

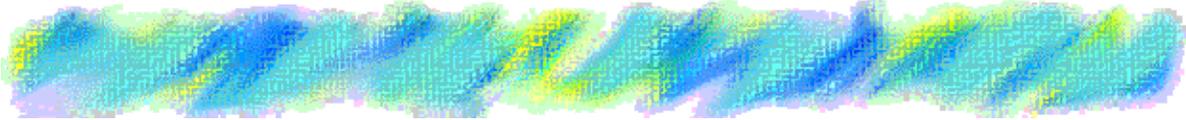


**Practice Guidelines for  
Recovery-Oriented Care  
for Mental Health and  
Substance Use Conditions**



**Connecticut Department of  
Mental Health and Addiction Services**

**Second Edition—December 2008**



## **Early Reviews of the Second Edition**

“These guidelines support the vision of transformation in the state of Connecticut. At a time when we are working to partner with people in recovery and their families, this document provides us with the directions as to how to move the system to the next level ... one in which there truly is a life in the community for all and where discrimination against those with behavioral health disorders is a thing of the past.”

Pat Rehmer, Deputy Commissioner  
Connecticut Department of Mental Health & Addiction Services

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“At a time when we are transforming mental health services toward a resiliency-focused recovery-based system of care, these revised Recovery Practice Guidelines are both timely and relevant. I was excited to be given the opportunity to preview them.”

Colette Anderson, Chief Executive Officer  
Connecticut Department of Mental Health & Addiction Services  
Western Connecticut Mental Health Network

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“I want to express my gratitude to ... those who contributed to the DMHAS Practice Guidelines for Recovery-Oriented Care document. I certainly appreciate the time and effort dedicated to writing the guidelines and even more impressed with the attention given to culture and cultural competence throughout. This is an excellent piece of work that presents a win-win situation for DMHAS and the state operated and funded agencies.”

Jose Ortiz, Director of the Office of Multicultural Affairs  
Connecticut Department of Mental Health & Addiction Services

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“This document lays the foundation for building the bridge between treatment and the recovery community. Created by collaboration, it is a blueprint for making the necessary changes to become a recovery-oriented system of care. These Guidelines raise the bar to a new level, especially regarding housing and women’s services!”

Barbara Geller, Director of State-Wide Services  
Connecticut Department of Mental Health & Addiction Services

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“This document is an amazing contribution to Connecticut’s health care system and the field as a whole. The practice guidelines provide an integrated mental health and substance use framework in which high quality, recovery-oriented services are within reach for individuals with co-occurring disorders. The guidelines help us to be more informed as we work with people to make recovery happen.”

Julienne Giard, Co-Occurring Program Manager  
Connecticut Department of Mental Health & Addiction Services

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“No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his[/her] own person, free from all restraint or interference of others, unless by clear and unquestioned authority of law.”

— United States Supreme Court  
*(Union Pacific Railway Co. v. Botsford)*

yale  
program  
for  
recovery  
and  
community  
health

**Prepared for the Connecticut Department of Mental Health and Addiction Services by the Yale University Program for Recovery and Community Health (Tondora, Heerema, Delphin, Andres-Hyman, O’Connell, & Davidson, 2008).**

## Foreword by Commissioner Thomas A. Kirk, Jr., Ph.D.

The document that you are about to read continues the precedent set by the 2006 edition and remains an extraordinary tool in its origins, content, and value. This edition represents a truly giant step forward in our multi-year, systemic journey initiated in 2000 to create a recovery-oriented health care system in Connecticut.

In this edition, we take the vision articulated in the first edition a couple of significant steps farther, in particular by building on important, cutting-edge work being done by several DMHAS workgroups that may, in the past, have been viewed as being on parallel tracks with the recovery initiative. This edition is intended especially to be responsive to the questions that have emerged over the last decade from practitioners, people in recovery, and others, as leaders in the Cultural Competence, Co-Occurring Disorders, Preferred Practices, Trauma, Gender, and Primary Health Care initiatives have been asked how their respective domains relate to the new recovery paradigm. This revision was undertaken with this primary concern in mind; that is, to *“connect the dots”* between these various initiatives and to integrate them all within the overarching framework of a recovery-oriented system for all of Connecticut’s citizens.

*...these guidelines stress that it is at the level of each person served—in collaboration with his or her family—that all of the advances introduced over the last decade come together in the provision of recovery-oriented care.*

The Introduction to this edition explains the thinking that allows for such integration. Fundamentally, these guidelines stress that it is at the level of each person served—in collaboration with his or her family—that all of the advances introduced over the last decade come together in the provision of recovery-oriented care. Since release of the first edition, this approach to integration has been articulated and promoted through adoption of Commissioner’s Policy Statement #33 requiring Individualized Recovery Planning. It is through the mechanism of an individual recovery plan that we ensure that in the care provided to each person and family:

- ⇒ practitioners are responsive to the person’s gender and cultural background;
- ⇒ practitioners assess for and are sensitive to histories of trauma;
- ⇒ practitioners are alert for identifying and addressing co-occurring conditions;
- ⇒ based on the informed decisions of the person and his or her family, practitioners employ the best interventions currently available; and
- ⇒ practitioners are attentive to medical issues and the impact of psychiatric medications on the person’s overall health and well-being.

In addition to incorporating standards from each of these initiatives and bringing them together in the service of supporting each person's unique recovery, this edition of the practice guidelines is informed by the Institute of Medicine's framework for ensuring quality care for mental health and substance use conditions. This framework emphasizes that quality care is safe, timely, person-centered, effective, efficient, and equitable, and is increasingly being adopted by health care systems across the U.S., as it embodies an important advance in increasing the quality and responsiveness of health care throughout all areas of medicine. In this edition, these domains have been integrated with the nine primary domains of recovery-oriented practice described in the first edition to yield a total of six domains. In a synergistic way, these domains take the IOM framework and adapt it specifically to the provision of recovery-oriented care; care that is provided in the community as well as in the clinic, and that takes as its first challenge engaging into trusting and caring relationships people who are at times reluctant and distrusting of health care in general, and of care for mental health and substance use conditions especially.

The framework we established for the DMHAS recovery initiative was designed to involve six basic tasks, which we defined as follows: 1) developing core values and principles based on the input of people in recovery; 2) establishing a conceptual and policy framework based on this vision; 3) building workforce competencies and skills; 4) changing programs and service structures; 5) aligning administrative and fiscal policies; and, finally, 6) monitoring, evaluating, and adjusting these efforts.<sup>1</sup> The first edition of the guidelines corresponded to the first three of these tasks, which were primarily carried out from 2000-2006. This second edition provides the road map for the remaining three tasks, which will be the focus of DMHAS efforts over the next several years.

*Taken together, we believe that all of these efforts and tools, carried out and utilized in collaboration with the recovery community, public and private non-profit practitioners, and other stakeholders, will result in a truly transformed system of care for mental health and substance use conditions.*

These guidelines will provide key directions for future efforts. To assist in the process of further system transformation, the guidelines will be supplemented by additional tools and practice change strategies, including policy development, changes in contractual language and expectations, the introduction of a highly innovative, strength-based electronic recovery management information system, and advanced training and education. Taken together, we believe that all of these efforts and tools, carried out and utilized in collaboration with the recovery community, public and private non-profit practitioners, and other

<sup>1</sup>Davidson, L., Kirk, T., Rockholz, P., Tondora, J., O'Connell, M.J. & Evans, A.C. (2007). Creating a recovery-oriented system of behavioral health care: Moving from concept to reality. *Psychiatric Rehabilitation Journal*, 31(1): 23-31.

stakeholders, will result in a truly transformed system of care for mental health and substance use conditions. One in which we can all take considerable pride, but, more importantly, one in which any Connecticut citizen in need will find a welcoming, safe, and supportive environment filled with encouraging and skilled staff available and dedicated to helping them along the way.

In the first edition, I mentioned that I believe that successful initiatives have a thousand fathers and mothers and failed initiatives are orphans. I continue to believe that our journey to a recovery-oriented service system has many parents. I thank all of those who have contributed thus far, and welcome any additional newcomers to join our efforts. I also would welcome any comments about the above or your opinion of this document at [Thomas.Kirk@po.state.ct.us](mailto:Thomas.Kirk@po.state.ct.us).

A handwritten signature in black ink, appearing to read "Thom Q. Kirk". The signature is written in a cursive style with a large initial "T" and "K".

December, 2008

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## Executive Summary

Recent federal documents state that the expectation for persons experiencing a mental health and/or substance use condition and their families should be “recovery.” How do people recover? And what can a mental health and addiction services system do to promote and support recovery? These questions have become the focus of a considerable amount of dialogue and debate between and among various constituencies within the mental health and substance use communities. Following a brief introduction to the topic, in which we clarify various sources of confusion about the term recovery and explain its relationship to other initiatives, these practice guidelines turn to operationalizing the various components of DMHAS’ vision of a recovery-oriented system of care. This vision was first put forth in 2002 with the signing of Commissioner’s Policy #83, “Promoting a Recovery-Oriented Service System,” reaffirmed in the 2007 release of a revision of Commissioner’s Policy #33, which is now entitled “Individualized Recovery Planning,” and has since been embodied in various DMHAS education, training, and program development initiatives. These guidelines represent a systematic effort to bring recovery into the everyday practice of mental health and substance use practitioners in Connecticut.

*These Guidelines represent a systematic effort to bring recovery into the everyday practice of mental health and substance use practitioners in Connecticut.*

## Defining our Terms

One major source of the confusion surrounding use of the term in recovery derives from a lack of clarity about the respective roles of health care practitioners and those of people with mental health and/or substance use conditions themselves. For the purposes of this document, we offer the following two definitions which we have found to distinguish usefully between the process of recovery and the provision of recovery-oriented care.

***Recovery*** refers to the ways in which a person ***manages*** a mental health and/or substance use condition in the process of restoring or developing a meaningful sense of belonging and positive sense of identity apart from this condition and while rebuilding a life despite or within the limitations imposed by this condition.

***Recovery-oriented care*** is what mental health and substance use treatment and rehabilitation practitioners ***offer*** in support of the person’s own long-term recovery efforts.

## **Practice Guideline Domains**

This edition of the practice guidelines are organized according to six domains described below. These domains are the result of an integration of the work completed for the first edition of these Guidelines, issued in 2006, the report of the Institute of Medicine issued in 2005 entitled *Improving the Quality of Health Care for Mental and Substance Use Conditions*, and review and integration of key documents from, and discussions with the leaders of, the DMHAS Cultural Competence, Co-Occurring Disorders, Gender, Trauma, Preferred Practices, and Health Promotion and Wellness initiatives. Relevant materials from these initiatives may be found in the Appendix.

### **A. Recovery-Oriented Care is Consumer and Family-Driven**

An essential characteristic of recovery-oriented health care is the primacy it places on the participation of people in recovery and their loved ones in all aspects and phases of the care delivery process. Participation ranges from framing the initial questions or problems to be addressed and designing the capacity and needs assessments to be conducted, to delivering, evaluating, and monitoring care, to the design and development of new services, interventions, and supports. The result of the active participation of people in recovery and families is a system that is guided by and responsive to their needs, values, and preferences.

### **B. Recovery-Oriented Care is Timely and Responsive**

Only one out of three people with a mental health condition seek or receive specialty health care, while the odds are even worse in the case of substance use conditions, where it is only one out of seven. This is particularly true among cultural communities, for whom it is not only access to care that is problematic but also retention in care, quality of care, and outcomes which remain comparatively poor. Practitioners can address these issues by promoting swift and uncomplicated entry and by removing barriers to receiving care; by making contact with the person rather than with the diagnosis or disability; by building trust over time; by attending to the person's stated goals and needs, by attending to each person's culturally-based and personal values and preferred ways of addressing challenges over time, and directly or indirectly, providing a range of services in addition to clinical care.

### **C. Recovery-Oriented Care is Person-Centered**

Consistent with the practice of patient-centered physical medicine, health care for mental health and substance use conditions is moving toward the provision of services and supports which are tailored to each individual's specific needs, values, and preferences. Implementing person-centered care involves basing all treatment and rehabilitative services and supports to be provided on an individualized, multi-disciplinary recovery plan developed in partnership with the person receiving these services and any others that he or she identifies as supportive of this process. While

based on a model of collaboration, significant effort is made to ensure that persons' rights to self-determination are respected and that all people are afforded maximum opportunity to exercise choice in the full range of treatment and life decisions.

Individualized recovery plans include a comprehensive and culturally competent assessment of the person's hopes, assets, strengths, interests, and goals and reflect a holistic understanding of his or her mental health and/or substance use conditions, general medical concerns, and desire to build or maintain a meaningful life in the community. In using this tool, practitioners adopt an asset-based approach with the understanding that focusing solely on deficits in the absence of a thoughtful analysis of strengths disregards the most critical resources an individual has on which to build in advancing in his or her recovery.

#### **D. Recovery-Oriented Care is Effective, Equitable, and Efficient**

A cornerstone of the recovery orientation of the DMHAS funded system of care is its emphasis on quality. Quality care is care which is effective, efficient, and equitable. Effective care is that which has been shown to be useful in reducing illness and disability and improving functioning and quality of life. It may be based on several different types and levels of evidence, and reflects the best care a system can offer at any given point in time. Equity speaks to the need to ensure that care does not vary in quality or effectiveness due to personal or social characteristics such as gender, culture, sexual orientation, religious affiliation, geographic location, or socioeconomic status. Finally, efficiency results from the thoughtful allocation and management of resources in such ways that maximize access and effectiveness and minimize barriers to care and/or recovery.

#### **E. Recovery-Oriented Care is Safe and Trustworthy**

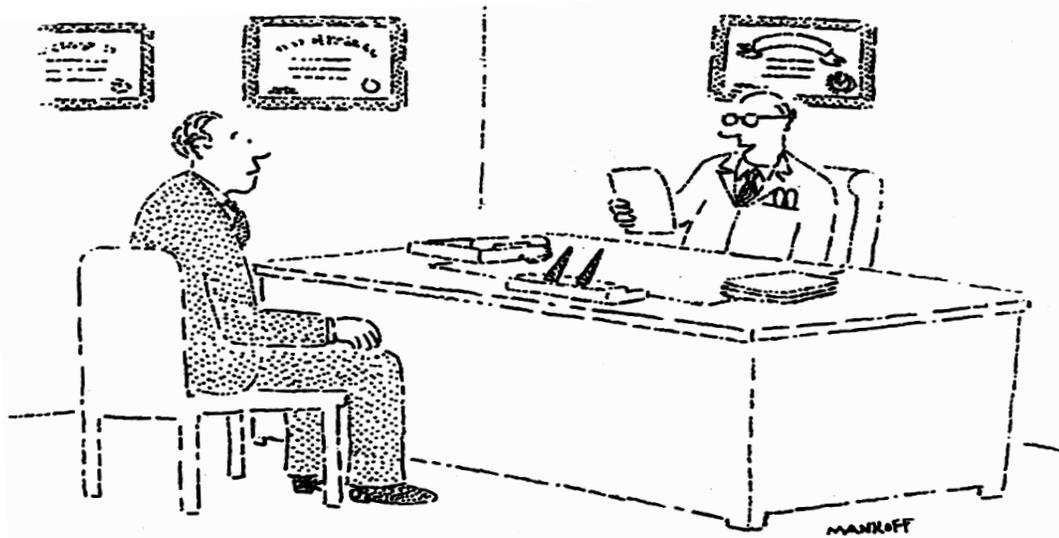
Recovery-oriented care is grounded in the Hippocratic Oath of "First, do no harm." As an extension of this principle—and in recognition of the prevalence of trauma histories in the lives of individuals with mental health and/or substance use conditions—concerted efforts are made to ensure that services and supports are safe for those who are intended to benefit from them. People should not be worse off as a result of accessing health care, and adverse effects or side effects of receiving treatments or participating in services should be avoided as much as possible. In addition, research has consistently demonstrated that a trusting relationship with a practitioner is one of the most important predictors of a positive outcome resulting from care; more so than any particular theoretical approach or evidence-based technique. In recognition of this fundamental role of interpersonal relationships in the provision of care, practitioners go beyond doing no harm and ensuring safety to cultivating trusting relationships which people have reason to view as helpful.

## F. Recovery-Oriented Care Maximizes Use of Natural Supports and Settings

Given its focus on life context, one tool required for effective recovery planning and the provision of recovery-oriented care is adequate knowledge of the person's local community, including its opportunities, resources, and potential barriers. Community mapping and development are participatory processes that involve people in mapping the resources and capacities of a community's individuals, its informal associations, and its structured institutions (e.g., faith communities, churches, non-traditional healers, neighborhood block watches, civic organizations, cafés, thrift stores, low cost or no cost social activities, etc.) as a means of identifying existing, but untapped or overlooked, resources and other potentially hospitable places in which the contributions of people with mental health and/or substance use conditions will be welcomed and valued.

In each of the following sections, practitioners are offered brief vignettes of the kinds of challenges typically faced in implementing recovery-oriented care. They also are given examples of what they are likely to hear from people in recovery when these guidelines have been implemented successfully. Following the domains of practice, there is a list of recommended resources for further reading on transformation to recovery-oriented care, as well as a glossary of recovery-oriented language and examples of strengths-based conceptualizations that are proposed as alternatives to current deficit-oriented ones. Finally, performance measures and tools based on these guidelines will be available in addenda in the near future to assist practitioners in assessing the recovery orientation of their own services and to assist people in recovery, family members, and advocates to evaluate the services offered.

### The Importance of Not Overlooking the (not so) Obvious



*“Well, this is a very impressive resume, you man. I think you’re going to make a fine patient.”*

## Introduction

Recent federal documents state that the expectation for persons experiencing a mental health and/or substance use condition and their families should be “recovery.” How do people recover? And what can systems of care do to promote and support recovery? These questions have since become the focus of a considerable amount of dialogue and debate between and among various constituencies within the mental health and substance use communities. Prior to attempting to operationalize the components of DMHAS’ vision of a recovery-oriented system of care, we thought it important to clarify these confusions, some of which are due to the fact that the notion of recovery is in transition, moving gradually from a well-established vision among people with mental health or substance use conditions to exerting more influence on practice.



For example, being “in recovery” has long been the guiding vision and goal of self-help<sup>2</sup> within the addiction recovery community. Primarily a force within self-help, however, this notion has not played as much of a role historically within the substance use services community, where concepts of treatment and relapse prevention have been more central. Having a fifty-year history of peaceful, if benign, co-existence, these two complementary approaches have recently entered into a period of partnership in which there is now considerable potential for them to build dynamically on each others’ strengths to promote a unified and coherent vision of recovery among people with substance use conditions.

Despite being a long-standing core value in addiction self-help, the notion of “recovery” has emerged as a dominant force within mental health just within the last decade. It has taken center stage through its prominent role in both the Surgeon General’s *Report on Mental Health*<sup>3</sup> and the President’s New Freedom Commission on Mental Health. In its influential *Final Report*, the Commission strongly recommended “fundamentally reforming” all of mental health care to be based on the goal of recovery<sup>4</sup>. In both of these reports, however—as well as in clinical and rehabilitative practice—there is considerable ambiguity and a tangible lack of clarity about what precisely is meant by recovery in mental health. As in the substance use field, much work remains to be done in mental health in developing a unified vision of recovery that can prove to be acceptable (as well as useful) to all involved parties.

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<sup>2</sup> Derived from Alcoholics Anonymous, these so-called “12-step” groups have expanded to include many other addictions and life conditions, and have consistently been shown to help promote and maintain abstinence.

<sup>3</sup> Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

<sup>4</sup> Department of Health and Human Services. (2003). *Achieving the promise: Transforming mental health care in America*. Rockville, MD: Substance Abuse and Mental Health Services Administration, p. 4.

Given its multiple and complicated parentage and the diverse constituencies involved, it is not surprising that it has been difficult to reach consensus on any one definition, or even on any one list of essential aspects, of the concept of recovery across mental health and substance use conditions. For the sake of clarity—as well as to facilitate future discussions as these concepts continue to evolve—we propose the following distinction as a prelude to articulating the Guidelines that will be used to guide the development, monitoring, and evaluation of clinical and rehabilitative services and supports offered within a recovery-oriented system of care. Rather than mutually exclusive, these two concepts—of recovery and recovery-oriented care—are intended to be somewhat overlapping and complementary, with the eventual goal of being brought together into a unified vision that can be promoted equally by people in recovery, their loved ones, health care practitioners, and the community at large. As we suggest in the final section of this Introduction, this vision can then be used to integrate various initiatives sponsored by DMHAS and other bodies over the last several years, bringing together such diverse topics as cultural competence, gender, trauma, preferred practices, co-occurring disorders, primary care, and others into one coherent framework grounded in each individual’s life and family context.



### ***Defining our Terms***

One major source of the confusion surrounding use of the term in recovery derives from a lack of clarity about the respective roles of health care practitioners and those of people with mental health and/or substance use conditions themselves. For the purposes of this document, we offer the following two definitions which we have found to distinguish usefully between the process of recovery (in which the person him or herself is engaged) and the provision of recovery-oriented care (in which the practitioner is engaged).

- ***Recovery*** refers to the ways in which a person ***manages*** a mental health and/or substance use condition in the process of restoring or developing a meaningful sense of belonging and positive sense of identity apart from this condition and while rebuilding a life despite or within the limitations imposed by this condition.
- ***Recovery-oriented care*** is what mental health and substance use treatment and rehabilitation practitioners ***offer*** in support of the person’s own long-term recovery efforts.

## Recovery

Given that the notion of recovery derives from the self-help and self-advocacy communities in both substance use and mental health, the first definition of recovery refers to *what people who have these conditions do to manage their mental health and/or substance use condition and to claim or reclaim their lives in the community*. In addition to managing the condition, this sense of recovery therefore also involves *what people do to overcome the effects of being perceived as “an addict” or “a mental patient”*—including rejection from society, alienation from one’s loved ones, poverty, substandard or unstable housing or homelessness, social isolation, unemployment, loss of valued social roles and identity, and loss of sense of self and purpose in life—in order to regain some degree of control over their lives.

Beginning with a common foundation, recovery in mental health and substance use can then be seen to divide into two distinct, but at times parallel and at other times overlapping, paths. Before turning to the characteristics of recovery-oriented care, we provide a brief overview of the similarities and differences between these two paths of recovery. Given the high rate at which mental health and substance use conditions co-occur in the same person, we understand that any given individual may be involved in either, or both, of these paths at the same time. For the sake of clarity, it still may be useful to highlight a few of the salient differences between them prior to turning to their implications for care.



*Substance Use Recovery*. Derived from the self-help community, people who are achieving or maintaining abstinence from substance use following a period of abuse or dependence have described themselves as being “in” this form of recovery for over half a century. Being “in recovery” in this sense has been used to signify that the

*People who are achieving or maintaining abstinence . . . have described themselves as being . . . in recovery for over half a century.*

person is no longer actively using substances but, due to the long-term nature of addiction, continues to be vulnerable to relapses and therefore has to remain vigilant in protecting his or her sobriety. In this tradition—in which continued vulnerability to relapse is seen as inherent to addiction—recovery does not connote cure. Unlike in most physical illnesses, people may consider themselves to be in recovery while continuing to be affected by their substance use condition.

Based on this definition, it is possible that many people who have used substances to an extent that would have met current diagnostic criteria for a substance use condition at one point earlier in their lives, but who are no longer actively using or having to focus on protecting their sobriety, would not consider themselves to be “in recovery.” While for some people it may apply to the remainder of their lives, being in recovery from substance use appears to pertain more specifically to the period following active use in which the person is consciously and actively involved in remaining abstinent and in which there continues to be a sense of vulnerability to relapse. In this sense, recovery in substance use is not only hard-won but often has to be protected and reinforced through persistent vigilance and adherence to the self-help and other principles that made it possible in the first place.

In addition to being in recovery from substance use, this process involves addressing the effects and side effects of use as well. The self-help tradition recognizes that living with a substance use condition generates many negative effects on one’s life beyond the substance use *per se*, including detrimental effects on one’s relationships, on one’s ability to learn or work, and on one’s self-esteem, identity, and confidence. With the toxic effects of substance use spreading to the person’s life

*Recovery involves the person’s efforts to abstain from substance use while resuming increasing responsibility for his or her overall life.*

as a whole, this sense of being in recovery involves the person’s efforts to abstain from substance use while resuming increasing responsibility for his or her life. It thus often involves returning to school or work, making amends to others who have been hurt, repairing damaged relationships, and, in general, learning to live a clean and sober life.

It also is true that for many people, achieving recovery may be the first time they have known how to live without an addiction, tracing its origins back to their earlier lives even prior to actual substance use. For these people, a clean and sober life is not so much restored by abstinence as it is created for the first time; a gain which they credit to their recovery above and beyond sobriety. It is not unusual in such cases for people in recovery to believe they are now a better person for having gone through the addiction and recovery process than if they had never used substances in the first place; a process White and Kurtz refer to as “transcendent recovery.”<sup>5</sup>

Given the fact that the term recovery has been used consistently in the substance use field for over half a century, it is not uncommon for practitioners to assume that use of the term in relation to health care represents nothing new or

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<sup>5</sup>White, W. & Kurtz, E. (2006). The varieties of recovery experience. *International Journal of Self Help and Self Care*, 3(1-2), 21-61.

different. In fact, an understandable response from many substance use practitioners to the notion of a recovery-oriented system of care has been on the order of “It’s about time you caught up to us. We’ve known about this, and practiced this way, for years.” As White points out, though, there are several important components to the

*Most significant ... is the shift from an acute care model to a recovery management model and the central role recovery support services play within this context.*

“New Recovery Movement” in substance use which represent departures from earlier practices.<sup>6</sup> Most significant of these components is the shift from an acute care model to a recovery management model and the central role motivational interventions and recovery support services play within this context.

A recovery management model involves viewing substance use as a long-term condition requiring long-term support. This is not to say that substance use cannot also be acute in nature. Many people do, in fact, experience a short-lived period of substance use and do not develop a prolonged condition to begin with. For such people experiencing only one acute and delimited episode of substance use, however, the notion of “recovery” is unlikely to have much relevance. Such individuals are unlikely to consider themselves, or to refer to themselves, for example, as being “in recovery.” For those individuals for whom being in recovery is a meaningful goal, the nature of their struggle with substance use is likely to be sustained. In such cases, an acute model of care is not the most useful or appropriate. Particularly in terms of system design, prolonged conditions call for longitudinal models that emphasize continuity of care over time.<sup>7</sup>

Recovery management models are based on the belief that full recovery is seldom achieved from a single episode of intervention or treatment, and that practitioners, as well as people in recovery, families, and policy makers, should not be disappointed or discouraged by the fact that there are no quick fixes. Similar to (other) continuing care medical illnesses, previous treatment of a person’s condition is not taken to be indicative of a poor prognosis, of non-compliance, or of the person’s not trying hard enough to recover. Relapses in substance use are viewed as further evidence of the severity of the person’s condition rather than as causes for discharge (e.g., we do not discharge a person from the care of a cardiologist for having a second or third heart attack). All of these principles suggest that treatment, rehabilitation, and support are not to be offered through serial episodes of

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<sup>6</sup>White, W. (2006). *Let’s go make some history: Chronicles of the New Addiction Recovery Advocacy Movement*. Washington, D.C.: Johnson Institute and Faces and Voices of Recovery. White, W. (1998) *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems. White, W., Boyle, M., & Loveland, D. (2003). Recovery management: Transcending the limitations of addiction treatment. *Behavioral Health Management* 23(3):38-44.

<sup>7</sup>White, W. (2001). The new recovery advocacy movement: A call to service. *Counselor*, 2(6), 64-67.

disconnected care from different providers, but through a carefully crafted system of care that ensures continuity of the person’s most significant healing relationships and supports over time and across episodes, programs, and agencies.

*. . . treatment, rehabilitation, and support are not to be offered through serial episodes of disconnected care from different providers, but through a carefully crafted system of care that ensures continuity of the person’s most significant healing relationships and supports over time.*

Within this context, there is an important role for recovery support services to play in increasing an individual’s “recovery capital,” enabling him or her to benefit from treatment and rehabilitation. With the advent of motivational interventions, “hitting bottom” is no longer viewed as a prerequisite for abstinence. Rather, we understand that at least some “recovery capital” is required for people to undertake the difficult and prolonged work of recovery.<sup>8</sup> By “recovery capital,” we mean to refer to the combination of external and internal resources that a person can bring to bear on the initiation and maintenance of recovery from a long-term disorder.<sup>9</sup> In addition to financial, material, and instrumental resources, recovery capital includes hope, motivation, self-confidence, having a valued social role, a home, and a sense of belonging within a community of one’s peers, and having supportive relationships with extended family and other caring people. Recovery support services are those services which enable people to acquire these various forms of recovery capital, whether that be through increasing motivation for change, obtaining stable housing, securing gainful employment, or finding a network of supportive friends.

The basic premise of this approach is that while people who already have recovery capital may either recover on their own or with limited formal help, those who have lost, or who never really had, adequate recovery capital will first have to acquire some amount of internal and external resources before being able to take up the challenge of recovery in a fully effective and sustained way. At its extreme, “losing everything” may leave the person not only without a foundation upon which to base his or her recovery, but also with nothing further left to lose. Such individuals are best understood as being in need, not of more addiction-related losses in their lives, but of additional recovery capital. Put simply, the major obstacle to recovery they face may be more the absence of hope and motivation than the absence of pain.

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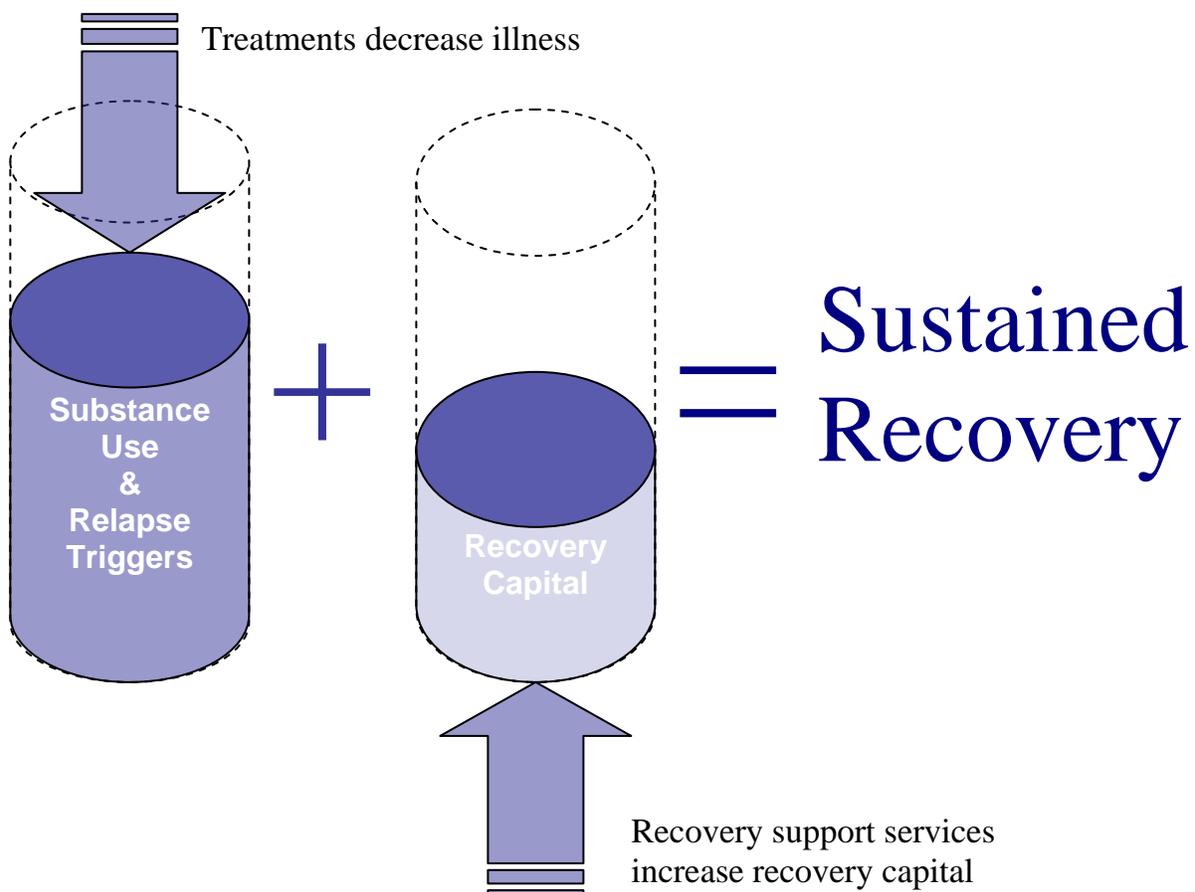
<sup>8</sup> Davidson, L., White, W., Sells, D., Schmutte, T., O’Connell, M.J., Bellamy, C. & Rowe, M. (2007). *Enabling or engaging? The role of recovery support services in addiction recovery*. Hartford, CT: Connecticut Department of Mental Health and Addiction Services.

<sup>9</sup> Granfield, R., & Cloud, W. (1999). *Coming clean: Overcoming addiction without treatment*. New York: New York University Press.

*Put simply, the major obstacle to recovery ... may be more the absence of hope and motivation than the absence of pain.*

Rather than enabling people to continue to use, recovery support services are now understood as enabling their recovery, as assisting people in establishing an environment supportive of recovery and in gaining the skills and resources needed to initiate and maintain recovery. Sober housing, transportation, child care, employment and educational supports, recovery coaching, and increased participation in prosocial recreational activities with peers offer an environment more conducive to recovery than homelessness, unemployment, social isolation, and poverty. In addressing these issues, recovery support services become complementary to, and supportive of, treatment rather than antithetical to or a replacement for treatment. As depicted in Figure 1 below, for people who have lost what recovery capital they might have had it may take the combination of increased recovery support services *and* treatment to reduce substance use and triggers while increasing the person's resources, skills, confidence, and social support in order to enter into and maintain long-term recovery.

**Figure 1. Respective Roles of Treatment and Recovery Support Services**



*Mental Health Recovery.* While the notion of being “in recovery” was developed by the self-help addiction community over half a century ago, it was first introduced into the mental health community approximately thirty years ago through the mental health consumer movement. In the process of its introduction into mental health, this sense of recovery took on a few characteristics specific to the history of the perception and treatment of mental illness in society. Being associated initially with being liberated from mental hospitals where they had been confined against their will (many, if not all, of the first self-advocates had previously been inpatients), the mental health consumer community viewed itself first and foremost as a civil rights movement rather than as part of any treatment or rehabilitative enterprise.<sup>10</sup>

For people with mental health conditions, prior to denoting anything like a cure or improvement in their mental health condition, recovery meant having one’s civil rights restored as a full and contributing member of society. It meant no longer being defined entirely by one’s mental health condition (i.e., as a mental patient) and having, as a result, one’s major life decisions—as well as one’s day-to-day life activities—determined by others. In addition to advocating for the radical reform of involuntary commitment laws and inpatient care, advocates have since been active in identifying ways in which community services also have unwittingly perpetuated the paternalism historically seen in institutional settings.<sup>11</sup>

*... prior to denoting anything like a cure or improvement in one’s mental health condition, recovery meant having one’s civil rights restored as a full and contributing member of society.*

While not inconsistent with use of the term within the substance use field, recovery within mental health thus acquires more of an emphasis on advocacy. This sense of recovery is proposed as a fundamental challenge to the “mentalism” which advocates see as continuing to permeate health and human services and to influence the ways in which people with mental health conditions are treated both inside and outside of the mental health system.<sup>10</sup> Similar to institutional racism, sexism, and other forms of prejudice, mentalism involves a set of attitudes and associated behaviors that have the effect of confining a segment of the general population to second-class citizenship. In this case, the discrimination is based on the belief that people with mental health conditions are more like children than adults,

*... recovery [poses] a fundamental challenge to ... “mentalism”*

<sup>10</sup>Davidson, L. (2006). What happened to civil rights? *Psychiatric Rehabilitation Journal*, 30(1), 11-14.

<sup>11</sup>Chamberlin, J. (1984). Speaking for ourselves: An overview of the Ex-Psychiatric Inmates’ Movement. *Psychosocial Rehabilitation Journal*, 2, 56-63.

unable to make their own decisions, to function independently, or to take care of themselves. They thereby require the care and direction of well-intended others in order to meet their basic needs—whether this care and direction be provided in hospital settings, as earlier, or, as is now more common, through community-based services.

Within this historical context, recovery has come to be a powerful rallying cry and tool in the advocacy movement's efforts to counteract mentalism and its legacy in the lives of people with mental health conditions. It has been fueled both by the personal conviction of people in recovery and by over thirty-five years of clinical research findings which consistently have demonstrated a broad heterogeneity in outcome over time and across domains of functioning in serious mental health conditions. Research has shown that mental health conditions not only come and go over time and vary significantly in severity and duration, but that even when a person is actively experiencing psychosis, they most often affect only some of the person's abilities, leaving other abilities intact.

Rather than subsuming the entirety of the person, mental health conditions are better understood—even in their most severe form—as disabilities that co-exist with other areas of competence within the context of the person's life.<sup>12</sup> Just as we would not assume that someone with a visual, auditory, or mobility impairment was unable to take care of him or herself because he or she could not see, hear, or ambulate unassisted, we need not assume that a person's mental health condition renders him or her unable or incompetent to be in control of his or her life. As other people with disabilities may require Braille signs, visual indicators of doorbells or ringing telephones, or wheelchairs, people with mental health conditions may require similar social and environmental supports in order to function optimally in community settings. As we have just begun to learn to identify and offer such supports, this represents a very promising, and important, area for future growth and development in the field.

It is at this juncture that the civil rights movement in mental health meets up with the sense of recovery used in substance use in order to promote a vision of mental health recovery. This sense of recovery involves viewing mental illness as only one aspect of a person who also has assets, interests, aspirations, and the desire

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<sup>12</sup> Beginning with the World Health Organization's International Pilot Study of Schizophrenia launched in 1967, there have been a series of long-term, longitudinal studies conducted around the world that have produced a consistent picture of a broad heterogeneity in outcome for severe psychiatric disorders. With respect to schizophrenia, this line of research has documented partial to full recovery in between 45-65% of each sample. In this context, recovery has been defined narrowly as amelioration of symptoms and other deficits associated with the disorder and a return to a pre-existing healthy state. We now know that up to two thirds of people achieve even this narrowly-defined form of recovery from psychosis, with many others able to function independently despite continued symptoms. For more on this research, see Davidson, L., Harding, C.M. & Spaniol, L. (2005). *Recovery from severe mental illnesses: Research evidence and implications for practice. Volume 1*. Boston, MA: Center for Psychiatric Rehabilitation of Boston University.

and ability to continue to be in control of his or her own life. Paralleling in some ways substance use recovery, this sense of recovery involves the person's assuming increasing control over his or her condition while reclaiming responsibility for his or her life; a life that previously had been subsumed by the condition.

*Mental illness is only one aspect of a person who otherwise has assets, strengths, interests, aspirations, and the desire and ability to continue to be in control of his or her own life.*

In other respects, however, this sense of recovery differs from recovery in substance use. For example, being in recovery from substance use invariably involves some degree of abstinence; it requires a change in the person's condition from being controlled by substance use to substance use being under at least some degree of the person's control. While vulnerability to relapse remains a core element of substance use recovery, a person who continues to use in the context of a lack of awareness of addiction cannot be viewed as in recovery.

The same cannot be said, however, for mental health conditions. In this respect, mental health recovery borrows from the disability rights movement in arguing that a person can be in recovery even while his or her mental health condition may not change. A person with paraplegia does not have to regain his or her mobility in order to have a satisfying life in the community. Being in recovery similarly cannot require a cure or remission of one's mental health condition or a return to a pre-existing state of health. Rather, it involves a redefinition of one's condition as only one aspect of a multi-dimensional person who is capable of identifying, choosing, and pursuing personally meaningful aspirations despite continuing to suffer the effects and side effects of the condition.

With recovery in both substance use and mental health now defined, it becomes more evident why we have said that recovery is *what the person does*. Substance use treatment providers are well aware that they have not been able to make a person stop using alcohol or other drugs. In this sense, substance use recovery has always been in the hands of the person. What may be different about recovery-oriented care in the substance use field are the number of things practitioners can now do over time to increase a person's desire to choose abstinence through the use of motivational enhancement strategies. In mental health, however, the idea that recovery is what the person with the mental health condition does is a less commonly accepted notion. With the assumption that mental health conditions incapacitate the person in his or her entirety, more of the focus has been on what practitioners can do to and for the person to alleviate his or her symptoms and suffering and enhance his or her functioning.

It is important to note that defining recovery in mental health as what the person with the mental health condition does in no way diminishes the importance of professional competence or the role of mental health practitioners. What it does, instead, is to shift the responsibility for deriving maximum

*Defining recovery ... as what the person with the mental health condition does in no way diminishes the importance of professional competence or the role of mental health practitioners.*

benefit from health care from the educated and caring people who provide services to the person him or herself who will benefit from using them. Rather than devaluing professional knowledge and experience, this approach moves psychiatry much closer to other medical specialties in which it is the health care specialist's role to assess the person, diagnose his or her condition, educate the person about the costs and benefits of the most effective interventions available to treat his or her condition, and then provide the appropriate interventions. No matter how expert or experienced the practitioner, it is then ideally left up to the person and his or her loved ones to make decisions about his or her own care. It is not the practitioner's role or responsibility to make such health care decisions *for* the person.<sup>13</sup> The idea of recovery extends this model of care to mental health and substance use conditions as well.<sup>14</sup>



### ***From Recovery to Recovery-Oriented Care***

In suggesting how care for mental health and substance use conditions might come to resemble more closely other forms of medical care, we have arrived at the point where recovery—i.e., what the person with a mental health and/or substance

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<sup>13</sup>Emergency medicine provides another exception in cases in which the issue of informed consent/permission to treat is suspended temporarily in order to perform life-saving measures. Such situations certainly occur in mental health and substance use as well, in which practitioners must take action to protect an individual or the public in the event of emergency or crisis situations as narrowly defined by statutes (e.g., suicidality, homicidality, and grave disability). In these cases, practitioners have solid legal ground on which to stand in making decisions for the person (i.e., against his or her will). As in medicine, however, this transfer of authority can only be a temporary measure, in effect only for as long as an acute episode takes to resolve. In all other cases, the decision of a judge is required in the state of Connecticut in order to terminate or otherwise place limits on a person's autonomy through the appointment of a conservator of person or other means.

<sup>14</sup>We are aware that some people define the recovery model as being in opposition to, or as an alternative for, the traditional 'medical model'. We view this as a false dichotomy, however, and view the recovery model as highly consistent with good medical care, but as applied to behavioral health. While recovery-oriented care may differ from traditional medical care by virtue of its focus on strengths, recovery capital, and community resources, it otherwise remains consistent with the medical model in terms of the role of the practitioner.

use condition does—comes into contact with recovery-oriented care—i.e., what practitioners of mental health and substance use treatment and rehabilitation offer in support of the person’s recovery. As we have suggested above, our focus on the process of recovery as the unique journey of each person should not be taken to suggest that there is no longer integral roles for practitioners, services, and supports.

There is no less of a need for practitioners, services, and supports in mental health and substance use care than in other forms of medicine. When we suggest that someone who has been in an accident follow a graduated plan of convalescence and exercise in order to regain his or her physical functioning, for example, we do not thereby diminish the importance of the orthopedist’s role in assessing the impact of the trauma, setting the broken bones, and prescribing an exercise plan, which may then need to be implemented with the assistance of a physical therapist and the support of the person’s family.

We know that while broken bones may heal of their own accord—with or without detriment to the person’s functioning—they are more likely to heal completely with timely and effective care.

*... recovery can be substantially supported and facilitated by the assistance of competent and experienced practitioners.*

Similarly, while the person might eventually regain his or her functioning following an accident without a graduated exercise plan or physical therapy, he or she is more likely to do so in an expedient and uncomplicated fashion, and is less likely to suffer unexpected setbacks, with the guidance of competent and experienced practitioners. Based on these considerations, we reject both assertions, either that: 1) the person will

not benefit from professional intervention or 2) the orthopedist is responsible for the person’s recovery. Although it is unquestionably each person’s own recovery, this recovery can be substantially supported and facilitated by the assistance of competent and experienced practitioners. The fact that we find it necessary to make this point, perhaps repeatedly, derives mostly from the history of stigma, discrimination, and prejudice which have viewed people with mental health and substance use conditions as incapable rather than from any wish to diminish the role of practitioners.

What, then, is the most appropriate role for the health care practitioner in relation to recovery? Similar to the example above, what the person in recovery is most in need of is information about the nature of his or her difficulties, education about the range of effective interventions available to overcome or compensate for these difficulties, access to opportunities to utilize these interventions in regaining functioning, and supports required in order to be successful in doing so. Drawing from the orthopedic analogy, the person will need to exercise and resume use of those faculties most directly affected by his or her trauma. In the case of mental health and substance use conditions, these faculties include the person’s cognitive, social, and emotional life as well as his or her sense of self, personal and social identity, and belonging within the community. If a person with a broken leg does not

try to walk again, he or she will not regain the use of the leg that was broken. If a person with a mental health or substance use condition does not try to reclaim responsibility for his or her life, he or she will be unable to regain functioning. This fact poses a fundamental challenge to the provision of recovery-oriented care.

*... what the person in recovery is most in need of is information about the nature of his or her difficulties, education about the range of effective interventions available to overcome or compensate for these difficulties, access to opportunities to utilize these interventions in regaining functioning, and supports required in order to be successful in doing so.*

Recovery-oriented practitioners can create or enhance access for people to a variety of educational, vocational, social, recreational, and affiliational activities in the community. Like the proverbial horse that cannot be made to drink, however, they cannot make the decisions *for* the person as to which, if any, of these activities he or she will participate in and find enjoyable or meaningful. The challenge confronting recovery-oriented practitioners may not, in this way, be unique. Cardiologists, for example, cannot make their patients stick to a heart-healthy diet any more than oncologists can keep some of their patients from smoking. What complicates the picture in the case of mental health and substance use conditions is the perception that the person's decision-making capacity may itself be among the faculties most directly affected by the condition.

As both mental health and substance use conditions are currently viewed primarily to be diseases of the brain, such a concern is understandable. In and of itself, however, this concern cannot be taken to lead inevitably to the conclusion that other, well-intentioned, people must therefore step in and make decisions for the person. In certain limited circumstances practitioners are legally authorized, if not also obligated, to do so. These circumstances include serious imminent risk of harm to the person and/or others (i.e., homicidality, suicidality, grave disability). In most other circumstances, however, practitioners are left in the difficult position of having to honor—if not actively support—the person's decisions, even in cases in which the practitioner is persuaded that it is the condition, rather than the person's best judgment, which is driving the decision-making process.

In the absence of conservatorship, guardianship, or other legal mechanisms, practitioners can educate, inform, discuss, debate, and attempt to persuade the person to embrace some options rather than others. If the person is ever to regain his or her functioning, however, in the end she or he will have to be accorded, in Deegan's terms, the "dignity of risk" and the "right to failure." As is true in most components of recovery-oriented care, it requires concerted effort and reflection—and perhaps supervision—as well as compassion, for practitioners to continue to view and treat

the person as sitting in the driver's seat of his or her own life when the person makes decisions that the practitioner views as detrimental. Given the damage that these disorders can do to the person's self-esteem and confidence, though, it is difficult to imagine how recovery can be achieved through other means.<sup>15</sup>

As suggested in the definition above, recovery-oriented care takes as its primary aim offering people with mental health and/or substance use conditions a range of effective and culturally-responsive interventions from which they may choose those services and supports which they find useful in promoting or protecting their own recovery. As further defined in Commissioner's Policy #83 on Recovery:

*A recovery-oriented system of care identifies and builds upon each person's assets, strengths, and areas of health and competence to support the person in achieving a sense of mastery over mental health and/or substance use conditions while regaining his or her life and a meaningful constructive sense of membership in the broader community.*

While the goal of recovery-oriented care may appear, in this way, to be relatively clear and straightforward, the ways in which care can be used to promote recovery are neither so clear nor so straightforward—neither, unfortunately, are the ways in which care, as currently configured, may impede or undermine recovery. The following guidelines are offered as a beginning roadmap of this territory, bringing together what we think we know at this point about how care can best promote and sustain recovery, and how care may need to be transformed to no longer impede it.



### ***Recovery-Oriented Care as an Integrating Framework***

These guidelines are drawn from over six years of conversations with practitioners, people in recovery, families, program managers, and system leaders, and are informed by the current professional literature on recovery and recovery-oriented practice. In addition, one of the major advances of this second edition of the Guidelines is that they now also benefit from many years of concerted efforts by DMHAS leadership in a variety of initiatives in the areas of cultural competence, integrated care for persons with co-occurring disorders, gender-responsive and

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<sup>15</sup>Deegan, P.E. (1992). The Independent Living Movement and people with psychiatric disabilities: Taking back control over our own lives. *Psychosocial Rehabilitation Journal*, 15, 3-19.

trauma-informed care, preferred practices, health promotion, and the integration of mental health and primary health care. Program guidelines and standards developed within each of these initiatives have been integrated within this edition under the overarching rubric of recovery-oriented care, as we describe next. These materials, along with a number of related tools, will be issued as addenda to this edition.

These guidelines focus primarily on the concrete work of practitioners and agencies so as to provide practical direction to individuals and collectives committed to implementing recovery-oriented care. We recognize, however, that many of the practices described require a broader commitment to significant and on-going administrative restructuring; activities in which DMHAS and its partners remain engaged. We offer these guidelines as only one piece of a much larger whole, but as an important step forward in the overall process of system transformation.

Prior to turning to the guidelines themselves, it will be important for us to clarify how the recovery-oriented care initiative relates to the other DMHAS-sponsored initiatives mentioned above, both past and present. This is a question often raised by concerned administrators who worry that staff are being inundated with unrelated—and at times even contradictory—messages, materials, and mandates. A common question, for example, concerns how the recovery initiative relates to the recent emphasis on “evidence-based” practices. Is there an evidence base for recovery or recovery-oriented care? Another example, alluded to above, is provided by the extensive attention DMHAS has paid over the preceding decade to developing a culturally competent workforce. How does recovery-oriented practice relate to issues of health care disparities and cultural competence? Similar questions have been raised in relation to co-occurring disorders, gender-sensitive and trauma-informed treatment, and health promotion and wellness. In this section we explain how recovery and recovery-oriented care offer useful concepts for integrating all of these diverse initiatives into one coherent framework based on each individual’s life and family context.

In order to describe how the concepts of recovery and recovery-oriented care can be used as integrating principles we suggest that it might be useful to refer to the

**Figure 2. Humpty Dumpty**

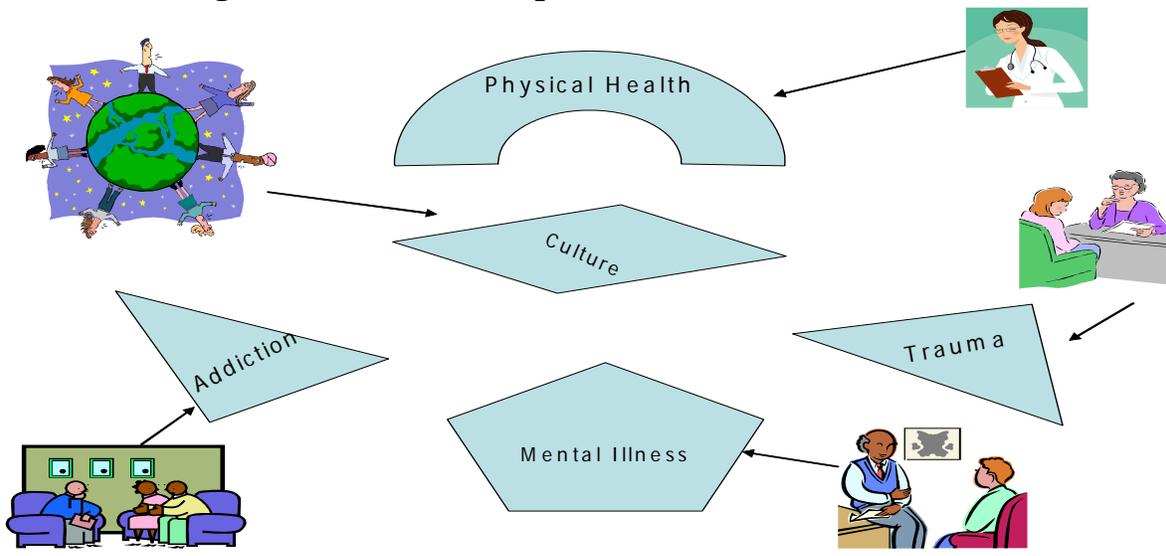


**Humpty Dumpty sat on a wall,  
Humpty Dumpty had a great fall.  
All the King's horses and all the  
King's men  
couldn't put Humpty Dumpty  
together again.**

“Humpty Dumpty Principle.”<sup>16</sup> For readers unfamiliar with this nursery rhyme, it is reproduced above. In brief, the Humpty Dumpty principle suggests that when what appear to be separate and distinct notions need to be brought together it often can be helpful to consider their common origins. Rather than trying to piece them back together after the fact, this approach suggests that in trying to integrate various initiatives we start first by returning to their shared point of departure. From the point of view of recovery, *all of these initiatives begin with the life context of the person.* As described above, recovery refers to what the person experiences and does in relation to a mental health and/or substance use condition. We suggest that this focus provides an extremely useful framework for integration.

By appealing to this principle, we are not suggesting, of course, that agencies or practitioners have pushed Humpty Dumpty off of the wall. It is an historical artifact that we all have inherited that the American health care system has evolved toward ever increasing specialization, resulting in the splintering off of the various aspects of any individual’s life into distinct and separate ‘silos’. We depict the end result of this process of specialization in the following series of images. As seen in Figure 3 below, from the perspective of treatment and rehabilitation providers the various initiatives related to culture, co-occurring disorders, trauma, and health promotion seem to be coming from different directions and may even involve different people. Substance use conditions traditionally have been treated by addiction counselors, for example, while mental health conditions have been treated by mental health clinicians. In the past, physical health was the responsibility of primary care staff, while cultural issues were viewed largely as falling outside of the purview of health care altogether.

**Figure 3. From the Perspective of the Service Provider**

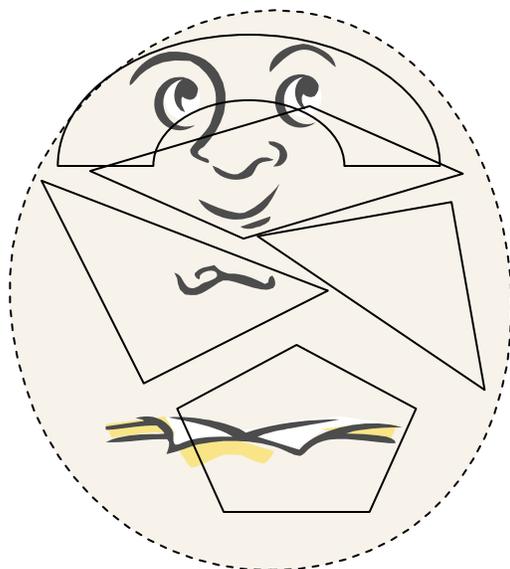


<sup>16</sup> Please forgive the use of nursery rhymes, as three of the authors currently have preschool children. They do, however, have a point, and this particular point was also made in the Winter, 2003 issue of *Arizona Health Futures*, where it was described in terms of “The Humpty Dumpty Syndrome.”

The Humpty Dumpty principle reminds us, however, that the situation depicted in Figure 3 is the result of an artificial process of division and extraction; a shattering into numerous pieces of what was originally a coherent and organic whole. These represent pieces that, as in the nursery rhyme, once they have been splintered apart are extremely difficult, if not impossible, to put back together again. Even our best effort to do so, depicted in Figure 4 below, still remains a poor approximation, a vestige, of the original, with much having been lost through the process of splitting off different parts of the person. That is why it is necessary, within a recovery-oriented framework, to return to the original and organic whole of the person and his or her ongoing life from which these pieces were extracted.

*It is necessary, within a recovery-oriented framework, to return to the original and organic whole of the person and his or her ongoing life.*

**Figure 4: Attempted Re-Integration**



We therefore do not begin with the care provider's perspective. Rather, we take a step backward first to prior to Humpty Dumpty's having fallen off the wall. From this perspective, from the perspective of the person, these various issues are not experienced nearly as separate as they are from the perspective of the various providers. When we take a step back to consider these issues from the person's own perspective we end up with questions like: Is my fatigue due to depression, to an iron deficiency, or perhaps to both? Is my edginess due to cravings for cocaine, to a generalized anxiety disorder, or to my fearful anticipation of a needed physical exam in

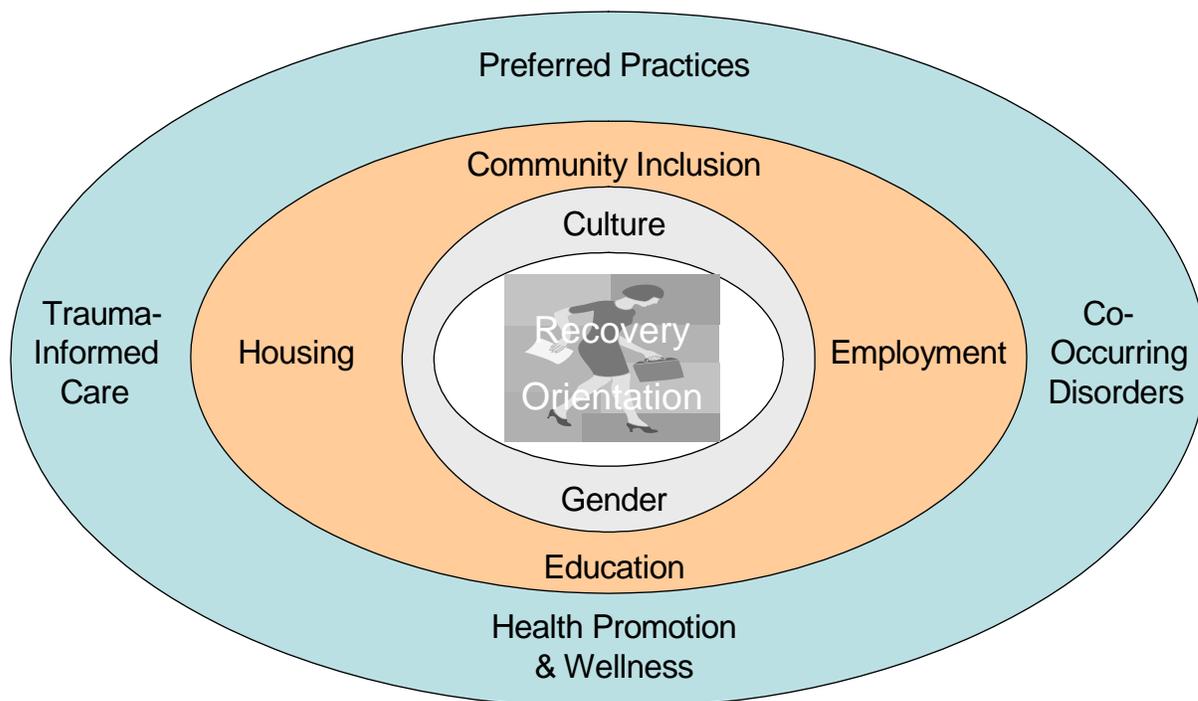
which I will be touched by a stranger; an experience which in the past has brought up memories of previous sexual abuse? From the person's perspective, all of these issues are inter-twined and are not so easily distinguished from one another.

We are aided in our efforts to restore these various pieces to their original whole by the fact, emphasized above, that the concept of recovery refers to what the person—rather than to what the care provider—does. Recovery, in this way, is already conceptualized from the perspective of the person. Shifting to a recovery orientation has already required us to become grounded in the person's own experiences. As a result, it lays a foundation for the re-integration of these various

issues; issues that are not experienced as separate and distinct in everyday life. This is why DMHAS suggests that its various initiatives come together through the vehicle of the Individualized Recovery Plan (see Section C). It is at the level of the individual or family, through this particular lens, that all of the various concerns described above come into play.

While we believe firmly in the importance of integration taking place at the level of the individual recovery plan, we also recognize the need to *“connect the dots”* of these initiatives at the level of the system as a whole. A conceptual framework for this level of integration is offered in Figures 5 and 6.<sup>17</sup> Figure 5 places the individual and/or family and the recovery orientation of the system as a whole in the center of the diagram and then builds concentric ovals around this core. Culture and gender are placed in the first oval because they are central to who a person is and what he or she will need and prefer in relation to the health care system. In the next oval we have put community inclusion, housing, employment, and education as these are the aims of recovery supports, being the cornerstones of the life in the community that people are pursuing. In the last oval we find the initiatives related to treatment, rehabilitation, and health promotion with the corresponding values of their being trauma-informed, evidence-based, and integrated across mental health, substance use, and primary care; interventions that also are offered in support of the person’s life on the firm foundation provided by recovery supports and the broader community.

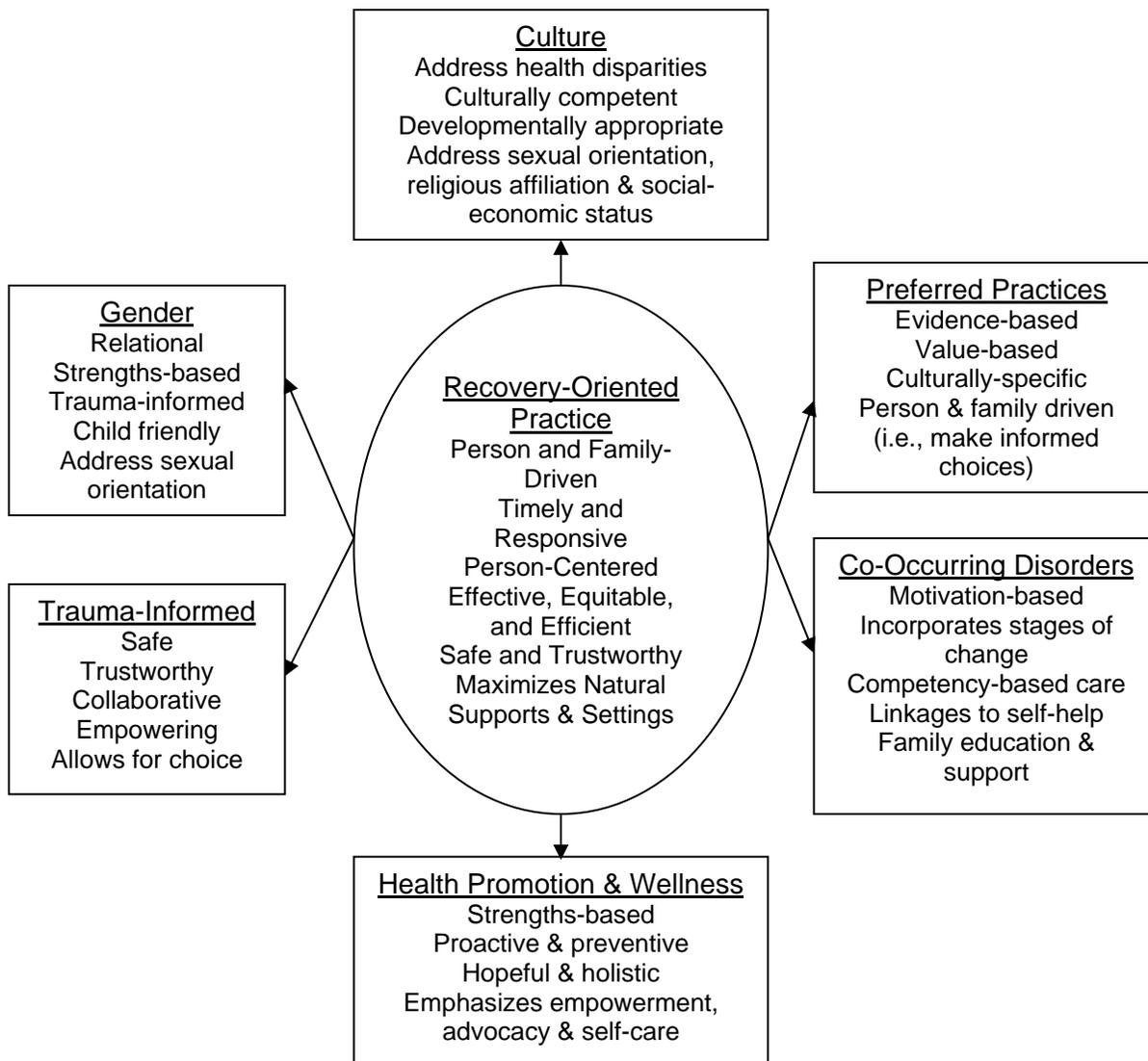
**Figure 5. Integration at the Level of the System of Care**



<sup>17</sup> We thank Julienne Giard for her suggestions and contributions of these figures.

Some of the specific ways in which these various dots are connected are described below. The incorporation of these initiatives into the overarching recovery vision is the major advance represented by this second edition of the Guidelines. Figure 6 below highlights those characteristics of the approaches to care developed by each initiative as they relate to recovery-oriented practice. While these domains and the elements within each are by no means exhaustive, they represent areas of activity in which DMHAS has made significant investments over the preceding decade. In terms of the Humpty Dumpty Principle, these address important components of the lives of the people we serve and need to be integrated within the overarching recovery framework. The guidelines which follow reflect our best effort to do so at this time. The following materials are a work in progress in this regard, and we solicit and welcome input and feedback from all stakeholders related to ways in which these guidelines may be improved, enhanced, and expanded.

**Figure 6. Recovery-Oriented Dimensions of Key DMHAS Initiatives**



## Health Care Disparities and Cultural Competence

Throughout the U.S. health care system, cultural disparities in both health and health care are pervasive and well documented.<sup>18</sup> Numerous federal reports and studies have outlined significant mental health and substance use inequities in access, service quality, and treatment outcomes. As articulated in Commissioner’s Policy Statement #76 on cultural competence, DMHAS is committed to developing and instituting an ongoing process for identifying and eliminating health disparities. The primary mechanism for eliminating such disparities is through the provision of culturally responsive and culturally competent care. In addition to ethnicity and race, cultural competence requires care to be responsive to gender and possible trauma history (see below), sexual orientation, religious affiliation, and social-economic status. Attending to these issues is a crucial aspect of promoting the recovery of all those served. Strategies for doing so are detailed in the *DMHAS Multicultural Practice Standards* and are integrated throughout these guidelines.

*DMHAS is committed to developing and instituting an ongoing process for identifying and eliminating health disparities. The primary mechanism for eliminating such disparities is through the provision of culturally responsive and culturally competent care.*

## Gender and Sexual Orientation

In addition to race and ethnicity, gender and sexual identity and/or orientation play crucial roles in health care and recovery. To address the disparities associated with these issues, care incorporates an understanding of the importance of gender and sexual orientation in determining how mental health and substance use conditions arise, are experienced and expressed, how people seek care and from whom, and what each individual’s needs, values, and preferences may be in relation to the care they will find acceptable and responsive to their concerns. Practice recommendations developed by the DMHAS Women’s Services Practice Improvement Collaborative and Preferred Practices Sexual and Gender Minorities Workgroup are reinforced throughout this edition of the Guidelines.

## Trauma

A related and extremely important, if under-appreciated, issue is that of the high prevalence of trauma among individuals with mental health and substance use conditions. Whether the trauma occurred prior to onset of the health condition(s) or during the course of the condition(s) and the person’s treatment within the health care

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<sup>18</sup>Department of Health and Human Services (2001). *Mental health: Culture, race, and ethnicity—A supplement to Mental health: A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General, Substance Abuse and Mental Health Services Administration.

system, practitioners need to be attentive to the impact of the trauma and tailor the care they offer to the person's unique history.<sup>19</sup> This is particularly true in the case of intrusive interventions such as restraint and seclusion, but is equally relevant in the case of physical health care needs (e.g., physical exams, mammography), safety concerns, and the development of trusting and helpful relationships. Guidelines developed by the DMHAS Trauma Initiative addressing these issues are integrated throughout this document.

## Co-Occurring Disorders

It is now recognized that more than one mental health or substance use condition may occur at any given time in one person's life; in fact, the situation of co-occurring disorders appears to be just as much the rule as the exception. For individuals with serious mental illnesses, for example, estimates of co-occurring

*...practitioners [need] to be prepared and competent to attend to and know how to respond both to mental health and substance use conditions in the populations they serve.*

substance use conditions are as high as 65%, while for persons with substance use conditions estimates of co-occurring mental illnesses are only slightly lower. It is safe to say that if a person has one of these types of disorders (mental health or substance use condition), his or her chances of having the other type is about 50/50 or one in two.<sup>20</sup> With this recognition comes the need for practitioners to be prepared to attend to and know how to respond both to mental health and substance use conditions in the populations they serve.

While not every program will offer specialty services for both conditions, separately or in combination, every program needs to have the capacity to identify the presence of either or both conditions and to know how to access and obtain appropriate care for the person and his or her complex needs. This expectation has been spelled out in detail in Commissioner's Policy Statement #84 on Serving People with Co-Occurring Mental Health and Substance Use Disorders, and is reflected throughout the following guidelines. In addition, the reader is referred to two key DMHAS documents, *Co-Occurring Enhanced Program Guidelines* and *Workforce Competencies for Providing Services to People with Co-Occurring Disorders* for additional details. [all of which may be found at [www.dmhas.state.ct.us](http://www.dmhas.state.ct.us)]

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<sup>19</sup>Markoff, L.S., Reed, B.G., Fallot, R.D., Elliott, D.E. & Bjelajac, P. (2005). Implementing trauma-informed alcohol and other drug and mental health services for women: Lessons learned in a multi-site demonstration project. *American Journal of Orthopsychiatry*, 75(4), 525-539.

<sup>20</sup>Drake, R.E., Mueser, K.T., Brunette, M.F., et al. (2004). A review of treatments for people with severe mental illnesses and co-occurring substance use disorders. *Psychiatric Rehabilitation Journal*, 27(4), 360-374.

## Preferred Practices

Increasing emphasis has been placed on the use of evidence-based practices in health care over the previous decade. Ordinarily, this is understood to refer to practices that have been established by the scientific method to be beneficial for a particular condition or combination of conditions. While different levels of evidence are accepted within the scientific tradition for different purposes, most understandings of evidence hold the randomized experimental trial to be the “gold standard” for scientific evaluation. Unfortunately, very few mental health or substance use practices have been evaluated in such a rigorous way and even fewer practices have been evaluated with diverse populations having complex needs. In such tightly controlled studies, many people served by the DMHAS-funded system of care would be excluded due to co-occurring disorders, linguistic or cultural needs, social-economic status and living situation, or other considerations. It therefore would be both impossible and inappropriate for DMHAS to adopt a narrow vision of the nature of “evidence” and limit the array of services and supports offered to those which have been evaluated through rigorous experimental trials.

It remains important nonetheless that the services and supports being offered are the best available for the persons being served at any given time. Quality in this sense can be determined using different forms and levels of evidence and can also be based on recovery-oriented values such as self-determination and choice or on an intervention’s effectiveness in decreasing health disparities based on its being culturally specific or competent (e.g., Proyecto Nueva Vida). Many of these practices are in the realm of “promising” rather than “evidence-based,” and DMHAS remains committed to collecting evidence on their effectiveness in generating positive outcomes as part of its ongoing quality improvement function. In the interim, guidelines are included below addressing the need for services and supports to be as effective, equitable, and efficient as possible.

*Quality...can be determined using different forms and levels of evidence and ... be based on recovery-oriented values such as self-determination and choice or on an intervention’s effectiveness in decreasing health disparities based on its being culturally specific or competent.*

## Health Promotion and Wellness

Most recent has been recognition that adults with serious mental health and/or substance use conditions will lose on the average one third of their expected life span due not to these conditions themselves but to serious medical problems and a lack of access to effective primary health care. This loss of 25 years of life to untreated or poorly treated medical conditions represents a public health crisis and calls for immediate and substantive action. In addition, the promotion of wellness through self-care and early intervention, both mental and physical, is an important component

of recovery-oriented care. Research has consistently shown that the earlier an illness or condition can be identified and addressed, the less the damage caused and the better the outcome. This principle has even been extended back to prior to the onset of a condition or the high risk behaviors which might lead to a condition, such as sharing hypodermic needles or having unprotected sex may lead to exposure to HIV. In the substance use field, there has been a considerable body of work carried out in the effort to prevent the onset of abuse and addiction, both in primary and secondary forms.<sup>21</sup> While strategies have yet to be shown to be effective in preventing most mental health conditions, progress has been made in detecting the early warning signs of mental illness and intervening early in the course of illness in order to promote recovery and prevent disability. Recovery-oriented systems invest significantly in these approaches so as to lessen the burden of disease and disability on the individuals served, the service system itself, and society at large.

*The promotion of wellness through self-care and early intervention, both mental and physical, is an important component of recovery-oriented care.*

Health promotion may be adopted as a broader term which also encompasses strategies and interventions for promoting both physical and mental health in individuals and families regardless of their health status. Encouraging and supporting an adult with a serious mental illness who takes anti-psychotic medication to maintain a healthy diet and to exercise regularly so as to avoid the development of Type II Diabetes is one example of health promotion. Strengthening families and assisting parents to enhance their parenting skills to lessen the likelihood that their children will use alcohol or other drugs is another example of health promotion. In general, promoting resilience and recovery involves enhancing protective factors and fostering wellness both prior to *and* following the onset of illness. Being strengths and wellness based, it involves a proactive process of helping individuals, families and communities to develop the resources and capabilities needed to maintain healthy lifestyles.

In this edition of the Guidelines, we include initial steps taken toward promoting health and wellness across the lifespan for citizens of Connecticut with or without mental health and substance use conditions. We also have integrated the initial steps taken by the DMHAS Preventive Health Initiative to incorporate medical issues and primary care within the scope of concern of mental health and substance use practitioners. This represents an area of tremendous need and will likely require much effort in the near future for significant progress to be made. Should there be a third edition of the Guidelines, we anticipate these areas to play even greater roles.

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<sup>21</sup> We thank Diane Harnad and the DMHAS Prevention Division for their contributions regarding prevention and health promotion.

# Practice Guideline Domains for Recovery-Oriented Care

- A. Recovery-oriented care is consumer and family-driven
- B. Recovery-oriented care is timely and responsive
- C. Recovery-oriented care is person-centered
- D. Recovery-oriented care is effective, equitable, and efficient
- E. Recovery-oriented care is safe and trustworthy
- F. Recovery-oriented care maximizes use of natural supports and settings

## A. Recovery-Oriented Care is Consumer and Family-Driven<sup>22</sup>

An essential characteristic of recovery-oriented care is the primacy it places on the participation of people in recovery and their loved ones in all aspects and phases of the care delivery process. Beginning with the Federal Rehabilitation Act of 1973 and reaffirmed in 1990 in Public Law 99-660, federal and state governments have mandated the involvement of people with mental health and substance use conditions in all components of designing and implementing systems of community-based care. This mandate has been confirmed consistently in numerous federal and state statutes and regulations issued since, and forms the foundation of CT DMHAS' Recovery and System Transformation Initiative.

*Recovery-oriented care requires that people in recovery be involved in all aspects and phases of the care delivery process, from the initial framing of questions or problems to be addressed and design of the needs assessments to be conducted, to the delivery and ongoing monitoring of care, to the design and development of new services and supports.*

For the involvement of people in recovery and their families to be meaningful and substantive, it must go well beyond their signing off on provider-driven treatment plans or endorsing the replication of practitioner-driven models of care. Recovery-oriented care requires that people in recovery be involved in all aspects and phases of the care delivery process, from the initial framing of questions or problems to be addressed and design of the needs assessments to be conducted, to the delivery and ongoing monitoring of care, to the design and development of new services and supports. It is in this way that consumer and family-driven care is distinguished from person-centered care (discussed in Section 3 below). Consumer and family-driven refers to the involvement of people in recovery and family members in the process of designing, monitoring, and changing systems of care; it is a systemic principle that refers to the ways in which care as a whole is reformed. Person-centered care, on the other hand, refers to the care provided to each individual being based on his or her unique needs, values, and preferences. In this sense, person-centered care unfolds at the level of each person's individualized recovery plan. While perhaps an essential element of a consumer and family-driven system, ***person-centered care is not by itself sufficient to making care recovery-oriented or responsive. Changes are also required at the system level to make sure that the right types of services and supports are available to be included in individualized recovery plans.***

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<sup>22</sup> By "family" we include all of those persons who an individual identifies as being part of his or her family, i.e., his or her immediate, intimate social network, regardless of biological ties.

## **You will know that you are working toward providing consumer and family-driven care when:**

### **At the System/Agency Level**

- A.1.** People in recovery are involved in every aspect of the service delivery system from evaluation, development, and provision of services to staff training. People in recovery comprise a significant proportion of representatives to an agency's board of directors, advisory board, or other steering committees and work groups. Persons in recovery are provided orientation to their committee role by the chair, and actively contribute to the group process. Their involvement in these groups is reflected in meeting minutes and in decision-making processes.
- A.2.** The input of people in recovery is valued, as embodied in the fact that the agency reimburses people for the time they spend participating in service planning, implementation, or evaluation activities, providing peer support and mentoring, and/or providing educational and training sessions. Where system involvement is a mutually negotiated volunteer activity, people in recovery are reimbursed for out of pocket expenses that may be associated with their participation.
- A.3.** Initial program orientation is supplemented by ongoing availability of information and agency updates to people in recovery and their loved ones. This information is provided in a variety of formats (e.g., information tables, service directories, educational programs, newsletters, web postings, etc.) to enable people in recovery and their loved ones to make informed choices about treatments, rehabilitation, and supports and to provide meaningful input about program and agency performance. Feedback is regularly solicited from people in recovery and their loved ones regarding their informational needs.
- A.4.** Policies are established and maintained that allow people in recovery maximum opportunity for informed choice and decision-making in their own care. For example, people in recovery are able to a) access their records with minimal barriers, b) incorporate psychiatric advance directives in their recovery and crisis plans, c) secure the services of local or state advocacy services as necessary, d) request transfer to an alternative provider within agency guidelines, and e) participate actively in agency planning activities. These policies and procedures are highlighted on admission to an agency and are routinely publicized throughout the agency through newsletters, educational postings, Empowerment Councils, etc.

This process is particularly crucial within services such as “money management” in which the line between providing a service and infringing on a person’s rights can easily be blurred in the absence of clear programmatic guidelines and safeguards.

- A.5.** Measures of satisfaction with services and supports are collected routinely and in a timely fashion from people in recovery and their loved ones. These data are used in strategic planning and quality improvement initiatives to evaluate and make meaningful changes in programs, policies, procedures, and interventions. Feedback mechanisms are in place to inform people in recovery and their loved ones of changes and actions taken based on their input. When possible, these data are collected by people in recovery and/or their loved ones, so as to elicit more frank responses from people who may be reluctant to share criticisms directly with practitioners.
- A.6.** Formal grievance procedures are established and made readily available to people in recovery and their loved ones to address their dissatisfactions with services. People in recovery and their loved ones are fully informed about these procedures on a regular basis, and the frequency and focus of grievances are tracked to inform agency or program quality improvement processes. Finally, safeguards are in place to ensure there is no retribution for using the grievance process.
- A.7.** Administration ensures ethical practice through clinical supervision and pro-active human resource oversight. This oversight prohibits the use of coercive practices and holds all staff accountable for affording people maximum choice and decision-making in their own care.
- A.8.** Assertive efforts are made to recruit people in recovery for a variety of staff positions for which they are qualified. These include positions for which their personal experience of recovery make them uniquely qualified (e.g., peer support), as well as positions for which they are qualified by virtue of licensure (e.g., nursing, psychiatry) or other training or work experience (clerical, administrative, medical records, etc.). Assertive efforts include establishing mentoring programs for employees in recovery so they can advance in their skills and attain the necessary credentialing that will allow them to occupy a more diverse range of service or administrative positions.
- A.9.** Active recruitment of culturally diverse people in recovery for existing staff positions is coupled with ongoing support for the development of a range of peer-operated services that function independent of, but in collaboration with, professional agencies. This will help to ensure that

the recovery community's role is supported, while avoiding co-opting by transforming it into an adjunct service provider. As one example, recovery community centers operated by people in recovery—which are neither treatment centers nor social clubs—offer a valuable resource at the level of the local community. They are places where people who are interested in learning about recovery, how to access available services and supports, and local activities can meet with other non-professionals to learn about recovery first-hand and to find understanding and resourceful role models to talk to.

Agencies can demonstrate their support for peer-operated services by offering material and consultative support to emerging programs. For example, technical assistance or mentoring regarding business management, fiduciary support and/or attainment of 501(c)3 status, human resource practices, etc., can greatly facilitate the establishment and long-term viability of peer-operated services. Care should be taken to ensure capacity-building in peer-operated programs over time.

- A.10.** Self-disclosure by employed persons in recovery is respected as a personal decision and is not prohibited by agency policy or practice. Supervision is available to discuss the complex issues which can arise with self-disclosure.
- A.11.** Rather than being limited to agency functions (e.g., length of hospital stays, readmission rates), process and outcomes evaluation is a continuous process with expectations for successful outcomes being drawn from a broad range of quality of life dimensions (e.g., in areas such as employment, social relationships, community membership, etc.)<sup>23</sup>. ***Maintenance of clinical stability alone is not considered an outcome, as recovery involves more than the absence of symptoms.***
- A.12.** Statistics on outcomes and satisfaction are made public so that individuals can make informed decisions about agencies and services that are effective for people who have similar needs and interests.
- A.13.** People in recovery are routinely invited to share their stories with current service recipients and/or to provide training to staff.
- A.14.** The agency offers to host regional and/or state events and advocacy activities for people in recovery and their loved ones, e.g., meetings of 12-step fellowships, Connecticut Community for Addiction Recovery, Advocacy Unlimited, NAMI CT, and Focus on Recovery-United.

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<sup>23</sup>Osher, T. & Osher, D. (2001). The paradigm shift to true collaboration with families. *The Journal of Child and Family Studies*, 10(3), 47-60.

**A.15.** In all phases of the care delivery process, agencies strive to achieve full transparency as it relates to informing and involving individuals in decisions that impact their care. For example, initial placement decisions across levels of care are made in collaboration with persons served and place an emphasis on honoring the person's expressed preferences. Discussions regarding placement include adequate information to ensure informed consent, but also more detailed material on the person's rights and responsibilities within each program.

#### At the Practitioner/Person in Recovery Level

**A.16.** Each person receiving care is provided with an initial orientation to agency practices regarding their rights, complaint procedures, treatment options for both mental health and substance use conditions, advance directives, access to their records, advocacy organizations (e.g., PAMI, Human Rights Commission), rehabilitation and community resources, and spiritual/chaplaincy services. Contact information on program staff and agency leaders is made available. Provision of orientation is documented in the person's health record.

**A.17.** Staff appreciate that many people in recovery may not, at first, share the understanding that they are key experts on the management of their own condition. Persons who have come to depend upon services and professionals to alleviate their distress may neither believe themselves capable of being an expert nor recognize that they are entitled to occupy such a role. Therefore, staff encourage individuals to exercise their responsibility and make meaningful contributions to their own care and to the system as a whole. For example, individuals are encouraged to become involved in local and state advocacy as a means of developing their confidence and skills in self-determination and collective action, agency efforts to enhance the participation of service users are widely publicized to the recovery community, and general education is offered regarding the necessity of active service-user involvement to achieve recovery outcomes. While people are to be encouraged to become involved at all levels of the system, not everyone will want to participate beyond the primary level of involvement, i.e., their personal recovery plan. As in other areas of choice and self-determination, this too is respected as a valid option.

**A.18.** Care planning is based on a shared decision making model in which persons in recovery and their loved ones view themselves as experts in determining their own needs, values, and preferences in relation to treatment, rehabilitation, and recovery supports. They seek information

about their concerns, review their options, ask questions about issues relevant to them, and make informed choices about their care. To support them in the process, decisional aids and other tools are made available to them so that their choices can be fully informed. As they progress in their own recovery, persons in recovery then offer feedback to practitioners about what they have learned about the opportunities and supports made available to them, the barriers to recovery they have encountered and overcome, and the ways in which practitioners' efforts have helped and hindered their own.

### **Example of how this might look in practice:**

Staff of a hospital had been through training on recovery-oriented care in which the trainer had stressed the importance of including people in recovery and their loved ones on advisory councils, committees, and other workgroups. They were at first perplexed, however, and could not think of ways to include the people on their inpatient units in the work of the hospital. For people to require inpatient care at this point in time they either have to be acutely or severely disabled by their illness. How, in this state, could they be included in the management of the hospital?

As they were discussing this dilemma, it occurred to one of the staff that perhaps the principle of participation could be applied even at this earliest stage of the process. Rather than the staff trying to think of ways to include patients in the management of the hospital, they could ask people how they might like to be included and what ideas they had about their involvement. This strategy paid off almost immediately when, after asking a group of patients how they might like to be involved, one person asked the staff leader what kinds of groups the hospital had that they could join. The staff member began to describe some of the hospital's existing management structures and when she came to the quality improvement initiative, another person asked her what kinds of things this group did. The staff member used the example of medication errors and ways to reduce them as an example of an important quality improvement initiative currently underway. This example piqued the patients' interest and they quickly turned the conversation to beginning to suggest different strategies for reducing medication errors.

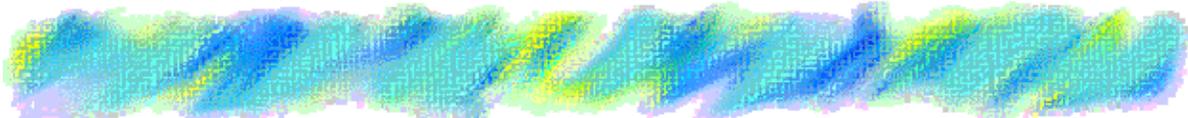
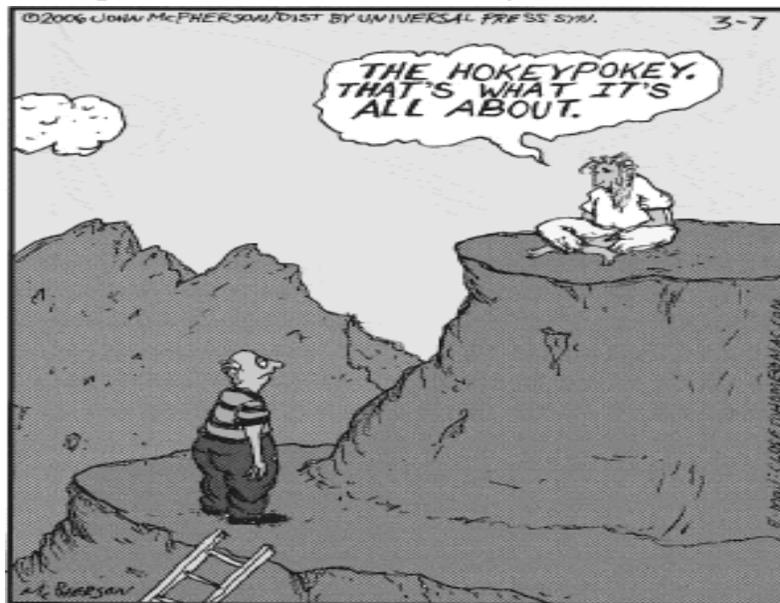
As a result of this discussion, patients were soon invited to brainstorm with the performance improvement team of the hospital about ways to reduce medication errors. The preferred strategy suggested by the patient representatives was for the nursing staff to ask each person to which she or he was about to administer a medication if, in fact, this was the person's correct medication(s). Not only would such a strategy provide an additional safeguard to patients taking medications given in error, but it also better prepared people to manage their own medications after discharge. This strategy was accepted by the performance improvement team and led

to a decrease in medication errors—and this prior to the time when JCAHO adopted its own policy of reviewing interventions with patients prior to administration.

### **What you will hear from people in recovery when you are working toward consumer and family-driven care:**

- *You know, at first I thought, “What do I know or what could I possibly say at this meeting?” But then, I could tell that what I had to say made a difference. People were really listening to me. I finally got a place at the table!*
- *I knew I was in recovery when I could help somebody else that was in the same awful place I used to be. But I think about where I am today: healthy, and drug free, and being a real Grandma. And getting back to work as a peer provider makes me feel good; makes me understand I can do this. I can really do this. And if I can do this, anybody can. Folks get hope when they see me.*
- *I don’t have to hide who I am – even the part of me that isn’t well. Because it’s that part of me and all the things I’ve experienced as a client here – good and bad – that gives me ideas for how things could change.*
- *I just didn’t think my program was a good fit for me. I was sticking it out, but lots of other folks stopped showing up. But then, somebody came in and we had a great talk about what was working and what wasn’t in the program. And some changes actually got made. Things are a lot better now. The group is packed every week!*

### **The Importance of Not Overlooking the (not so) Obvious**



## B. Recovery-Oriented Care is Timely and Responsive

The 1999 U.S. Surgeon General's *Report on Mental Health*<sup>24</sup> suggested that for every one person who seeks specialty mental health care for a diagnosable mental health condition, there remain two individuals, with similar conditions, who will neither gain access to nor receive such care. This report was followed by a supplement on culture, race, and ethnicity, which further identified lack of access to care as an even more formidable obstacle to recovery among people of color.<sup>25</sup> While this situation may seem dire, the proportion of people who access and receive care to those who are in need of such care is even worse in the case of substance use conditions, with approximately one out of seven people actually receiving active substance use treatment. And the story does not end with access. Once they access care, many people with mental health and substance use conditions do not stay in treatment or rehabilitation long enough to benefit from the care offered, with as many as 50% of people not returning after an initial intake visit. These facts clearly warrant the attention of the health care system to enhancing access, engagement, retention, and outcomes through a focus on increasing the timeliness and responsiveness of care while at the same acting to reduce stigma, discrimination, and other barriers.

As we noted in the introduction, it is optimal to foster wellness, enhance protective factors, and promote healthy living prior to the onset of mental health and substance use conditions. Given the current state of our science and society, this is not always possible, of course; nor perhaps will it ever be possible to prevent all mental health and substance use conditions. In the case of those individuals who are at high risk for or who do develop a condition, a first crucial issue therefore is that of access.

*...it is optimal to foster wellness, enhance protective factors, and promote healthy living prior to the onset of mental health and substance use conditions.*

***Access to care*** involves facilitating swift and uncomplicated entry into care, and can be increased through a variety of means. These include: 1) conducting outreach to persons who may not otherwise receive information about services or who may avoid institutional settings where services are provided; 2) establishing numerous points of entry into a wide range of treatment, rehabilitative, social, and other support services. For example, a public health nurse working with a homeless outreach team facilitates a person's entry into health care, a clinician might help the person gain access to vocational services and entitlement income support, and, with

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<sup>24</sup>U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

<sup>25</sup>U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

the person's permission, all of these service providers meet with or talk to each other regularly to coordinate their work with the person; and 3) ensuring that information about services is linguistically appropriate and made readily available and understandable to people through public education and information, liaison with other agencies, links to self-help groups, and other venues.

Access to care also involves removing barriers to receiving care, including bureaucratic red tape, intimidating or unwelcoming physical environments and program procedures, scheduling requirements and modes of service provision that conflict with the life situations and demands of persons with mental health and substance use conditions. It also means that access to care goes far beyond mere

*...access to care goes far beyond mere eligibility to receive services to the care being acceptable to those individuals for whom it is intended.*

eligibility to receive services to the care being acceptable to those individuals for whom it is intended. Finally, access to care involves moving away from certain philosophies of treatment previously adhered to by some practitioners—including hitting bottom (e.g., “Addicts can’t be helped until they hit bottom and have lost everything”) and incrementalism (e.g., “We can’t house people with addictions until they’ve been in recovery for 6 months”)—and toward stages of

change approaches, recognizing that addressing basic needs, employment, and housing can enhance motivation for treatment, rehabilitation, and recovery.

***Engagement into services*** is closely tied to access. Engagement involves making contact with the person rather than with the diagnosis, building trust over time, attending to the person's stated needs and, directly or indirectly, providing a range of services in addition to clinical care. The process of engagement benefits from new understandings of motivational enhancement, which see people standing at various points on a continuum from pre-readiness for treatment to being in recovery, rather than being either motivated or unmotivated. Engagement also involves sensitivity to the thin line between persuasion and coercion and attention to the power differential between the service provider and the person receiving or potentially receiving services, and the ways in which these factors can undermine personal choice. Finally, methods of ensuring engagement are integrated within and are part of providing good clinical and rehabilitative care, not adjuncts to them.

Once engaged in care, people will assess the ***timeliness of services*** they receive based on several considerations. One dimension of timely care is waiting times, such as delays in scheduling appointments, visiting practitioners, and entering hospital emergency departments. Racial, ethnic, and socioeconomic disparities exist within each of these indicators of timeliness, such that many people of color and people who are poor wait longer for health care than others. As just one example,

compared to non-Hispanic whites, African Americans experience longer waits in emergency departments and are more likely to leave without being seen.<sup>26</sup>

Another aspect of timeliness includes perceptions of inadequate care and unmet need; areas which unfortunately demonstrate similar disparities. For instance, people with lower education and income and Hispanics/Latinos are more likely to report unmet health care needs and more difficulties obtaining care.<sup>27</sup> Such access to care goes far beyond mere eligibility to receive services to the care being acceptable to those individuals for whom it is intended.

*Indicators of responsiveness include the extent to which [people] feel that their providers listen carefully, explain things in a way that they understand, demonstrate respect for what they say, and spend enough time with them.*

Once engaged into care, people in recovery and their loved ones evaluate the extent to which the services are *responsive* to their wants, needs, and preferences, including their cultural preferences. Some indicators of responsiveness include the extent to which they feel that their providers listen carefully, explain things in a way that they understand, demonstrate respect for what they say, and spend enough time with them. Racial and ethnic differences have also been found documented in each of these domains. For example, Hispanics/Latinos are more likely than non-Hispanic Whites to report that their providers did not “explain themselves clearly” or “listen carefully” and to be significantly less satisfied with their mental health treatment. Moreover, whereas African Americans report being more satisfied than Whites with the responsiveness of their health care, the quality of the care they receive across a variety of health conditions is inferior to that received by Whites. Given these findings, it is perhaps not surprising that African and Hispanic-origin Americans are more likely than Whites to leave treatment prematurely, perpetuating a demoralizing cycle of diminished access, unmet needs, and poorer outcomes.

As one dimension of providing timely and responsive care, it therefore becomes incumbent upon practitioners to be attentive to these types of disparities and to provide culturally responsive and competent care. Issues of disparities are also addressed in Section D as an aspect of equity. In this section we focus less on the identification and redress of such disparities and more on how care can be timely and responsive in the case of each individual and/or family. In this case, in addition to

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<sup>26</sup> Institute of Medicine, Board of Health Services Policy, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. *Unequal treatment: Confronting racial and ethnic disparities in Health Care*. Washington DC: Institute of Medicine; 2003.

<sup>27</sup> Wells, K., Klap, R., Koike, A., & Shelbourne, C. (2001). Ethnic disparities in unmet need for alcoholism, drug abuse, and mental health care. *American Journal of Psychiatry*, 158, 2027-2032.

access and engagement, a final component of quality care is the *continuity* which practitioners can provide across episodes, programs, and agencies. This is important as recovery in both substance use and mental health, in the sense in which we are using it in this document, refers to a prolonged or long-term process. It does not refer, that is, to an acute phenomenon such as recovery from the flu or from a broken bone. This is not to say that substance use or mental health conditions cannot also be acute in nature. Many people do, in fact, experience one episode of mental illness or a short-lived period of substance use and do not develop prolonged conditions to begin with. For such people experiencing only one acute and delimited episode of either substance use or mental illness, however, the notion of recovery may not have much relevance.

For those individuals for whom being in recovery is a meaningful goal, the nature of their struggle with a mental health and/or substance use condition is likely to be sustained. In such cases—which, it should be acknowledged, comprise a significant segment of Connecticut citizens receiving care from DMHAS-funded programs—an acute model of care is not the most useful or appropriate. Particularly in terms of system design, prolonged conditions call for longitudinal models that emphasize continuity of care over time and across programs. Consistent with the principles under-girding the “new recovery movement” in substance use, the long-term nature of addiction and mental illness suggests a number of parameters for developing new models of care that go beyond loosely linked acute episodes<sup>28</sup>. These are included below.

### **You will know that you are offering timely and responsive care when:**

#### **At the System/Agency level**

- B.1.** Systems invest significantly in prevention and health promotion approaches to lessen the burden of disease and disability on the individuals served, the service system itself, and society at large.
- B.2.** A range of interventions are used to enhance protective factors, to help individuals, families, and communities to develop the resources and capabilities needed to maintain healthy lifestyles, and to foster wellness both prior to and following onset of mental health and/or substance use conditions.
- B.3.** Focused efforts are made to identify and intervene early in youth and young adults experiencing the early warning signs of, or being in the early stages of developing, a mental health condition.

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<sup>28</sup>White, W. (2001). The new recovery advocacy movement: A call to service. *Counselor*, 2(6), 64-67.

- B.4.** School and community-based educational and other health promotion efforts are made to help prevent youth and young adults from abusing alcohol, smoking, and using illicit drugs.
- B.5.** Practitioners can go where people are, rather than insisting that people come to their programs or agencies. Services and structures (e.g., hours of operation and locations of services) are designed around the needs, characteristics, and preferences of the people receiving services, including race, ethnicity, culture, age, and linguistic preference.
- B.6.** Practitioners provide, or can help the person gain swift access to, a wide range of services. People can access these services from many different points. In a “no wrong door” approach to providing care, individuals can also self-refer to a range of service options (e.g., specialized rehabilitation supports) without the need for referral from a primary clinical provider. In addition, individuals can access DMHAS-funded rehabilitation programs without being mandated to participate in clinical care. To manage resources responsibly, self-referrals will be subject to admission and oversight and also may need approval by a licensed entity to satisfy reimbursement and accreditation needs.
- B.7.** There is not a strict separation between clinical and case management functions though there may be differences in expertise and training of the people providing these services. Services and supports address presenting clinical issues, but are also responsive to pressing social, housing, employment, and spiritual needs. For example, employment is valued as a central element of recovery. Skill building and promoting employment are competencies included in all staff job descriptions, including clinicians, with only those people who have the most complex or profound needs being referred to specialized programs.
- B.8.** The assessment of motivation is based on a “stages of change” model, and services and supports incorporate motivational enhancement strategies which assist practitioners in meeting each person at his or her own level. Training in these strategies is required for all staff in order to help move people toward recovery. As a result, providers recognize that establishment of a trusting relationship often is necessary before they can be effective in helping individuals to change substance use behaviors and/or learn to better manage a mental health condition.
- B.9.** Staff actively look for signs of organizational barriers or other obstacles to care before concluding that a person is non-compliant with treatment or unmotivated for care. Once identified, staff remove or find ways to overcome these obstacles. Examples include offering safe, welcoming,

and child and family-friendly waiting areas, having on-site child care available during appointments, making parking available, planning access to public transportation, and providing information and links to referrals in several languages based on local community needs.

- B.10.** Agencies have “zero reject” policies that do not exclude people from care based solely on symptoms, substance use, or unwillingness to participate in prerequisite activities. For example, vocational agencies do not employ screening procedures based on arbitrary “work readiness” criteria; such criteria have limited predictive validity regarding employment outcomes. In addition, such procedures suggest that individuals must maintain stability or abstinence before they can pursue a life in the community, when, in fact, employment may often be a path through which people become stable in the first place.
- B.11.** Staff have an “open case” policy which dictates that a person’s refusal of services, even despite intensive and long-term outreach and engagement, does not require that he or she be dropped from the “outreach” list. This person may still accept services at another time. Committee structures and supervision are in place to evaluate the fine line between assertive outreach versus potential harassment or coercion. In addition, the agency establishes guidelines regarding what defines a person as being in “active” treatment versus “outreach,” and considers how such definitions impact program enrollment, documentation standards, 30 day drop out lists, case load definitions, and reimbursement strategies.
- B.12.** From an administrative perspective, the system is structured based on a commitment to and practice of motivational enhancement, with reimbursement for pre-treatment and recovery management supports. This structure includes flexibility in outpatient care, including low-intensity care for those who do not presently benefit from high-intensity treatment.
- B.13.** Agencies do not exclude individuals with self-injurious behaviors from services or require elimination of these behaviors before treatment can commence. Rather, appropriate care is offered for these issues.
- B.14.** Outpatient substance use treatment clinicians are paired with outreach workers to capitalize on the moments of crisis that can lead people to accept treatment and to gain access to their appropriate level of care. These teams work from a framework of patience, persistence, and hope.
- B.15.** Mental health professionals, substance use specialists, and people in recovery are placed in critical locales to assist in the early stages of

engagement, e.g., in shelters, in courts, in hospital emergency rooms, and in community health centers. Agencies develop and establish the necessary memoranda of agreement and protocols to facilitate this co-location of services.

- B.16.** Agencies employ staff with first person experiences of recovery who have a special ability to make contact with and engage people into services and treatment.
- B.17.** Housing and support options are available for those who are not yet engaged in recovery, but who may begin to engage in their own recovery if housing and support are available to them.
- B.18.** The availability of sober housing is expanded to make it possible for people to go immediately from residential or intensive outpatient treatment programs into housing that supports their recovery.
- B.19.** Services are designed to be welcoming to all individuals and there is a low threshold (i.e., minimal requirements) for entry into care. There also is an emphasis on outreach and pre-treatment recovery support services that can ensure that individuals are not unnecessarily excluded from care. If a person is denied care, they are connected to appropriate alternatives including an appointment at another agency. Eligibility and reimbursement strategies for this group of individuals (outreach and pre-engagement) are established and refined as necessary over time.
- B.20.** People have a flexible array of options from which to choose and these options allow for a high degree of individualization and a greater emphasis on the physical/social ecology (i.e., context) of recovery.
- B.21.** The overall focus of care shifts from preventing relapse to promoting recovery. Services are not primarily oriented toward crisis or problem resolution, e.g., detoxification and stabilization. There is a full array of recovery support services, including proactive, preventive supports and post-crisis, community-based resources such as adequate safe housing, recovery community centers operated by people in recovery, sustained recovery coaching, monitoring, and early re-intervention.
- B.22.** Outcomes tracking is influenced by the system's commitment to ensuring continuity of care. For example, less emphasis is placed on a review of the short-term outcomes of single episodes of care and more emphasis is placed on recovery roadmaps that highlight the long-term effects of service combinations and sequences on those outcomes

valued by the person such as quality of life domains including satisfaction with housing, relationships, and employment.

- B.23.** The range of valued expertise is expanded beyond specialized clinical and rehabilitative professionals and technical experts to include the contributions of multiple individuals and services. These individuals may include peers in paid or volunteer positions, mutual aid groups, indigenous healers, faith community leaders, primary care providers, and other natural supports. Of particular importance is knowledge of the 12-Steps used in AA/NA self-help groups and assertively linking people with groups that are welcoming to their specific needs and preferences. Valuing and incorporating such community resources in ongoing care planning is essential to decreasing dependence on formal health care and assisting the person to develop a more natural recovery network. In this spirit, the community, rather than an agency or program, is viewed as the context for sustained recovery.
- B.24.** New technologies (e.g., tele-medicine and web-based applications and self-help resources) are incorporated as service options to enhance illness self-management collaborative treatment relationships.
- B.25.** Access to housing, employment, and other supports that make recovery sustainable is enhanced. This includes changing policies and laws that restrict people's access to employment and home ownership, such as having a criminal record for non-violent, one-time, drug-dealing offenses or offenses related to a mental health condition.
- B.26.** Policy formulation and legislative advocacy at the administrative level is coupled with on-going efforts to work collaboratively with a variety of state systems to ensure continuity of care, e.g., with the Department of Correction to put into place plans for re-entry or with resources such as Oxford Houses and rental assistance for people with substance use conditions coming out of jails and prisons.
- B.27.** Advocacy efforts are extended beyond institutional policies and procedures to the larger community, including stigma-busting, community education, and community resource development activities in order to facilitate sustained recovery and community inclusion,
- B.28.** Agencies adopt a set procedure for informing people of changes in care of treatment/rehabilitation provider, hours of operation, or service and support options in advance. During these transitions, people are offered a choice and a voice in what happens next with their care.

## At the Practitioner/Person in Recovery Level

- B.29.** The central concern of engagement shifts from: “How do we get this person into treatment?” to: “How do we nest the process of recovery within this person’s natural environment?” For example, people have often asked for meeting places and activities to be available on weekends, especially for those who are in the early stages of their recovery.
- B.30.** Continuity of care, especially for individuals with trauma histories, means a shifting of the services offered to the individual and not a transfer of the person from one program to another, requiring changing care providers or settings. This is particularly critical for individuals for whom the presence of ongoing supportive relationships is perhaps the most essential aspect of healing. To the extent possible, screening processes within different programs and collaborating agencies also are shared to avoid unnecessary repetition of intrusive questions.
- B.31.** Staff plan proactively with people to identify and address potential barriers to access such as child or elder care, lack of transportation, changing job schedules, or physical disability or health issues that might pose obstacles.
- B.32.** Within the context of a responsive continuum of care, individuals work in collaboration with their recovery team to select those services from an array of options that meet their particular needs and preferences at a given point in time. Individuals are not expected or required to progress through a continuum of care in a linear or sequential manner. For example, individuals are not required to enroll in a group home as a condition of hospital discharge when this is determined solely by professionals to be the most appropriate level of care.

### Example of how this might look in practice:

It has been customary to view resumption of ordinary community activities such as employment and education as requiring and following after symptom reduction and clinical stability in both substance use and mental health care. This requirement for a linear sequence of steps toward recovery is both not supported by research (i.e., recovery is not a linear process) and is unlikely to be responsive to the wishes and priorities of at least some, if not most, people accessing care.<sup>29</sup> For these individuals, it will be important for practitioners to be responsive to the person’s own

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<sup>29</sup>Ridgway, P. & Zipple, A. (1990). The paradigm shift in residential services: From the linear continuum to supported housing. *Psychosocial Rehabilitation Journal*,

goals and priorities as much as possible and to view resumption of ordinary activities as a vehicle *for* recovery rather than as its reward. The following story of Celeste<sup>30</sup> exemplifies this shift, as well as many of the other guidelines described above.

*Celeste* was a 38 year old woman with schizophrenia who experienced prominent hallucinations and paranoia. Although she expressed an interest in working, her first clinician was concerned with her psychiatric status and tried to get Celeste to focus first on taking medication and getting some relief from her symptoms. For her part, Celeste did not identify the hallucinations and paranoia that she appeared to be experiencing as “symptoms” and was very skeptical of and reluctant to take medications. Given her symptoms, the clinician believed that Celeste could not yet work and thus focused her efforts on psycho-education and on trying to persuade Celeste to give the medication a try. When Celeste brought up her interest in working, the clinician suggested she attend a skills group for people who were interested in, but not yet ready for, employment, hoping to address the sources of her difficulties before turning to Celeste’s stated desires to work.

Were Celeste’s disability related to her mobility or vision, it would be obvious that this approach would result in her not acquiring a job until she no longer needed to use a wheelchair or had regained her vision. As it was, Celeste was soon discharged from treatment due to her failure to attend scheduled meetings and her refusal to be evaluated by a psychiatrist. From her perspective, she found the clinician indifferent to her needs and wants, saw no change in her condition, and began to feel that the agency was simply trying to drug her into a state of passivity and hopelessness; evidence for which she unfortunately found in the agency’s waiting room among some of the older, more ‘chronic’, clients. She did not want to become one of them.

After refusing these services but showing up repeatedly in hospital emergency rooms due to persistent, harassing voices, Celeste was then approached by an outreach worker from the same agency who suggested that she could in fact work despite her disability. This clinician encouraged Celeste’s desire to work, and offered to help her find a job which interested her.

With frequent personal contact and assistance with transportation, Celeste then pursued and got a job working at a fabrics store. She then found, however, that hearing voices and feeling paranoid made it difficult for her to be comfortable at work, and asked her clinician if she could do anything to help. The clinician described pharmacologic and psychosocial approaches to symptom management and suggested to Celeste that she discuss these concerns with her family and with a psychiatrist or nurse practitioner at the agency, who might be able to suggest which medications in

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<sup>30</sup> All names used in the stories included in this volume are fictional and do not refer to real people. While the stories are taken from experience, they involve the blending of multiple stories and details have been disguised to protect the privacy of each of the individuals involved.

particular could help with these difficulties. Celeste then disclosed to the clinician that she had been forcibly medicated during a previous hospitalization and that the idea of meeting with a psychiatrist brought back these painful and humiliating memories.

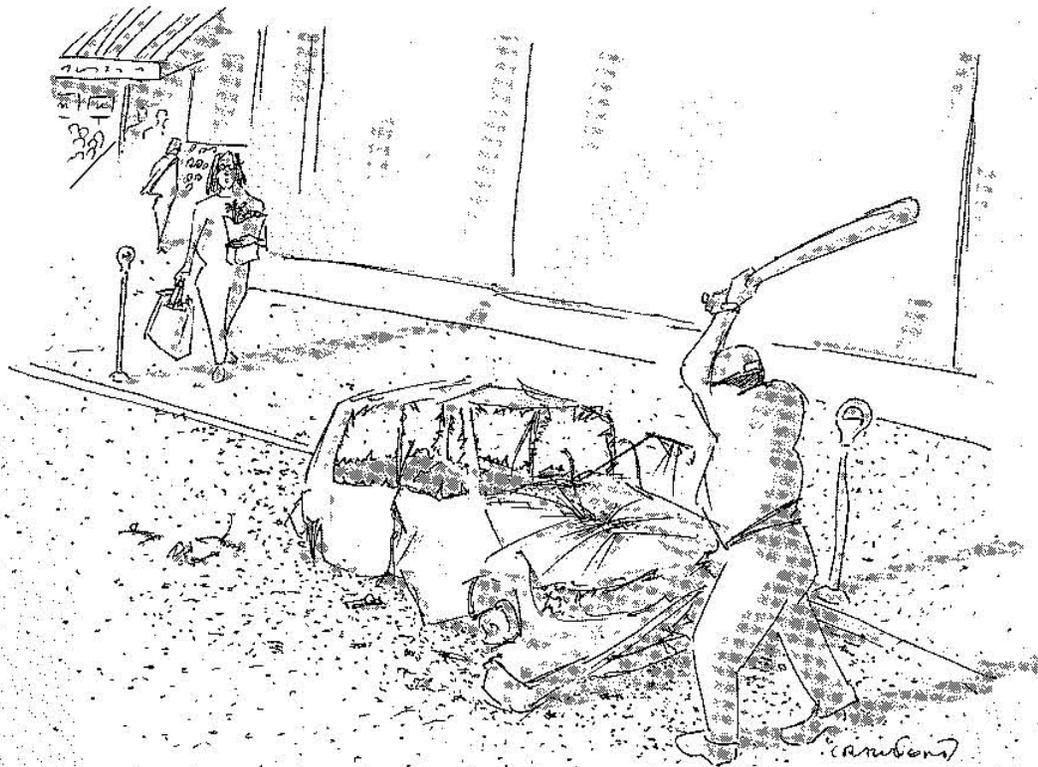
With encouragement, and after some reluctance, Celeste eventually chose to describe her situation to a nurse, who, based on Celeste's concerns about being "drugged," initially suggested a low dose of an anti-psychotic medication, explaining to Celeste that this would not make her too tired to work. Celeste found some relief from hearing voices due to the medication, and, less harassed by the voices, began to feel more comfortable at the store. She began to bring in some of her sewing projects and made friends with a few of her co-workers, finding that her paranoia significantly decreased accordingly. In her case, working turned out to serve several functions, including giving her a reason to use treatment and helping to offset her symptoms.

### **What you will hear from people in recovery when you are offering timely and responsive care:**

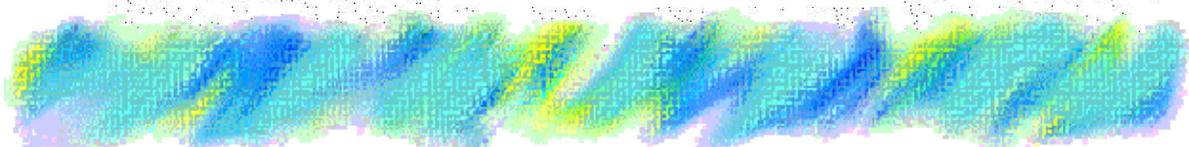
- *I hated going to their building. Everybody looked at me as I was walking up the block like "Oh, I wonder if he's a patient there – crazy and on dope." So, I just never went. But, they came to me on my own turn and my own terms. Today, I think my case manager is the reason I'm still alive.*
- *I got help with the kinds of things that were most important to me – like getting my daughter back, and putting food on the table for her. Since they were willing to help me with that stuff, I figured "Hey, maybe I should listen to what they are telling me and try out that program they keep talking about." Today I've been clean for 9 months ...*
- *It used to be I was terrified of leaving detox. I'd go back to the same crappy environment and be back out on the streets in a matter of days. But, I got into some sober housing and it changed my life.*
- *Nobody wanted anything to do with me before. It was always "Come back and see us when you get serious about your recovery... when you've got some clean urines." But, then, this program tried to help me out with getting this job I had wanted for a really long time. Now, I am working part time and I've finally got a reason to try to be sober every day.*
- *People respected that I was doing the best I could. It was two steps forward one step back for a long time, but overall, I was moving in the right direction for the first time in as long as I could remember. But they stuck with me for the long haul. Now, I've been clean for 18 months, and someone still calls me every day to check in – even if its just to day "Hi, How ya' doin'?"*

- *I didn't get kicked out of the program because I had a dirty urine – it used to be that happened every week. This time, I had been clean for two months. My case manager reminded me of how good it was in those two months and I wanted to get back there.*
- *They knew I needed to work on my recovery AND my life at the same time. That meant getting a part-time job, paying off my debts, working on my marriage, and learning how to enjoy myself again and to do it all drug-free.*

### **The Importance of Not Overlooking the (not so) Obvious**



*“Still won't start?”*



### C. Recovery-Oriented Care is Person-Centered

The Institute of Medicine defines patient-centered care as “health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients’ wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care.” In addition, patient-centered care is guided by the patient’s values and is personalized to ensure that practitioner instructions are properly understood and followed. Given the history of stigma that continues to accrue to both mental health and substance use conditions, several different components will need to be incorporated into recovery-oriented care to make it fully person-centered. Primary among these is the shift from deficit-driven treatment, care, or service planning to person-driven recovery planning. Essential to this shift is basing care on the person’s own goals and life circumstances, identifying and building on the person’s resources and strengths, and, finally, orienting care and supports to the community arenas in which the person wishes to participate.

*Essential to this shift [to person-centered care] is basing care on the person’s own goals and life circumstances, identifying and building on the person’s resources and strengths, and, finally, orienting care and supports to the community arenas in which the person wishes to participate.*

In accordance with the Connecticut General Statutes, as well as Federal and Joint Commission guidelines regarding the need for individualized care, all treatment and rehabilitative services and supports to be provided shall be based on an ***individualized, multidisciplinary recovery plan*** developed in collaboration with the person receiving these services and any others that he or she identifies as supportive of this process. While based on a model of collaboration and partnership, significant effort will be made to ensure that individuals’ rights to self-determination are respected and that individuals are afforded maximum opportunity to exercise choice in the full range of treatment and life decisions. The individualized recovery plan will satisfy the criteria of treatment, service, or care plans required by other bodies (e.g., CMS, CARF) and will include a comprehensive and culturally competent assessment of the person’s hopes, assets, strengths, interests, and goals in addition to a holistic understanding of his or her mental health and substance use conditions and other medical concerns within the context of his or her ongoing life.

*...significant effort will be made to ensure that individuals’ rights to self-determination are respected and that individuals are afforded maximum opportunity to exercise choice in the full range of treatment and life decisions.*

Typical examples of such life context issues include employment, education, housing, spirituality, social and sexual relationships, parenting, and involvement in meaningful and pleasurable activities. In order to ensure competence in these respective areas, including competence in addressing the person's cultural background and affiliations, the multi-disciplinary team may not be limited to psychiatrists, nurses, psychologists, social workers, and substance use counselors, but also include rehabilitative and peer staff, and, wherever possible, relevant natural supports, community representatives, and/or others identified by the person.

Building on a *strength-based assessment* process, recovery planning both encourages and expects the person to draw upon his or her strengths to participate actively in the recovery process. Focusing solely on deficits in the absence of a thoughtful analysis of strengths disregards the most critical resources an individual has on which to build in his or her efforts to adapt to stressful situations, confront environmental challenges, improve his or her quality of life, and advance in his or her unique recovery journey. As improvement depends, in the end, on the resources, efforts, and assets of the individual, family, or community, a recovery orientation encourages practitioners to view the glass as half full rather than half empty<sup>31</sup>.

Following principles that have been articulated at length by Rapp and others<sup>32</sup>, strength-based approaches allow practitioners to balance critical needs that must be met with the resources and strengths that individuals and families possess to assist them in this process. This perspective encourages practitioners to recognize that no matter how disabled, every person continues to have strengths and capabilities as well as the capacity to continue to learn and develop. The failure of an individual to display competencies or strengths is therefore not necessarily attributed to deficits within the person, but may rather, or in addition, be due to the failure of the service system and broader community to adequately elicit information in this area or to create the opportunities and supports needed for these strengths to be displayed.

While system and assessment procedures have made strides in recent years regarding inquiry into the area of individual resources and capacities, simply asking an individual what strengths they possess or what things they think they are "good at" may not be sufficient to solicit the information that is critical to the recovery planning process. For example, many people who have prolonged conditions will at first report that they have no strengths. Such a response should not be taken at face value, but rather to represent the years of difficulties and failures they may have endured and the degree of demoralization which has resulted. Over time, it is not uncommon for such individuals to lose touch with the healthier and more positive aspects of themselves and become unable to see beyond the "patient" or "addict" role.

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<sup>31</sup>Saleebey, D. (2001). The diagnostics strengths manual. *Social Work*, 46, (2), 183-187.

<sup>32</sup>Rapp, C.A. (1998). *The Strengths Model: Case management with people suffering from Severe and Persistent Mental Illness*. New York: Oxford University Press.

When facing such circumstances, practitioners conceptualize one of their first steps as assisting this person to get back in touch with his or her previous interests, talents, and gifts. The guidelines below are intended to assist practitioners in conducting a comprehensive, strength-based assessment that can help people to rediscover themselves as capable persons with a history, a future, and strengths and interests beyond their symptoms, deficits, or functional impairments. It is important throughout this process that practitioners maintain a belief in the individual's potential for growth and development, up to, and including, the ability to exit successfully from services and manage their recovery independently. Practitioners also solicit the person's own hopes, dreams, and aspirations, encouraging individuals to pursue their preferred goals even if doing so presents potential risks or challenges.

*A comprehensive, strength-based assessment ... can help people to rediscover themselves as capable persons with a history, a future, and strengths and interests beyond their symptoms, deficits, or functional impairments.*

For example, many people identify returning to work as a primary recovery goal. Practitioners may advise against this step based on their concern that an individual either is not “work ready” or that employment will be detrimental to his or her recovery (e.g., by endangering his or her disability benefits). While such advice is based on good intentions, it sends a powerful message to the individual and can reinforce self-doubts and feelings of inadequacy. Rather than discouraging the person from pursuing this goal, the practitioner can have a frank discussion with the person about his or her concerns while simultaneously highlighting the strengths that the individual can draw upon to take the first step toward achieving this goal.

In this vein, individualized recovery planning explicitly acknowledges that recovery entails the person's taking risks to try new things, and is enhanced by the person having opportunities to learn from his or her own mistakes and their natural consequences. This represents an important source of progress in the person's efforts to rebuild his or her life in the community that—similar to exercising one's muscles—cannot proceed without an exertion of the person's own faculties.

In order to orient the work of practitioners to assisting the person in rebuilding his or her life in the community, we suggest replacing the traditional language of “case manager” with the concept of *recovery guide*. The sentiment that “we're not cases, and you're not managers”<sup>33</sup> has been accepted increasingly as a fundamental challenge to the ways in which health care is conceptualized within a recovery-

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<sup>33</sup>Everett, B. & Nelson, A. (1992). We're not cases and you're not managers. *Psychosocial Rehabilitation Journal*, 15(4), 49-60.

oriented system. During this time, the predominant vehicle for offering services to many adults with serious conditions has evolved from the team-based and *in vivo* approach of intensive case management to the introduction of strength-based and rehabilitative forms of case management that attempt to shift the goals of care from stabilization and maintenance to enhanced functioning and community integration.

From the perspective of recovery, though even these inherited models of case management limit the progress that otherwise could be made in actualizing the shift from a deficit- and institution-based framework to a recovery paradigm. This paradigm calls for innovative models of community-based practice that move beyond the management of cases to the creation of a more collaborative model that highlights the person's own role in directing his or her life and, within that context, his or her own treatment (in much the same way that people, in collaboration with their health care professionals, make decisions about their own medical care for other conditions such as hypertension). One such model that is emerging within DMHAS is that of the community or recovery guide or mentor.

Rather than replacing any of the skills or expertise that practitioners have obtained through their training and experience, the recovery guide model offers a useful framework in which these interventions and strategies are framed as critical tools that the person can use in his or her own recovery. In addition, the recovery guide model, depicted below, offers both practitioners and people in recovery a recovery roadmap of the territory they will be exploring together.

Prior to attempting to embark with a person on his or her recovery journey, practitioners appreciate that the first step in the process of treatment, rehabilitation, or recovery is often to engage in a relationship a reluctant, disbelieving, but nonetheless distressed, even suffering, person. In this sense, practitioners recognize that most people will not know or accept that they have a substance use or mental health condition at first, and therefore will frequently not seek help on their own. The initial focus of care is thus on the person's own understanding of his or her predicament (i.e., not necessarily the events or difficulties which brought him or her into contact with care providers), and on the ways in which the practitioner can be of assistance in addressing this predicament, regardless of how the person understands it at the time.

It also is important to note that within this model, care incorporates the fact that the lives of people in recovery did not begin with the onset of their conditions, just as their lives are not encompassed by substance use or mental health treatment and rehabilitation. Based on recognition of the fact that people were already on a journey prior to the onset of their conditions, and therefore prior to coming into contact with care, the focus of care shifts to the ways in which this journey was impacted or disrupted by each person's condition(s). For example, practitioners strive to identify and understand how the person's substance use or mental illness has impacted on or changed the person's aspirations, hopes, and dreams. If the person

appears to be sticking resolutely to the hopes and dreams he or she had prior to onset of the condition, and despite of or without apparent awareness of the condition and its disabling effects, then what steps need to be taken for him or her to get back on track or to take the next step or two along this track? Rather than the reduction of symptoms or the remediation of deficits—goals that we assume the person shares with care providers—it is the person’s own goals for a life beyond or despite his or her condition that drive treatment, rehabilitation, and recovery planning and efforts.

**Figure 6. Conceptual Model for the Recovery Guide**



**You will know that you are providing person-centered care when:**

**At the System/Agency Level**

- C.1.** An individual may select or change practitioners within agency guidelines and is made aware of the procedures for doing so.
- C.2.** In the spirit of true partnership and transparency, all parties have access to the same bodies of information so that people in recovery can embrace and effectively carry out responsibilities associated with the recovery plan<sup>34</sup>. People also are automatically offered a copy of their written plans, assessments, and progress notes.

<sup>34</sup>Osher, T., & Osher, D. (2001). The paradigm shift to true collaboration with families. *The Journal of Child and Family Studies*, 10(3), 47-60.

- C.3.** Individuals are not required to attain or maintain clinical stability or abstinence from substance abuse or self-injury before they are supported by practitioners in pursuing such goals as employment.
- C.4.** Goals and objectives are driven by the person's current values and needs and not solely by commonly desired clinical outcomes, e.g., recovery is a process that may or may not begin with the individual understanding or appreciating the value of abstinence or of taking medications.
- C.5.** The focus of planning is on how to create pathways to meaningful and successful community life as opposed to maintaining stability or abstinence from substance use or self-injury. Person-centered plans document areas such as physical health, family and social relationships, employment or education, spirituality, housing, recreation, and civic and community participation unless such areas are not of interest to the person. Achieving interdependence with natural supports is a valued goal for many people who express a strong preference to live in typical housing, to have friendships and intimate relationships with a wide range of people, to work in regular employment settings, and to participate in school, worship, recreation, and other pursuits alongside other community members.<sup>35</sup> Such preferences often speak to the need to reduce time spent in segregated settings designed solely for people with a substance use or mental health condition.
- C.6.** Recovery is viewed as a fundamentally social process, involving supportive relationships with family, friends, peers, community members, and practitioners. Recovery plans respect the fact that services and practitioners should not remain central to a person's life over time and maximize the role of natural supports. Exit criteria from formal services are clearly defined. Given the unpredictability of illness, and life more generally, however, readmission also remains uncomplicated, with avenues clearly defined for people on discharge.
- C.7.** A focus on community is consistent not only with person-centered care but with the need for fiscal efficiency. Practitioners and people in recovery are mindful of the limited resources available for specialized services and focus on community solutions and resources first by asking "Am I about to recommend or replicate a service or support that is already available in the broader community?" At times this has direct implications for the development of interventions within recovery plans, e.g., creating on-site health and fitness opportunities such as

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<sup>35</sup>Reidy, D. (1992). Shattering illusions of difference. *Resources*, 4(2), 3-6.

exercise classes without first exploring to what extent that same opportunity might be available in the community through public recreational departments, YMCAs, etc. If natural alternatives are available in the community, individuals are informed of these opportunities and to the extent to which what is offered is culturally responsive and accessible, they are supported in pursuing activities in such integrated settings.

- C.8.** There is a flexible application of process tools, such as the Assessment of Person-Centered Planning Facilitation Integrity Questionnaire, to promote quality service delivery. Assuming attention is paid to the larger organizational culture, process tools can be helpful in defining the practice and then monitoring its effective implementation.<sup>30</sup>
- C.9.** Language used is neither stigmatizing nor objectifying. “Person-first” language is used to acknowledge that the condition is not as important as the person’s individuality and humanity. Employing person-first language does not mean that a person’s condition is hidden or seen as irrelevant; but that it also is not to be the sole focus of any description.
- C.10.** Exceptions to person-first and empowering language that are preferred by some persons in recovery are respected. For instance, the personal preferences of some individuals with substance use disorders, particularly those who work the 12-Steps as a primary tool of their recovery, may at times be inconsistent with person-first language. Within the 12-Step Fellowship, early steps in the recovery process involve admitting one’s powerlessness over a substance and acknowledging how one’s life has become unmanageable. It is also common for such individuals to introduce themselves as: “My name is X and I am an alcoholic.” This preference is respected as a part of the person’s recovery process, and it is understood that it would be contrary to recovery principles to pressure the person to identify as “a person with alcoholism” in the name of person-first language. Use of person-first language is in the service of the person’s recovery; it is not a super-ordinate principle to which the person must conform. *While the majority of people prefer to be referred to in first-person language, when in doubt the person is asked what he or she prefers.*
- C.11.** Recognizing the “dignity of risk,” administrators reward planning teams that encourage individual self-determination rather than those which focus primarily on compliance and containment.

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<sup>30</sup>Osher, T., Osher, D. & Blau, G. (2005a). Family-driven Care: A working definition. Alexandria, VA: Federation of Families for Children's Mental Health. [http://ffcmh.org/systems\\_whatish.htm](http://ffcmh.org/systems_whatish.htm).

- C.12.** Training and resources for developing individualized recovery plans, conducting strengths-based assessments, and serving as a recovery guide are readily available to individuals and practitioners.

#### At the Practitioner/Person in Recovery Level

- C.13. Core principles of “person-centered” planning are followed in the process of building individualized recovery plans.**
- C.13.1.** Consistent with the principle of “nothing about us, without us,” practitioners actively partner with individuals in shared decision-making, creating integrated and collaborative recovery plans. The individual is centrally involved in all planning meetings and/or case conferences regarding his or her recovery services and supports.
- C.13.2.** The individual has reasonable control as to the location and time of planning meetings, as well as to who is involved, including conserved persons who wish to have an advocate or peer support worker present. Planning meetings are conducted and services are delivered at a time that does not conflict with other activities that support recovery such as employment. The individual can extend invitations to any person she or he believes will be supportive of his or her efforts toward recovery. Invitations extended are documented in the recovery plan. If necessary, the person (and family or friends as relevant) are provided with support before the meeting so that they can be prepared and participate fully.<sup>36</sup>
- C.13.3.** The language of the plan is understandable to all participants, including the person, his or her family and friends, and the non-professional or natural supports he or she has invited. Where technical or professional terminology is necessary, this is explained to all participants.
- C.13.4.** When individuals are engaged in rehabilitation services, rehabilitation practitioners are involved in planning meetings (at the discretion of the individual) and are given copies of the resulting plan.
- C.13.5.** Within the planning process, a diverse, flexible range of options is available so that people can access and choose those supports that will best assist them in their recovery. These choices and service options are clearly explained to the individual, and documentation reflects the options considered.

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<sup>36</sup>Osher, D. & Keenan, S. (2001). From professional bureaucracy to partner with families. *Reaching Today's Youth*, 5(3), 9–15.

- C.13.6.** Goals are based on the day-to-day life and unique problems, interests, preferences, and strengths of the individual, and interventions are clearly related to the attainment of these stated goals. Such goals may include safety, medical and dental care, income development including employment, relationships and sexuality, and children’s or family concerns such as parenting and/or reunification. In the case of children and youth, the unique goals of the family are also considered, with youth increasingly driving the process as they approach the age of maturity. In cases in which preferred supports do not exist, the team works collaboratively with the individual or family to develop the support or to secure an acceptable alternative.
- C.13.7.** Planning focuses on the identification of concrete next steps, along with specific timelines, that will allow the person to draw upon existing areas of strength to move toward recovery and his or her vision for the future. Individuals, including non-paid, natural supports who are part of the planning process, commit to assist the individual in taking those next steps. The person takes responsibility for his or her part in making the plan work. Effective recovery plans help people rise to this challenge regardless of their mental health or substance use status.
- C.13.8.** Information on rights and responsibilities of receiving services is provided at recovery planning meetings. This information should include a copy of the mechanisms through which the individual can provide feedback to the practitioner and/or agency, e.g., protocol for filing a complaint or compliments regarding the provision of services.
- C.13.9.** Teams reconvene as necessary to address life goals, accomplishments, and barriers. Planning is characterized by celebrations of successes, and meetings can occur beyond regular, established parameters (e.g., 6-month reviews) and crises (e.g., to prevent hospitalization or relapse).
- C.14. A wide range of interventions and contributors to the planning and care process are recognized and respected.**
- C.14.1.** Practitioners acknowledge the value of the person’s existing relationships and connections. In addition, interventions complement, rather than interfere with, what people are already doing to keep themselves well, e.g., drawing support from friends and loved ones.<sup>37</sup> When natural supports are actively engaged in the planning process, the action steps to which they are committed are written in the plan.

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<sup>37</sup>Osher, D. and Webb, L. (1994). *Adult Literacy, Learning Disabilities, and Social Context: Conceptual Foundations for a Learner-Centered Approach*. Washington, DC, U.S. Department of Education.

- C.14.2.** The plan identifies a wide range of both professional resources and alternative strategies to support the person’s recovery, particularly those which have been helpful to others with similar struggles. Information about medications and other treatments are combined with information about self-help, peer support, exercise, nutrition, daily maintenance activities, spiritual practices and affiliations, homeopathic and naturopathic remedies, etc.
- C.14.3.** Recovery plans consider not only how the individual can access and receive needed supports from the health care system and broader community, but how the individual can, in turn, give back to others. People have identified this type of reciprocity in relationships as being critical to building recovery capital and to the recovery process as a whole. Therefore, individuals are encouraged to explore how they can make meaningful contributions in the system or in the community, e.g., through advocacy, employment, or volunteering.
- C.14.4.** Person-centered plans reflect an integration of clinical care and/or rehabilitation services along with the use of natural supports, and encourage and highlight an active role for the individual. As such, the “interventions” section of individualized recovery plans include formal interventions but also action steps which have been offered by natural supports and those to which the individual has committed (see C.15.1.).
- C.15. The planning process honors the “dignity of risk” and “right to fail” as evidenced by the following:**
- C.15.1.** Unless determined to require conservatorship by a judge, individuals are presumed competent and entitled to make their own decisions. As part of recovery, they are encouraged and supported by practitioners to take risks and try new things. Only in cases involving imminent risk of harm to self or others is a practitioner authorized to override decisions of the individual. Person-centered care does not eliminate practitioners’ obligations to take action to protect the person or the public in the event of emergent or crisis situations, but limits the authority of practitioners to specifically delimited circumstances defined by relevant statutes.
- C.15.2.** In all other cases, practitioners are encouraged to offer their expertise and suggestions respectfully within the context of a collaborative relationship, clearly outlining for the person his or her range of options and possible consequences. Practitioners support the “dignity of risk” and sit with their own discomfort as the person tries out new choices and experiences that are necessary for recovery.

- C.15.3.** In keeping with this stance, practitioners encourage individuals to write their own crisis and contingency plans (such as psychiatric advanced directives or the crisis plans of the WRAP model). Ideally, such plans are directed by the individual but developed in collaboration with the entire team so as to share responsibility and resources in preventing or addressing crises. Such plans provide detailed instructions regarding preferred interventions and responses in the event of crisis, and maximize an individual’s ability to retain some degree of autonomy and self-determination at a time when he or she is most likely to have these rights compromised.<sup>38</sup> This plan is kept in an accessible location and can be made available for staff providing emergency care.
- C.16. Person-centered care identifies and builds on a person’s strengths and resources as evidenced by the following:**
- C.16.1.** A discussion of strengths is a central focus of every assessment, care plan, and case summary. Assessments begin with the assumption that people are key experts on their own recovery and that they have learned much in the process of living with and working through their struggles.
- C.16.2.** Initial assessments recognize the power of simple, yet powerful, questions such as “What happened? What do you think would be helpful? What are your goals in life?” Self-assessment tools rating level of satisfaction in various life areas can be useful ways to identify diverse goal areas around which supports can then be designed.
- C. 16.3.** Practitioners interpret perceived deficits within a strength and resilience framework, as this allows the individual to identify less with the limitations of his or her condition. For example, an individual who takes medication irregularly may be perceived as “non-compliant,” “lacking insight,” or “requiring monitoring.” This same individual, however, could also be seen as “making use of alternative coping strategies such as exercise and relaxation to reduce reliance on medications” or could be praised for “working collaboratively to develop a contingency plan for when medications are to be used on an ‘as-needed’ basis.” (Additional examples are provided in the Appendix)
- C.16.4.** While strengths of the individual are a focus of the assessment process, thoughtful consideration also is given to potential strengths and resources within the individual’s family, natural support network, service system, and community at large. This is consistent with the

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<sup>38</sup>Kendziora, K. T., Bruns, E., Osher, D., Pacchiano, D., & Mejia, B. (2001). *Wraparound: Stories from the Field*. Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

view that recovery is not a solitary process but rather a journey toward interdependence within one's community of choice.

- C.16.5.** The diversity of strengths that can serve as resources for the person and his or her recovery planning team is respected. Saleeby, for example, has recommended conceptualizing strengths broadly to include the following dimensions: skills (e.g., gardening, caring for children, speaking Spanish, doing budgets); talents (e.g., playing the bagpipes, cooking); personal virtues and traits (e.g., insight, patience, sense of humor, self-discipline); interpersonal skills (e.g., comforting the sick, giving advice, mediating conflicts); interpersonal and environmental resources (e.g., extended family, good neighbors); cultural knowledge and lore (e.g., healing ceremonies and rituals, stories of cultural perseverance); family stories and narratives (e.g., migration and settlement, falls from grace and redemption); knowledge gained from struggling with adversity (e.g., how one came to survive past events, how one maintains hope and faith); knowledge gained from occupational or parental roles (e.g., caring for others, planning events); spirituality and faith (e.g., a system of meaning to rely on, a declaration of purpose beyond self); and hopes and dreams (e.g., personal goals and vision, positive expectations about a better future)<sup>39</sup>.
- C.16.6.** In addition to the assessment of individual capacities, it is beneficial to explore other areas not traditionally considered "strengths," e.g., the individual's most significant or most valued accomplishments, ways of relaxing and having fun, ways of calming down when upset, preferred living environment, educational achievements, personal heroes, most meaningful compliment ever received, etc.
- C.16.7.** Assessment explores the whole of people's lives while ensuring emphasis is given to the individual's expressed and pressing priorities. For example, people experiencing difficulties with substance use or mental health often place less emphasis on symptom reduction and abstinence than on desired improvements in other areas of life such as work, safe housing, or relationships. For this reason, it is beneficial to explore in detail each persons' needs and resources in these areas.
- C.16.8.** Strength-based assessments ask people what has worked for them in the past and incorporate these ideas in the recovery plan. People are more likely to use strategies that they have personally identified or developed rather than those that have been suggested to them by others.

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<sup>39</sup>Saleeby, D. (2001). The diagnostics strengths manual. *Social Work, 46*(2), 183-187.

- C.16.9.** Guidance for completing a strength-based assessment may be derived from certain interviewing strategies employed within solution-focused approaches. For example, DeJong and Miller recommend the following types of inquiry: exploring for exceptions (occasions when the problem could have occurred but did not), imagining a future when the problem has been solved and exploring, in detail, how life would then be different; assessing coping strategies, i.e., asking how an individual is able to cope despite the presence of such problems; and using scaling questions (where the individual rates his or her current experience of the problem) to elucidate what might be subtle signs of progress.<sup>40</sup>
- C.16.10.** Illness self-management strategies and daily wellness approaches such as WRAP<sup>41</sup> are respected as highly effective, person-directed, recovery tools, and are fully explored in the strength-based assessment process.
- C. 16.11.** Cause-and-effect explanations are offered with caution in strength-based assessment as such thinking can lead to simplistic resolutions that fail to address the person's situation. In addition, simplistic solutions may inappropriately assign blame for the problem to the individual, with blame being described as "the first cousin" of deficit-based models of practice.<sup>42</sup> For example, to conclude that a person did not pay rent as a direct consequence of his or her "non-compliance" with medications could lead to an intrusive intervention to exert control over the individual's finances or medication. Strength-based assessments respect that problem situations are usually the result of complex, multi-dimensional influences, and explore with the person in more detail the various factors that led to his or her decisions and behavior (e.g., expressing displeasure with a negligent landlord).
- C.16.12.** Strength-based assessments are developed through in-depth discussion with the individual as well as attempts to solicit collateral information regarding strengths from the individual's family and natural supports. Since obtaining all of the necessary information requires time and a trusting relationship with the person, a strength-based assessment may need to be completed (or expanded upon) after the initial contact as treatment and rehabilitation unfold. While each situation may vary, the assessment is written up as soon as possible in order to help guide the work and interventions of the recovery team. Modular approaches to

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<sup>40</sup>DeJong, G. & Miller, S. (1995) How to interview for client strengths, *Social Work*, (40), 729-736.

<sup>41</sup>Copeland, M. (2002). *The depression workbook: A guide for living with depression and manic depression. Wellness Recovery Action Plan*. Oakland, CA: New Harbinger Publications.

<sup>42</sup>Cowger, C.D. (1994). Assessing client strengths: Clinical assessment for client empowerment. *Social Work* 39(3), 262-268.

service delivery, billing, and reimbursement are considered by local and state administrative leadership, e.g., certain information is gathered in the first 24 hours with additional areas being assessed by the end of one week, one month, etc.

- C.16.13.** Efforts are made to record the individual’s responses verbatim rather than translating the information into professional language. This helps to ensure that the assessment remains narrative-based and person-centered. If technical language must be used, it is translated appropriately and presented in a person-first, non-offensive manner, e.g., avoiding the language of dysfunction, deficit, or disorder.
- C.16.14.** Practitioners are mindful of the power of language and carefully avoid the subtle messages that professional jargon has historically conveyed to people with mental health and/or substance use conditions and their loved ones. Language is used that is empowering, avoiding the eliciting of pity or sympathy, as this can cast people in a passive victim role and reinforce negative stereotypes. For example, just as we have learned to refer to “people who use wheelchairs” as opposed to “the wheelchair bound” we should refer to “persons who use medication as a recovery tool” as opposed to people who are “dependent on medication for clinical stability.” In particular, words such as “hope” and “recovery” are used frequently in delivery and documentation of care.
- C.16.15.** While important for certain purposes (e.g., treatment, reimbursement), practitioners avoid using diagnostic labels as “catch-all” means of describing an individual (e.g., “she’s a borderline”). Such labels yield minimal information regarding the person’s actual experience or manifestation of their condition. Alternatively, a person’s needs are not well captured by a label, but by an accurate description of his or her functional strengths and limitations. While diagnostic profiles are required for other purposes (e.g., decisions regarding medication, justification of level of care), strength-based assessment places limited value on diagnosis per se. In addition, acknowledging limitations and areas of need are not viewed as accepting one’s fate as “a mentally ill person” or “an addict.” Rather, identifying and accepting one’s current limitations is seen as a constructive step in the process of recovery. Gaining a sense of perspective on both strengths and weaknesses is critical in this process as it allows the person to identify, pursue, and achieve life goals despite the lingering presence of illness or disability.
- C.16.16.** Persons in recovery give thoughtful consideration to the strengths and resources available within their existing relationships (e.g., with family,

friends, neighbors, workplace, faith community, etc.) and incorporate these strengths and resources into their recovery plan, as appropriate.

**C.16.17.** Persons in recovery review their personal history for successes and periods of enhanced functioning they have experienced, as well as strategies they have used to manage difficult situations and to achieve goals. They build their recovery plans based in part on making use of these strengths and strategies to address new and future challenges.

**C.16.18.** Persons in recovery discuss their strengths and successes with others, including friends, family, and colleagues, as appropriate, in order to gain perspective and generate new ideas to support the recovery planning process.

**C.17. Practitioners providing recovery-oriented care function as recovery or community guides as evidenced by the following:**

**C.17.1.** The primary vehicle for the delivery of most mental health or substance use treatment is the relationship between the practitioner and the person in recovery. The care provided is grounded in an appreciation of the possibility of improvement in the person's condition, offering people hope and/or faith that recovery is "possible for me."

**C.17.2.** Practitioners convey belief in the person even when he or she cannot believe in him or herself and serve as a gentle reminder of his or her potential. In this sense, staff envision a future for the person beyond the role of "mental patient" or "addict" based on the person's own desires and values and share this vision with the person through the communication of hope and positive expectations.

**C.17.3.** Practitioners assess where each person is in relation to the various stages of change (e.g., pre-contemplation, preparation, etc.) with respect to the various dimensions of his or her recovery. Interventions are appropriate to the stages of change relevant to each focus of treatment and rehabilitation (e.g., a person may be in an action phase related to his or her substance use but be in pre-contemplation related to his or her mental health condition).

**C.17.4.** Care is based on the assumption that as a person recovers from his or her condition, the substance use or mental health condition then becomes less of a defining characteristic of self and more simply one part of a multi-dimensional sense of identity that also contains strengths, skills, and competencies. Services elicit, flesh out, and cultivate these positive elements at least as much as, if not more than,

assessing and ameliorating difficulties. This process is driven by the person in recovery through inquiries about his or her hopes, dreams, talents, and skills, as well as perhaps the most important question of “How can I be of help?”

- C.17.5.** Interventions are aimed at assisting people in gaining autonomy, power, and connections with others. Practitioners regularly assess the services they are providing by asking themselves: “Does this person gain power, purpose (valued roles), competence (skills), and/or connections (to others) as a result of this interaction?” and, equally important: “Does this interaction interfere with the acquisition of power, purpose, competence, or connections to others?”
- C.17.6.** Opportunities and supports are provided for the person to enhance his or her own sense of personal agency. For example, practitioners understand that medication is only one tool in a person’s “recovery tool box” and learn about alternative methods and self-management strategies in which people use their own experiences and knowledge to apply wellness tools that work best for them. Sense of agency involves not only feeling effective and able to help oneself but also being able to positively impact the lives of others. Practitioners can promote this by thoughtfully balancing when to do for someone, when to do with someone, and when to let someone do for him or herself. Knowing when to hold close and support and protect, when to encourage someone while offering support, when to let someone try alone and perhaps stumble, and when to encourage a person strongly to push themselves is an advanced, but essential, skill for practitioners to develop. While these are intuitive skills that all practitioners struggle to refine over time, prior to taking action it is often beneficial for practitioners to ask the question: “Am I about to do for this person something she or he could manage to do more independently?” Acting for another person when unnecessary, even with the best of intentions, can send messages of low expectations and incapacity.
- C.17.7.** Individuals are allowed the right to make mistakes, and this is valued as an opportunity for them to learn. People in recovery report that they have found meaning in adverse events and failures and that these have subsequently helped them to advance in their recovery. In accordance with this, practitioners recognize that their role is not necessarily to help people avoid adversity or to protect them from failure. For example, the re-experiencing of symptoms can be viewed as a part of the recovery process and not necessarily a failure or setback. The “dignity of risk” ensues following a thoughtful and proactive planning process in which practitioners work collaboratively with individuals to

develop relapse prevention plans, including advance directives which specify personal and treatment preferences in the event of future crises.

- C.17.8.** People are allowed to express their feelings, including anger and dissatisfaction, without having these reactions immediately or routinely attributed to symptoms or relapse.
- C.17.9.** Care is not only attentive to cultural differences across race, ethnicity, and other distinctions of difference (e.g., sexual orientation), but incorporates this sensitivity at the level of the individual. Only an individual-level process can ensure that practitioners avoid stereotyping people based on broad or inaccurate generalizations (e.g., what all lesbians want or need), and enable them instead to tailor services to the specific needs, values, and preferences of each person, taking into account each individual's ethnic, racial, and cultural affiliations.
- C.17.10.** Rather than dwelling on the person's distant past or worrying about the person's long-term future, practitioners focus on preparing people for the next one or two steps of the recovery process by anticipating what lies immediately ahead, by focusing on the challenges of the present situation, and by identifying and helping the person avoid or move around potential obstacles in the road ahead. Although the practitioner deemphasizes the person's early personal history (because it may not be relevant) and long-term outcome (because it cannot be predicted), either of these perspectives may be invoked should they prove useful in the current situation. Especially as these issues pose barriers to recovery, practitioners utilize appropriate clinical skills within the context of a trusting relationship in order to enhance the person's capacity to overcome, compensate for, or bypass these barriers.
- C.17.11.** Interventions are oriented toward increasing the person's recovery capital as well as decreasing his or her distress and dysfunction. Grounded in a person's "life-context," interventions take into account each person's unique history, experiences, situations, developmental trajectory, and aspirations. In addition to culture, race, and ethnicity, this includes less visible but equally important influences on each person's development, including both the traditional concerns of practitioners (e.g., family composition and background, history of substance use and relapse triggers) as well as less common factors such as personal interests, hobbies, and role models that help to define who each person is as an individual and as a member of his or her network.

- C.17.12.** Practitioners are willing to offer practical assistance in the community contexts in which people live, work, and play. In order to effectively address “individuals’ basic human needs for decent housing, food, work, and ‘connection’ with the community,” practitioners are willing to go where the action is, i.e., they get out of their offices and out into the community.<sup>43</sup> They are prepared to go out to meet people on their own turf and on their own terms, and to “offer assistance which they might consider immediately relevant to their lives.”<sup>44</sup>
- C.17.13.** Care is not only provided in the community but is also oriented toward increasing the quality of a person’s involvement in community life. Thus, the focus of care is considered more important than locus of where it is provided. The focus of care includes the process of overcoming the social and personal consequences of living with psychiatric and/or substance use disorders. These include gaining an enhanced sense of identity and meaning and purpose in life and developing valued social roles and community connections despite a person’s continued symptoms or disability. Supporting these goals requires that practitioners have an intimate knowledge of the communities in which people live, the community’s available resources, and the people who are important to them, whether it is a friend, parent, employer, landlord, or grocer. Practitioners also are knowledgeable about informal support systems that are in communities such as support groups, singles clubs, and other special interest groups, and actively pursue learning more about other possibilities that exist to help people connect.
- C.17.14.** Efforts are made to identify sources of incongruence between the person and his or her environment and to increase person-environment fit. This is done both by helping the person assimilate into his or her environment (through symptom management, skill acquisition, etc.) and by helping the community to better accommodate people with disabilities (through education, stigma reduction, the creation of niches, etc.), with the common goal being to develop multiple pathways into and between members of communities.
- C.17.15.** In order to counteract the often hidden effects of stigma, practitioners explicitly draw upon their own personal experiences when considering the critical nature of various social roles in the lives of all individuals (e.g., being a parent, a worker, a friend, etc), continuing to view people

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<sup>43</sup>Curtis, L.& Hodge, M. (1994). Old standards, new dilemmas: Ethics and boundaries in community support services. *Psychosocial Rehabilitation Journal*, 18(2), 13-33.

<sup>44</sup> Rosen, A. (1994). Case management: The cornerstone of comprehensive local mental health services. *Australian Hospital Association, Management Issues Paper No. 4*. April, 47-63.

in recovery squarely within the context of their daily lives (i.e., as opposed to within institutional settings).

### **Example of how this might look in practice**

At times, following a training on functioning as a recovery guide, practitioners have asked how to get people who appear to be disinterested or who lack motivation or personal goals to get on the tour bus. One response is that we are to get on their ‘bus’, join them on their recovery journey, rather than try to persuade them to join us on ours. How to do so, however, is the challenge. The following story provides one example of what this process might look like; in this case involving a real bus.

*Tyrese* was a man in his 40’s who spent the majority of his days sitting in a chair or on a couch at the drop-in center, smoking cigarettes and watching television. While he conversed with others on occasion, he seemed just as happy to sit by himself, lost in his thoughts, cigarette smoke, or the television show that happened to be on at the moment. His appearance was disheveled and he would occasionally blurt out something which appeared to be in response to hallucinated voices. In this respect, Tyrese was perhaps not as alone as he appeared. Although this drop-in center had a fairly lenient policy regarding “hanging out,” the staff eventually became concerned about Tyrese and what, if anything, he was getting from his visits to the drop-in center. He repeatedly turned down invitations to participate in activities and responded to the suggestions of his peers and staff about what else he might do by conveying disinterest. He appeared to be stuck, and the staff began to feel stuck with him as well.

When it came time for his service review, the only goal which Tyrese could identify that interested him was a job. He had no work history, had not graduated high school, had no identifiable skills, and could not—or would not—state any more clearly what kind of job he might be interested in. All of the efforts the members and staff of the drop-in center made to involve Tyrese in activities were fruitless. Everyone appeared to have run out of ideas and figured that it was least better for Tyrese to come to the drop-in center everyday even if he did nothing than to remain at home alone.

Shortly after the staff became resigned to viewing the drop-in center as a better alternative for Tyrese than his staying home alone it occurred to a staff member to wonder about what Tyrese’s home life was like. Where, in fact, did he live? And with whom? It had not occurred to them to ask, or when they did ask, Tyrese had not been forthcoming with answers. No one seemed to know much about his life outside of the drop-in center. With this recognition, one staff member—the one who first wondered about what Tyrese did outside of the drop-in center, and with whom—decided that this was a mystery that could be solved. He decided to spend

more time with Tyrese and try to learn more about his life. Tyrese, however, would not answer the usual questions of who he lived with, where, etc. Finally, more out of desperation than anything else, the staff member asked Tyrese “Well, how do you get here every day?” To this question, and to the staff member’s surprise, a small light shone in Tyrese’s eyes and he responded “I take the bus.” “Which bus?” the staff member persisted. After further discussion it emerged that Tyrese in fact took two buses to the drop-in center each day, that he lived on the other side of town, and that Tyrese did not mind the 45 minute bus ride but, in fact, enjoyed the rides back and forth as much as his time at the drop-in center.

Tyrese, it turned out, enjoyed buses, enjoyed riding buses, and knew more about the bus system in this city than just about anyone else outside of the bus company. When the staff member asked to accompany Tyrese home from the center one day, Tyrese talked non-stop throughout the 45 minute ride and change of buses about the different routes, the different schedules, and how he had learned over the years to be able to get from any point in the city to any other point by taking no more than three buses. The staff member also noticed that while he was on the bus, Tyrese appeared to be animated, attentive, and interested. He didn’t have time to entertain or respond to voices, as he was busy greeting the bus driver, explaining the routes to his fellow rider, and savoring each moment of the ride. At the end of their first ride together, it came as no surprise to the staff member that Tyrese confided to him that what he liked most about the drop-in center was the fact that it provided bus tokens at a reduced rate (and had a wide screen television).

The staff member shared his experiences with Tyrese and his new insights into his life outside the drop-in center with the staff, but no one had any immediate ideas about what to do with this information. Then, when budget cuts came down from the state and the program had to give up its van and transportation service, the staff had to brainstorm and problem solve about how some clients would be able to get to the center. During this discussion, one staff member initially quipped that perhaps Tyrese could teach other members how to use the bus service. What started out as a joke quickly was turned into a proposal, however, and Tyrese was approached with the idea. Would he be interested in teaching other members about the city’s bus system, and would he be willing at first to ride with them and show them the routes until they became comfortable themselves?

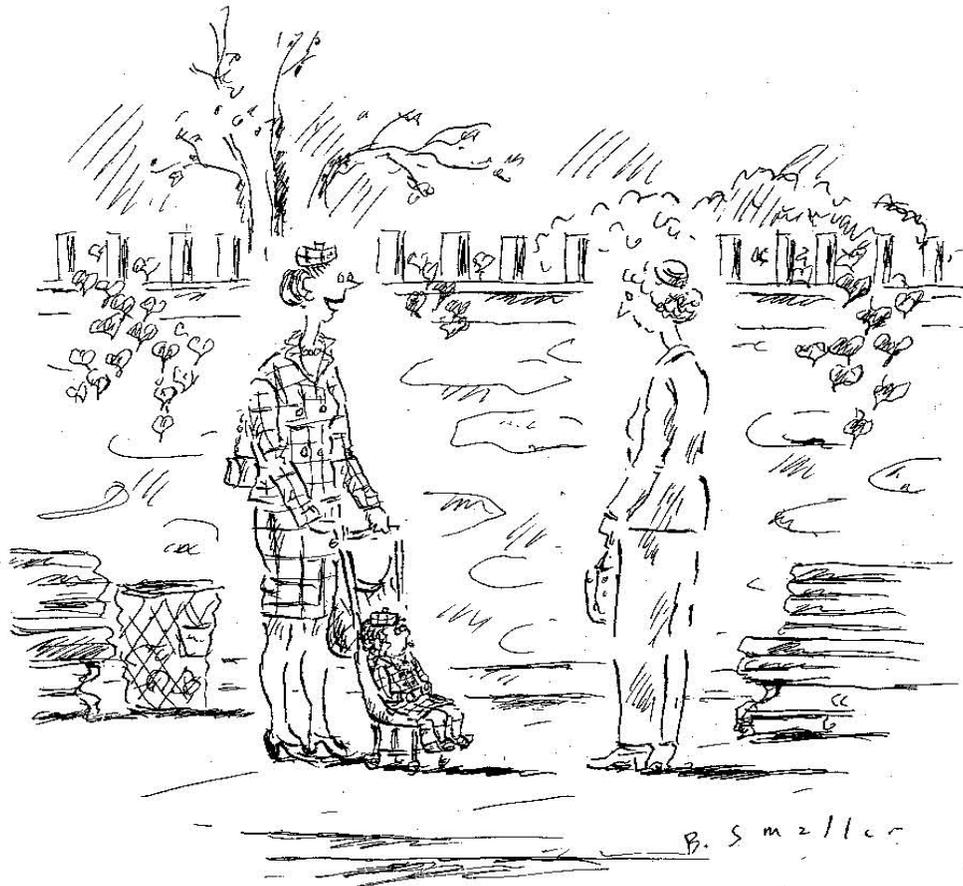
To the staff’s surprise, Tyrese’s eyes again lit up and he responded with excitement. The fact that the staff were even willing to pay him for this service did not seem to be as important to him as the fact that he was being seen, and valued, for what he had to offer. While becoming the bus trainer did not stop his voices or initially improve his hygiene, it did engage Tyrese in the life of the center, enabled him to make friends among his peers, and got him up off the couch. Over time, however, he did wash and cut his hair so that he could wear a new baseball cap he had bought with the word “conductor” on the front.

## What you will hear from people in recovery when you are offering person-centered care:

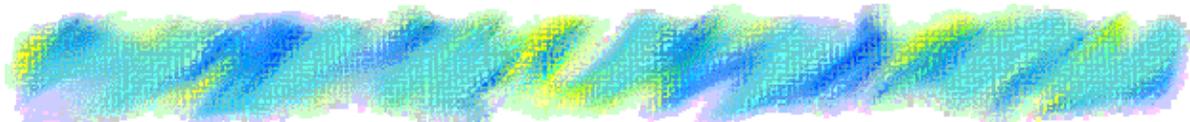
- *It's amazing what you can do when you set your mind to it ... especially when you're no longer supposed to have one!*
- *She believed in me, even when I didn't believe in myself. Hope was the biggest gift she could have given me... and it saved my life.*
- *It made such a huge difference to have my pastor there with me at my planning meeting. He may not be my father, but he is the closest thing I've got. He knows me better than anyone else and he had some great ideas for me.*
- *I used to think my life was over, but my illness isn't a death sentence. Its just one small part of who I am. Sometimes I forget about those other parts – the healthy parts of me. But my counselor always reminds me. You really need someone like that in your life.*
- *Not everybody thought it was a good idea for me to try to get my daughter back. But they realized that without her, I didn't have a reason to be well. So, we figured out a plan for what to do if I couldn't handle the stress, and my team has stood beside me every step of the way. Was it "too stressful" at times? You bet! But every day is a blessing now that I wake up and see her smiling face!*
- *I thought I was so alone in my problems. I may not feel as though I have much strength right now, but I realize I can draw strength from all the people around me... my friends, my neighbors, my pastor, and my counselors here.*
- *When they asked me about what I was good at and what sorts of things in my life made me happy, at first I didn't know who they were talking to. Nobody ever asked me those kinds of questions before. Just sitting through that interview, I felt better than before I had walked through the door!*
- *No one here treats me like a label. Just because I have schizophrenia, that doesn't tell you a whole lot. My roommate does too, but we couldn't be more different. Folks here take the time to get to know lots of things about me, not just the things that go along with my diagnosis.*
- *When he asked me, "So how can I best be of help!" I thought, "Oh great, I've really got a green one. You are supposed to be the professional—you tell me!" But I get it now. I need to decide what I need to move ahead in my recovery. And I needed to know it was OK to ask people for that. That was the key.*

- *When she ever showed up on my doorstep with a bag of clothes so my baby could start kindergarten, I knew this one was different. I couldn't care about myself or my recovery until I knew my kids were OK. She didn't pity me, or look for a pat on the back. She just knew, this was what I needed and it made all the difference in my recovery.*
- *I was terrified of going back to that hospital. My case manager couldn't guarantee me that it wouldn't happen again. But we sat down together and did a plan for how to make things different if there ever was a "next time." Knowing my dog would get fed, making sure somebody talked to my landlord so I wouldn't get evicted, and being able to write down how the staff could help me if I lost control... All those things made the idea of going back less scary.*

### **The Importance of Not Overlooking the (not so) Obvious**



*"Isn't it funny? We have the exact same taste!"*



## D. Recovery-Oriented Care is Effective, Equitable, and Efficient

Quality is considered a cornerstone for the DMHAS-funded system of health care. For care to be characterized by quality as well as its recovery orientation, it is essential that it be effective, equitable, and efficient. Effective care is that which has been shown to be useful in reducing illness and disability and improving functioning and quality of life. It may be based on several different types and levels of evidence, and reflects the best care a system can offer at any given point in time. Equity ensures that care is provided to all those who would benefit from it and speaks to the need to ensure that care does not vary in quality or effectiveness due to personal or social characteristics such as gender, ethnicity, race, sexual orientation, religious affiliation, geographic location, or socioeconomic status. Finally, efficiency results from the thoughtful allocation and management of resources in such ways that maximize access and effectiveness and minimize barriers and wasted time or effort.

*It remains important ... that the services and supports offered are the best available for the persons being served at any given time.*

As we noted in the Introduction, *effectiveness* has been emphasized in recent years through a focus on the ‘evidence’ base that has been established for any particular intervention. Ideally, this evidence would be collected scientifically and would meet rigorous criteria for having demonstrated the benefits it generates in relation to a given condition or combination of conditions. Unfortunately, very few practices have been evaluated in such a rigorous way and even fewer practices have been evaluated with diverse populations having complex needs. Being tightly controlled studies, many people served by the DMHAS-funded system of care would be excluded from randomized clinical trials due, for example, to co-morbid conditions, linguistic or cultural needs, or social-economic status and living situation. It therefore would be inappropriate for DMHAS to adopt a narrow vision of the nature of “evidence” and to limit the array of services and supports offered to those which have been evaluated through rigorous experimental trials.

It remains important nonetheless that the services and supports offered are the best available for the persons being served at any given time. In addition to the accumulation of scientific evidence, the utility of interventions can be determined based on the experiences and feedback of those individuals who have used them, the ability of such interventions to engage individuals who otherwise would not be served, and by the degree to which such interventions are requested or selected by the people for whom they are intended. Within this context, then, choice plays a key role in helping to identify which interventions are responsive to the needs of which individuals. It is especially important to take choice into account in this way because the few evidence-based practices that exist have been developed and evaluated with

narrowly defined populations. With recognition of this dimension of the current system, concerns with effectiveness necessarily lead to concerns with equity.

*Equity*, as noted above, relates to care being provided to all those who will benefit from it and in such a way that it does not vary in quality or effectiveness depending upon such factors as gender, ethnicity, race, sexual orientation, religious affiliation, geographic location, or socioeconomic status. While in some arenas this concern with equity might translate into a commitment to provide the same care to every person irrespective of their culture, race, etc., it is precisely this kind of ‘one-size-fits-all’ model which has not worked in medicine in general and in mental health and substance use in particular. The ample literature on health disparities mentioned earlier has demonstrated convincingly that equity can only be achieved by tailoring

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care to the unique needs, values, and preferences of individuals and, on a broader scale, of the communities from which they come. It is for this reason that DMHAS views the primary mechanism for eliminating health disparities as being the provision of culturally responsive and competent care. In addition to ethnicity and race, cultural

competence requires care to be responsive to gender and possible trauma history, sexual orientation, religious affiliation, and social-economic status.

In this section of the Guidelines, we therefore reiterate some of the key principles and standards articulated by the DMHAS Office of Multicultural Affairs separately in its *Multicultural Behavioral Health Care: Best Practice Standards and Implementation Guidelines*. We also include principles and guidelines related to gender and trauma suggested by the DMHAS Women’s Services Practice Improvement Collaborative and several consultants who have been involved in introducing trauma-informed and trauma-sensitive care into the DMHAS-funded system of care over the preceding decade.<sup>45</sup> We address stigma and discrimination as barriers to equity and, in order to explicitly address the prevalence of co-morbid or co-occurring conditions within the populations served by DMHAS-funded care and their impact on a person’s access to effective care, this section also incorporates the suggestions of Commissioner’s Policy Statement #84 on Serving People with Co-Occurring Mental Health and Substance Use Disorders along with the Co-Occurring Enhanced Program Guidelines and Workforce Competencies developed by the DMHAS Workgroup on Co-Occurring Disorders.

<sup>45</sup> In particular, the work of Roger Fallot and Maxine Harris of Community Connections in Washington, D.C.

At this point in time, it is difficult to articulate guidelines for ensuring that care is provided in an optimally *efficient* manner. Much remains to be learned in this area, and there are ongoing efforts to collect the kinds of data which would enable practitioners to determine which forms of care delivered in which ways represent maximum efficiency. It is possible, however, to suggest that timely and responsive care offered earlier in the course of illness, or earlier in the course of a given episode, will be more cost and time efficient than care that is delayed or sought at a later point in time when the condition has wrought more havoc in the person's life and in the lives of his or her loved ones. It also is reasonable to suggest that it is more efficient to provide services in the least restrictive, least costly, and least intensive setting possible, and that systems need not recreate through artificial means those settings which already exist in the broader community. For the purposes of these Guidelines, then, efficiency will be interpreted primarily in terms of the intensity, location, duration, and timeliness of the care offered based on the suggestion that people will derive the most benefit from being able to access the services and supports needed at the time and for as long as they are needed, with the emphasis in care shifting from acute, institutional-basis services to more natural and community-based supports over time as the person progresses in his or her recovery.

*It is more efficient to provide services in the least restrictive, least costly, and least intensive setting possible ...systems need not recreate through artificial means those settings which already exist in the broader community.*

**You will know that you are providing effective,  
equitable, and efficient care when:**

**At the System/Agency Level**

- D.1. Systemic structures and practices which inhibit the adoption of recovery-oriented practices are identified and addressed.**
- D.1.1.** Well intentioned efforts to provide a full continuum of care have led to a system in which people are sometimes expected to enter in, and progress through, a range of services in a sequential fashion as they stabilize and move toward enhanced functioning and independence. The misapplication of this model has led to systems of care in which individuals are then expected to jump through hoops in order to earn their way into less restrictive settings (e.g., an expectation that they prove they can prepare three meals a day or keep their living space clean before they can move out of a group home) or to earn the right to participate in preferred services (e.g., an expectation that they comply with medication before they will be referred to supported employment).

In addition to there being an accumulating body of evidence which demonstrates the failure of such a continuum approach and its lack of efficiency, this sequential movement through pre-existing continua of supports is inconsistent with the civil rights perspective noted above and contradicts current knowledge suggesting that recovery is neither a linear process nor a static end product or result. Rather, it is for many a life-long experience that involves an indefinite number of incremental steps in various life domains, with people moving fluidly between the various domains over time (as opposed to moving through them in a systematic, linear way). Rather than a pre-established continuum of services, what is necessary is a flexible array of supports that each person can choose from at different points in time depending upon his or her phase of recovery and unique needs and preferences. This array is also constantly evolving based on the input of persons in recovery, the experience of practitioners, and the research literature.

- D.1.2.** The structure of certain outcome indicators places significant pressures on agency staff to operate in a manner that they see as inconsistent with recovery-oriented care. For example, staff might like to support persons in making choices regarding their housing preferences, such as moving to a less intensive level of supported housing. They may legitimately be concerned, though, that they will be held accountable should the result of such a person's choice ultimately be a negative one. This accountability is not limited to the potential adverse events themselves, but is further accentuated through the agency's collection of mandatory performance data, such as statistics regarding the number of individuals who move from housed to homeless.

The resulting need to portray the agency's performance on such indicators as positive creates a strong incentive for the maintenance of stability as a desired outcome in and of itself. In contrast, a desired goal of recovery-oriented care is to promote growth, independence, and wellness; goals which sometimes involve the taking of reasonable risks that may result in interim set-backs. At both the agency and system level, quality management tools and outcome indicators are examined and mechanisms are built in to track the trade-off which sometimes exists as we support individuals in taking risks to grow and advance in recovery while requiring practitioner accountability within the system.

- D.1.4.** Quality assurance and independent audits by people in recovery and families are funded and coordinated. Outcomes and assessment of quality do not focus solely on the rating of services or supports, but on whether the choices people make are personally meaningful and whether recovery-oriented care leads to a valued community life.

**D.1.5.** Initial placement and service design currently is driven by practitioners' assessments of what the individual seeking services needs. While this assessment remains a critical element of the process, it also is coupled with questions, directed to the person and answered in his or her own words, which solicit the individual's perception of what care would be most helpful at the time. Individuals are engaged as active partners in their care in this way from the outset of treatment.

This can only be achieved with greater transparency in the system of care as a whole and with greater involvement of the person and family in all important decision-making processes, including the decision of initial level of care and team or program assignment.

**D.1.6.** Despite legislative advances in the past decade, the structure of federal and state disability, benefits, and vocational programs continue to impede the wish of many individuals of entering, or reentering, the workforce, thereby excluding them from an activity which many have described as a cornerstone of recovery. Rigid definitions of disability, earnings limits which perpetuate poverty, a lack of supported employment programs, and complex referral procedures drastically reduce the likelihood that individuals will access necessary supports and return to meaningful employment. To integrate employment within the larger system of care, the task of assisting people in pursuing employment and education is taken to be inherent to the responsibilities of the entire practitioner network, including those not specifically charged with work service or supported education activities.

**D.2. The implementation of recovery-oriented care is currently both impeded and facilitated by funding, reimbursement, and accreditation structures. Ongoing efforts are made to lessen the barriers and increase the incentives offered by these structures to promote the creative formulation of recovery-oriented goals and objectives.**

**D.2.1.** Rules and regulations dictating eligibility and reimbursement for Medicaid and other public programs must be adapted at the federal level over time for greater relevance to innovative, recovery-oriented approaches. Even though Medicaid is funded by federal dollars, it remains primarily a state-administered program, however, and considerable flexibility exists already in using these funds to support innovative, community-based, recovery-oriented services and supports.

**D.2.2.** Within existing funding structures, training and technical assistance is provided to practitioners implementing recovery-oriented practices to assist them in learning how to translate people's wishes into reimbur-

sable service goals and to describe their interventions in a manner that generates payment. Above and beyond these “necessary” (i.e., billable) services, the individualized recovery plan also incorporates action steps taken by both the person in recovery and his/her natural supports.

**D.2.3.** Operating in this manner is consistent with the growing understanding that recovery-oriented practices cannot be limited to being an add-on to existing care for which additional funding must always be secured. Rather, recovery-oriented care begins with discovering ways to be creative and flexible within the constraints of existing resources. In some cases, for example, braiding funds may enable collaborations to move beyond funding silos to provide people with flexible, highly individualized services.<sup>46</sup> Programs that successfully utilize such alternatives are expanded.<sup>47</sup>

**D.2.4.** Self-directed funding opportunities are piloted both on a collective basis and through individualized budget programs. The Florida “Self-Directed Care” initiative is an example of such a program that shifts fiscal control from the hands of service providers to the hands of service users. Within this program, participants are given control of their service dollars and then are free to shop around to weave together the type and frequencies of services that may best respond to their individual interests and preferences. While this approach has proponents, there is also an inherent tension and uncertainty about whether there is any guarantee that high quality services will be available to purchase if there are no consistent funding underpinnings. A robust practitioner network is needed and it must be easily accessible.

**D.3. Training and staff development is prioritized as an essential function to increase practitioners’ competency in providing recovery-oriented care.**

**D.3.1.** As consensus emerges regarding the knowledge and skills needed to implement recovery-oriented care, this information leads to development of competency models, and these models are disseminated broadly as guidance for training programs and licensing bodies which prepare and accredit future and current providers of mental health and substance use care. These models also are used to address training gaps

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<sup>46</sup>Osher, D., Dwyer, K. & Jackson, S. (2004). *Safe, supportive, and successful schools step by step*. Longmont, CO: Sopris West; Poirier, J., Osher, D. & Tierney, M. (in press). Understanding the new environment of public school funding: How pupil services are funded. In C. Franklin, M.B. Harris & C. Allen-Meares (Eds.) *School social work and mental health workers training and resource manual*. New York: Oxford University Press.

<sup>47</sup>Blessing, Tierney, Osher, Allegretti-Freeman, & Abrey. (2005). *Person-centered planning: Learning from other communities*, Washington D.C.: Substance Abuse and Mental Health Services Administration.

in pre-certification curriculum as well as ongoing professional development activities.

- D.3.2.** Once established, competency models—which are largely under-utilized—are incorporated into human resource activities (e.g., hiring, routine performance evaluation, promotion decisions, staff development targets, etc.) as a means of promoting accountability.
- D.3.3.** An analysis of current staff competencies and self-perceived training needs guide the development of on-going skill-building activities at the agency level. For example, practitioners are frustrated by the fact that they are overwhelmed by a constant stream of change mandates for which they receive little or no training or support. There are beneficial, self-reflective tools<sup>48</sup> that can be used to conduct a training needs analysis which identifies both strengths and areas in need of improvement as it relates to the provision of recovery-oriented care. Gaps in skill sets can be identified and prioritized for development.
- D.3.4.** Training in and of itself does not allow practitioners to develop the enhanced skill set and increased sense of efficacy that will allow them to carry out the complex responsibilities and roles of the recovery-oriented practitioner. Competency-based training therefore is coupled with on-going mentoring support, clinical supervision, recovery-oriented case conferences, and opportunities for peer consultation.
- D.3.5.** Agency leaders are involved in ongoing training so that there is consistency between proposed recovery-oriented practices and administrative structures. This allows direct care staff to be supported and allows agency leadership the opportunity to proactively identify and address systemic barriers that prohibit adoption of recovery-oriented practices.
- D.3.6.** Training and staff development activities are sensitive to the confusion which can be involved with the adoption of recovery-oriented practice. Recovery-oriented care does *not* imply that there is no longer any role for the practitioner to play. Rather, the practitioner’s role has changed from that of all-knowing, all-doing caretaker to that of a skilled educator, coach, mentor, cheerleader, or facilitator<sup>49</sup>—roles that are not

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<sup>48</sup>Campbell-Orde, T., Chamberlin, J., Carpenter, S. & Leff, S. (2005). *Measuring the promise: A compendium of recovery measures, Volume II*. Boston: Human Services Research Institute.

<sup>49</sup>Adams, N. & Grieder, D. (2005). *Treatment planning for person-centered care: The road to mental health and addiction recovery*. San Diego, CA, US: Elsevier Academic Press; Davidson, L., Tondora, J., Staeheli, M., O’Connell, M.J., Frey, J. & Chinman, M.J. (2006). Recovery guides: An emerging model of community-based care for adults with psychiatric disabilities. In A. Lightburn & P. Sessions (Eds.), *Community-based clinical practice*. Oxford University Press, New York.

always consistent with one's clinical training or expertise. One effective educational strategy is to use a combination of literature, outcomes or efficacy data, and personal accounts such as recovery dialogues to help practitioners learn the new roles of advisor, mentor, guide, coach, or supports broker.<sup>50</sup>

Further, those involved in educating practitioners about self-determination and recovery-oriented care have found that acknowledging staff's fears and doubts, rather than dismissing or shaming them, is more likely to lead them to accept a new role in the lives of the people they serve.<sup>51</sup> The application of sophisticated and effective clinical practices in the larger context of collaborative partnerships and self-determination is a training area that requires ongoing attention.

**D.3.7.** No matter how competent the workforce, no matter how ripe the culture, and no matter how compatible the funding mechanisms, recovery-oriented care will not become a reality unless people in recovery and their families understand it, are supported in using it, and come to view it as a basic expectation of quality care. Therefore training initiatives regarding recovery-oriented care do not neglect the needs of people in recovery and families to develop their own capacity to self-direct their treatment and life decisions. Some may already do this with great skill and acumen. Others may be reluctant to assume the seat of power, having been socialized by their culture<sup>52</sup> or taught by practitioners and agencies that their preferred role is one of deferential compliance.<sup>53</sup> Ideally, training initiatives put all stakeholders, including people in recovery, families, and practitioners, at the same table.

**D.4. Forces at the societal level (e.g., stigma, discrimination, lack of basic resources, etc.) that undermine recovery and community inclusion are identified and addressed.**

**D.4.1.** A lack of basic resources and opportunities (e.g., jobs, affordable housing, primary medical care, educational activities) in the broader community significantly complicates the task of recovery for persons with mental health and/or substance use conditions. This lack of resources and opportunities often stems from inadequate knowledge

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<sup>50</sup>Jonikas, Cook, Fudge, Hiebechuk & Fricks. (2005). *op cit*.

<sup>51</sup>Holburn, S. & Vietze, P. (2002). *Person-centered planning: Research, practice, and future directions*. Baltimore: Paul Brookes Publishing.

<sup>52</sup>Harry, B., Kalyanpur, M. & Day, M. (1999). *Building cultural reciprocity with families*. Baltimore, MD: Paul Brookes.

<sup>53</sup>Katz, E. & Danet, B. (1973). *Bureaucracy and the public*. New York: Basic Books.

and skills on the part of community organizations regarding how to create welcoming and accessible environments for all people. Health care practitioners have significant expertise to address this skill and knowledge gap, and are prepared to offer supportive guidance and feedback at both the individual and community level. For example, consultation with an employer regarding the impact of a medication on an individual's stamina can lead to a reasonable accommodation in the work place which allows greater productivity and success on the job—an outcome which is ultimately beneficial to both parties. Provided appropriate support and consultation, many community members are excellent collaborators and become facilitators of community inclusion.

**D.4.2.** Despite the promise of such collaborations, discrimination against people with mental health and/or substance use conditions will most likely continue for the foreseeable future. Community collaborations and education are therefore coupled with efforts on the part of practitioners to recognize instances of discrimination, to understand relevant disability legislation (e.g., the Americans with Disabilities Act), and to develop effective relationships with state and local resources (e.g., the Connecticut Legal Rights Project, the Office of Protection and Advocacy, the Equal Opportunity Employment Commission, advocacy organizations, etc.) to facilitate individual's access to and support in self-advocacy. This type of knowledge is built within the consumer community so people in recovery can protect themselves by recognizing and rectifying instances of discrimination.

**D.4.3.** Agencies are cautious to avoid the establishment of 'one stop shops'. In an effort to respond simultaneously to individuals' complex needs while also protecting them from discrimination, agencies may develop in-house alternatives to community activities based on concern that the community will never accept individuals with mental health and/or substance use conditions. As a result, agencies may create in artificial settings activities that already exist in the natural community; e.g., developing in house medical clinics, movie nights, GED classes, social events, etc. Agencies providing a one stop shop may also inadvertently contribute to the development of chronic "patienthood" as well as the perpetuation of discriminatory practices in the community. It therefore is incumbent upon recovery-oriented systems to work with community partners to uphold their obligation to respect people with mental health and/or substance use conditions as citizens who have the right to be treated according to the principles of law that apply to all individuals.<sup>54</sup>

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<sup>54</sup>National Council on Disability. (2000). *From privileges to rights: People labeled with psychiatric disabilities speak for themselves*. Downloaded from <http://www.ncd.gov/newsroom/publications/privileges.html>

- D.5.** Agency administrators monitor the treatment outcomes and satisfaction of individuals based on race and ethnicity, gender, gender identity, sexual orientation, trauma history, and religious and socio-economic background and implement changes in services and service delivery to address disparities.
- D.6.** Qualified interpreters are available within one hour for crisis situations and within twenty-four hours for routine situations. Information about qualified interpreters is maintained in the agency and the list of such resources is updated at least annually. Staff is trained and knowledgeable about when and how to utilize interpreters across diverse groups.
- D.7.** Practitioners make available and disseminate culturally-relevant and linguistically-appropriate information regarding local mental health and addiction services, as well as non-traditional and self-help resources in a wide variety of formats.
- D.8.** Staff has and uses an available list of culturally- and linguistically-accessible services within the facilities and throughout the community.
- D.9.** The agency's educational materials are made available to individuals served and reflect the language and culture of those persons.
- D.10.** The social and physical environment within the agency reflects the diversity and culture of the persons served. Waiting areas and offices display magazines, art, music, etc., reflective of the diversity of persons served.

#### At the Practitioner/Person in Recovery Level

- D.11.** Care is tailored to address individuality and uniqueness, taking into account how race and ethnicity, gender, gender identity, sexual orientation, trauma history, and religious and socio-economic background and their unique interests, strengths, and goals all play a role in people's needs, values and preferences. Prejudicial remarks are addressed immediately.
- D.12.** Initial and ongoing assessments include cultural factors which may affect treatment and rehabilitation services and supports. Bilingual/bicultural staff are available to assess individuals both in their preferred language and within the context of their cultural heritage.
- D.13.** Involvement of family members, friends, and natural supports in the assessment process is invited and documented in the person's record.

- D.14.** Individuals in recovery are viewed as a primary source of information for identifying barriers to recovery. Information is solicited from individuals who are diverse in their gender, race and ethnicity, sexual orientation, religious and socio-economic background, family make-up (e.g. primary caregivers), and trauma history to increase access of these populations to effective care.
- D.15.** Recovery plans respect the fact that services and practitioners need not remain central to a person's life over time. Currently, many systems lack clearly defined exit criteria and it is not uncommon for individuals to feel as if they will be attached to a formal system for life following their entry into care. This perception perpetuates a sense of chronicity through which individuals lose hope that they will be able to resume a meaningful and productive daily life beyond treatment. In contrast, exit criteria are established and used to engage people in a collaborative decision-making process regarding the potential advantages and risks of moving to a lower level of care, with effort being made to respect the individual's desire to "graduate." When a person is strongly advised against "graduation," there is evidence in the recovery plan of concrete steps being taken by the individual and the team to reach this ultimate goal. In establishing exit criteria, agencies take caution to avoid punitive measures by which individuals are discharged from services for displaying signs or symptoms of their condition.

### **Example of how this might look in practice:**

A key component of effective care involves appreciating a person's cultural affiliations and the role of community resources in promoting and sustaining recovery. While practitioners will not always be intimately familiar with the nature of these affiliations or resources, they will be prepared to find out more about them as needed and to make connections to others members of these communities who can offer information, guidance, and/or direct support. This was the case for Shirley, who described how her counselor's attention to her faith and connection to her church helped to serve as a turning point in her recovery and in her life.

*Shirley* was a woman in her forties who had been through a detox program several times and each time had been referred to an outpatient program for ongoing treatment for an opiate addiction. Following discharge from detox, however, Shirley would soon pick back up with her drug-using friends and resume drug use, attending the program only sporadically and eventually being discharged for ongoing use and poor attendance. After three similar episodes of drug use followed by detox followed by inconsistent outpatient treatment followed by a resumption of drug use, the team

at the outpatient program decided that a new approach was needed to engage Shirley in care. Shirley was assigned a counselor who had recently taken training in motivational interviewing and the counselor began to practice her newly learned motivational interviewing skills with Shirley. In exploring what happened following discharge from detox, Shirley described returning to her old friends because, in her words, they “accept me as I am.” With her family having been alienated by her drug use and having no other friends except for her drug-using peers, Shirley quickly became isolated and lonely once back out in the community. And with no where to go and nothing to do during the day except for a few hours a week spent at the outpatient program, Shirley felt inevitably drawn back to her old friends. It was a trap that she could not find a way out of.

In further discussions, Shirley’s counselor asked her about other times or places in her life in which she had felt a similar sense of being accepted. Were these the only people in her life, was this the only community, from which she felt such a degree of understanding and appreciation of who she was and what she had to offer without asking or requiring her to change? Shirley first identified that the feeling of having to change to please people was very prominent in her family, and one reason for their falling out and no longer having contact with each other. She had always had a stormy relationship with her father in particular, who she described as ‘whipping’ her with his belt and hitting her whenever she would step out of line. She then pointed out that it was this same sense of having to change which she picked up from the outpatient program, and one reason why she only attended sporadically—she did not feel accepted there “as she was.” With the counselor’s persistence in focusing more on the positives and strengths, however, Shirley eventually recalled and disclosed that she had felt that sense of acceptance from her church prior to drug use. It was not only her family who could not tolerate her drug use, but it was her church as well, and this sense of rejection appeared to be even more devastating to Shirley than her alienation from her family. At least at church she had once felt accepted unconditionally, or so she thought.

When asked by the counselor how she knew she was no longer accepted at church, Shirley was at first stuck for an answer. She couldn’t recall anything happening that gave her that sense; in fact, she had stopped going to church once she started using, assuming that ‘addicts’ would not be welcomed there. Shirley had been raised in a Baptist community which had strong prohibitions against alcohol and drug use. She thought that her drug use—which had become common knowledge within this small community—would be cause for her to be humiliated and rejected. She had chosen, instead, to stay away from church altogether so as not to run this risk. As a result, she ended up feeling rejected nonetheless.

Talking about church did not seem particularly helpful to Shirley at first, as it only served to remind her of the sense of rejection she had felt and to add further to her sense of guilt over her drug use. Resuming drug use and resuming her friendships

with other people who were similarly using opiates was one way of blocking out or covering over this sense of guilt. How would talking about church change that? Over time, though, the counselor was able to ask Shirley if she had ever seen anyone else who had used drugs being humiliated or rejected from her church. Would Shirley be interested in contacting her pastor and asking him about the church's attitude toward people who had 'fallen' into drug use? Were not forgiveness and loving acceptance important aspects of her religion as well? Shirley declined calling her pastor because he was an intimidating figure, she was afraid of him and his potential response. Were there church elders, then, who Shirley might feel comfortable talking with instead? Was there anyone in the church community who she still had a connection with and who she could discuss her concerns with? After much hesitation, Shirley identified an older woman who had taught Sunday school and who had always been kind to her; someone she had felt she could go to when she was in trouble when she was younger. She, however, would not be comfortable calling this person. It had been too many years and too much had happened; too much "water under the bridge."

After much consideration, Shirley eventually became comfortable, though, with having the counselor call this church elder and ask her a few questions. When the counselor made the call, she was assured that no one would be turned away from the church and that many people still had very positive feelings toward Shirley; in fact, the elder said that they missed her at church and had been very worried about her. They had heard about her being out "on the streets" and wished that she would come back and let folks help her out. While Shirley was surprised by the counselor's report of this conversation, she still did not feel comfortable enough to return to the church on her own, being unsure of the kind of reception she would receive. The counselor then suggested that they could pay the church a visit together, and perhaps arrange to meet with the elder there as a gradual way back in. Once having arranged for Shirley and the elder to be in the same room back at the church, the counselor did not feel that there was much else that she needed to do to help Shirley reconnect. The hugs that were given and tears that were shed, by both parties, were adequate testament that the church community still held much significance for Shirley and that it had been very important for her to return.

Shirley's drug use did not immediately stop, of course. She continued to struggle with her addiction for a while, went through detox a few more times, and relapsed a few more times as well before she was able to make a solid enough connection back to her church community that she no longer needed the acceptance offered by her drug-using peers. In retrospect, though, Shirley, who described how her counselor's attention to her faith and connection to her church helped to serve as a turning point in her recovery and in her life.

Now that she had re-established this connection and had her life going in the right direction, she was confident that she would not go back to the life of addiction again. She now knew how much she had to lose, as she had lost it all once before.

## What you will hear from people in recovery when you are offering effective, equitable, and efficient care:

- *The thought of getting discharged was so terrifying to me I almost didn't want to get well. But my case manager and I made sure that I had people and places I could go to for support when I needed it—and these folks had been involved in our work all along. It made a huge difference in my feeling good about taking the next step.*
- *I just didn't buy it when my clinician started talking to me about this thing called "consumer-driven care"... But she proved to me that she was for real in terms of making some changes in how we worked together— even referred me to a local self-advocacy center. I had been sitting back letting other folks call the shots, and then complaining when things got messed up. A Peer Specialist at the advocacy center called me out on it. I realized that I had gotten comfortable letting other folks make decisions for me, and I know now that I gotta take charge of my own recovery.*
- *My yoga class at the mental health center got cancelled, and instead, they gave us a coupon to try out some free lessons at the city Rec Department. At first I was so disappointed. But once I tried it out, I loved it. I now take pilates in addition to yoga and I also joined a hiking club. I feel healthier physically and mentally...*
- *My mental illness was the least of my worries when it came to getting back to work after I got discharged from the hospital. I was terrified about losing my benefits and my employer gave me a really hard time when I asked if I could come in a half hour late one morning in order to see my doctor. My therapist and I sat down and he helped me sort out what would happen to my benefits and gave me some great information about how I could talk to my boss and request some accommodations that would help me be successful on the job. I have been back now for almost a year, and I just got the Employee of the Month Award.*
- *I used to get so pissed when I got asked to sign off on the treatment plans my doctor had to send to the insurance company. Half the time, I could barely tell that it was MY plan. It didn't reflect any of the things I had said were important. My new doctor explained to me how the insurance and billing things work. And then we worked on the plan together. It still wasn't perfect, but at least I kind of knew where he was coming from and that he really HAD heard what I was trying to say.*



## E. Recovery-Oriented Care is Safe and Trustworthy

Like all medical care, recovery-oriented care for mental health and substance use conditions is grounded in the Hippocratic Oath of “First, do no harm.” As an extension of this principle—and in recognition of the unfortunate prevalence of trauma in the lives of individuals with these conditions—concerted efforts are made to ensure that mental health and substance use services and supports are safe for those who are intended to benefit from them. People should not be worse off as a result of accessing health care, and any adverse effects or side effects of receiving treatments or participating in services are to be avoided as much as possible.

Unfortunately, and for the foreseeable future, the very act of seeking care for mental health and/or substance use conditions may be viewed by some people as harmful and damaging. There are at least two major sources of this situation—and of considerable suffering—that make accessing and benefiting from care itself a labor intensive and difficult process. Foremost among these is the discrimination that continues to affect people with mental health and/or substance use conditions in society at large and, even more importantly, within the health care system itself. This discrimination results in people with mental health and/or substance use conditions being viewed and treated as second-class citizens in a variety of life domains. One byproduct of repeated discrimination is that people come to view and treat themselves as second-class citizens as well.

*...discrimination ... continues to affect people with mental health and/or substance use conditions in society at large and, even more importantly, within the health care system itself. This discrimination results in people with mental health and/or substance use conditions being viewed and treated as second-class citizens in a variety of life domains. One byproduct of repeated discrimination is that people come to view and treat themselves as second-class citizens as well.*

What advocates within the mental health community have come to call “internalized stigma” presents a second significant obstacle to accessing care and to recovery, undermining the self-confidence and self-esteem required for the person to take steps toward improving his or her life. The demoralization and despair that are associated with internalized stigma and feelings of inferiority also tap the person’s sense of hope and initiative, adding further weight to the illness and its effects.

Given this legacy, it becomes incumbent upon practitioners to identify and address those elements and characteristics of the current service system and the broader community that unwittingly contribute to the exacerbation of symptoms and

the creation and perpetuation of disability and dependency in individuals with mental health and substance use conditions. It also becomes incumbent upon the practitioner to pay careful and close attention to earning the trust of a person who is considering taking part in, unsure of, or new to care. As we noted above, the engagement process

*Research has consistently demonstrated that a trusting relationship with a practitioner is one of the most important predictors of a positive outcome resulting from care for a mental health and/or substance use condition; more so than any particular theoretical approach or evidence-based technique.*

requires the cultivation of a trusting relationship. Here we note that this is true of just about every person seeking or receiving care, even if he or she does not require assertive outreach. Research has consistently demonstrated that a trusting relationship with a practitioner is one of the most important predictors of a positive outcome resulting from care for a mental health and/or substance use condition; more so than any particular theoretical approach or evidence-based technique. In recognition of this fundamental role of interpersonal

relationships in recovery, practitioners go beyond doing no harm and ensuring safety to cultivating trusting relationships which the persons being served view as helpful.

To this point in the Guidelines, our guiding assumption has been that mental health and substance use conditions are illnesses like any others and that, with few exceptions, seeking and receiving care for these disorders should resemble care provided for other medical conditions. Although we have made a point of stressing the need for outreach and engagement to ensure access to care, we otherwise may have given the reader the impression that people with mental health and/or substance use conditions are educated consumers of health care and that they will naturally act on their own behalf in making appropriate choices in this and other domains.

Experienced practitioners will no doubt consider such a perspective simplistic and naïve, and will suggest that up to 80% of the work entailed in treating these conditions is devoted to helping people to arrive at such a position of being willing to accept care. Once a person recognizes that he or she has a mental health and/or substance use condition and agrees to participate in treatment and/or rehabilitation, the bulk of the more difficult work may appear to be done. We appreciate this sentiment, and agree that it may take a generation or more (of eliminating stigma and discrimination) before many more people experiencing these conditions will be able to access and benefit from care in a more straightforward and uncomplicated manner.

Regardless of where any particular individual is in the process of understanding his or her condition and participating actively in his or her own recovery, practitioners are obliged to treat people with dignity and respect and to offer them safe and supportive environments. In addition to doing no harm themselves,

practitioners may need to identify sources of harm which have been done to individuals in the past so as not to recreate those situations in the present. For example, while trauma may not be intrinsic to mental health or substance use per se, there is considerable evidence that suggests that people experiencing these conditions at the present time have a greatly increased chance of having experienced a history of trauma earlier in their lives, as well as being at increased risk for exposure to victimization and trauma currently. One component of providing safe and trustworthy care thus becomes recognizing and being sensitive to the histories of trauma people may bring with them into treatment and also preparing them to take care of themselves, and to avoid further victimization, into the future.

Finally, determining what has been helpful to people in managing distress in the past and noting their preferences for how they would like to be treated in the future should they become distressed is an essential step toward ensuring that the care provided will be experienced as safe and trustworthy.

### **You will know that you are providing safe and trustworthy care when:**

#### **At the System/Agency Level**

- E.1.** Agencies make concerted efforts to avoid all involuntary aspects of treatment such as involuntary hospitalization or medication.
- E.2.** Recommendations from individuals with trauma histories are aggregated and reviewed so services can be structured in a way that helps people feel safe. Special focus is placed on making inpatient, day treatment, intensive outpatient, and outpatient programs feel safe.
- E.3.** Training and resources on trauma-informed treatment are readily available to and utilized by practitioners, including training related to professional boundaries, confidentiality, dual relationships, and sexual harassment, as well as clinician self-care and vicarious trauma.
- E.4.** Efforts are made to ensure that individuals have their health care needs addressed and have ready access to primary health care services, including preventative health and dental care and health promotion, both to enhance and promote health and to reduce reliance on crisis or emergency care. Inquiries on health status and health care access are made during initial admission and periodically, e.g. every 6 months, thereafter. Exercise, nutrition, and other aspects of healthy living are promoted by the agency and interested individuals are linked to community resources that can enhance their active participation in maintaining a healthy lifestyle.

- E.5.** Policies and practices support healthy connections with children, family, significant others, and community.
- E.6.** In the process of developing advance directives or upon admission, individuals are asked to describe the strategies or intervention that have worked well for them in the past to assist them in managing their distress. They also are asked to specify for the staff the ways in which they would, and would not, prefer to be treated should they become distressed during their stay within the care setting. These preferences are documented in the person's health record and staff are made aware of the person's preferences in advance of the use of more restrictive interventions (e.g., restraints or seclusion).

### At the Practitioner/Person in Recovery Level

- E.7. Internal barriers to recovery are identified and addressed.**
  - E.7.1.** It is important to acknowledge that some people with mental health and/or substance use conditions may be reluctant to assume some of the rights and responsibilities promoted in recovery-oriented systems. They may initially express reluctance, fears, mistrust, and even disinterest when afforded the right to take control of their treatment and life decisions. On these occasions, practitioners explore and address the multiple factors influencing mistrustful, reluctant or disinterested responses, as they often result from a complex interaction of the person's conditions and his or her past experiences in the health care system. Significant training and skill building within the recovery community is necessary to support people in embracing expanded roles and responsibilities. Education and ongoing support and mentoring for this purpose are perhaps best offered through mental health advocacy organizations and peer-run programs.
  - E.7.2.** Individuals with mental health and/or substance use conditions often have histories of trauma which impact on treatment and recovery. For example, there is considerable evidence that suggests that people living with these conditions at the present time have a greatly increased chance of having experienced a history of trauma earlier in their lives as well as being at increased risk for future victimization.<sup>55</sup> Evidence also suggests that the failure to attend to a person's history of sexual and/or physical abuse seriously undermines the treatment and rehabilitation enterprise, leading to a poor prognosis, while approaches that

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<sup>55</sup>Sells, D., Rowe, M., Fisk, D. & Davidson, L. (2003). Violent victimization of persons with co-occurring psychiatric and substance use disorders. *Psychiatric Services*, 54(9), 1253-1257.

are responsive to trauma significantly improve treatment effectiveness and outcomes.<sup>56</sup> Similar processes resulting from patterns of relating in a person's family context or immediate social environment may pose additional barriers to the person's recovery.

**E.7.3.** The above barriers represent more of an interaction between a person's condition and his or her experiences in the health care system and the community at large. In addition, the symptoms of certain illnesses themselves may also pose direct impediments to the recovery process. Hallucinations and delusions, for example, may compete with the information a person is receiving from health care practitioners, thereby discouraging the person from taking prescribed medications or participating in other treatment or rehabilitation. Similarly, impairments in such areas as working memory, executive processes, language, attention and concentration, and problem solving<sup>57</sup> can undermine a person's abilities to articulate and assert his or her personal wants, needs, and preferences in the context of a relationship with a clinical practitioner. Such cognitive impairments may be further aggravated by negative symptoms, currently considered to be among the most unremitting and malignant of the impairments associated with psychosis.<sup>58</sup> These include a lack of goal-directed activity, withdrawal, apathy, and affective flattening, all of which can create the impression that individuals are not interested in taking an active role in their care, thereby placing them at increased risk of being underestimated and undervalued as partners in the recovery planning process.

In certain conditions, the elimination or reduction of substance use or symptoms may also come with great ambivalence, e.g., while episodes of mania can be destructive, they may include a heightened sense of creativity, self-importance, and productivity that are difficult to give

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<sup>56</sup>For more details in this regard the reader is referred to the guidelines developed by R. Fallot and M. Harris as part of the DMHAS Trauma Initiative entitled *Trauma-Informed Services: A Self-Assessment and Planning Protocol*.

<sup>57</sup>Saykin, A., Gur, R.C., Gur, R.E., Mozley, D., Mozley, R.H., Resnick, S., Kester, B. & Stafinick, P. (1991). Neuropsychological function in schizophrenia: Selective impairment in memory and learning. *Archives of General Psychiatry*, 48, 618-624.; Bell, M. & Lysaker, P. (1995). Psychiatric symptoms and work performance among people with severe mental illness, *Psychiatric Services*, 46(5), 508-510; Westermeyer, J. & Harrow, M. (1987). Factors associated with work impairments in schizophrenic and nonschizophrenic patients. In R. Grinker & M. Harrow (Eds.), *Clinical research in schizophrenia: A multidimensional approach*. p. 280-299. Springfield: Charles Thomas Books; Cornblatt, B. & Erlenmeyer-Kimling, L. (1984). Early attentional predictors of adolescent behavioral disturbances in children at risk for schizophrenia. In Watt, N.F., James, A.E. (eds.). (1984). *Children at risk for schizophrenia: A longitudinal perspective*. (pp. 198-211). New York, NY, US: Cambridge University Press; Seltzer, J., Cassens, G., Cioocca, C. & O'Sullivan, L. (1997). Neuropsychological rehabilitation in the treatment of schizophrenia. *Connecticut Medicine*, 61(9), 597-608.

<sup>58</sup>Torrey, E.F. (1988). *Surviving schizophrenia: A family manual (Rev. ed.)*. New York: Harper & Row.

up. Being able to identify and address these and other aspects of illness requires knowledge and skill on the part of the practitioner. There thus is ongoing professional development regarding emerging evidence-based and recovery-oriented practices which allow people to manage, or bypass, their symptoms to build a gratifying life in the community.

- E.8.** Individuals request and receive supports and accommodations that help them to feel safe. They also describe for practitioners strategies that have worked for them in the past in managing their distress and suggest the ways in which they would like, and would not like, to be treated in the future should they become distressed.
- E.9.** Staff invite individuals to share their childhood and/or adult history of experiencing violence and abuse at a pace which is comfortable for them and also ask them what they will need in order to feel safer. Individuals notify staff of any concerns they have about personal safety and join with practitioners in developing safety plans.
- E.10.** Staff appreciate that understanding an individual's trauma history is an important part of assessing that person's relationships within his or her natural support network, at the same time recognizing that the process utilized in trauma screening may be more important than any of the specific content of the questions and answers.

### **Example of how this might look in practice:**

One of the concerns about recovery-oriented practice that practitioners frequently raise has to do with the person's safety, particularly safety in relation to his or her own choices and decisions. A fundamental principle of recovery-oriented care is that practitioners elicit and honor the person's autonomy, agency, and self-determination. How is it possible to uphold that principle, they ask, and at the same ensure the person's safety? Are these not contradictory impulses? As in the following vignette, these principles may seem at times to be at odds with each other in practice. This fact represents one more reason to emphasize that recovery-oriented practice—rather than being merely “common sense”—actually requires clinical sophistication, advanced skills, and supervision. Here, as in life, there are few simple answers.

*Yolanda*, a 30-year old woman living in a supportive housing program, came to a consultant's attention because she had a troublesome habit of leaving the building in the middle of the night and wandering around the downtown area of a small city. The staff had tried in vain to convince Yolanda to stop her late night walks, at first trying to persuade her that it was too dangerous for her to be out alone at night in the city. When persuasion had not worked, the staff established program

parameters and rules which stipulated that Yolanda would not be allowed out of the building after 10:00 p.m., as she could not be trusted to cease this activity on her own and did not appear to appreciate the danger to which she was exposing herself. These efforts were in vain also, however, as Yolanda continued to “slip out” at night and disregard the new program rules no matter what consequences were put into place. The program was voluntary and the building was unlocked, and the staff had no way of preventing her from leaving short of physically blocking her way. They brought this situation to the attention of the program consultant, who had been stressing the need for client choice and self-determination in helping the program adopt a more recovery-oriented approach.

Initially the consultant asked the staff if they knew why Yolanda left the building in the middle of the night; did they know what she was after? She wondered with the staff what Yolanda was trying to accomplish during her late night walks, and whether or not this same agenda could be pursued in other, less dangerous, ways. Yolanda, for her part, however, was not interested in such discussions. At this point in time, she was not willing or able to disclose to the staff where she went or why, and was not willing or able to consider other alternatives, when she saw no reason to curtail her walks. The staff were torn between their wish to respect Yolanda’s right to make her own decisions and choices and their strong desire and need to keep her safe. Arguments and disagreements broke out between staff who took up either side of this ambivalence, with some blaming others for being paternalistic and others responding by faulting their colleagues for being careless, irresponsible, and even unethical. What were they to do?

After many lengthy and heated discussions about the issue, and after many conversations with Yolanda exploring her reasons for leaving the building and assessing her understanding of the degree to which she was exposing herself to risk, the staff finally agreed to a middle road. They reasoned that they could respect Yolanda’s choices without necessarily abandoning her to the ravages of illness or the dangers of the street. After having determined that Yolanda appreciated the risk she was taking each night that she left the building after dark, the staff brainstormed with her what steps could be taken to minimize the risks she took in doing so. What did other women do who needed to be out by themselves after dark? First, the staff took Yolanda to a store so that she could buy a rape whistle and a can of pepper spray. Once she realized that the staff were taking her wish to continue to take late night walks seriously, Yolanda shared with them that she was in fact frightened at times and that she would like to know how to take better care of herself in such situations. As a next step, Yolanda then asked the staff if they would transport her to a self-defense course for women at the local YWCA, for which she promptly registered.

While her late night walks did not stop, the staff felt better about having done everything that they could think of and that was within their power to ensure Yolanda’s safety while honoring her autonomy. As a result of these efforts,

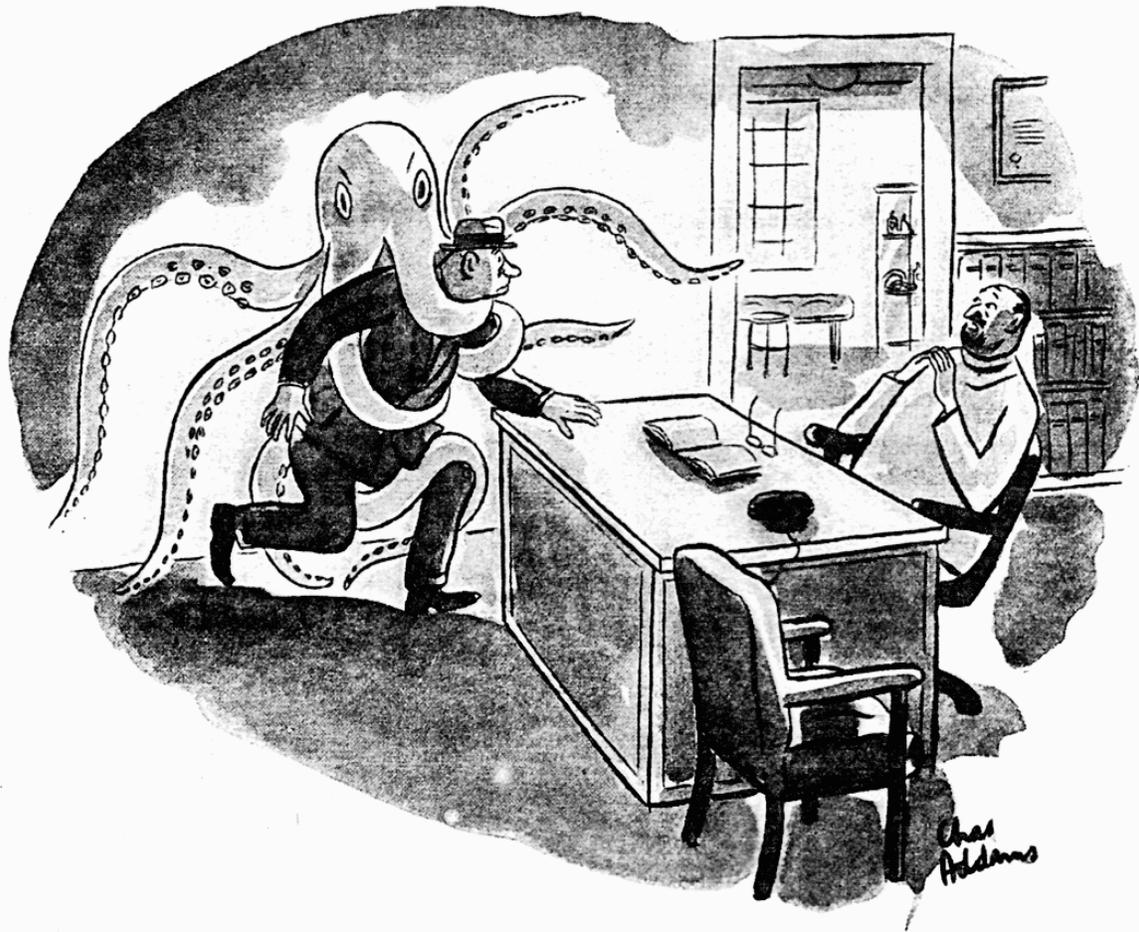
Yolanda's levels of trust in the staff and engagement in the program increased, she acquired new skills in self-defense, and she met potential new friends outside of the mental health system. For their part, the staff channeled their continued fears for Yolanda's safety and their anxieties about the liability they bore by making sure that they documented their conversations with Yolanda, her decisions, and the steps they had taken in all the appropriate places and, with Yolanda's permission, by discussing her situation with the local police and asking them to keep an eye out for her in their late night rounds. While she still will not tell the staff where she goes at night or why, she does report that she has become somewhat friendly with the cops who are on the night shift.

### **What you will hear from people in recovery when you are offering safe and trustworthy care:**

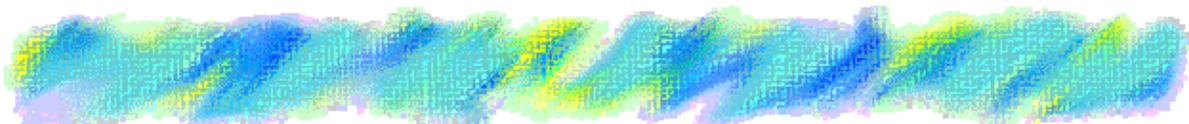
- *I had always been under somebody's thumb. I learned to "behave" to get what I wanted and needed. I did what the money manager said, what the doctor said, and what the house manager said. I did it for everyone else but ME. So, I never learned how to do it on my own. But now I'm in a program where my case manager pushes me to try new things and to take responsibility for my life and my recovery. I get to make decisions, and they may not always be good ones. But my case manager is there for me to pick me up and help me try again. Two steps forward, one step back, but I'm getting there.*
- *I vowed after the last time that I'd never go back to the hospital. I remember "going off" in the ER because I was trying to tell them my little girl was gonna get off the bus and there won't be nobody there to get her. But they didn't understand me 'cause I wasn't right at the time. I told my therapist about this and me and her sat down together and made a list of everything I gotta do and take care of as a mother if I can't be there for my girl. And then she put that in my chart. If there ever is a next time, at least I know my baby will be OK.*
- *After my father passed away, I started to have terrible flashbacks of the abuse I suffered at his hand as a child. I had always thought that when he was gone, I'd finally be at peace. But, everything in my world just fell apart after he died. The abuse was all I thought about. I had been clean for two years, but I turned back to booze and drugs - totally lost control. I ended up in the hospital after an overdose. But when I woke up, there was my therapist, sitting right by my bedside. I heard later that she tore into the ER staff when they strapped me down to a gurney because I guess I lost it. I had shared with her the darkest secrets of my abuse, and she made damn sure I didn't have to re-live that in the hospital.*

- *I ran out of money last month and I couldn't come up with the rent. I admit, I was using and I blew a ton of my check on dope. But I was about to get kicked out of my apartment and I had no place to go. I told my case manager. I thought for sure he'd rat me out to my PO, but I didn't have no choice. I needed help. My case manager didn't rat me out... didn't even lay into me. He just laid out the options – what I had to do to get out of the jam. He helped me get back into rehab and worked out a plan with my landlord. Now I feel like I got a fresh start...*

### **The Importance of Not Overlooking the (not so) Obvious**



*“Now just sit down and tell me what seems to be the trouble.”*



## F. Recovery-Oriented Care Maximizes Use of Natural Supports and Settings

Given its focus on life context, one tool required for effective recovery planning and recovery-oriented practice is adequate knowledge of the person's local community, including its opportunities, resources, and potential barriers. This knowledge is to be obtained and updated regularly at a community-wide level for the areas in which a program's service recipients live, but also is to be generated on an individual basis contingent on each person's interests, talents, and needs.

Historically falling under the purview of social work and rehabilitation staff, the function of identifying, cataloguing, and being familiar with community resources both within and beyond the formal health care system can be carried out by staff from any discipline with adequate training and supervision. In most cases, however, this expertise will reside with local community-based practitioners rather than with inpatient or residential staff located at a distance from the person's community of origin. In such cases, close coordination between inpatient/residential and outpatient staff will be required to obtain and integrate this information into the individualized recovery plan. Regardless of how it is provided, a comprehensive understanding of the community resources and supports that are available to address the range of a person's needs as he or she identifies them is essential to the recovery planning process across the continuum of care.

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***Asset-based community development*** is one useful strategy for developing this comprehensive understanding of local resources and supports. Based on the pioneering work of Kretzmann and McKnight,<sup>59</sup> asset-based community development (ABCD) is a widely recognized capacity-focused approach to community development that can help open doors into communities for persons who have been labeled or otherwise marginalized, and through which people in recovery can build social capital and participate in community life as citizens rather than solely as recipients of care for mental health and/or substance use conditions.

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<sup>59</sup>Kretzmann, J.P. & McKnight, J.L. (1993). Building Communities from the Inside Out. Chicago, IL. ACTA Publications.

Through the cultivation of mutually beneficial relationships, ABCD has been shown to be an effective technology for capitalizing upon the internal capacities of low-income urban neighborhoods and rural communities, particularly as the depth and extent of associational life in these communities is often vastly underestimated. Whereas community development has historically been deficit- or problem-based and fueled by “needs assessments” and “needs maps,” ABCD operates on the premise that every person in a community has gifts, strengths, skills, and resources to be contributed to the community and that community life is shaped, driven, and sustained by the contributions of an involved and interdependent citizenry. Capacity, strength, and resources are also derived from community associations (religious, civic, recreational, political, social, etc.) and from community institutions (schools, police, libraries, parks, human services, etc.).

Asset-based community development is a participatory process that involves all persons in mapping the resources and capacities of a community’s individuals, its informal associations, and its structured institutions, as a means of identifying existing, but untapped or overlooked, resources and other potentially hospitable places in which the contributions of people with mental health and/or substance use conditions will be welcomed and valued.<sup>60</sup> Information about individuals, community associations, and institutions is collected through the sharing of stories and in one-on-one interviews that foster the development of personal relationships.

The relationships, resource maps, and capacity inventories that result from this process serve to guide on-going community development and provide a means by which people can expand their existing social networks and involvement in community activities. Pride in past achievements is strengthened, new opportunities for creative endeavor are discovered, resiliency is experienced, and hope is sustained. It is important to note that the primary producers of outcomes in this process are not institutions but individuals strengthened by enhanced community relationships. ABCD ultimately helps people in recovery derive great benefit from access to a range of naturally occurring social, educational, vocational, spiritual, and civic activities involved in their return to valued roles in the life of their community.

### **You will know that you are maximizing use of natural supports and settings when:**

#### **At the System/Agency Level**

- F.1.** Agencies provide both formal and informal supports aimed at increasing the engagement and contributions of a diverse range of people. For example, agencies offer multi-family psycho-education and

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<sup>60</sup>McKnight, J. (1992). Redefining community. *Journal of Social Policy*, Fall/Winter, 56-62.

support groups as well as informal social gatherings. Engagement of other natural community supports beyond family members might also be facilitated by the establishment of “community collaboratives.” Collaboratives bring together, on a regular basis, leadership from agencies within the system of care as well as from the community at large. They focus on developing a shared vision to guide their work as well as on the capacity-building of services that promote long-term recovery, community integration, and career advancement, e.g., supported education/career retraining and employer consultation regarding reasonable workplace accommodations.

Collaboratives may be led by leadership from LMHAs or substance use treatment agencies, but should also include representation from the following: the Bureau of Rehabilitation Services, Adult Education, community colleges, Departments of Recreation, Regional Work Force Development Boards, faith/religious communities, college Offices for Disability Services, local business leaders and Chamber of Commerce members, providers of primary medical care, and other local stakeholders where appropriate. Expanded partnerships with community organizations will result in greater utilization of their services and activities by people in recovery. As such, representatives from these organizations should be included in the recovery team when appropriate and when desired by the person in recovery.

- F.2.** People in recovery and other community members experience a renewed sense of empowerment and social connectedness through voluntary participation in civic, social, recreational, vocational, religious, and educational activities in the community. Opportunities for employment, education, recreation, social involvement, civic engagement, and religious participation are therefore regularly identified and are compiled in asset maps, capacity inventories, and community resource guides. These informational resources are made available to individuals on their initial agency orientation and are updated over time as knowledge about the local community grows.
- F.3.** Community leaders representing a range of community associations and institutions work together with people in recovery to carry out the process of community development.
- F.4.** Asset maps and capacity inventories created collaboratively by actively involved community stakeholders reflect a wide range of *natural* gifts, strengths, skills, knowledge, values, interests, and resources available to a community through its individuals, associations, and institutions.

In other words, they are not limited to social and human services or professional crisis or emergency services (e.g., the botanica).

- F.5.** Agencies engage in collaborative partnerships with a range of services and supports to aid recovery planning. Service and support options are available to individuals that are sensitive to gender, race, ethnicity, sexual orientation, trauma history, religious affiliation, social-economic status, and each person's unique interests, values, and preferences.
- F.6.** Community development is driven by a creative, capacity-focused vision identified and shared by community stakeholders. It is neither deficit-oriented nor driven by needs assessments and needs maps.
- F. 7.** Asset maps and capacity inventories include a range of options that recognize the connections people make based on their gender, race, ethnicity, sexual orientation, trauma history, religious affiliation, social-economic status, and their personal and family interests and activities.

#### At the Practitioner/Person in Recovery Level

- F.8.** People in recovery and other labeled and/or marginalized persons are viewed primarily as citizens and not as clients, and are recognized for the gifts, strengths, skills, interests, and resources they have to contribute to community life.
- F. 9.** High value is placed on the less formal aspects of associational life that take place, for instance, in neighborhood gatherings, block watch meetings, coffee klatches, salons, barbershops, book groups, knitting and craft circles, restaurants, pubs, diners, etc.
- F.10.** The relational process of gathering information about community assets and capacities through personal interviews and sharing of stories is recognized as being as important as the information that is collected.
- F.11.** **Forces at the societal level (e.g., stigma, discrimination, lack of basic resources, etc.) which undermine recovery and community inclusion are identified and addressed.**
- F.12.1.** A lack of basic resources and opportunities (e.g., jobs, affordable housing, primary medical care, educational activities) in the broader community significantly complicates the task of recovery. This lack of resources and opportunities often stems from inadequate knowledge and skills on the part of community organizations regarding how to create welcoming and accessible environments for all people. Health care practitioners have significant expertise to address this skill and

knowledge gap, and are prepared to offer supportive guidance and feedback at both the individual and community level.

- F.12.2.** Long-term recovery is often enhanced by meaningful occupation. Work, whether volunteer or paid, offers people the opportunity to play social roles that are valued by their community. Job sites offer new relationships based on competencies and strengths, in addition to enhanced income. Rather than waiting until symptoms or substance use abate before attempting employment, many people find that their symptoms or use are actually reduced by working as meaningful involvement is a healthier alternative to social isolation and empty time. Practitioners therefore encourage people to pursue employment that is of interest to them, and people in recovery actively pursue employment, unless they specify that they are not interested in employment at the time.

### **Example of how this might look in practice:**

Perhaps as one legacy of de-institutionalization or, alternatively, out of concern related to the ready availability of drugs and alcohol in the community, practitioners are concerned at times about encouraging people to participate in activities which lie beyond the borders of the health care system. And “a life in the community,” as envisioned by the President’s New Freedom Commission on Mental Health, is indeed fraught with risks, challenges, and difficulties. It is, however, where the vast majority of individuals with mental health and substance use conditions wish to live and also where they have the right to do so. Recovery-oriented practitioners view the community as offering opportunities as well as challenges, pleasures as well as risks, and successes as well as difficulties, as in the story below.

*Robert* was a man in his early 30’s from an Irish background who had grown up in a small town outside of Boston. As do many people when they develop a serious mental illness, Robert had moved to the city and had unfortunately become disconnected from his family. Also like many first generation American immigrants, Robert had been expected to finish school and acquire a profession, helping to support his large family. While his three brothers went on to college and took secure, well-paying jobs, Robert had dropped out, wandered around the country, and had refused to work—even in the family business. Eventually his parents insisted that he move out, and Robert landed in a working class neighborhood in Boston, alone, on disability, and with not much to live for.

Robert appeared to have few, if any, goals, except for wanting a girlfriend and a car. His recovery mentor did not know what to do for Robert, as he was already connected to services, dutifully took his medication, and maintained his one room

within a SRO not far from the clinic. Otherwise, Robert remained aloof and suspicious, and would not divulge much information about his history or interests. Based on Robert's few expressed goals, the recovery mentor explained that if Robert wanted a car he should get a job so that he could afford to buy and maintain one, and that if he wanted a girlfriend he should find places to hang out where he might meet women. In response to this suggestion Robert initially looked puzzled and then explained to the recovery mentor that he already had a place to hang out where there were plenty of women, at least on the weekends, but that he couldn't meet or attract them because he didn't have a car. The problem was not access or proximity, but not having his own wheels. "What self-respecting woman," he asked, "would go out with a 33-year old man who didn't have his own car?"

Rather than pressing the point about getting a job to be able to afford a car, the recovery mentor was intrigued to learn that Robert did, indeed, have a place to "hang out." Apparently, Robert spent most afternoons and evenings sitting at the bar of a neighborhood pub, chatting with the bartender and other regulars and watching sports on one of the several television sets suspended above it. He was a Red Sox, Patriots, and Celtics fan, often stayed until the bar closed around 2 a.m., and then returned to his room to sleep well into the late morning. After lunch at the social club and attending to any errands or appointments, Robert would then return to the pub for the rest of the day. All he needed, as far as he was concerned, was a car and girlfriend.

When the recovery mentor discussed this new information with Robert's psychiatrist, they both became concerned about Robert spending all of his time at a bar and wondered how much he was drinking and what effect his drinking was having on the efficacy of his medications. Perhaps Robert was not benefiting as much as he might from the medicine, and perhaps his progress was stalled, because he was drinking too much, perhaps even on a daily basis. They agreed that what Robert needed was to start attending AA meetings or, if he did not agree to that, then perhaps to join the dual disorder group at the clinic. Robert, they surmised, was one of those people who had had an undetected co-occurring addiction and needed more intensive treatment.

When the psychiatrist and recovery mentor tried to discuss these concerns with Robert he denied drinking alcohol at all and insisted that he was a "tea totaller." When they expressed doubts in his veracity he became angry, shouting at the two of them that they could come with him to the pub if they wanted to and find out for themselves if they didn't believe him—before promptly storming out of the office. Robert then didn't show up for his regular appointments with the recovery mentor for several weeks and repeatedly hung up on him when he called, insisting that the recovery mentor was "in cahoots" with his parents and could no longer be trusted.

After several weeks and several offers, Robert finally agreed to meet the recovery mentor at the pub. The recovery mentor explained that he was willing to

take Robert up on his offer and to find out for himself, as long as Robert would agree to his doing so. They met at the pub the next afternoon, and Robert proudly introduced the recovery mentor to the bartender and some of the other customers, saying that he was an ‘old friend’ visiting from out of town. The recovery mentor was impressed with the familiarity with which Robert addressed and chatted with the people there and his level of apparent comfort, wondering what had happened to Robert’s usual aloof and suspicious demeanor. It then occurred to the recovery mentor that he had never seen Robert outside of the clinic before, and that perhaps his paranoia was increased when he was in such a setting. His medical record, after all, noted that Robert had had several involuntary hospitalizations in the past and perhaps was not comforted by being in a mental health setting. He did appear to be comforted, however, by being in a pub.

When the recovery mentor commented on how “at home” Robert appeared to be in a pub, Robert explained that it should be no surprise as he was virtually raised in a pub. The family business, as it turns out, was a neighborhood pub, and all family activities and events revolved around the pub. He did his homework at the pub, had his meals at the pub, brought his dates to the pub, and, eventually, got kicked out of the pub. His fond reminiscences of family life quickly turned sour, as he related that his father and three brothers were all “drunks.” Respectable, responsible drunks, perhaps, but drunks nonetheless. He had never fit in, and when he reached sixteen and still wouldn’t join them in drinking, tensions in his family only increased.

Robert was clearly spent after disclosing so much personal information to the recovery mentor, and quickly turned his attention to the horse race on ESPN. The recovery mentor took the opportunity to jokingly inquire of the bartender about Robert’s preferred beverages and found out that Robert did, in fact, drink a lot of tea along with a fair amount of tonic water and lime. Armed with lots of new, rich, and interesting information about Robert to ponder, and to discuss with the psychiatrist, the recovery mentor left the pub that afternoon wondering why he didn’t leave his office, and the clinic, more often.

### **What you will hear from people in recovery when you are natural supports and settings:**

- *All those years I spent in Social Skills groups, I met the same 20 people I knew from Clozaril Clinic and the Clubhouse. It didn’t exactly expand my social horizons! Now I am playing basketball in one of the city leagues and there is this girl I’ve got my eye on who comes to the games. My therapist and I have been talking a lot about how I could strike up a conversation with her.*
- *I just wanted to get back to my life: my friends, and my job, and my church activities. My recovery was important, but it didn’t matter so long as I didn’t*

*have those things in my life to look forward to. It was those things that kept me going in my darkest days.*

- *Just having a place to hang out, where I blend in with the crowd... where no one knows me as a patient on the ACT team. That is when I am most peaceful.*
- *It wasn't enough for me to just get better. I appreciated everyone's help, but I felt like such a charity case all the time. What really made a difference was when my counselor helped me to get a volunteer position at the local nursing home. Sometimes I read to the folks, or we play cards. It may not be fancy, but it feels right to me. I don't just have to take help from everybody else, I have valuable things to give back in return.*
- *I knew all about the places where folks could go to get help if you had a problem with drugs or mental illness. What I had forgotten about was how to have FUN! My case manager gave me this terrific list of low-cost activities that happen right around the corner from my apartment, and I never even knew this stuff was right under my nose. It's opened up a whole new world for me. I made some great friends, and one of them is even looking for some part-time help in her art store--so I'm gonna get a job out of it too! Things happen in the strangest ways sometimes...*

### **The Importance of Not Overlooking the (not so) Obvious**



*“We’ve considered every potential risk except the risks of avoiding all risks.”*

## Recommended Resources for Further Reading



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## NOTES