

Practice Guidelines for Recovery-Oriented Behavioral Health Care



Connecticut Department of
Mental Health and Addiction Services



“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)

Prepared for the Connecticut Department of Mental Health and Addiction Services by the Yale University Program for Recovery and Community Health (Tondora & Davidson, 2006).

Forward by Commissioner Thomas A. Kirk, Jr., Ph.D.

The document that you are about to read is an extraordinary one in its origins, its content, and its value as another step toward achieving and maintaining a recovery-oriented health care service system in Connecticut.

In my view, if not *the* most important, the following document is one of the most significant products to result within the last five years from the public/private partnership composed of persons in recovery, families, staff and leadership of DMHAS, prevention specialists, private nonprofit service providers, the academic community, and other advocates and stakeholders. This collective group has focused on assessing and improving the quality of services available for persons with mental illness and/or substance use disorders in the State of Connecticut.

Consider a few of its origins. Listening to the suggestions and continuing guidance of those who need or use our services is one of the most basic and essential characteristics of a recovery-oriented service system. Thus, beginning in 1999 we asked Advocacy Unlimited, Inc. and the Connecticut Community for Addiction Recovery, Inc. to work together to develop a set of **Recovery Core Values** that could serve as guideposts for DMHAS as it began the journey of restructuring its service system. The result was 27 principles divided into four categories: **Direction, Participation, Programming and Funding/Operations**. Go to www.dmhas.state.ct.us, click on major Initiatives, then “Recovery Initiative” for further information about the Recovery Core Values.

Well before 1999, there had been “champions” of recovery in any number of state and private service sectors who understood the meaning of “recovery” and the importance of it in the lives and care of the people receiving services. They now had the opportunity to speak in a louder voice and educate the rest of us. We all stand on the shoulders of those who came before us.

DMHAS later hosted a few statewide Recovery Conferences, established a Recovery Institute and Centers of Excellence, and conducted a series of consensus-building retreats for executive directors, medical and clinical leadership, and several other stakeholder groups within the mental health and addiction service communities and elicited their views about the concept of recovery, what it would mean for their activities, and what gaps needed to be addressed and barriers removed for us to achieve a recovery-oriented system.

All of the above, and other work, led to the signing in September 2002 of **Commissioner’s Policy Statement No. 83 on “Promoting a Recovery-Oriented Service System.”** This landmark policy designated the concept of recovery as the overarching goal, guiding principle, and operational framework for the system of care supported by the DMHAS. It incorporated the Recovery Core Values. It stated that:

“We shall firmly embed the language, spirit, and culture of recovery throughout the system of services, in our interactions with one another and with those persons and families who trust us with their care.”

In addition, this policy envisioned and mandated services characterized by:

“...a high degree of accessibility, effectiveness in engaging and retaining persons in care

...effects shall be sustained rather than solely crisis-oriented or short-lived

...age and gender appropriate, culturally competent, and attend to trauma and other factors known to impact on one’s recovery

...whenever possible, shall be provided within the person’s home community, using the person’s natural supports.”

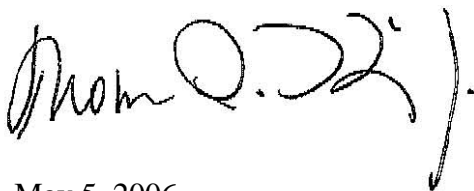
But how do you actually do a recovery-oriented service system? This key question remained after all of the above work and many current activities—too numerous to mention. Absent answers to this question, one may think “all this recovery stuff is conceptual ... it has no real meaning or practical reality. The focus will not really change our system.”

The following document answers this question by identifying eight domains of a recovery-oriented service system ranging from degree of participation of persons in recovery in the recovery planning and system development process to “Identifying and Addressing Barriers to Recovery.” It then lists a dozen or so concrete, practical and well-researched action steps or guidelines in each domain. It answers questions like: “**You will know when you are placing primacy on the participation of people in recovery when...**”

The document gives examples, identifies potential barriers, and uses the words of people in recovery to explain what each domain means and what they can expect in that domain. It includes a glossary and distinguishes a **Deficit-based Perspective** from a **Recovery-oriented, Asset-based Perspective**. As service providers review their Agency Recovery Assessment Plans and as DMHAS fiscal, service, and quality staff go about their business, they now will have a roadmap to inform policy, develop outcomes and funding strategies, and a framework to monitor our fidelity with the guidelines of a recovery-oriented health care system. Persons in recovery and other recipients of services will know what to expect, what they need to be educated about, and what they have a right to demand in their interactions with the system.

It is said that successful initiatives have a thousand fathers and mothers and failed initiatives are orphans. I believe our journey to a recovery-oriented and transformed service system has many parents. I hope this document will help those who either cannot understand or who have not yet embraced a recovery-oriented service system to become another parent of this journey.

I would welcome any comments about the above or your opinion of this document at Thomas.Kirk@po.state.ct.us.



May 5, 2006

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Executive Summary

The notion of recovery has become the focus of a considerable amount of dialogue and debate between and among various constituencies within the mental health and addiction communities. Following a brief introduction to the topic, in which we clarify various sources of confusion about the term, these practice guidelines begin to operationalize the various components of DMHAS' vision of a recovery-oriented system of behavioral health care. This vision was first put forth in Commissioner's Policy #83, "Promoting a Recovery-Oriented Service System," and has since been embodied in various DMHAS education, training, and program development initiatives. These guidelines represent the first systematic effort to bring recovery into the concrete everyday practice of DMHAS-funded providers.

Defining our Terms

One major source of the confusion surrounding use of the term in recovery in behavioral health derives from a lack of clarity about the respective roles of behavioral health practitioners and those of people with behavioral health disorders 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 with a mental illness and/or addiction **experiences** and **manages** his or her disorder in the process of reclaiming his or her life in the community.*

***Recovery-oriented care** is what psychiatric and addiction treatment and rehabilitation practitioners **offer** in support of the person's recovery.*

Practice Guidelines

A. Primacy of Participation

An essential characteristic of recovery-oriented behavioral 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 the initial framing of questions or problems to be addressed and design of the capacity and needs assessments to be conducted, to the delivery, evaluation, and monitoring of care, to the design and development of new services, interventions, and supports.

Practice guidelines to be included in this domain:

- A.1.** People in recovery are routinely invited to share their stories with current service recipients and/or to provide training to staff.
- A.2.** 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.
- A.3.** Agencies reimburse people for the time they spend providing input into services, providing peer support and mentoring, and/or providing educational and training sessions for clients or staff.
- A.4.** Each person served is provided with an initial orientation to agency practices.
- A.5.** Initial orientation is supplemented by the routine availability of information and agency updates to people in recovery and their loved ones.
- A.6.** Policies are established and maintained that allow people in recovery maximum opportunity for choice and control in their own care.
- A.7.** Measures of satisfaction are collected routinely and in a timely fashion from people in recovery and their loved ones.
- A.8.** Formal grievance procedures are established and made readily available to people in recovery and their loved ones to address their dissatisfaction with services.
- A.9.** Administration enforces ethical practice (e.g., "first, do no harm") through proactive human resource oversight.
- A.10.** Assertive efforts are made to recruit people in recovery for a variety of staff positions for which they are qualified.
- A.11.** Active recruitment of 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.
- A.12.** Self-disclosure by employed persons in recovery is respected as a personal decision and is not prohibited by agency policy or practice.
- A.13.** Staff encourage individuals to claim their rights and to make meaningful contributions to their own care and to the system as a whole.
- A.14.** The agency offers to host local, regional, state, and/or national events and advocacy activities for people in recovery and their loved ones.

B. Promoting Access and Engagement

For every one person who seeks and/or receives behavioral health care for a diagnosable psychiatric disorder or addiction there are from two (in mental health) to six (in addiction) individuals, with similar conditions, who will neither gain access to nor receive such care. Recovery-oriented practitioners promote access to care by facilitating swift and uncomplicated entry and by removing barriers to receiving care. Engagement involves making contact with the person rather than with the diagnosis or disability, building trust over time, attending to the person's stated goals and needs and, directly or indirectly, providing a range of services in addition to clinical care.

Practice guidelines to be included in this domain:

- B.1.** The service system has the capacity to go where the potential client is, rather than always insisting that the client come to the service.
- B.2.** People can access a wide range of services from many different points.
- B.3.** There is not a strict separation between clinical and case management functions.
- B.4.** Assessment of motivation is based on a stages of change model, and interventions incorporate motivational enhancement strategies which assist providers in meeting each person where he or she is.
- B.5.** Staff look for signs of organizational barriers or other obstacles to care before concluding that a client is non-compliant or unmotivated.
- B.6.** Agencies have "zero reject" policies that do not exclude people from care based on symptomatology, substance use, or unwillingness to participate in prerequisite clinical or program activities.
- B.7.** Agencies have an "open case" policy which dictates that a person's refusal of services, despite intensive and long-term engagement efforts, does not require that he or she be dropped from the "outreach" list.
- B.8.** The system builds on a commitment to and practice of motivational enhancement, with reimbursement for pre-treatment and recovery management supports.
- B.9.** Outpatient addiction treatment clinicians are paired with outreach workers to capitalize on the moment of crisis that can lead people to accept treatment, and to gain access to their appropriate level of care.
- B.10.** Mental health and addiction practitioners, including people in recovery, are placed in critical locales to assist in the early stages of engagement.
- B.11.** The agency employs staff with first hand experience of recovery who have a special ability to make contact with and engage people into care.

- B.12.** Housing and support options are available for people who are not yet interested in, or ready for, detoxification, but who may begin to engage in their own recovery if housing and support are available to them.
- B.13.** 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.

C. Ensuring Continuity of Care

Recovery is seldom achieved from a single episode of care, so practitioners, as well as people in recovery, families, and policy makers, need to recognize that there are no quick fixes in behavioral health. Similar to other chronic illnesses, previous treatment of a person's condition also should not be taken to be indicative of a poor prognosis, non-compliance, or the person's not trying hard enough to recover. Relapses in substance use and exacerbations of psychiatric symptoms are to be viewed as further evidence of the severity of the person's condition rather than as causes for discharge. All of these principles suggest that treatment, rehabilitation, and support are not to be offered through serial episodes of disconnected care offered by different providers, but through a carefully crafted system that ensures continuity of the person's most significant healing relationships and supports over time and across episodes and agencies.

Practice guidelines to be included in this domain:

- C.1.** The central concern of engagement shifts from: "How do we get the client into treatment?" to: "How do we nest the process of recovery within the person's natural environment?"
- C.2.** Services are designed to be welcoming to all individuals and there is a low threshold (i.e., minimal requirements) for entry into care.
- C.3.** Eligibility and reimbursement strategies for outreach and engagement strategies are established and refined by administrative leadership.
- C.4.** People have a flexible array of options from which to choose and options are not limited to what "programs" are available.
- C.5.** Individuals are not expected or required to progress through a pre-determined continuum of care in a linear or sequential manner.
- C.6.** In a Recovery Management Model, an individual's stage of change is considered at all points in time, with the focus of care on enhancing existing strengths and recovery capital.

- C.7.** Goals and objectives in the recovery plan are not defined by staff based on clinically-valued outcomes (e.g., reducing symptoms, increasing adherence), but rather are defined by the person with a focus on building recovery capital and pursuing a life in the community.
- C.8.** The focus of care shifts from preventing relapse to promoting recovery.
- C.9.** Valued outcomes are influenced by a commitment to ensuring continuity of care and generating long-term effects in the lives of people in recovery.
- C.10.** 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.
- C.11.** Individuals are seen as capable of illness self-management and interventions support this as a valued goal of recovery-oriented services.
- C.12.** New technologies (e.g., tele-medicine and web-based applications and self-help resources) are incorporated as service options to enhance illness self-management treatment relationships.
- C.13.** Access is enhanced to housing, employment, and other supports that make recovery sustainable.
- C.14.** 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.
- C.15.** To facilitate sustained recovery and community inclusion, advocacy efforts are extended beyond institutional policies and procedures to the larger community, including stigma-busting, community education, and community resource development activities.

D. Employing Strengths-Based Assessment

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 recovery. Strengths-based approaches allow providers to balance critical needs that must be met with the resources and strengths that people possess to assist them in this process.

Practice guidelines to be included in this domain:

- D.1.** A discussion of strengths is a central focus of every assessment, care plan, and case summary.
- D.2.** Initial assessments recognize the power of simple, yet powerful, questions such as “What happened? And what do you think would be helpful? And what are your goals in life?”
- D.3.** Staff interpret perceived deficits within a strengths and resilience framework, as this will allow the individual to identify less with the limitations of their disorder.
- D.4.** While strengths of the individual are a focus of the assessment, thoughtful consideration also is given to potential strengths and resources within the individual’s family, natural support network, service system, and community at large.
- D.5.** The diversity of strengths that can serve as resources for the person and his or her recovery planning team is respected.
- D.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, personal heroes, educational achievements, etc.
- D.7.** Assessments explore the whole of people’s lives while ensuring emphasis is given to the individual’s expressed and pressing priorities.
- D.8.** Assessments ask people what has worked for them in the past and incorporate these ideas in the recovery plan.
- D.9.** Guidance for completing the assessment may be derived from interviewing strategies used within solution-focused approaches to care.
- D.10.** Illness self-management strategies and daily wellness approaches such as WRAP are respected as highly effective, person-directed, recovery tools, and are fully explored in the assessment process.
- D.11.** Cause-and-effect explanations are offered with caution, 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.
- D.12.** Assessments are developed through in-depth discussion with the person as well as attempts to solicit collateral information regarding strengths from the person’s family and natural supports.
- D.13.** Efforts are made to record the individual’s responses verbatim rather than translating the information into professional language.

- D.14.** Staff are mindful of the power of language and carefully avoid the subtle messages that professional language has historically conveyed to people with psychiatric disorders, addictions, and their loved ones.
- D.15.** Practitioners avoid using diagnostic labels as a means of describing an individual, as such labels often yield minimal information regarding the person’s experience or manifestation of the illness or addiction.
- D.16.** Language used is neither stigmatizing nor objectifying. “Person first” language is used to acknowledge that the disability is not as important as the person’s individuality and humanity.
- D.17.** Exceptions to person-first and empowering language that are preferred by some persons in recovery are respected.

E. Offering Individualized Recovery Planning

All treatment and rehabilitative services and supports to be provided shall be based 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 taken to ensure that individuals’ rights to self-determination are respected and that all 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) and will include a comprehensive and culturally sensitive assessment of the person’s hopes, assets, strengths, interests, and goals and will reflect a holistic understanding of his or her behavioral health conditions, general medical concerns, and desires to build or maintain a meaningful life in the community

Practice guidelines to be included in this domain:

- E.1. Core principles of “person-centered” planning are followed in the process of building individualized recovery plans. For example:**
 - E.1.1.** Consistent with the “nothing about us, without us” dictum, staff actively partner with the individual in all planning meetings and/or case conferences regarding his or her recovery services and supports.
 - E.1.2.** The individual has reasonable control as to the location and time of planning meetings, as well as to who is involved.
 - E.1.3.** The language of the plan is understandable to all participants, including the focus person and his or her non-professional, natural supports. Where technical or professional terminology is necessary, this is explained to all participants in the planning process.

- E.1.4.** When individuals are engaged in rehabilitation services (e.g., housing social, or educational/employment areas), rehabilitation practitioners are involved in all planning meetings (at the discretion of the individual) and are given copies of the resulting plan.
- E.1.5.** Within the planning process, a diverse, flexible range of options must be available so that people can access and choose those supports that will best assist them in their recovery.
- E.1.6.** Goals are based on the individual's unique interests, preferences, and strengths, and objectives and interventions are clearly related to the attainment of these stated goals.
- E.1.7.** Planning focuses on the identification of concrete next steps, along with specific timelines, that will allow the person to draw upon existing strengths to move toward recovery and his or her vision for the future.
- E.1.8.** Assessments begin with the assumption that individuals are the experts on their own recovery, and that they have learned much in the process of living with and working through their struggles.
- E.1.9.** Information on rights and responsibilities of receiving services is provided at all recovery planning meetings.
- E.1.10.** The individual has the ability to select or change his or her service providers within relevant guidelines and is made aware of the procedures for doing so.
- E.1.11.** In the spirit of true partnership and transparency, all parties must have access to the same information if people are to embrace and effectively carry out responsibilities associated with the recovery plan.
- E.1.12.** The team reconvenes as necessary to address life goals, accomplishments, and barriers.

- E.2. **A wide range of interventions and contributors to the planning and care process are recognized and respected. For example:****
- E.2.1.** Practitioners acknowledge the value of the person's existing relationships and connections.
- E.2.2.** The plan identifies a wide range of both professional supports and alternative strategies to support the person's recovery, particularly those which have been helpful to others with similar struggles.
- E.2.3.** Individuals are not required to attain, or maintain, clinical stability or abstinence before they are supported by the planning team in pursuing such goals as employment.

- E.2.4. Goals and objectives are driven by a person’s current values and needs and not solely by commonly desired clinical/professional outcomes.
- E.3. **Community inclusion is valued as a commonly identified and desired outcome. For example:**
 - E.3.1. The focus of planning and care is on how to create pathways to meaningful and successful community life and not just on how to maintain clinical stability or abstinence.
 - E.3.2. Recovery plans respect the fact that services and practitioners should not remain central to a person’s life over time, and exit criteria from formal services are clearly defined.
 - E.3.3. Recovery plans consider not only how the individual can access and receive needed supports from the behavioral health system and the community, but how the individual can, in turn, give back to others.
 - E.3.4. Practitioners 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?”
- E.4. **The planning process honors the “dignity of risk” and “right to fail” as evidenced by the following:**
 - E.4.1. Prior to appealing to coercive measures, practitioners relentlessly try different ways of engaging and persuading individuals in ways which respect their ability to make choices on their own behalf.
 - E.4.2. Unless determined to require conservatorship by a judge, individuals are presumed competent and entitled to make their own decisions.
 - E.4.3. Practitioners are encouraged to offer their expertise and suggestions respectfully within the context of a collaborative relationship, outlining for the person the range of options and their possible consequences.
 - E.4.5. In keeping with this stance, practitioners encourage individuals to write their own crisis and contingency plans.
- E.5. **Administrative leadership demonstrate a commitment to both outcomes and process evaluation. For example:**
 - E.5.1. Outcomes evaluation is a continuous process involving expectations for successful outcomes in a broad range of life domains.
 - E.5.2. There is a flexible application of process tools, such as fidelity scales, to promote quality service delivery.

F. Functioning as a Recovery Guide

The sentiment that “we’re not cases, and you’re not our managers” has been accepted increasingly as a fundamental challenge to the ways in which behavioral health care is conceptualized within a recovery-oriented system. Rather than replacing any of the skills or clinical and rehabilitative expertise that practitioners have obtained through their training and experience, the recovery guide model offers a useful framework in which these interventions and strategies can be framed as tools that the person can use in his or her own recovery.

Practice guidelines to be included in this domain:

- F.1.** The primary vehicle for the delivery of most behavioral health interventions is the relationship between the practitioner and the person in recovery. The care provided must be 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.”
- F.2.** Providers assess where each person is in relation to the various stages of change with respect to the various dimensions of his or her recovery.
- F.3.** Care is based on the assumption that as a person recovers from his or her condition, the addiction or psychiatric disorder then becomes less of a defining characteristic and more simply one part of a multi-dimensional sense of identity that also contains strengths and competencies.
- F.4.** Interventions are aimed at assisting people in gaining autonomy, power, and connections with others.
- F.5.** Opportunities and supports are provided for the person to enhance his or her own sense of personal and social agency.
- F.6.** Individuals are allowed the right to make mistakes, and this is valued as an opportunity for them to learn.
- F.7.** People are allowed to express their feelings, including anger and dissatisfaction, without having these reactions attributed to the illness.
- F.8.** 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.
- F.9.** 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.

- F.10.** Interventions are oriented toward increasing the person’s recovery capital as well as decreasing his or her distress and dysfunction.
- F.11.** Practitioners are willing to offer practical assistance in the community contexts in which their clients live, work, learn, and play.
- F.12.** Care is not only provided in the community but is also oriented toward increasing the quality of a person’s involvement in community life.
- F.13.** Efforts are made to identify sources of incongruence between the person and his or her environment and to increase person-environment fit.
- F.14.** 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, continuing to view people in recovery squarely within the context of their daily lives.
- F.15.** Rather than devaluing professional knowledge, the “recovery guide” approach moves behavioral health 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.
- F.16.** Recovery is viewed as a fundamentally social process, involving supportive relationships with family, friends, peers, community members, and practitioners

G. Community Mapping and Development

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 involves 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 disabilities and/or addiction will be welcomed and valued.

Practice guidelines to be included in this domain:

- G.1.** People in recovery 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.

- G.2.** Community leaders representing a range of community associations and institutions work together with people in recovery to carry out the process of community development.
- G.3.** Opportunities for employment, education, recreation, social and civic involvement, and religious participation are regularly identified and are compiled in asset maps, capacity inventories, and community guides.
- G.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.
- G.5.** Value is placed on the less formal aspects of associational life that take place in neighborhood gatherings, block watch meetings, salons, coffee clatches, barbershops, book groups, etc.
- G.6.** Institutions do not duplicate services that are widely available in the community through individuals and associations.
- G.7.** Community development is driven by a creative, capacity-focused vision identified and shared by community stakeholders.
- G.8.** 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.

H. Identifying and Addressing Barriers to Recovery

There currently are elements and characteristics of the service delivery system and the broader community that unwittingly contribute to the creation and perpetuation of chronicity and dependency in individuals with behavioral health disorders. There also are several aspects of behavioral health disorders and their place within contemporary society that complicate the person's efforts toward recovery. The competent behavioral health care practitioner will have tools and strategies for identifying and addressing these barriers to recovery.

Practice guidelines to be included in this domain:

- H.1. There is a commitment at the local level to embrace the values and principles of recovery-oriented care and to move away from the dominant illness-based paradigm. Systemic changes that reflect this paradigm shift include the following:**
 - H.1.1.** Stakeholders understand the need for recovery-oriented system change as a civil rights issue which aims to restore certain elementary freedoms to American citizens with psychiatric disorders and/or addictions.

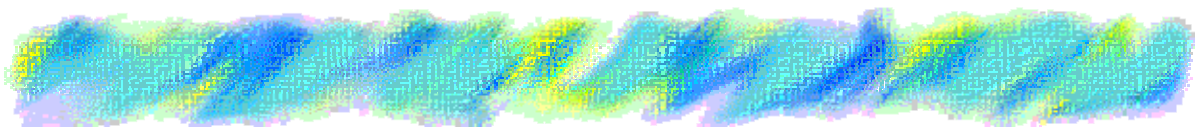
- H.1.2.** Stakeholders work together to move away from the criteria of “medical necessity” toward “human need,” from managing illness to promoting recovery, from deficit-oriented to strengths-based, and from symptom relief to personally-defined quality of life.
- H.1.3.** The possibility of recovery, and responsibility for delivering recovery-oriented care, are embraced by stakeholders at all levels of the system.
- H.2. Systemic structures and practices which impede the adoption of recovery-oriented practices are identified and addressed. Representative change strategies in this area include the following:**
- H.2.1.** Sequential movement through a pre-existing continuum of care is no longer required, as it is inconsistent with a civil rights perspective and contradicts current knowledge suggesting that recovery is neither a linear process nor a static end product or result.
- H.2.2.** Agencies need to have coordinating structures to attend to both the prioritization and integration of the range of new initiatives, policies, and procedures they are attempting to implement at any given time.
- H.2.3.** Performance and outcome indicators need to reflect the fact that the 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 setbacks.
- H.2.4.** Continual quality assurance and independent audits are conducted by people in recovery and families trained in recovery-oriented care.
- H.2.5.** Initial placement and service design are driven as much by the person’s perception of what services and supports would be most helpful as by the staff’s assessments of what the individual seeking services needs.
- H.2.6.** Recovery plans respect the fact that services and practitioners should not remain central to a person’s life over time.
- H.2.7.** To integrate employment within the larger system, the task of assisting people in entering employment and education is made inherent to the responsibilities of the entire practitioner network, including those not specifically charged with supported employment or education tasks.
- H.3. Implementation of recovery-oriented care needs to be facilitated, rather than impeded, by funding, reimbursement, and accrediting structures. Change strategies to address this issue include:**
- H.3.1.** Even though Medicaid is funded by federal dollars, it remains primarily a state-administered program, and considerable flexibility exists in using these dollars to support innovative, community-based, supports.

- H.3.2.** Within existing funding structures, training and technical assistance can be provided to practitioners attempting to implement recovery-oriented practices to assist them in learning how to translate the wishes of people in recovery into reimbursable service goals and to describe their interventions in a manner that will generate payment.
- H.3.3.** Rather than being an add-on to existing services, transformation to recovery-oriented care begins with discovering ways to be creative and flexible within the constraints of existing resources.
- H.3.4.** Self-directed funding opportunities should be considered both on a collective basis and through individualized budget programs.
- H.4. **Training and staff development is prioritized as an essential function to increase individual practitioners' competencies in providing recovery-oriented care. Necessary change strategies to address this issue include the following:****
- H.4.1.** As consensus emerges regarding the knowledge and skills needed to implement recovery-oriented care, this information must lead to the development of competency models, and these models must be disseminated broadly as guidance for training programs and licensing bodies which prepare and accredit providers of behavioral health care.
- H.4.2.** Once established, competency models should be incorporated in all human resource activities as a means of promoting accountability and quality improvement.
- H.4.3.** An analysis of staff's current competencies and self-perceived training needs should guide the development of on-going skill-building activities at the agency level.
- H.4.4.** Competency-based training must be coupled with on-going mentorship, enhanced supervision, recovery-oriented case conferences, and opportunities for peer consultation.
- H.4.5.** Clinical directors and agency leaders should be involved in ongoing training initiatives so that there is consistency between proposed recovery-oriented practices and the system's administrative structures.
- H.4.6.** Recovery-oriented care does *not* imply that there is no longer any role for the practitioner to play. Rather, the provider's role has changed from that of all-knowing, all-doing caretaker to that of coach, architect, cheerleader, facilitator, mentor, or shepherd—roles that are not always consistent with one's clinical training or experiences.
- H.4.7.** Training initiatives need to support people in recovery and families to develop their own capacity to self-direct their care and life decisions.

- H.5. Forces at the societal level which undermine recovery and community inclusion are identified and addressed. Necessary change strategies to address this issue include the following:**
- H.5.1.** Behavioral health practitioners have significant expertise to address the lack of basic resources and opportunities in the broader community, and are prepared to offer supportive guidance and feedback at both the individual and community level.
- H.5.2.** Community collaborations and education must be coupled with efforts on the part of behavioral health practitioners to recognize instances of discrimination, to understand relevant disability legislation, and to effectively utilize state and local resources.
- H.5.3.** Agencies are cautioned to avoid the establishment of ‘one stop shopping’ service programs which may inadvertently contribute to the perpetuation of discriminatory and unethical practices on the part of community members. We must continue to work with community partners to uphold their obligation to respect people with behavioral health disorders as citizens who have the right to be treated according to the principles of law that apply to all other individuals
- H.5.4.** Professionals and service recipients should be mindful of the limited resources available for specialized services and should 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?”
- H.6. Certain internal barriers unique to behavioral health disorders are identified and addressed. Necessary change strategies to address these barriers include the following:**
- H.6.1.** Staff appreciate the fact that, based on a complex interaction of the person’s conditions and his or her past experiences in the behavioral health care system, people with behavioral health disorders 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. Exploring and addressing the many factors influencing such responses is an important component of care.
- H.6.2.** Research indicates that many individuals with behavioral health disorders also have histories of trauma. Failure to attend to such histories may seriously undermine the treatment and rehabilitation enterprises, and further complicate the person’s own efforts toward recovery.

H.6.3. Certain symptoms of illnesses may also pose direct impediments to the recovery process. In certain conditions, the elimination or reduction of 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 up. Being able to identify and address these and other sequelae requires knowledge and skill on the part of the clinical practitioner.

In each of the following sections, practitioners are given examples of what they are likely to hear from people in recovery when these guidelines have been implemented successfully. In addition, 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-based ones.



Introduction

The notion of recovery has become the focus of a considerable amount of dialogue and debate between and among various constituencies within the mental health and addiction communities. Prior to attempting to operationalize the various 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 addictions or mental illnesses to exerting more influence on the practice of behavioral health care providers.



For example, being “in recovery” has long been the guiding vision and goal of self-help¹ within the addiction community. Primarily a force within self-help, however, this notion has not played as much of a role historically within the addiction service provider 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 addictions.

Despite being a long-standing core value in addiction, the notion of “recovery” has emerged as a dominant force within mental health just within the last decade. Most recently, it has taken center stage through its prominent role in both the Surgeon General’s *Report on Mental Health*² 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 recovery³. 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 addiction, much work remains to be done in mental health in developing a coherent and unified vision of recovery that can prove to be acceptable (as well as useful) to all involved parties.

¹ 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.

² Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

³ 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 in behavioral health. 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 behavioral health care. Rather than mutually exclusive, these two concepts 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, behavioral health care providers, and the community at large.



Defining our Terms

One major source of the confusion surrounding use of the term in recovery in behavioral health derives from a lack of clarity about the respective roles of behavioral health practitioners and those of people with behavioral health disorders 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 with a mental illness and/or addiction ***experiences*** and ***manages*** his or her disorder in the process of reclaiming his or her life in the community.
- ***Recovery-oriented care*** is what psychiatric and addiction treatment and rehabilitation practitioners ***offer*** in support of the person's own recovery efforts.

Recovery

Given that the notion of recovery derives from the self-help and self-advocacy communities in both addictions and mental health, the first definition of recovery refers to *what people who have these conditions do to manage their mental illness and/or addiction 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 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 own lives.

As experiences of being discriminated against are viewed as traumatic and irreversible, advocates also argue that a return to a pre-existing state of health (as another alternative definition of recovery) is not only impossible, but also would diminish the gains the person has had to make to overcome the disorder and its effects. Overcoming the scars of stigma requires the development and use of new muscles, often leaving people feeling stronger than prior to the onset of their illness.

Beginning with a common foundation, recovery in addiction and in mental health 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 to recovery. Given the high rate at which addiction and mental illness 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.



Addiction Recovery. Derived from the self-help community, people who are achieving or maintaining abstinence from drug or alcohol use following a period of addiction have described themselves as being “in” this form of recovery for over half a century. Being “in recovery” in this sense is meant to signify that the 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, nor does it entail remission of the signs, symptoms, or other deficits of a disorder as is common to recovery in other medical illnesses. Unlike in most physical illnesses, people may consider themselves to be in recovery while continuing to be affected by their addiction.

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

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 an addiction 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 addiction 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 addiction 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 the addiction, this process involves addressing the effects and side effects of the addiction as well. The self-help tradition recognizes that living life with an addiction generates many negative effects on one’s life beyond the addiction *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.

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

With the toxic effects of addiction spreading to the person’s life as a whole, this sense of being in recovery involves the person’s efforts to abstain from substance use while also 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 how 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 their 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 become addicted in the first place.



Mental Health Recovery. It was this same sense of being “in recovery” that was first introduced into the mental health community approximately thirty years ago through the self-help/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 (many, if not all, of the first self-advocates were former inpatients), the mental health self-help community viewed itself first and foremost as a civil rights movement rather than as part of any treatment or rehabilitative enterprise.

For people with mental illnesses, prior to denoting anything like a cure or improvement in their psychiatric 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 illness (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 many of the discriminatory practices historically seen in institutional settings.

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

Within mental health, then, two related but distinct uses of the term recovery have emerged. While not inconsistent with use of the term within addiction, the first of these two senses acquires a different emphasis as an advocacy issue. 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 psychiatric disabilities are treated both inside and outside of

mental health⁴. Similar to other forms of prejudice, a set of attitudes and that have the effect of of the general population to

... recovery [poses] a fundamental challenge to ... "mentalism"

racism, sexism, and mentalism involves associated behaviors confining a segment second-class citizen

ship. In this case, the discrimination is based on the belief that people with mental illness are more like children than adults, 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, as earlier, in hospital settings or, as is now more common, through community 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 illnesses. It has been fueled both by the personal conviction of people in recovery and by over thirty years of clinical research findings which consistently have demonstrated a broad heterogeneity in outcome over time and across domains of functioning in serious mental illness. Research has shown that mental illness not only comes and goes over time and varies significantly in severity and duration, but that even when a person is actively experiencing psychosis, it most often affects only some of the person's abilities, leaving other abilities intact.

Rather than subsuming the entirety of the person, mental illnesses 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.

Rather than subsuming the entirety of the person, mental illnesses 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.⁵ 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 illness renders him or her unable or

⁴ Chamberlin, J. (1984). Speaking for ourselves: An overview of the Ex-Psychiatric Inmates' Movement. *Psychosocial Rehabilitation Journal*, 2, 56-63.

⁵ 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*. Boston, MA: Center for Psychiatric Rehabilitation of Boston University.

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 illness may require similar social and environmental supports in order to function optimally in community settings. While 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.

It is at this juncture that the civil rights movement in mental health meets up with the sense of recovery used in addiction in order to promote an alternative vision of mental health recovery. This second sense of recovery involves viewing psychiatric disorder as only one aspect of a person who otherwise has assets, interests, aspirations, and the desire and ability to continue to be in control of his or her own life. Paralleling in some ways addiction recovery, this sense of recovery involves the person's assuming increasing control over his or her illness while reclaiming responsibility for his or her life; a life that previously had been subsumed by the disorder.

Recovery involves viewing psychiatric disorder as 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 addiction. For example, being in recovery from an addiction invariably involves some degree of abstinence; it requires a change in the person's condition from being controlled by the addiction to the addiction being under at least some degree of the person's control. While vulnerability to relapse remains a core element of addiction recovery, a person who continues to use cannot be viewed as in recovery; i.e., active substance use in the context of a lack of awareness of the addiction, or in the lack of any progress made toward decreasing use, precludes recovery.

The same cannot be said, however, for mental illness. In this respect, mental health recovery borrows from the disability rights movement in arguing that recovery remains possible even while a person's 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 psychiatric disorder or a return to a pre-existing state of health. Rather, it involves a redefinition of one's illness 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 illness.

With recovery in both addiction and mental health now defined, it becomes more evident why we have said that recovery is *what the person does*. Addiction treatment providers are well aware that they have not been able to make a person stop using drugs or alcohol. In this sense, addiction recovery has always been in the hands of the person with the addiction. What may be different about recovery-oriented care in the addiction 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 illness does is a less commonly accepted notion. With the assumption that mental illness incapacitates 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 pertaining to what the person with the mental illness does in no way diminishes the importance of professional competence or the role of mental health care practitioners. What it does, instead, is to shift the responsibility for deriving maximum benefit from health care services from the educated and caring people who provide them to the person him or herself who needs to use them. Rather than

This definition of . . . recovery in no way diminishes the importance of professional competence or the role of . . . health care practitioners.

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.⁶ The idea of recovery extends this conventional model of care to behavioral health as well.

⁶ 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 behavioral health 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 statutory laws (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.

From Recovery to Recovery-Oriented Care

In suggesting how behavioral health 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 behavioral health condition does—comes into contact with recovery-oriented care—i.e., what practitioners of mental health and substance abuse 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 individual should not be taken to suggest that there is no longer an integral role for services and supports.

This is no more true in behavioral health 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. 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 experts. 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 against people with behavioral health conditions rather than from any wish to devalue or diminish the role of behavioral health practitioners.

What, then, is the most appropriate role for the behavioral health care provider in relation to recovery? Similar to the example provided 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 the supports required in order to be successful in doing so.

. . . 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 the 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 behavioral health 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 his or her 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 psychiatric or substance use disorder does not try to reclaim responsibility for his or her life, he or she will be unable to regain his or her functioning. This fact poses a fundamental challenge to the provision of recovery-oriented care.

Like the proverbial horse that cannot be made to drink, recovery-oriented practitioners can create or enhance access for people in recovery to a variety of educational, vocational, social, recreational, and affiliational activities in the community. They cannot, however, 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 to behavioral health. 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 behavioral health is the perception that the person's decision-making capacity is itself among the faculties most directly affected by the illness.

As both psychiatric and substance use disorders 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 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 illness, 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 Pat Deegan’s terms, the “dignity of risk” and the “right to failure.”⁷ As is true in most components of recovery-oriented care, it requires concerted effort and reflection—and perhaps supervision—as well as compassion, for behavioral health practitioners to continue to view and treat the person as sitting in the driver’s seat of his or her own life. 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.

As suggested in the definition above, recovery-oriented care takes as its primary aim offering people with psychiatric and/or addictive disorders 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:

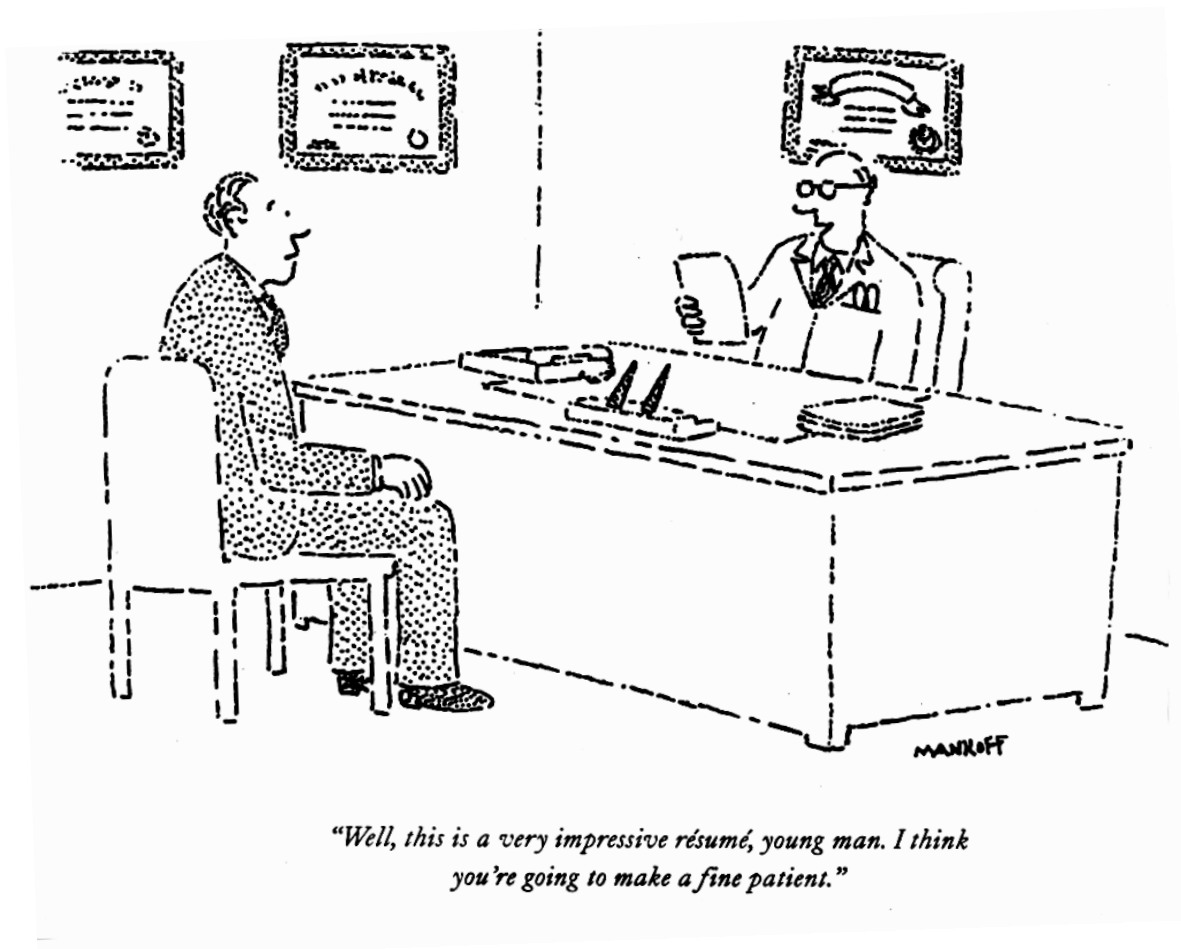
A recovery-oriented system of care identifies and builds upon each person’s assets, strengths, and areas of health and competence to support the person in achieving a sense of mastery over mental illness and/or addiction while regaining his or her life and a meaningful, constructive sense of membership 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. These guidelines are drawn from over two years of conversations with practitioners, people in recovery, families, and program managers, and are informed by the current professional literature on recovery and recovery-oriented practice.

These guidelines focus primarily on the concrete work of practitioners and provider agencies so as to provide practical and useful direction to individuals and collectives that are committed to implementing recovery-oriented care. We recog-

⁷Deegan, 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.

nize, however, that many of the practices described will require a broader commitment of agency leadership to significant and on-going administrative restructuring. 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. Equally important steps were taken in the past through the development of practice standards for culturally competent care⁸ (which therefore are not duplicated here), and future efforts are planned to address the crucial roles of prevention and early intervention and the need for ongoing evaluation and monitoring of the outcomes of care.



⁸ State of Connecticut Department of Mental Health and Addiction Services Office of Multicultural Affairs. (2001). *Multicultural behavioral healthcare: Best practice standards and implementation guidelines*. Hartford, CT: State of Connecticut Department of Mental Health and Addiction Services

Practice Guidelines for Recovery-Oriented Behavioral Health Care

- A. Primacy of Participation
- B. Promoting Access and Engagement
- C. Ensuring Continuity of Care
- D. Employing Strengths-Based Assessment
- E. Offering Individualized Recovery Planning
- F. Functioning as a Recovery Guide
- G. Community Mapping, Development, and Inclusion
- H. Identifying and Addressing Barriers to Recovery

A. The Primacy of Participation

An essential characteristic of recovery-oriented behavioral 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. 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 behavioral health disorders in all components of designing and implementing systems of community-based behavioral health care. This mandate has been confirmed consistently in numerous federal and state statutes and regulations issued since, and forms the foundation of CT DMHAS's Recovery and System Transformation Initiative.

For the involvement of people in recovery and their families to be meaningful and substantive, it must go well beyond asking them to sign off on provider-driven treatment plans or to endorse the adoption or 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 capacity and needs assessments to be conducted, to the delivery, evaluation, and ongoing monitoring of care, to the design and development of new services, interventions, and supports.

As recovery is what the person with the behavioral health condition *does*, rather than something that can be done *to* or *for* the person by a care provider, people in recovery, by definition, are understood to be the foremost experts on their own needs and preferences for assistance in managing their condition and reconstructing their lives. As a result, recovery-oriented care consistently elicits and is substantially informed by the input and involvement of people in recovery across all levels, from recovery planning led by individual clients (see Section E, Individualized Recovery Planning), to program development and evaluation, to policy formulation.

**You will know that you are placing primacy
on the participation of people in recovery when:**

- | |
|--|
| <p>A.1. People in recovery are routinely invited to share their stories with current service recipients and/or to provide training to staff.</p> <p>A.2. 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.</p> |
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- A.3.** 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 for clients or staff. 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.4.** Each person served is provided with an initial orientation to agency practices regarding client rights, complaint procedures, treatment options, 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 record.
- A.5.** Initial orientation is supplemented by the routine 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.6.** Policies are established and maintained that allow people in recovery maximum opportunity for choice and control 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 agency admission and are routinely publicized throughout the agency through newsletters, educational postings, Consumer Empowerment Councils, etc. This process is particularly crucial within services such as "money management" where the line between providing a service and infringing on people's rights can easily be blurred in the absence of clear programmatic guidelines and safeguards.

A.7. 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.

- A.8.** 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.
- A.9.** Administration enforces ethical practice through proactive human resource oversight. This oversight prohibits the use of coercive practices, and holds all staff accountable for affording people in recovery maximum control over their own treatment and rehabilitation.
- A.10.** 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 disability and 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 agency positions.
- A.11.** Active recruitment of 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, the professional agency. 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 should be available in all areas. Such recovery centers are neither treatment centers nor social clubs. They are places where people who are interested in learning about recovery can meet with other non-professionals to get support, learn about recovery and treatment resources, and simply find people to talk to. Agencies can demonstrate their support for peer-operated services by offering material and supervisory support to

emerging programs. For example, technical assistance or mentoring regarding business management, attainment of 501(c)3 status, human resource practices, etc., can greatly facilitate the establishment and long-term viability of emerging peer-operated services. Care should be taken to ensure capacity-building and enhanced independence in the peer-operated program over time. As with all community support programs, peer-operated services should be well integrated with the agency at large in terms of committee membership and with recovery planning at the individual level.

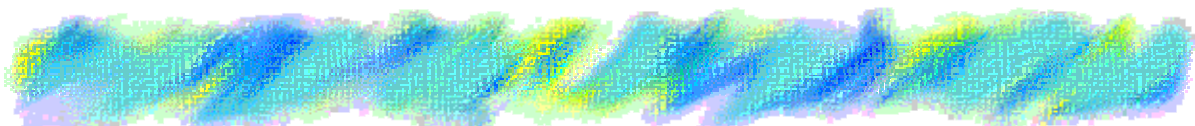
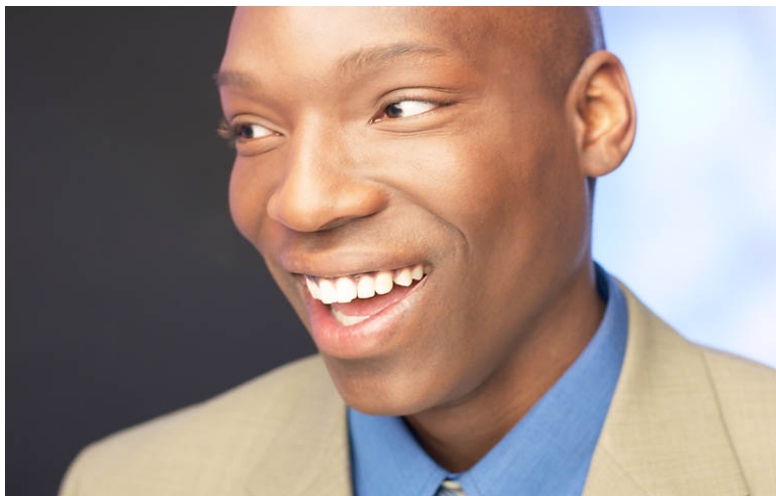
- A.12.** Self-disclosure by employed persons in recovery is respected as a personal decision and is not prohibited by agency policy or practice. Supervision is available to discuss the complex issues which can arise with self-disclosure.

- A.13.** Staff appreciate that many people in recovery may not, at first, share the understanding that they are the foremost 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 the expert nor recognize that they are entitled to occupy this role. Therefore, staff encourage individuals to claim their rights and to 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 self-determination, this too is respected as a valid choice.

- A.14.** The agency offers to host local, 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, and Focus on Recovery-United.

**What you will hear from people in recovery
when you are placing primacy on their participation:**

- *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 in the work field as a peer provider makes me feel good; makes me understand that I can do this. I can really do this. And if I could do this, anybody can do this. Folks get hope when they look at 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!*



B. Promoting Access and Engagement

A core principle of the deinstitutionalization movement of the 1950s and beyond was that persons with psychiatric disabilities should receive mental health services in the least restrictive setting possible within their home communities. Community mental health centers and clinics were developed in large part in response to this principle. Unfortunately, many persons with psychiatric disabilities did not receive care due to a variety of factors such as: inadequate funding for community-based services, administrative and bureaucratic barriers that discouraged people from seeking care, expectations of motivation for treatment that did not take into account internal (to the clinic) or external (in the person's environment) barriers to care, a lack of knowledge of ways to engage people living in the community into mental health treatment, clients' avoidance of the mental health system because of previous negative experiences, and persons' inability to meet the requirements of treatment (e.g. appointment times, etc.) due to the exigencies of their lives of poverty and/or homelessness, or due to their psychiatric symptoms. Thus, many people who were eligible for services did not receive them, and suffered impoverished lives without adequate treatment, social support, or material resources in the community.

For these, and additional, reasons, the recent U.S. Surgeon General's *Report on Mental Health*⁹ suggested that for every one person who seeks and receives specialty mental health care for a diagnosable psychiatric disorder, 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 color¹⁰.

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 addiction, with approximately 1 out of 7 people with an addiction actually receiving active behavioral health treatment. These facts clearly warrant the attention of the behavioral health system, including a greater focus on efforts to enhance access and engage people in care.

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

⁹Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

¹⁰Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

other support services. For example, a public health nurse working with a homeless outreach team facilitates a person's entry into behavioral health care, a clinician might help the person gain access to vocational services and entitlement income support, and, with the client'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 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, schedule conflicts, and modes of service provision that conflict with the life situations and demands of persons with psychiatric disabilities or addiction. It also means that access to care goes far beyond mere eligibility to receive services. Finally, access to care involves moving away from traditional philosophies of treatment—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 and recovery.

Engagement into services is closely tied to access to care. Engagement involves making contact with the person rather than with the diagnosis or disability, 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 sees 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 involves sensitivity to the thin line between persuasion and coercion and attention to the power differential between the service provider and the client or potential client, and the ways in which these factors can undermine personal choice. Finally, methods of ensuring access and engagement are integrated within and are part of providing good clinical and rehabilitative care, not adjuncts or qualifications to them.

**You will know that you are
promoting access and engagement when:**

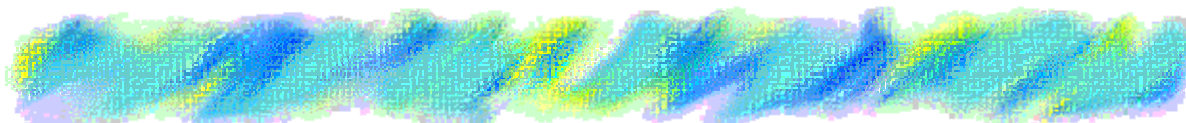
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| <p>B.1. The service system has the capacity to go where the potential client is, rather than always insisting that the client come to the service. Services and structures (e.g., hours of operation and locations of services) are designed around client needs, characteristics, and preferences.</p> |
|--|

- B.2.** The team provides, 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 an array of services, 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. However, self referrals will be subject to admission and oversight and need approval by a licensed entity to satisfy reimbursement and accreditation needs.
- B.3.** 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 an important element of recovery. Skill building and finding employment are competencies included in all staff job descriptions, including clinical providers, with only the most difficult-to-place clients being referred to specialized programs.
- B.4.** The assessment of motivation is based on a stages of change model, and services and supports incorporate motivational enhancement strategies which assist providers in meeting each person at his or her own level. Training in these strategies is required for all staff who work with people with addictions in order to help move people toward recovery.
- B.5.** Staff and agencies look for signs of organizational barriers or other obstacles to care before concluding that a client is non-compliant with treatment or unmotivated for care, e.g., meeting the needs of women with children for daycare.
- B.6.** Agencies have “zero reject” policies that do not exclude people from care based on symptomatology, substance use, or unwillingness to participate in prerequisite clinical or program activities. For example, vocational rehabilitation agencies do not employ screening procedures based on arbitrary “work readiness” criteria, as such criteria have limited predictive validity regarding employment outcomes. In addition, such procedures suggest that individuals must attain, and maintain, clinical stability or abstinence before they can pursue a life in the community, when, in fact, employment and other meaningful activities are often a path through which people become stable in the first place.

- B.7.** 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 an “active” versus an “outreach” client, and considers how such definitions impact program enrollment, documentation standards, 30 day drop out lists, case load definitions, and reimbursement strategies.
- B.8.** From an administrative perspective, the system builds on a commitment to and practice of motivational enhancement, with reimbursement for pre-treatment and recovery management supports. This includes flexibility in outpatient care, including low-intensity care for those who do not presently benefit from high-intensity treatment.
- B.9.** Outpatient substance abuse treatment clinicians are paired with outreach workers to capitalize on the moment of crisis that can lead people to accept treatment, and to gain access to their appropriate level of care.
- B.10.** Mental health professionals, addictions 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. The agency develops and establishes the necessary memoranda of agreement and protocols to facilitate this co-location of services.
- B.11.** The team or agency employs staff with first person experience of recovery who have a special ability to make contact with and engage people into services and treatment.
- B.12.** Housing and support options are available for those who are not interested in, or ready for, detoxification, but who may begin to engage in their own recovery if housing and support are available to them. Provider ambivalence regarding harm reduction approaches and the issue of public support for persons who are actively using must be addressed in regard to this point.
- B.13.** 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.

What you will hear from people in recovery when you are promoting access and engagement:

- *I didn't want nothing to do with them at first. But, folks from the Center just kept showing up . . . they didn't drop me or let me get off on the wrong track... they didn't give up, they just stuck by me. It was like a velvet bulldozer.*
- *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...*
- *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 be sober every day.*
- *They knew when to take "no" for an answer. They didn't stay on my back all the time, but I knew they were always there for me if I needed them. Now I don't say "no" so often.*



C. Ensuring Continuity of Care

Recovery in both addiction and in 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 illness 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 is unlikely to have much relevance. Such individuals are unlikely to consider themselves, or to refer to themselves, for example, as being “in recovery” from psychiatric or substance use disorders. In the face of the significant stigma and discrimination which continue to accrue to psychiatric and substance use disorders in the general public, these persons seldom disclose their psychiatric or addiction history or define themselves in terms of this isolated episode of illness, preferring to return quietly to the normal lives they led previously. Without giving much thought to the repercussions of their condition for their social role or sense of identity, such individuals are unlikely to describe themselves as being “in recovery” from anything.

For those individuals for whom being in recovery is a meaningful goal, the nature of their struggle with mental illness and/or addiction is likely to be sustained. In such cases—which, it should be acknowledged, comprise a significant segment of Connecticut citizens receiving care from DMHAS—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 undergirding the “new recovery movement” in addictions, 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 episodes¹¹.

These models are based on the belief that full recovery is seldom achieved from a single episode of treatment, and that providers, as well as clients, families, and policy makers, should not be disappointed or discouraged by the fact that there are no quick fixes. Similar to (other) chronic medical illnesses, previous treatment of a person’s condition also should not be 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 and exacerbations of psychiatric symptoms are to be 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

¹¹White, W. (2001). The new recovery advocacy movement: A call to service. *Counselor*, 2(6), 64-67.

second or third heart attack). All of these principles suggest that treatment, rehabilitation, and support are not to be offered through serial episodes of disconnected care offered by 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.

**You will know that you are
ensuring continuity of care when:**

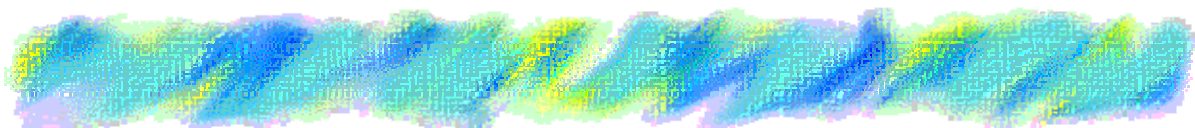
- C.1.** The central concern of engagement shifts from: “How do we get the client into treatment?” to: “How do we nest the process of recovery within the person’s natural environment?” For example, people have often asked for meeting places and activities to be available on weekends, especially for those individuals who are in the early stages of their recovery.
- C.2.** 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 receive written explanations as to why and are connected to appropriate alternatives including appointment and transportation.
- C.3.** Eligibility and reimbursement strategies for this group of individuals (i.e., outreach and pre-engagement) are established and refined as necessary over time by administrative leadership.
- C.4.** People have a flexible array of options from which to choose, and options are not limited to what “programs” are available. These options allow for a high degree of individualization and a greater emphasis on the physical/social ecology (i.e., context) of recovery.
- C.5.** 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. Rather, within the context of a responsive continuum of care, individuals work in collaboration with their recovery team to select those services from within the array that meet their particular needs and preferences at a given point in time.

- C.6.** In a Recovery Management Model, an individual's stage of change is considered at all points in time and the focus of care is on enhancing existing strengths and recovery capital. The assessment of problems and needs is consistently coupled with an assessment of resources and strengths both in initial and in on-going recovery planning. This is best achieved by including the person's family/kinship network and/or any natural supports she or he believes would be supportive of recovery.
- C.7.** Goals and objectives in the recovery plan are not defined by practitioners based on clinically-valued outcomes (e.g., reducing symptoms, increasing adherence), but rather are defined by the person with a focus on building recovery capital and pursuing a life in the community.
- C.8.** 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 with feedback, and early re-intervention if necessary. The concept of "aftercare" is irrelevant as all care is conceptualized as continuing care and there is a commitment to provide ongoing, flexible supports as necessary.
- C.9.** Valued outcomes are influenced by the system's commitment to ensuring continuity of care. For example, less emphasis is placed on a professional review of the short-term outcomes of single episodes of care (e.g., readmission or incarceration rates) and more emphasis is placed on 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.
- C.10.** 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. Valuing and incorporating such community resources in ongoing care planning is viewed as essential to decreasing dependence on formal behavioral health care and assisting the person to develop a more natural recovery network. In this spirit, the community, rather than the clinic, agency, or program, is viewed as the ultimate context for sustained recovery.

- C.11.** Individuals are seen as capable of illness self-management and interventions support this as a valued goal of recovery-oriented services. People are actively involved in all aspects of their care including policy development, assessment, goal setting, and evaluation. These different forms of involvement build capacity for independent community living and are powerful antidotes to the passivity and dependence that may have resulted from years of being a recipient of professionally-prescribed and delivered care. In the process of decreasing the power differential that traditionally has characterized relationships between clients and providers, care is conceptualized within a partnership or consultant framework in which services—while available over the long-term—may be time-limited and accessed by the person when and as she or he deems necessary.
- C.12.** 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.
- C.13.** 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 having a criminal record for non-violent, one-time, drug-dealing offenses or offenses related to psychiatric disability.
- C.14.** 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 Corrections to put into place plans for re-entry, with resources such as Oxford Houses and rental assistance for people with substance use disorders coming out of jails and prisons.
- C.15.** In order to facilitate sustained recovery and community inclusion, advocacy efforts are extended beyond institutional policies and procedures to the larger community, including stigma-busting, community education, and community resource development activities.

What you will hear from people in recovery when you are ensuring continuity of care:

- *They were there for me – no strings attached. I didn't walk through the door and get a whole bunch of expectations dumped on me.*
- *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 everyday 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 of how good it was in those two months and I wanted to get back there.*
- *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.*
- *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.*



D. Employing Strengths-Based Assessment

As described above, traditional behavioral health services have been based on a narrow and acute medical model that perceives mental illnesses and addictions as diseases that can be treated and cured. While this approach works effectively for many people, for many others it primarily serves to add additional weight to their already heavy burdens. In this case, providers have had an unfortunate tendency to overlook the remaining and co-existing areas of health, assets, strengths, and competencies that the person continues to have at his or her disposal—what remains “right” with people—by focusing on the assessment and treatment of their deficits, aberrations, and symptoms—what is “wrong” with people. Emphasizing the negative in this way has led to a tremendous sense of hopelessness and despair among both clients and the behavioral health practitioners who serve them.

In addition, whether one has a psychiatric disability or an addiction, 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 the process of improvement depends, in the end, on the resources, reserves, efforts, and assets of and around the individual, family, or community, a recovery orientation thus encourages providers to view the glass as half full rather than half empty¹².

Following principles that have been articulated at length by Rapp and others¹³, strengths-based approaches allow professionals 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 providers 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

¹²Saleebey, D. (2001). The diagnostics strengths manual. *Social Work*, 46, (2), 183-187.

¹³Rapp, C.A. (1998). *The Strengths Model: Case management with people suffering from Severe and Persistent Mental Illness*. New York: Oxford University Press.

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.

When facing such circumstances, providers need to 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 providers in conducting a comprehensive, strengths-based assessment that can help people to rediscover themselves as capable persons with a history, a future, and with strengths and interests beyond their symptoms, deficits, or functional impairments.

You will know that you are providing strengths-based assessment when:

- D.1.** A discussion of strengths is a central focus of every assessment, care plan, and case summary. Assessments begin with the assumption that individuals are the experts on their own recovery, and that they have learned much in the process of living with and working through their struggles. This strengths-based assessment is conducted as a collaborative process and all assessments in written form are shared with the individual.
- D.2.** Initial assessments recognize the power of simple, yet powerful, questions such as “What happened? And what do you think would be helpful? And 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.
- D.3.** Practitioners attempt to interpret perceived deficits within a strengths and resilience framework, as this will allow the individual to identify less with the limitations of their disorder. For example, an individual who takes their medication irregularly may automatically be perceived as “non-compliant,” “lacking insight,” or “requiring monitoring to take meds as prescribed.” 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.”

- D.4.** While strengths of the individual are a focus of the assessment procedure, 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 view that recovery is not a solitary process but rather a journey toward interdependence within one's community of choice.
- D.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)¹⁴.
- D.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.
- D.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 problems with mental illness or addiction often place less emphasis on symptom reduction and abstinence than on desired improvements in other areas of life such as work, financial security, safe housing, or relationships. For this reason, it is beneficial to explore in detail each individuals' needs and resources in these areas.

¹⁴Saleeby, D. (2001). The diagnostics strengths manual. *Social Work*, 46(2), 183-187.

- D.8.** Strengths-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 prescribed for them by others.
- D.9.** Guidance for completing a strengths-based assessment may be derived from certain interviewing strategies employed within solution-focused approaches to treatment. 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 progress¹⁵.
- D.10.** Illness self-management strategies and daily wellness approaches such as WRAP¹⁶ are respected as highly effective, person-directed, recovery tools, and are fully explored in the strengths-based assessment process.
- D.11.** Cause-and-effect explanations are offered with caution in strengths-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 practice¹⁷. For example, to conclude that an individual did not pay his or her 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. Strengths-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).

¹⁵DeJong, G. & Miller, S. (1995) How to interview for client strengths, *Social Work*, (40), 729-736.

¹⁶Copeland, M. (2002). *The depression workbook: A guide for living with depression and manic depression. Wellness Recovery Action Plan*. Oakland, CA: New Harbinger Publications.

¹⁷Cowger, C.D. (1994). Assessing client strengths: Clinical assessment for client empowerment. *Social Work* 39(3), 262-268.

- D.12.** Strengths-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 strengths-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 Planning Team. Modular approaches to 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.
- D.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, disorder.”
- D.14.** Practitioners are mindful of the power of language and carefully avoid the subtle messages that professional language has historically conveyed to people with psychiatric diagnoses, addictions, and their loved ones. Language is used that is empowering, avoiding the eliciting of pity or sympathy, as this can cast people with disabilities 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 “individuals 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 documentation and delivery of services.
- D.15.** Practitioners avoid using diagnostic labels as “catch-all” means of describing an individual (e.g., “she’s a borderline”), as such labels yield minimal information regarding the person’s actual experience or manifestation of their illness or addiction. 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 may be required for other purposes (e.g., decisions regarding medication, justification of level of care), asset-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 disability.

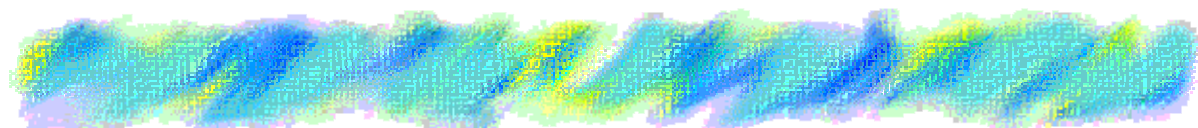
D.16. Language used is neither stigmatizing nor objectifying. At all times "person first" language is used to acknowledge that the disability is not as important as the person's individuality and humanity, e.g., "a person with schizophrenia" versus "a schizophrenic" or a "person with an addiction" versus "an addict." Employing person-first language does not mean that a person's disability is hidden or seen as irrelevant; however, it also is not to be the sole focus of any description about that person. To make it the sole focus is depersonalizing, and is no longer considered an acceptable practice.

D.17. 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 unique 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 or principles. 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 with disabilities prefer to be referred to in first-person language, when in doubt ask the person what he or she prefers.

What you will hear from people in recovery when you are employing strengths-based assessment:

- *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.*

- *Being in recovery means that I know I have certain limitations and things I can't do. But rather than letting these limitations be an occasion for despair and giving up, I have learned that in knowing what I can't do, I also open up the possibilities of all I can do.*¹⁸
- *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 at the Center.*
- *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.*



¹⁸Deegan, P.E. (1993). Recovering our sense of value after being labeled mentally ill. *Journal of Psychosocial Nursing*, 31(4), 7-11.

E. Offering Individualized Recovery Planning

In accordance with the Connecticut General Statutes, as well as Federal and JCAHO 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 taken to ensure that individuals' rights to self-determination are respected and that all 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) and will include a comprehensive and culturally sensitive assessment of the person's hopes, assets, strengths, interests, and goals in addition to a holistic understanding of his or her behavioral health conditions and other medical concerns within the context of his or her ongoing life.

Typical examples of such life context issues include employment, education, housing, spirituality, social and sexual relationships, 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 will not be limited to physician/psychiatrists, nurses, psychologists, and social workers, but may also include rehabilitative and peer staff, and wherever possible, relevant community representatives and/or others identified by the person.

Building on the strengths-based assessment process, individualized recovery planning both encourages and expects the person to draw upon his or her strengths to participate actively in the recovery process. It is imperative throughout this process that providers maintain a belief in the individual's potential for growth and development, up to, and including, the ability to exit successfully from services. Providers 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.

For example, many people identify returning to work as a primary recovery goal. It is not uncommon for practitioners to advise against this step based on an assumption 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.

You will know that you are offering Individualized Recovery Planning when:

E.1. Core principles of “person-centered” planning are followed in the process of building individualized recovery plans. For example:

E.1.1. Consistent with the “nothing about us, without us” dictum, providers actively partner with the individual in all planning meetings and/or case conferences regarding his or her recovery services and supports.

E.1.2. 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 as relevant) are provided with support before the meeting so that they can be prepared and participate as equals¹⁹.

E.1.3. The language of the plan is understandable to all participants, including the focus person and his or her non-professional, natural supports. Where technical or professional terminology is necessary, this is explained to all participants in the planning process.

¹⁹Osher, D. & Keenan, S. (2001). From professional bureaucracy to partner with families. *Reaching Today's Youth*, 5(3), 9–15.

- E.1.4.** When individuals are engaged in rehabilitation services, the rehab practitioners are involved in all planning meetings (at the discretion of the individual) and are given copies of the resulting plan.
- E.1.5.** Within the planning process, a diverse, flexible range of options must be 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.
- E.1.6.** Goals are based on the individual's unique interests, preferences, and strengths, and objectives, and interventions are clearly related to the attainment of these stated goals. In the case of children and youth, the unique goals of the family are also considered, with the youth increasingly driving the process as he or she approaches the age of maturity. In cases in which preferred supports do not exist, the recovery team works collaboratively with the individual to develop the support or to secure an acceptable alternative.
- E.1.7.** 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 disability status.
- E.1.8.** A discussion of strengths is a central focus of all recovery plans (See Section #D). Assessments begin with the assumption that individuals are the experts on their own recovery, and that they have learned much in the process of living with and working through their struggles.
- E.1.9.** Information on rights and responsibilities of receiving services is provided at all 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.
- E.1.10.** The individual has the ability to select or change his or her service providers within eligible guidelines and is made aware of the procedures for doing so.

E.1.11. In the spirit of true partnership and transparency, all parties must have access to the same information if people are to embrace and effectively carry out responsibilities associated with the recovery plan²⁰. Clients are automatically offered a copy of their written plans, assessments, and progress notes. Knowing ahead of time that a copy will be shared is a simple but powerful strategy that can dramatically impact both the language of the plan and the content of its goals and objectives.

E.1.12. The team reconvenes 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., “all-treaters” meetings to address hospitalization or relapse).

E.2. A wide range of interventions and contributors to the planning and care process are recognized and respected. For example:

E.2.1. Practitioners acknowledge the value of the person’s existing relationships and connections. If it is the person’s preference, significant effort is made to include these “natural supports” and unpaid participants as they often have critical input and support to offer to the team. Interventions should complement, not interfere with, what people are already doing to keep themselves well, e.g., drawing support from friends and loved ones²¹.

E.2.2. The plan identifies a wide range of both professional supports 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.

E.2.3. Individuals are not required to attain, or maintain, clinical stability or abstinence before they are supported by the planning team in pursuing such goals as employment. For example, in some systems access and

²⁰Osher, T., & Osher, D. (2001). The paradigm shift to true collaboration with families. *The Journal of Child and Family Studies*, 10(3), 47-60.

²¹Osher, 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.

referral to vocational rehabilitation programs may be controlled by a clinical practitioner, and people are often required to demonstrate “work readiness” or “symptomatic stability” as a prerequisite to entry. In addition to an abundant literature which has shown that screening procedures and criteria have limited predictive validity, this structure also neglects that fact that activities such as working are often the path through which people become clinically stable in the first place.

- E.2.4.** Goals and objectives are driven by the person’s current values and needs and not solely by commonly desired clinical/professional 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.

E.3. Community inclusion is valued as a commonly identified and desired outcome. For example:

- E.3.1.** The focus of planning and care is on how to create pathways to meaningful and successful community life and not just on how to maintain clinical stability or abstinence. Person-centered plans document areas as physical health, family and social relationships, employment/education, spirituality, housing, social relations, recreation, community service and civic participation, etc., unless such areas are designated by the person as not-of-interest. For example, traditional planning has often neglected the spiritual and sexual aspects of peoples’ lives. Achieving interdependence with natural community supports is a valued goal for many people in recovery 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 members²². Such preferences often speak to the need to reduce time spent in segregated settings designed solely to support people labeled with a behavioral health disorder.

- E.3.2.** Recovery plans respect the fact that services and practitioners should not remain central to a person’s life over time, and 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.

²²Reidy, D. (1992). Shattering illusions of difference. *Resources*, 4(2), 3-6.

E.3.3. Recovery plans consider not only how the individual can access and receive needed supports from the behavioral health system and the 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 should be encouraged to explore how they can make meaningful contributions in the system or in the community, e.g., through advocacy, employment, or volunteering.

E.3.4. A focus on community is consistent not only with person-centered care principles but with the need for fiscal efficiency. Practitioners and people in recovery should be mindful of the limited resources available for specialized services and should 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 service interventions within recovery plans, e.g., creating on-site health and fitness opportunities such as exercise classes without first exploring to what extent that same opportunity might be available in the broader community through public recreational departments, YMCAs, etc. If natural alternatives are available in the community, individuals should be informed of these opportunities and to the extent to which what is offered is culturally responsive and accessible, they should be supported in pursuing activities of choice in integrated settings.

E.4. The planning process honors the “dignity of risk” and “right to fail” as evidenced by the following:

E.4.1. Prior to appealing to coercive measures, practitioners try different ways of engaging and persuading individuals in ways which respect their ability to make choices on their own behalf.

E.4.2. Unless determined to require conservatorship by a judge, individuals are presumed competent and entitled to make their own decisions. As part of their 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 the decisions of the individual. Person-centered care does not take away a practitioner’s obligation 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 involving imminent risk as defined by relevant statutes.

E.4.3. 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.

E.4.5. 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 crises²³. 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 taken away. This plan is kept in an accessible location and can be made available for staff providing emergency care.

E.5. Administrative leadership demonstrate a commitment to both outcomes and process evaluation. For example:

E.5.1. Outcomes evaluation in a provider-driven paradigm is typically limited to change in specific agency functions (e.g., length of hospital stays) as well as by the need to protect the image of the agency (e.g., consumer satisfaction)²⁴. In a consumer or family-driven paradigm, in contrast,

evaluation is a continuous process and expectations for successful outcomes in a broad range of quality of life dimensions (e.g., in areas such as employment, social relationships, community membership, etc.) are high. The maintenance of clinical stability alone is not accepted as a treatment outcome as the experience of recovery is about much more than the absence of symptoms or distress.

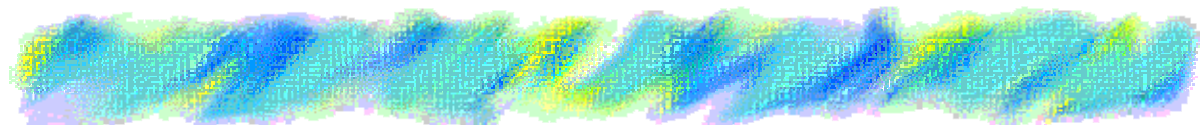
²³Kendziora, K. T., Bruns, E., Osher, D., Pacchiano, D., & Mejia, B. (2001). *Wraparound: Stories from the Field*. Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

²⁴Osher, T. & Osher, D. (2001). The paradigm shift to true collaboration with families. *The Journal of Child and Family Studies*, 10(3), 47-60.

E.5.2. There is a flexible application of process tools, such as the Assessment of Person-Centered Planning Facilitation Integrity Questionnaire²⁵, 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 implementation²⁶.

What you will hear from people in recovery when you are offering individualized recovery planning:

- *It's amazing what you can do when you set your mind to it ... especially when you're no longer supposed to have one!*
- *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 in the world and he had some great ideas for me.*
- *I had been working on my recovery for years. Finally, it felt like I was also working on my 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 whole 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!*



²⁵Holburn, S. (2001). How science can evaluate and enhance person-centered planning. *Research and Practice for Persons with Severe Disabilities*, 27(4), 250-260.

²⁶Osher, 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_whatism.htm.

F. Functioning as a Recovery Guide

The sentiment that “we’re not cases, and you’re not managers”²⁷ has been accepted increasingly as a fundamental challenge to the ways in which behavioral health care is conceptualized within a recovery-oriented system. During this time, the predominant vehicle for offering services to many adults with serious disabilities has evolved from the team-based and *in vivo* approach of intensive case management to the introduction of strengths-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.

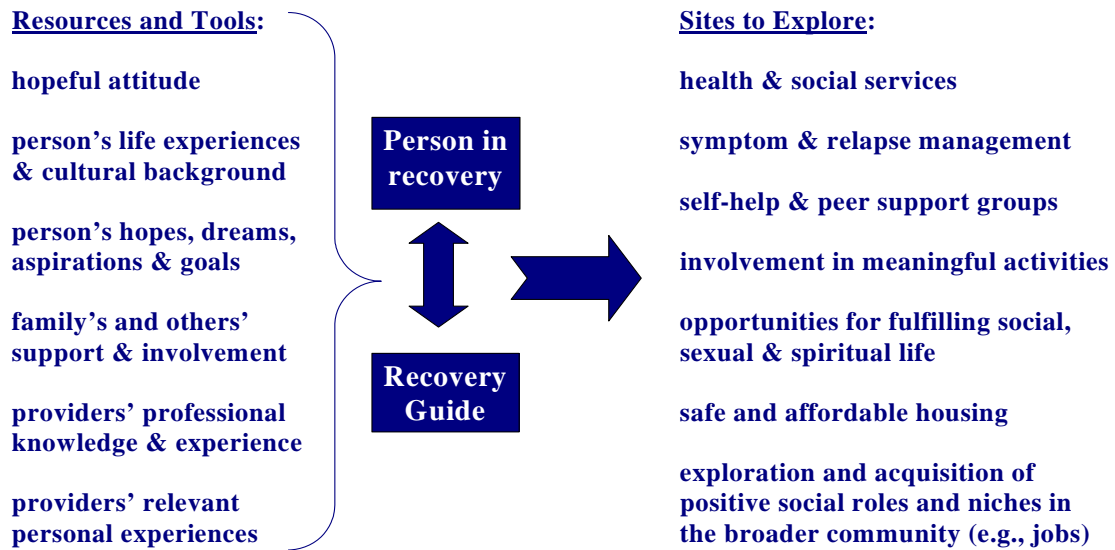
From the perspective of recovery, however, even these inherited models of case management limit the progress that otherwise could be made in actualizing the shift from a deficit- and institution-based framework to a recovery paradigm. This paradigm calls for innovative models of community-based practice that move beyond the management of cases, and beyond merely semantic changes that introduce new terms for old practices, to the creation of a more collaborative model which respects 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.

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

Prior to attempting to embark with a client on his or her journey of recovery, however, 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 suffering, person. In this sense, practitioners accept that most people with behavioral health disorders will not know that they have an addiction or psychiatric disorder 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.

²⁷Everett, B. & Nelson, A. (1992). We’re not cases and you’re not managers. *Psychosocial Rehabilitation Journal*, 15(4), 49-60.

Figure 1. Conceptual Model for the Recovery Guide



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 disorders, just as their lives are not encompassed totally by substance abuse or psychiatric treatment and rehabilitation. Based on recognition of the fact that people were already on a journey prior to the onset of their disorders, 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 disorder(s).

For example, practitioners strive to identify and understand how the person's substance use or psychiatric disorder 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 disorder, and despite of or without apparent awareness of the disorder 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 will share with care providers—it is the person's own goals for his or her life beyond or despite his or her disability that drive the treatment, rehabilitation, and recovery planning and efforts.

**You will know that you are functioning
as a Recovery Guide when:**

- F.1.** The primary vehicle for the delivery of most behavioral health interventions is the relationship between the practitioner and the person in recovery. The care provided must be 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." 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 positive expectations and hope.
- F.2.** Providers 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 disorder but be in pre-contemplation related to his or her psychiatric disorder).
- F.3.** Care is based on the assumption that as a person recovers from his or her condition, the addiction or psychiatric disorder 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?"
- F.4.** 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?"
- F.5.** Opportunities and supports are provided for the person to enhance his or her own sense of personal and social 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. Providers can achieve this by thoughtfully balancing when to do for someone, do with someone, or 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 must struggle to refine over time, prior to taking action it is always 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.” Strong messages of low expectations and incapability are given, and reinforced, every time unnecessary action is undertaken for a person, instead of with them.

- F.6.** 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.
- F.7.** People are allowed to express their feelings, including anger and dissatisfaction, without having these reactions attributed to symptoms or relapse.
- F.8.** 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.

- F.9.** 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 (see section #H below).
- F.10.** Interventions are oriented toward increasing the person’s recovery capital as well as decreasing his or her distress and dysfunction (see Sections #C and #H). 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 behavioral health 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.
- F.11.** Practitioners are willing to offer practical assistance in the community contexts in which their clients 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 community²⁸. 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”²⁹.

²⁸Curtis, L.& Hodge, M. (1994). Old standards, new dilemmas: Ethics and boundaries in community support services. *Psychosocial Rehabilitation Journal*, 18(2), 13-33.

²⁹Rosen, A. (1994). Case management: The cornerstone of comprehensive local mental health services. *Australian Hospital Association, Management Issues Paper No. 4*. April, 47-63.

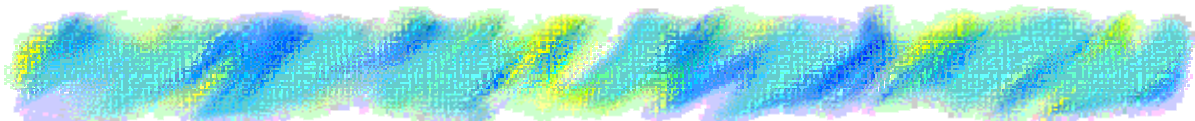
- F.12.** Care is not only provided in the community but is also oriented toward increasing the quality of a person's involvement in community life. Thus, the focus of care is considered more important than locus of where it is provided. The focus of care includes the process of overcoming the social 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 their clients 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.
- F.13.** 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.
- F.14.** 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 in recovery squarely within the context of their daily lives (i.e., as opposed to within institutional settings).
- F.15.** Community-focused care supplements, and is not meant to be a substitute for, the practitioner's existing expertise and services. Rather than devaluing professional knowledge and experience, the "recovery guide" 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. There is an expectation that practitioners engage in on-going professional education so that they are aware of, and can deliver, a wide range

of evidence-based and emerging practices. But 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.

- F.16.** Recovery is viewed as a fundamentally social process, involving supportive relationships with family, friends, peers, community members, and practitioners. Interventions serve to minimize the role that professionals play in people’s lives over time and maximize the role of natural supports. While the provider-person relationship can be a powerful component of the healing and recovery process, individuals must also develop and mobilize their own natural support networks to promote sustained recovery and independent community life.

What you will hear from people in recovery when you are functioning as a recovery guide:

- *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.*
- *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.*



G. Community Mapping and Development

Given its focus on life context, one tool required for effective recovery planning 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 behavioral health 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 providers 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.

Asset-based community development is one essential strategy for developing this comprehensive understanding of local resources and supports. Based on the pioneering work of Kretzmann and McKnight ("Building Communities from the Inside Out"), 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 clients.

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 underestimated³⁰. 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

³⁰Kretzmann, J.P. & McKnight, J.L. (1993). Building Communities from the Inside Out. Chicago, IL. ACTA Publications.

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 fully 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 disabilities will be welcomed and valued³¹. 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 you are engaged in
community mapping and development when:**

- | | |
|---------------------------------------|--|
| <p>G.1.</p> <p>G.2.</p> | <p>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.</p> <p>Community leaders representing a range of community associations and institutions work together with people in recovery to carry out the process of community development.</p> |
|---------------------------------------|--|

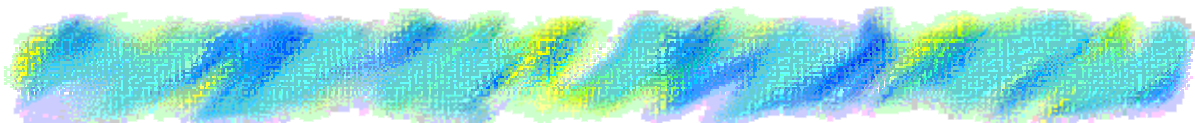
³¹McKnight, J. (1992). Redefining community. *Journal of Social Policy, Fall/Winter*, 56-62.

- G.3.** 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. Therefore, opportunities for employment, education, recreation, social involvement, civic engagement, and religious participation are 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.
- G.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.
- G.5.** High value is placed on the less formal aspects of associational life that take place, for instance, in neighborhood gatherings, block watch meetings, coffee clatches, salons, barbershops, book groups, knitting and craft circles, restaurants, pubs, diners, etc.
- G.6.** Institutions do not duplicate services that are widely available in the community through individuals and associations.
- G.7.** 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.
- G.8.** 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.

What you will hear from people in recovery when you are engaged in community mapping and development:

- *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...*
- *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...*



H. Identifying and Addressing Barriers to Recovery

To this point, our guiding assumption has been that behavioral health disorders 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 behavioral health disorders 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 providers will no doubt consider such a perspective simplistic and naïve, and will suggest that up to 80% of the work entailed in treating behavioral health disorders is devoted to helping people to arrive at such a position of being willing to receive care for their conditions. Once a person accepts that he or she has a behavioral health disorder 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 before many more people experiencing these conditions will be able to access and benefit from care in such a straightforward and uncomplicated manner.

For the foreseeable future, there will continue to be two major sources of complications—and of considerable suffering—that make accessing and benefiting from care a labor intensive and difficult process. These two types of barriers to recovery reside both external to the person, in societal stigma and discrimination and in the ways in which care has historically been structured and provided, and internal to the person, intrinsic to the nature of the illnesses themselves. In order to promote recovery, providers must be able to identify and address the variety of barriers encountered in each of these domains.

In terms of external barriers, there currently are elements and characteristics of the service delivery system and the broader community that unwittingly contribute to the exacerbation of symptoms and the creation and perpetuation of chronicity and dependency in individuals with behavioral health disorders. Foremost among these is the discrimination that continues to affect people with mental illnesses and/or addictions in society at large and, even more importantly, within the behavioral health system itself.

This discrimination results in people with behavioral health disorders 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 significant obstacle 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.

Beyond the impact of stigma and discrimination, there are a variety of ways in which the health care system and the broader community make recovery more difficult. These range from the lack of affordable housing and accessible, high quality medical care to the employment disincentives built in to entitlement programs, to the punitive aspects of some care settings and programs (e.g., in which people are discharged for manifesting the symptoms of their illness). Identifying and assisting the person to overcome these barriers to the degree that is possible is an important component of the work of the recovery-oriented behavioral health care practitioner.

In terms of internal barriers, there are several aspects of behavioral health disorders and their place within contemporary society that complicate and undermine the person's efforts. For example, while trauma may not be intrinsic to behavioral health per se, there is considerable evidence that suggests that people experiencing behavioral health disorders 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 trauma and victimization currently.

Perhaps more directly as a consequence of the illness itself, there also are symptoms of behavioral health disorders that pose their own barriers. The hallucinations and delusions often found in psychotic illnesses, for example, may compete as a source of information with that being offered to the person by health care practitioners, thereby discouraging the person from taking prescribed medications or otherwise participating in treatment or rehabilitation. The heightened sense of creativity and self-importance that often accompanies episodes of mania similarly may lead a person down a path that diverges from the one preferred by his or her loved ones and care providers. As destructive as they may appear to the person's loved ones or care providers, giving up delusions or mania often comes with its own costs. As a young man with a psychotic disorder once poignantly asked: "If you had the choice between being a CIA operative or a mental patient, which would you choose?"

Accepting that these and other elements associated with the disorders themselves undermine a person's efforts to cope with his or her illness, recovery-oriented practitioners become familiar with these issues and adept in working proactively with the person to overcome or bypass their destructive impact. Many of the skills and techniques traditionally utilized by clinicians within the context of office-based practice find their greatest utility and effectiveness in this domain, whether offered inside, or outside, of the office.

**You will know you are addressing
external and internal barriers to recovery when:**

- H.1.** **There is a commitment at the local level to embrace the values and principles of recovery-oriented care and to move away from the dominant illness-based paradigm. The practices identified throughout this document can only grow in a culture that fully embraces recovery principles and values. Systemic changes that reflect this paradigm shift include the following:**
- H.1.1.** Stakeholders understand the need for recovery-oriented system change as a civil rights issue which aims to restore certain elementary freedoms (e.g., self-determination, community inclusion, etc.) to American citizens with psychiatric diagnoses and/or addictions.
- H.1.2.** Stakeholders work together to move away from the criteria of “medical necessity” toward “human need,”³⁵ from managing illness to promoting recovery, from deficit-oriented to strengths-based, and from symptom relief to personally-defined quality of life. Perhaps most critical is the fundamental shift in power involved in realigning systems to promote recovery-oriented care—the shift away from prioritizing expert knowledge over respect for personal autonomy and self-determination³².
- H.1.3.** The possibility of recovery, and the responsibility to deliver recovery-oriented care, must be embraced by all stakeholders at all levels of the system. While many exciting things are occurring in agencies across the country, recovery-oriented change tends to occur in a fairly fragmented manner with a relatively small number of progressive practitioners or advocates taking on a large amount of responsibility for carrying out the recovery mission. For example, certain programs and staff in behavioral health systems (e.g., peer staff, rehabilitation providers, community-based case managers, etc.) are uniquely positioned to be leaders in the mission to provide recovery-oriented care, and the contributions of these programs should be respected and capitalized upon. Taking a lead in the recovery mission is a natural fit for such programs for a variety of reasons including their structure as private-

³⁵ Tondora, J., Pocklington, S., Gorges, A., Osher, D. & Davidson, L. (2005). *Implementation of person-centered care and planning: From policy to practice to evaluation*. Washington D.C.: Substance Abuse and Mental Health Services Administration.

³⁶ Osher, T. & Osher, D. (2001). The paradigm shift to true collaboration with families. *The Journal of Child and Family Studies*, 10(3), 47-60; WNYCCP. (2005). *Foundations of person-centeredness. Training curriculum*, Western New York Care Coordination Program. Rochester, NY: Coordinated Care Services.

non profit entities, their rehabilitation expertise, lower pressure and demands to deliver only medically necessary care, and their direct affiliations with the state or national consumer/recovery movement. However, agencies and systems must guard against the complacency which results when recovery is seen as being a “nice add-on,” but “not part of my job” or as being manifest only in “special” (sometimes “token”) programs that are split off from the functioning of the agency as a whole. Recovery-oriented system change will only take hold and thrive if it is understood that it is the shared mission of all stakeholders and that the task of promoting recovery—as the overarching aim of all behavioral health services—is a part of everyone’s job. Resources and guidelines are emerging which define exactly what that job is depending on what one’s role is as a practitioner (e.g., primary clinician, peer specialist, supported employment specialist) within the system.

H.2. Systemic structures and practices which inhibit the adoption of recovery-oriented practices are identified and addressed. Representative change strategies in this area include the following:

H.2.1. 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 greater 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 or outpatient psychotherapy groups before they will be referred to a supported employment program).

In addition to there being an accumulating body of evidence which demonstrates the failure of such a continuum approach, this sequential movement through a pre-existing continuum of supports is inconsistent with the civil rights perspective noted above and it contradicts current knowledge suggesting that recovery is neither a linear process or 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 these dimensions in a systematic, linear process). 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 should be constantly evolving based on the input of persons in recovery, the experience of practitioners, and the research literature.

- H.2.2.** There is often a lack of clarity regarding system priorities when agencies attempt to implement numerous initiatives simultaneously, e.g., evidence-based practice versus recovery-oriented programming. While such initiatives may not be incompatible, competing demands—even complementary ones—can diffuse the effort and resources of the agency and inhibit the adoption of any new practices. It is critical that there are coordinating structures to attend to both the prioritization and integration of new initiatives, policies, and procedures.
- H.2.3.** 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; however, that they will be held accountable should the result of such an individual’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 setbacks. At both the agency and system level, quality management tools and outcome indicators should be examined and mechanisms should be built in to track the trade-off which sometimes exists as we support individuals in taking risks to grow and advance in their recovery.
- H.2.4.** Processes for continual quality assurance and independent audits by people in recovery and families trained in recovery-oriented care need to be funded and coordinated. Outcomes and assessment of quality should not focus solely on the rating of services/supports, but on whether the choices people make are personally meaningful and whether recovery-oriented care leads to a valued community life.

- H.2.5.** Initial placement and service design currently is driven by practitioners' assessments of what the individual seeking services needs. While this assessment should remain a critical element of the referral process, it should be coupled with questions, directed to the person and answered in his or her own words, which solicit the individual's perception of what services and supports would be most helpful. Individuals must be engaged as active partners in their care 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/program assignment.
- H.2.6.** Recovery plans respect the fact that services and practitioners should not remain central to a person's life over time. Currently, many behavioral health systems lack clearly defined exit criteria and it is not uncommon for individuals to feel as if they will be attached to the formal system for life following their entry into care. This 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 should be 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" whenever possible. When an individual is strongly advised by the recovery team against "graduation," there should be 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 must take caution to avoid punitive measures by which individuals are discharged from services for displaying symptoms of their illness or addiction.
- H.2.7.** 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 services and return to meaningful employment. To integrate employment within the larger system of care, the task of assisting people in entering employment and education must be inherent in the responsibilities of the entire practitioner network, including those not specifically charged with work service or supported education activities.

H.3. The implementation of recovery-oriented care is facilitated, rather than impeded, by funding, reimbursement, and accreditation structures. Intrinsic to any dialogue regarding systemic barriers to recovery-oriented care is the need to address funding structures that recognize a limited range of clinical interactions as reimbursable services, and documentation requirements that hinder creative formulation of recovery-oriented goals and objectives. Necessary change strategies to address these barriers include the following:

H.3.1. Rules and regulations dictating eligibility and reimbursement for Medicaid and other public supports must be adapted at the federal and state 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, and considerable flexibility exists already in using these dollars to support innovative, community-based, recovery-oriented services and supports.

H.3.2. Within existing funding structures, training and technical assistance can be provided to practitioners attempting to implement recovery-oriented practices to assist them in learning how to translate the wishes of people in recovery into reimbursable service goals and to describe their interventions in a manner that will generate payment.

H.3.3. Operating in this manner is consistent with the growing understanding that recovery-oriented practices cannot be 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 services³³. Programs that successfully utilize such alternatives must be explored for expansion³⁴.

H.3.4. Self-directed funding opportunities should be considered both on a collective basis and through individualized budget programs. The Florida “Self-Directed Care” initiative is an example of such a program

³³Osher, 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.

³⁴Blessing, Tierney, Osher, Allegretti-Freeman, & Abrey. (2005). *Person-centered planning: Learning from other communities*, Washington D.C.: Substance Abuse and Mental Health Services Administration. .

which 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 accessible³⁵.

H.4. Training and staff development is prioritized as an essential function to increase individual practitioners' competency in providing recovery-oriented care. Necessary change strategies to address this issue include the following:

H.4.1. As consensus emerges regarding the knowledge and skills needed to implement recovery-oriented care, this information must lead to the development of competency models, and these models must be disseminated broadly as guidance for training programs and licensing bodies which prepare and accredit future and current providers of mental health care. For example, competency models regarding the delivery of recovery-oriented care should be used to address training gaps in pre-certification curriculum as well as ongoing professional development activities.

H.4.2. Once established, competency models—which are largely under-utilized in general in behavioral health—should be incorporated in all human resource activities (e.g., hiring, routine performance evaluation, promotion decisions, staff development targets, etc.) as a means of promoting accountability and quality improvement.

H.4.3. An analysis of staff's current competencies and self-perceived training needs should 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

³⁵Jonikas, J., Cook, J., Fudge, C., Hiebechuk, F. & Fricks, L. (2005). *Charting a meaningful life: Planning ownership in person/family-centered planning*. Washington D.C.: Substance Abuse and Mental Health Services Administration.

are beneficial, self-reflective tools (e.g., the CAI, RSA, RKI, etc.³⁶) 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 by training administrators.

- H.4.4.** Training in and of itself will not allow providers to develop the enhanced skill set and the increased sense of efficacy that will allow them to carry out the complex responsibilities and roles of the recovery-oriented practitioner. Competency-based training must be coupled with on-going mentor support, enhanced supervision, recovery-oriented case conferences, and opportunities for peer consultation.
- H.4.5.** Directors of clinical services and agency leaders should be involved in ongoing training initiatives so that there is consistency in proposed recovery-oriented practices and the system's administrative structures. This allows direct care staff to feel supported and respected and it allows agency leadership the opportunity to proactively identify, and address, any systemic barriers that prohibit the adoption of recovery-oriented practices.
- H.4.6.** Training and staff development activities must be sensitive to the role confusion which can result 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 in the treatment and recovery process. Rather, the provider's role has changed from that of all-knowing, all-doing caretaker to that of coach, architect, cheerleader, facilitator, mentor, or shepherd³⁷—roles that are not always consistent with one's clinical training or experiences. One effective educational strategy may be using a combination of literature, outcomes/efficacy data, and personal accounts such as recovery dialogues to help practitioners learn the new roles of advisor, mentor, or supports broker³⁸.

³⁶Campbell-Orde, T., Chamberlin, J., Carpenter, S. & Leff, S. (2005). *Measuring the promise: A compendium of recovery measures, Volume II*. Boston: Human Services Research Institute.

³⁷Adams, 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.

³⁸Jonikas, Cook, Fudge, Hiebecuk & Fricks. (2005). *op cit*.

Further, those involved in educating providers 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 their clients' lives³⁹. 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.

H.4.7. 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 demand it as a basic expectation of quality care. It is imperative that training initiatives regarding recovery-oriented care 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 culture⁴⁰ or taught by professionals and agencies that their preferred role is one of deferential compliance⁴¹. Ideally, training initiatives put all stakeholders, including people in recovery, families, and practitioners, at the same table.

H.5. Forces at the societal level (e.g., stigma, discrimination, lack of basic resources, etc.) which undermine recovery and community inclusion are identified and addressed. Necessary change strategies to address this issue include the following:

H.5.1. 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 behavioral health disorders. 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. Behavioral health practitioners have significant expertise to address this skill and knowledge gap, and should be prepared to offer supportive guidance and feedback at both

³⁹Holburn, S. & Vietze, P. (2002). *Person-centered planning: Research, practice, and future directions*. Baltimore: Paul Brookes Publishing.

⁴⁰Harry, B., Kalyanpur, M. & Day, M. (1999). *Building cultural reciprocity with families*. Baltimore, MD: Paul Brookes.

⁴¹Katz, E. & Danet, B. (1973). *Bureaucracy and the public*. New York: Basic Books.

the individual and community level. For example, consultation with a community employer regarding the impact of a certain 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 the individual and the employer. Provided appropriate support and consultation, many community members are excellent collaborators and can become facilitators of the recovery and community inclusion process.

H.5.2. Despite the promise of such collaborations, discrimination against people with behavioral health disorders will most likely continue for the foreseeable future. Community collaborations and education must therefore be coupled with efforts on the part of behavioral health practitioners to recognize instances of discrimination, to understand relevant disability legislation (e.g., the Americans with Disabilities Act), and to effectively utilize 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.). This type of knowledge also must be built within the consumer community so that people in recovery can protect themselves by recognizing and rectifying experiences of discrimination.

H.5.3. Agencies are cautioned to avoid the establishment of 'one stop shopping' service programs. In an effort to respond simultaneously to individuals' multi-dimensional needs while also protecting them from the experience of stigma and discrimination, there is a tendency for agencies to develop "in-house" alternatives to community activities based on concern that the community will never accept or welcome individuals with behavioral health disorders. As a result, agencies often create in artificial settings, activities that already exist in the natural community. For example, developing in house medical clinics, movie nights, GED classes, social events, etc. Agencies which fall into this trap of providing a one stop shop for the needs of people with mental illness or addiction inadvertently contribute to the development of chronic "patient hood" as well as the perpetuation of discriminatory and unethical practices on the part of community members. We must continue to work with community partners to uphold their obligation to respect people with behavioral health disorders as citizens who have the right to be treated according to the principles of law that apply to all other individuals⁴².

⁴²National 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>

H.5.4. A focus on promoting access to community opportunities is consistent not only with recovery-oriented principles but with the need for fiscal efficiency. Professionals and service recipients should be mindful of the limited resources available for specialized services and should 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 service interventions within recovery plans, e.g., creating on-site health and fitness opportunities such as exercise classes without first exploring to what extent that same opportunity might be available in the broader community through public recreational departments, YMCAs, etc. If natural alternatives are available in the community, the individual should be informed of these opportunities and then supported in accessing them based on his or her preferences.

H.6. Certain internal barriers unique to behavioral health disorders are identified and addressed. Necessary change strategies to address these barriers include the following:

H.6.1. It is important to acknowledge that people with behavioral health disorders 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. It is critical to explore and address the multiple factors influencing such responses, as they often result from a complex interaction of the person’s conditions and his or her past experiences in the behavioral health care system. As suggested by Jonikas and colleagues⁴³, there are many factors involved when people in recovery “resist” recovery-oriented system change, including a lack of trust that human service systems or various care providers will cede control, service eligibility criteria that require an emphasis on illness and crisis in order to receive assistance; learned helplessness consequent from years of dependency (especially for those in institutional settings); an inability to, or discomfort with, articulating personal preferences and ideas; and feelings of pressure that they must “get it right the first time” or else be blamed for their failures when assuming greater control in the recovery process. Significant training and skill building within the recovery community is necessary to

⁴³Jonikas, Cook, Fudge, Hiebechuk & Fricks. (2005). *op cit*.

address this internal barrier and to support people in embracing expanded roles and responsibilities. Education and ongoing support and mentoring is perhaps best offered through mental health advocacy organizations and peer-run programs.

H.6.2. Individuals with serious behavioral health disorders often have histories of trauma which impact on treatment and recovery. For example, while trauma may not be intrinsic to behavioral health per se, there is considerable evidence that suggests that people living with behavioral health disorders 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 victimization⁴⁴. Evidence also suggests that the failure to attend to a person's history of sexual and/or physical abuse will seriously undermine the treatment and rehabilitation enterprise, leading to a poor prognosis, while approaches that are responsive to trauma significantly improve treatment effectiveness and outcomes. 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. Within the context of urban poverty and violence, e.g., the only incentive offered by abstinence may be a decreased immunity to the horrors that a person faces on a daily basis.

H.6.3. The above barriers represent more of an interaction between a person's condition and his or her experiences in the behavioral health system and the community at large. In addition, the symptoms of certain illnesses themselves may also pose direct impediments to the recovery process. As we described above, for example, hallucinations and delusions may compete with the information a person is receiving from health care professionals, 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 solving⁴⁵ can undermine a person's abilities to articulate and assert his

⁴⁴Sells, 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.

⁴⁵Saykin, 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,

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 that are currently considered to be among the most unremitting and malignant of the impairments associated with psychosis⁴⁶. 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 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 up. Being able to identify and address these and other sequelae requires knowledge and skill on the part of the clinical practitioner. There must be a commitment to ongoing professional development regarding emerging evidence-based and recovery-oriented practices which allow people to manage, or bypass, their symptoms to build a personally gratifying life in the community.

What you will hear from people when you are addressing external and internal barriers to recovery:

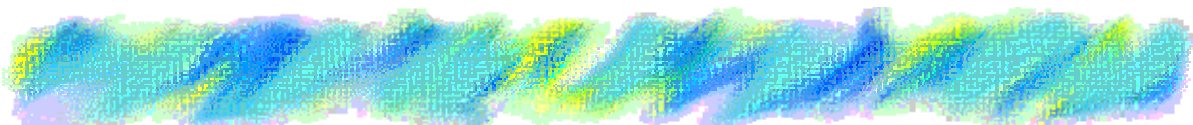
- *My mental illness was the least of my worries when it came to getting back to work after I got discharged from the hospital. I was terrified about losing my benefits and my employer gave me a really hard time when I asked if I could come in a half hour late one morning in order to see my doctor. My 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*

NY, US: Cambridge University Press; Seltzer, J., Cassens, G., Ciocca, C. & O'Sullivan, L. (1997). Neuro-psychological rehabilitation in the treatment of schizophrenia. *Connecticut Medicine*, 61(9), 597-608.

⁴⁶Torrey, E.F. (1988). *Surviving schizophrenia: A family manual (Rev. ed.)*. New York: Harper & Row.

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.

- *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.*
- *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 real comfortable letting other folks make decisions for me, and I know now that I gotta take charge of my own recovery and the Peers at the Center are helping me to do that...*



Recommended Resources for Further Reading



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APPENDIX

Glossary of Recovery-Oriented Language

Examples of Strength-Based Conceptualizations

Glossary of Recovery-Oriented Language

Creation of a recovery-oriented system of care requires behavioral health care practitioners to alter the way they look at mental illness and addiction, their own roles in facilitating recovery from these conditions, and the language they use in referring to the people they serve. The following glossary and associated tables are intended as tools for providers to use as they go about making these changes in practice.⁴⁷ Not meant to be exhaustive, this material will be further enhanced in the process of implementing recovery-oriented practices across the state.

Given its central role in the remaining definitions, we will start with the term “recovery” itself, followed by a list, in alphabetical order, of other key terms.

Recovery: there are several different definitions and uses of this term in behavioral health. In the addiction recovery community, for example, this term refers to the achievement and maintenance of abstinence from alcohol, illicit drugs, and other substances (e.g., tobacco) or activities (e.g., gambling) to which the person has become addicted, vigilance and resolve in the face of an ongoing vulnerability to relapse, and pursuit of a clean and sober lifestyle.

In mental health there are several other forms of recovery. For those fortunate people, for example, who have only one episode of mental illness and then return to their previous functioning with little, if any, residual impairment, the usual sense of recovery used in primary care is probably the most relevant. That is, such people recover from an episode of psychosis or depression in ways that are more similar to, rather than different from, recovery from other acute conditions.

Persons who recover from an episode of major affective disorder or psychosis, but who continue to view themselves as vulnerable to future episodes, may instead consider themselves to be “in recovery” in ways that are more similar to, than different from, being in recovery from a heart attack or chronic medical condition. Many others will recover from serious mental illness over a longer period of time, after perhaps 15 or more years of disability, constituting an additional sense of recovery found in some other medical conditions such as asthma. More extended periods of disability are often associated with concerns about the effects and side effects of having been labeled with a mental illness as well as with the illness itself, leading some people to consider themselves to be in recovery also from the trauma of having been treated as mental patients.

⁴⁷ Credit for many of the addiction entries goes to William White, with text appreciatively borrowed and adapted from his unpublished manuscript *The Language of Addiction Recovery: An Annotated Glossary*.

Finally, those people who view taking control of their illness and minimizing its disruptive impact on their lives as the major focus of their efforts might find the sense of recovery used in the addiction self-help community to be most compatible with their own experiences. Such a sense of recovery has been embraced, for instance, among some people who suffer from co-occurring psychiatric and addictive disorders who consider themselves to be in “dual recovery.”

For purposes of simplicity and clarity, the Connecticut Department of Mental Health and Addiction Services has adopted the following single definition to capture the common elements of these various forms of recovery:

“Recovery involves a process of restoring or developing a meaningful sense of belonging and positive sense of identity apart from one’s condition while rebuilding a life despite or within the limitations imposed by that condition.”

Other Key Terms

Abstinence-Based Recovery: is the resolution of alcohol- and other drug-related problems through the strategy of complete and enduring cessation of the non-medical use of alcohol and other drugs. The achievement of this strategy remains the most common definition of recovery in addiction, but the necessity to include it in this glossary signals new conceptualizations of recovery that are pushing the boundaries of this definition (see partial recovery, moderated recovery, and serial recovery).

Affirmative Business: see Social Cooperative/Entrepreneurialism

Asset-Based Community Development: a technology for identifying and charting the pathways and destinations in the local community most likely to be welcoming and supportive of the person’s efforts at community inclusion. A first step is the development of local resource maps (see below). A strategy of community preparation is then used to address gaps identified in the resource maps through educational and other community building activities aimed at decreasing stigma and creating a more welcoming environment in partnership with local communities.

Asset Mapping: part of asset-based community development (above) referring to the process of identifying opportunities in local communities for people in recovery to take up and occupy valued social roles in educational, vocational, social, recreational, and affiliational (e.g., civic, spiritual) life. Although not a literal “map” (i.e., as in contained on a piece of paper), asset mapping involves developing and utilizing virtual or mental landscapes of community life that highlight resources, assets, and opportunities that already exist in the person’s local community.

Choice: a key concept in recovery-oriented care, choice refers to the central role people with psychiatric disabilities and/or addictions play in their own treatment, rehabilitation, recovery, and life. Within the behavioral health system, people in recovery need to be able to select services and supports from among an array of meaningful options (see menu below) based on what they will find most responsive to their condition and effective in promoting their recovery. Both inside and outside of the behavioral health system, people in recovery have the right and responsibility for self-determination and making their own decisions, except for those rare circumstances in which the impact of the illness or addition contributes to their posing imminent risks to others or to themselves.

Citizenship: a strong connection to the rights, resources, roles, and responsibilities that society offers people through public institutions and associational life.

Community Supports: material and instrumental resources (including other people), and various forms of prostheses that enable people to compensate for enduring disabilities in the process of pursuing and being actively involved in naturally-occurring community activities of their choice.

Consumer: literally means someone who purchases services or goods from others. Historically has been used in mental health advocacy to offer a more active and empowered status to people who otherwise were being described as “clients” or “mental patients.” Given the fact that people in recovery have not really viewed themselves as consumers in the traditional sense (ala Ralph Nader), this term has never really generated or been met with wide-spread use.

Continuity of Care/Contact: is a phrase used to underscore the importance of sustained, consistent support over the course of recovery. Such support can come from living within a community of shared experience and hope, but also can refer to the reliable and enduring relationship between the individual in recovery and his or her recovery coach. Such sustained continuity is in marked contrast to the transience of relationships experienced by those who have moved through multiple levels of care or undergone multiple treatment relationships.

Disparities in Healthcare: differences in access, quality, and/or outcomes of health care based on such issues as race, ethnicity, culture, gender, sexual or religious orientation, social class, or geographic region.

Empowerment: is the experience of acquiring power and control over one’s own life decisions and destiny. Within the addiction recovery context, there are two different relationships to power. Among the culturally empowered (those to whom value is ascribed as a birthright), addiction-related erosion of competence is often countered by a preoccupation with power and control. It is not surprising then that

the transformative breakthrough of recovery is marked by a deep experience of surrender and an acceptance of powerlessness. In contrast, the culturally disempowered (those from whom value has been systematically withheld) are often attracted to psychoactive drugs in their desire for power, only to discover over time that their power has been further diminished. Under these conditions, the initiation of recovery is often marked by the assumption of power and control rather than an abdication or surrender of power.

Within the mental health context, empowerment typically refers to a person first taking back control of his or her own health care decisions prior to regaining control of his or her major life decisions and destiny. As such, “empowerment” has been used most by advocacy groups in their lobbying efforts to make mental healthcare more responsive and person-centered. In either community, empowerment is meant to be inspiring, horizon-raising, energizing, and galvanizing. The concept of empowerment applies to communities as well as individuals. It posits that the only solution to the problems of addiction and/or mental health in disempowered communities lies within those very communities. It is important to note that, by definition, one person cannot “empower” another, as to do so undermines the very premise of the term, which attributes power over the person’s decisions, recovery journey, and life to the person him or herself.

Evidence-Based Practices: are clinical, rehabilitative, and supportive practices that have scientific support for their efficacy (under ideal conditions) and effectiveness (in real world settings). Advocacy of evidence-based practice is a commitment to use those approaches that have the best scientific support, and, in areas where research is lacking, a commitment to measure and use outcomes to elevate those practices that have the greatest impact on the quality of life of individuals, families and communities.

Faith-Based Recovery: is the resolution of alcohol and other drug problems within the framework of religious experience, beliefs, and rituals and/or within the mutual support of a faith community. Faith-based recovery frameworks may serve as adjuncts to traditional recovery support programs or serve as alternatives to them.

Harm Reduction (as a stage of recovery): is most often viewed as an alternative to, and even antagonistic to, recovery, but can also be viewed as a strategy of initiating or enhancing early recovery. The mechanisms through which this can occur include preventing the further depletion of recovery capital, increasing recovery capital when it does not exist, and enhancing the person’s readiness for recovery via the change-encouraging relationships through which harm reduction approaches are delivered.

Inclusion: refers to a person's right to be afforded access to, and to participate in, naturally occurring community activities of his or her choice.

Illness Self-management: is the mastery of knowledge about one's own illness and assumption of primary responsibility for alleviating or managing the symptoms and limitations that result from it. Such self-education and self-management shifts the focal point in disease management from the expert caregiver to the person with the illness.

Individualized Care: see Person-Centered Care.

Indigenous Healers and Institutions: are people and organizations in the natural environment of the recovering person who offer words, ideas, rituals, relationships, and other resources that help initiate and/or sustain the recovery process. They are distinguished from professional healers and institutions not only by training and purpose, but through relationships that are culturally-grounded, enduring, and often reciprocal and/or non-commercialized.

Initiating Factors: are those factors that spark a commitment to recovery and an entry into the personal experience of recovery. Factors which serve this recovery priming function are often quite different than those factors that later serve to sustain recovery. Recovery-initiating factors can exist within the person and/or within the person's family and social environment as well as in the behavioral health system. These factors can include pain-based experiences, e.g., anguish, exhaustion, and boredom with addictive lifestyle; death of someone close; external pressure to stop using; experiences of feeling humiliated; increased health problems; failures or rejections; or suicidal thoughts. Less well-recognized, however, are the hope- and pleasure-based experiences: pursuing interests and experiencing enjoyment and success; exposure to recovery role models; new intimate relationships; marriage, parenthood, or other major positive life change; a religious experience; or new opportunities.

Jump Starts: see Initiating Factors.

Menu (of services and/or supports): an array of options from which people can then choose to utilize those services and/or supports they expect will be most effective in assisting them to achieve their goals and most responsive to their individual, familial, and socio-cultural values, needs, and preferences.

Micro Enterprise: see Social Cooperative/Entrepreneurialism.

Moderated Recovery: is the resolution of alcohol or other drug problems through reduction of alcohol or other drug consumption to a sub-clinical level (shifting the

frequency, dosage, method of administration, and contexts of drug use) that no longer produces harm to the individual or society. The concept takes on added utility within the understanding that alcohol and other drug problems exist on a wide continuum of severity and widely varying patterns of acceleration and deceleration. The prospects of achieving moderated recovery diminish in the presence of lower age of onset, heightened problem severity, the presence of co-occurring psychiatric illness, and low social support. The most common example of moderated resolution can be found in studies of people who develop alcohol and other drug-related problems during their transition from youth to adulthood. Most of these individuals do not go on to develop enduring substance-related problems, but instead moderate their use through the process of maturation.

Motivational Interventions: is a non-confrontational approach to eliciting recovery-seeking behaviors that was developed by Miller and Rollnick. This approach emphasizes relationship-building (expressions of empathy), heightening discrepancy between an individual's personal goals and present circumstances, avoiding argumentation (activation of problem-sustaining defense structure), rolling with resistance (emphasizing respect for the person experiencing the problem and his or her sense of necessity and confidence to solve the problem), and supporting self-efficacy (expressing confidence in the individual's ability to recover and expressing confidence that they will recover). As a technique of preparing people to change, motivational interviewing is an alternative to waiting for an individual to "hit bottom" and an alternative to confrontation-oriented intervention strategies.

Multiple Pathways of Recovery: reflects the diversity of how people enter into and pursue their recovery journey. Multiple pathway models contend that there are multiple pathways into psychiatric disorder and addiction that unfold in highly variable patterns, courses and outcomes; that respond to quite different treatment approaches; and that are resolved through a wide variety of recovery styles and support structures. This is particularly true among ethnic minority and religious communities, but diversity is to be found wherever there are people of different backgrounds.

Mutual Support/Aid Groups: are groups of individuals who share their own life experiences, strengths, strategies for coping and hope about recovery. Often called "self-help" groups, they more technically involve an admission that efforts at self-help have failed and that the help and support of others is needed. Mutual aid groups are based on relationships that are personal rather than professional, reciprocal rather than fiduciary, free rather than fee-based, and enduring rather than transient (see also Indigenous Healers and Institutions).

Natural Recovery: is a term used to describe those who have initiated and sustained recovery from a behavioral health disorder without professional intervention or

involvement in a formal mutual aid group. Since people in this form of recovery neither access nor utilize behavioral health services, it is difficult to establish the prevalence or nature of this process, but it is believed to be common.

New Recovery Advocacy Movement: depicts the collective efforts of grassroots recovery advocacy organizations whose goals are to: 1) provide an unequivocal message of hope about the potential of long term recovery from behavioral health disorders, and 2) to advocate for public policies and programs that help initiate and sustain such recoveries. The core strategies of the New Recovery Advocacy Movement are: 1) recovery representation, 2) recovery needs assessment, 3) recovery education, 4) recovery resource development, 5) policy (rights) advocacy, 6) recovery celebration, and 7) recovery research.

Natural Support: technical term used to refer to people in a variety of roles who are engaged in supportive relationships with people in recovery outside of behavioral health settings. Examples of natural supports include family, friends, and other loved ones, landlords, employers, neighbors, or any other person who plays a positive, but non-professional, role in someone's recovery.

Partial Recovery: is 1) the failure to achieve full symptom remission (abstinence or the reduction of alcohol/drug use below problematic levels), but the achievement of a reduced frequency, duration, and intensity of use and reduction of personal and social costs associated with alcohol/drug use, or 2) the achievement of complete abstinence from alcohol and other drugs but a failure to achieve parallel gains in physical, emotional, relational, and spiritual health. Partial recovery may precede full recovery or constitute a sustained outcome.

Peer: within behavioral health, this term is used to refer to someone else who has experienced first-hand, and is now in recovery from, a mental illness and/or addiction.

Peer-Delivered Services: any behavioral health services or supports provided by a person in recovery from a mental illness and/or addiction. This includes, but is not limited to, the activities of peer specialists or peer support providers (see below), encompassing also any conventional behavioral health intervention which a person in recovery is qualified to provide. Examples of these activities range from medication assessment and administration by psychiatrists and nurses who disclose that they are in recovery to illness management and recovery education by peers trained in providing this evidence-based psychosocial intervention. An underlying assumption here is that there is "value added" to any service or support provided by someone who discloses his or her own recovery journey, as such disclosure serves to combat stigma and inspire hope.

Peer-Operated or Peer-Run Programs: a behavioral health program that is developed, staffed, and/or managed by people in recovery. In contrast to peer-run businesses (described below) which are self-sustaining and able to generate profits, peer-run programs are typically private-non-profit and oriented to providing behavioral health services and supports such as respite care, transportation to and from healthcare appointments, recovery education, and advocacy.

Peer-Run Businesses: see Social Cooperative/Entrepreneurialism

Peer Specialist: a peer (see above) who has been trained and employed to offer peer support to people with behavioral health conditions in any of a variety of settings. These settings may range from assertive or homeless outreach in shelters, soup kitchens, or on the streets, to part of a multi-disciplinary inpatient, intensive outpatient, or ambulatory team, to roles within peer-run or peer-operated programs (see below).

Peer Support: while falling along a theoretical continuum, peer support differs both from traditional mutual support groups as well as from consumer-run drop-in centers or businesses. In both mutual support groups and consumer-run programs, the relationships peers have with each other are thought to be reciprocal in nature; even though some peers may be viewed as more skilled or experienced than others, all participants are expected to benefit. Peer support, in contrast, is conceptualized as *involving one or more persons who have a history of significant improvement in either a mental illness and/or addiction and who offers services and/or supports to other people with mental illnesses or addictions who are considered to be not as far along in their own recovery process.*

Person-Centered Care: behavioral health care that is based on the person's and/or family's self-identified hopes, aspirations, and goals, which build on the person's and/or family's own assets, interests, and strengths, and which is carried out collaboratively with a broadly-defined recovery management team that includes formal care providers as well as others who support the person's or family's own recovery efforts and processes, such as employers, landlords, teachers, and neighbors.

Person in Recovery: a person who has experienced a mental illness and/or addiction and who has made progress in learning about and managing his or her behavioral health condition and in developing a life outside of, or in addition to, this condition.

Recovery Capital: is the quantity and quality of internal and external resources that one can bring to bear on the initiation and maintenance of recovery from a life-changing disorder. In contrast to those achieving natural recovery, most people with

psychiatric or addictive disorders entering treatment have never had much recovery capital or have dramatically depleted such capital by the time they seek help.

Recovery Celebration: is an event in which recovered and recovering people assemble to honor the achievement of recovery. Such celebrations serve both healing and mutual support functions but also (to the extent that such celebrations are public) serve to combat social stigma attached to addiction or mental illness by putting a human face on behavioral health disorders and by conveying living proof of the possibility and enduring nature of recovery from these disorders.

Recovery Coach/Guide (Recovery Support Specialist): is a person who helps remove personal and environmental obstacles to recovery, links the newly recovering person to the recovery community and his or her broader local community, and, where not available in the natural community, serves as a personal guide and mentor in the management of personal and family recovery.

Recovery Community (Communities of Recovery): is a term used to convey the sense of shared identity and mutual support of those persons who are part of the social world of recovering people. The recovery community includes individuals in recovery, their family and friends, and a larger circle of “friends of recovery” that include both practitioners working in the behavioral health fields as well as recovery supporters within the wider community. Recovery management is based on the assumption that there is a well-spring of untapped hospitality and service within this community that can be mobilized to aid those seeking recovery for themselves and their families. “Communities of recovery” is a phrase coined by Kurtz to convey the notion that there is not one but multiple recovery communities and that people in recovery may need to be introduced into those communities where the individual and the group will experience a goodness of “fit.” The growth of these divergent communities reflects the growing varieties of recovery experiences.

Recovery Management: is the provision of engagement, education, monitoring, mentoring, support, and intervention technologies to maximize the health, quality of life, and level of productivity of persons with severe behavioral health disorders. Within the framework of recovery management, the “management” of the disorder is the responsibility of the person with the disorder. The primary role of the professional is that of the recovery consultant, guide, or coach.

Recovery-Oriented Practice: a practice oriented toward promoting and sustaining a person’s recovery from a behavioral health condition. DMHAS policy defines recovery-oriented practice as one that “*identifies and builds upon each individual’s assets, strengths, and areas of health and competence to support the person in managing his or her condition while regaining a meaningful, constructive, sense of membership in the broader community.*”

Recovery-Oriented Systems of Care: are systems of health and human services that affirm hope for recovery, exemplify a strengths-based orientation, and offer a wide spectrum of services and supports aimed at promoting resilience and long term recovery from behavioral health disorders.

Recovery Planning and Recovery Plans: in contrast to a treatment or service plan, is developed, implemented, revised, and regularly evaluated by the client. Consisting of a master recovery plan and regular implementation/action plans, the recovery plan covers life domains in addition to behavioral health issues (e.g., physical, finances, employment, legal, family, social life, personal, education, and spiritual). In mental health settings, recovery planning follows the principles described above under person-centered care.

Recovery Priming: see Initiating Factors.

Recovery Support Services: are designed to 1) remove personal and environmental obstacles to recovery, 2) enhance identification and participation in the recovery community, and 3) enhance the quality of life of the person in recovery. Such services include outreach, engagement and intervention services; recovery guiding or coaching, post-treatment monitoring and support; sober or supported housing; transportation; child care; legal services; educational/vocational supports; and linkage to leisure activities.

Serial Recovery: is the process through which individuals with multiple concurrent or sequential problems resolve these problems and move toward optimum level of functioning and quality of life. Serial recovery refers to the process of sequentially shedding two or more drugs, or to the overlapping processes involved in recovering from addiction and co-occurring psychiatric or other physical disorders.

Social Cooperative/Entrepreneurialism: the development and operation of small businesses (“micro enterprises”) by people in recovery based on their talents and interests and in partnership with their local community. The resulting businesses offer goods and services to the general public and may be either for profit or not for profit, but should be at least financially self-sustaining, although perhaps subsidized through tax breaks or other government means.

Spirituality: refers to a system of religious beliefs and/or a heightened sense of perception, awareness, performance, or being that informs, heals, connects, or liberates. For people in recovery, it is a connection with hidden resources within and outside of the self. There is a spirituality that derives from pain, a spirituality that springs from joy or pleasure, and a spirituality that can flow from the simplicity of daily life. For many people, the spiritual has the power to sustain them through adversity and inspire them to make efforts toward recovery. For some, this is part of

belonging to a faith community, while for others it may be the spirituality of fully experiencing the subtlety and depth of the ordinary as depicted in such terms as harmony, balance, centeredness, or serenity. All of these can be part of the many facets of recovery.

Triggering Mechanisms: see Initiating Factors.

User/Service Recipient: a person who receives or uses behavioral health services and/or supports, preferred by some people as an alternative to “consumer” or “person in recovery.”

Valued-Based Practice: a practice which has not yet accrued a base of evidence demonstrating its effectiveness in promoting recovery, but for which there are other persuasive reasons to view it as having been a helpful resource, and as being a helpful resource in the future, for people with behavioral health conditions. Examples of value-based practices include peer-based services that offer hope, role modeling, and mentoring and culturally-specific programs oriented toward cultural subgroups.

WRAP (Wellness Recovery Action Planning): a self-help approach to illness management and wellness promotion developed by Mary Ellen Copeland.

Moving from a Deficit-Based to a Strengths-Based Approach to Care

The following are examples of how language, thinking, and practice shift in the evolution of a recovery-oriented system of care

Presenting Situation	Deficit-based Perspective		Recovery-oriented, Asset-based Perspective	
	Perceived Deficit	Intervention	Perceived Asset	Intervention
Person re-experiences symptoms	Decompensation, exacerbation, or relapse	Involuntary hospitalization; warning or moralizing about “high risk” behavior (e.g., substance use or “non-compliance”)	Re-experiencing symptoms as a normal part of the recovery journey; an opportunity to develop, implement, and/or apply coping skills and to draw meaning from managing an adverse event	Express empathy and help person avoid sense of demoralization; highlight how long it may have been since symptoms had reappeared; provide feedback about the length of time it takes to achieve sustained change; offer advice on strategies to cope; reinforce sense of self-efficacy
Person demonstrates potential for self-harm	Increased risk of suicide	Potentially intrusive efforts to “prevent suicide”	Indicators of potential for self-harm are important signals to respond differently. The person is likely to have a weakened sense of efficacy and feel demoralized, and thus may require additional support. On the other hand, the person has already survived tragic circumstances and extremely difficult ordeals, and should be praised for his or her prior resilience and perseverance.	Rather than reducing risk, the focus is on promoting safety. Supportive, ongoing efforts are oriented to “promote life,” e.g., enabling people to write their own safety/prevention plans and advance directives. Express empathy; reinforce efficacy and autonomy; enhance desire to live by eliciting positive reasons and motivations, with the person, not the provider, being the source of this information.
Person takes medication irregularly	Person lacks insight regarding his or her need for meds; is in denial of illness; is non-compliant with treatment; and needs monitoring to take meds as prescribed.	Medication may be administered, or at least monitored, by staff; staff may use cigarettes, money, or access to resources as incentives to take meds; person is told to take the meds or else he or she will be at risk of relapse or decompensation, and therefore may need to be hospitalized.	Prefers alternative coping strategies (e.g., exercise, structures time, spends time with family) to reduce reliance on medication; has a crisis plan for when meds should be used. Alternatively, behavior may reflect ambivalence regarding medication use which is understandable and normal, as approximately half of people with any chronic health condition (e.g., diabetes, asthma) will not take their medication as prescribed.	Individual is educated about the risks and benefits of medication; offered options based on symptom profile and side effects; and is encouraged to consider using meds as one tool in the recovery process. In style and tone, individual autonomy is respected and decisions are ultimately the person and his or her loved ones to make. Explore person’s own perspective on symptoms, illness, and medication and invite him or her to consider other perspectives. Person is resource for important ideas and insights into the problem and is invited to take an active role in problem solving process.

Presenting Situation	Deficit-based Perspective		Recovery-oriented, Asset-based Perspective	
	Perceived Deficit	Intervention	Perceived Asset	Intervention
Person makes poor decisions	Person's judgment is impaired by illness or addiction; is non-compliant with directives of staff; is unable to learn from experience	Potentially invasive and controlling efforts to "minimize risk" and to protect the person from failure, rejection, or the other negative consequences of his or her decisions	Person has the right and capacity for self-direction (i.e., Deegan's "dignity of risk" and the "right to fail"), and is capable of learning from his or her own mistakes. Decisions and taking risks are viewed as essential to the recovery process, as is making mistakes and experiencing disappointments and set backs. People are not abandoned to the negative consequences of their own actions, however, as staff stand ready to assist the person in picking up the pieces and trying again.	Discuss with the person the pros, cons, and potential consequences of taking risks in the attempt to maximize his or her opportunities for further growth and development. This dialogue respects the fact that all people exercise poor judgment at times, and that making mistakes is a normal part of the process of pursuing a gratifying and meaningful life. Positive risk taking and working through adversity are valued as means of learning and development. Identify discrepancies between person's goals and decisions. Avoid arguing or coercion, as decisions made for others against their will potentially increase their learned helplessness and dependence on professionals.
Person stays inside most of the day	Person is withdrawing and becoming isolative; probably a sign of the illness; can only tolerate low social demands and needs help to socialize	Present the benefits of spending time outside of the house; offer the person additional services to get the person out of the house to a clubhouse, drop-in center, day program, etc.	Person prefers to stay at home; is very computer savvy; and has developed skills in designing web pages; frequently trades e-mails with a good network of NET friends; plays postal chess or belongs to collectors clubs; is a movie buff or enjoys religious programs on television. Person's reasons for staying home are seen as valid.	Explore benefits and drawbacks of staying home, person's motivation to change, and his or her degree of confidence. If staying home is discordant with the person's goals, begin to motivate for change by developing discrepancies. If leaving the house is important but the person lacks confidence, support self-efficacy, provide empathy, offer information/advice, respond to confidence talk, explore hypothetical change, and offer to accompany him or her to initial activities.
Person denies that he or she has a mental illness and/or addiction	Person is unable to accept illness or lacks insight	Educate and help the person accept diagnoses of mental illness and/or addiction; facilitate grieving loss of previous self	Acceptance of a diagnostic label is not necessary and is not always helpful. Reluctance to acknowledge stigmatizing designations is normal. It is more useful to explore the person's understanding of his or her predicament and recognize and explore areas for potential growth.	In addition to exploring person's own understanding of his or her predicament, explore symptoms and ways of reducing, coping with, or eliminating distress while eliciting ways to live a more productive, satisfying life.

Presenting Situation	Deficit-based Perspective		Recovery-oriented, Asset-based Perspective	
	Perceived Deficit	Intervention	Perceived Asset	Intervention
Person sleeps during the day	Person's sleep cycle is reversed, probably due to illness; needs help to readjust sleep pattern, to get out during the day and sleep at night.	Educate the person about the importance of sleep hygiene and the sleep cycle; offer advice, encouragement, and interventions to reverse sleep cycle	Person likes watching late-night TV; is used to sleeping during the day because he or she has always worked the night shift; has friends who work the night shift so prefers to stay awake so she or he can meet them after their shift for breakfast. Person's reasons for sleeping through the day are viewed as valid.	Explore benefits and drawbacks of sleeping through the day, the person's motivation to change, the importance of the issue and his or her degree of confidence. If sleeping through the day is discordant with the person's goals, begin to motivate change by developing discrepancy, as above.
Person will not engage in treatment	Person is non-compliant, lacks insight, or is in denial	Subtle or overt coercion to make person take his or her medications, attend 12-step or other groups, and participate in other treatments; alternatively, discharge person from care for non-compliance	Consider range of possible reasons why person may not be finding available treatments useful or worthy of his or her time. It is possible that he or she has ambivalence about treatment, has not found treatment useful in the past, did not find treatment responsive to his or her needs, goals, or cultural values and preferences. Also consider factors outside of treatment, like transportation, child care, etc. Finally, appreciate the person's assertiveness about his or her preferences and choices of alternative coping and survival strategies	Compliance, and even positive behaviors that result from compliance, do not equate, or lead directly, to recovery. Attempts are made to understand and support differences in opinion so long as they cause no critical harm to the person or others. Providers value the "spirit of noncompliance" and see it as sign of the person's lingering energy and vitality. In other words, he or she has not yet given up. Demonstrate the ways in which treatment could be useful to the person in achieving his or her own goals, beginning with addressing basic needs or person's expressed needs and desires; earn trust.
Person reports hearing voices	Person needs to take medication to reduce voices; if person takes meds, he or she needs to identify and avoid sources of stress that exacerbate symptoms	Schedule appointment with nurse or psychiatrist for med evaluation; make sure person is taking meds as prescribed; help person identify and avoid stressors	Person says voices have always been there and views them as a source of company, and is not afraid of them; looks to voices for guidance. Alternatively, voices are critical and disruptive, but person has been able to reduce their impact by listening to walkman, giving them stern orders to leave him or her alone, or confines them to certain parts of the day then they pose least interference. Recognize that many people hear voices that are not distressing.	Explore with person the content, tone, and function of his or her voices. If the voices are disruptive or distressing, educate person about possible strategies for reducing or containing voices, including but not limited to medication. Ask person what has helped him or her to manage voices in the past. Identify the events or factors that make the voices worse and those that seem to make the voices better or less distressing. Plan with the person to maximize the time he or she is able to manage or contain the voices.