principles as unifying concepts in provision of holistic mental health, physical health and addiction services.
C) The presence of co-occurring substance and mental health disorders is reliably detected through screening processes.
D) Development of well coordinated referral procedures to collaborative agencies for effective parallel treatment of co-occurring disorders. (If integrated services are not available.)

Coercive Interventions

The use of coercive measures, such involuntary orders for treatment, is not compatible with recovery principles. Therefore, service providers of ROS will make every effort to minimize or eliminate the use of coercive interventions to the greatest extent possible. When they are unavoidable, they should be used with great care and circumspection. Involuntary treatment

arrangements will occur in the least restrictive environments possible to meet the needs of disabled individuals and maintained for the shortest period of time possible. Individuals must be treated with compassion and respect during episodes of incapacitation and are offered choices to the greatest extent possible with regard to their treatment plan. Attempts to transition to voluntary treatment status will be strongly encouraged to assure that recovery principles might be restored to treatment processes (Onken et al 2002; AACP 2001; Davis 2002, Huckshorn 2004).

Indicators:

A) Appointment of consumer advocacy liaisons to courts and involuntary treatment authorities
B) Development of strategies to engage and empower clients on involuntary status that are incorporated into treatment plans and agency programming.
C) Demonstration of reduction in the use of coerced treatment options over defined periods.

Seclusion and Restraint

The use of seclusion and restraint should be used only in extreme situations where safety is threatened. When necessary, it should be kept to a minimum and should be implemented in the most humane manner possible. The use of simultaneous seclusion and restraint should never be used, and processes to assure that these measures are discontinued as soon as possible should be developed. Debriefing for all individuals involved in the incident should be required and effective quality monitoring and improvement processes should be in place (Jonikas et al, 2004; Currier, Allen, & Fisher 1994; NAMI Policy Research Institute 2003, Huckshorn 2004).

Indicators:

A) Development of crisis plans employing progression of interventions designed to deescalate volatile situations
B) Constraint of individuals who are presenting clear threats to their own or other's safety and welfare are guided by both individualized plans and agency policy.
C) Debriefing occurs after all incidents requiring restraint or seclusion.
D) All staff potentially able to respond to a volatile incident is trained in de-escalating techniques and alternatives to forceful constraint.

SUPPORTS

Advocacy and Mutual Support

Facilitation of contact with and participation in peer advocacy groups and mutual support programs is an important aspect of ROS. Liaison with entities involved in these activities should be established to enable this process. Intensive community based peer mentoring/sponsorship programs, consumer managed peer support networks and peer run drop-in centers are examples of these services (Fisher 1994; Chinman et al 2001; Carling 1995; Mowbray et al 1996; Rootes, Aanes 1992; Kurtz 1990; Cheung, Sun 2001).

Indicators:

A) Active facilitation of participation of service users in peer advocacy organizations is demonstrated.

B) An agency liaison with local advocacy and support groups is identified and active.
C) Majority of consumers participate in peer support activities.

Access Facilitating Processes

Development of resources available to improve access to services should include, but should not be limited to communication aids (language accommodation), child care, transportation, mobile services and pharmacy, collaborative relationships with primary care providers, and an ombudsperson or peer advocate to address other barriers to access (Roth et al 1999; Onken et al 2002; Lehman et al 2002).

Indicators:

A) Agency records will reflect liaisons with agencies providing access related services
B) Effective processes in place to obtain services for persons who are not adequately insured or otherwise unable to access existing services financially.
C) Completion of access analysis identifying systemic barriers to receiving services
D) Service users report satisfaction with their access to services they have chosen.

Family Services

Family education and empowerment activities supportive of recovery principles will strengthen attempts by consumers to establish recovery and should be developed by providers of recovery-oriented services. By broadening family members' understanding of recovery processes and their role in fostering autonomy and growth with their loved ones who are disabled, they can be engaged to develop coping skills and to become active supports to a consumer's efforts to enter and maintain recovery (Mueser et al 2002; Pitschel-Walz et al 2001; Baxter, Diehl 1998; Onken et al 2002).

Indicators:

A) Family involvement in agencies will be reflected in educational, social and advocacy programming by the agency.
B) Liaison and collaboration with advocacy groups will be reflected in family oriented programming.
C) Incorporation of family participants in treatment team and planning processes (when desired by consumer)
D) Family psycho-education provided for all consumers with some family involvement when desire by the service user).

Employment and Education

A full array of training, education and employment opportunities will be available to consumers who wish to broaden their experience and independence. Developing life skills and putting them to use is often one of the most self-affirming and confidence enhancing activities that recovering persons can engage in. ROS will support the aspirations of consumers and guide them to processes for achieving them rather than dismissing such aspirations as unrealistic (Roth et al 1999; Onken et al 2002; Lehman et al 2002; Carlson et al 2001).

A) Development of a substantial array of employment and training opportunities with various levels of support for these activities

B) Consumers experience support for their vocational choices and assistance in pursuing them.
C) Process for vocational counseling and support is integrated with other aspects of the recovery process
D) Individualized placement and support is predominant approach to vocational rehabilitation.

Housing

A full array of independent living and supported housing options will be available to consumers and efforts should be made to support the consumer's preferences regarding their living situation. Housing which is tolerant of autonomous behaviors and which makes few demands upon residents will be available, including housing that is tolerant of poorly controlled substance use (Onken et al 2002; AACP 2001; Tsemberis et al 2004).

A) Consumers express satisfaction with available housing options
B) Consumers feel that their housing preferences are respected and accommodated to the greatest extent possible.
C) A full array of housing options are available including various tolerant housing options
D) All housing options support independence, choice and progression.

Assessment Tools to Measure Recovery from Systems and Individual Level

Assessment tools have been developed to measure recovery at both the individual and system level. Agencies taking on the challenge of creating recovery oriented systems of care may wish to review the available tools, choose and use one or more to assist in measuring progress and effectiveness. AACP's ROSE (Recovery Oriented Services Evaluation) is currently in development and incorporates many of the indicators contained in this document. The most recent list of recovery measurement instruments can be obtained through the Human Services Research Institute (HSRI) in Cambridge, MA.

Conclusion

Recovery oriented services represent a philosophical approach to service provision that compliments whatever other specific intervention or protocol that may be provided to ameliorate the symptoms of illness As such, they represent a set of values that should govern human services and clinical relations and therefore have virtue beyond tangible or observable outcomes. However, even with this in mind, a the review of the literature indicates that several of the elements included in these guidelines do, in fact, enhance the quality of life for persons with behavioral disabilities, and many would consider this the outcome of greatest importance.

The establishment of recovery-oriented services will require a transformation of the way professionals have been trained to think about their roles and the cultures in which services are provided. This re-conceptualization will include an understanding that the helper's role should be facilitative rather than directive; hope inspiring rather than pessimistic; autonomy enhancing rather than paternalistic; and collaborative rather than autocratic. Recovery oriented services will enhance the capacity for every individual to reach their full potential. These guidelines can be used by organizations to assess their own progress in establishing ROS and to begin the process of establishing measurable indicators for quality monitoring.

Recovery facilitating cultures can be integrated into all systems of care, irrespective of populations and need to e considered similar to universal precautions or universal best practice. They will also be useful to macro-systems and regulatory agencies in developing standards and establishing accountability. Recovery oriented services and the values and philosophy they espouse will be useful to consumer and other advocacy groups in their attempts to assist the transformation of our current behavioral health systems of care.

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