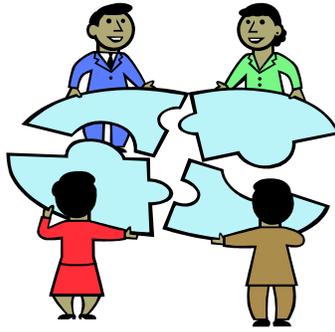# Recovery for ME

Mental Health Services:
Practice Guidelines for Recovery-Oriented Care

September 2011

Acknowledgments

Thank you to the participants of the Community Service Network monthly conference calls for their thoughtful feedback on the guidelines development, and to the Consumer Council System of Maine for helpful and well-organized comments. This document for Maine would not have been possible without their support and guidance. We are also grateful to the State of Connecticut Department of Mental Health and Addiction Services for its generosity in sharing a well-developed set of guidelines from which Maine could adapt and adopt.

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Foreword

This is an exciting and challenging time of "shift" when it comes to both national and state service delivery systems. In both substance abuse and mental health services, there is a call for recovery-oriented systems, highlighting a new emphasis on recovery. In Maine, this shift will be more than simply using different words to define what we do. A call for true Recovery-Oriented Systems of Care is a call to a **new way of understanding and conducting how we work.**

The term *Recovery-Oriented Systems of Care (ROSC)* reflects how services are both devised and implemented to promote long-term recovery, while including recovering individuals at the center of the planning process. This inclusion goes beyond the individual treatment plans we write, relying on recovering people to be system-change advisors, planners, and service-delivery specialists. The mental health field has a long history of including consumers as stakeholders and advisors in various ways; the spirit and intent of ROSC is to place a new emphasis on recovery - and the individuals in recovery - as its central tenet. **The recovery process becomes the *goal,* rather than a focus on service delivery, with the personal healing process determined by the individual's choices.**

The paradigm shift entailed by ROSC is a belief that **recovery is not only possible, but an expectation.** "Hope" becomes "reality," strengthening the belief everyone holds that healing occurs. Our current service-delivery systems are geared toward meeting, and intervening with, symptoms of illness, whereas "recovery management" is the center of ROSC implementation. This perspective points to recovery as a long-term process with its own stages and support needs.

Historically, our systems have had great difficulty defining recovery, partly because recovery is neither about systems nor service delivery. Recovery is the personal life-change process a person chooses to begin to heal whatever ails him or her. It could be a broken hip or leg, an addiction, or a mental health condition requiring focused self-care and assistance from others.

Recovery is about getting better, improving what is broken, and enhancing the quality of one's life. The recovery process is filled with hope, expectation, and real fulfillment, as well as courage, commitment, and dedicated effort. As service planners and administrators, we must respect that we do not undertake the hard work of recovery but we can uphold this vision and create the environment that supports these personal journeys.

We need also serve as witnesses to the presence of recovery in the lives of those we support and to offer positive reminders for those who grow weary at moments, whether they're colleagues, providers, or service participants. The process of recovery can be mundane and tedious, fierce, scary, and sometimes interrupted. **Our ability to hold onto the vision of recovery through all of these landscapes helps others to actualize this daily experience in their own lives.**

Guy R. Cousins
Acting Director of Adult Mental Health Services
Director, Office of Substance Abuse

Executive Summary

Maine is undertaking a major effort to transform the public mental health system to one that is fully recovery oriented. This is a systematic initiative targeting the statewide system of care as a whole, rather than creating a few new recovery programs or adding a few new recovery elements like peer supports onto the existing system. **Instead of treating and/or rehabilitating people, the system's primary responsibility is the support of people in their own efforts to manage and overcome mental health conditions as they rebuild their lives.** The responsibility and source of recovery shifts from the expertise of the provider to the efforts and expertise of the person.

These practice guidelines represent a systematic effort to bring recovery into the everyday practice of mental health practitioners in Maine. They are organized into five domains, based on the feedback from the many stakeholders, particularly the Consumer Council System of Maine. These domains are:

- **Recovery-Oriented Care Is Consumer Driven**
- **Recovery-Oriented Care Maximizes the Use of Natural Supports and Settings**
- **Recovery-Oriented Care Is Person Centered**
- **Recovery-Oriented Care Is Timely, Responsive, and Trustworthy**
- **Recovery-Oriented Care Is Effective, Equitable, and Efficient**

Following the domains, there are self-assessment checklists, plus a table for providers for moving to a strength-based approach to care.

Defining Our Terms

In this document, OAMHS **offers the following two definitions to distinguish between the process of recovery and the provision of recovery-oriented care by service providers.**

> **Recovery is:** *A journey of healing and transformation that enables a person to live a meaningful, satisfying, and contributing life in a community of his or her choice. Recovery is an individual process, a way of life, an attitude, and a way of approaching life's challenges. The need is to meet the challenges of one's life and find purpose within and beyond the limits of the illness while holding a positive sense of identity.*
>
> **Recovery-oriented care is:** *The treatment and rehabilitation that practitioners offer in support of the person's own recovery journey.*

(**Note:** The federal Substance Abuse and Mental Health Services Administration (SAMHSA), the public health agency within the Department of Health and Human Services, has developed a new definition of recovery and recovery-oriented care. This definition was finalized after stakeholder input was gathered for Maine's working definition. Please see Appendix A, page 1, for this definition.)

Introduction

How do people recover? And what can a mental health service system do to promote and support recovery? These questions have been the focus of considerable discussion within the mental health community, with consumers and consumer organizations holding strong to the belief that **recovery is possible for *all* individuals.**

The vision of recovery put forth by individuals with lived experiences goes far beyond the notion of maintenance, stability, and treatment. Rather, it highlights the things that **comprise a good life for all of us, including social connectedness, housing, education, jobs, and full participation in the community of one's choice.**

But how do you go beyond "feel-good" language to real-world policies, experiences, and a system of care that positively impacts a person's life? In the Acknowledgements, we thank the State of Connecticut Department of Mental Health and Addiction Services for sharing its guidelines. Other states have also taken the lead in developing procedures to transform policy, services, and systems. The Office of Adult Mental Health Services (OAMHS) wanted to know: Why can't we create something like this in Maine? The answer, of course, is that we *can*.

We started with a top-to-bottom look at current policies and how we do business. We then devised guidelines for improving our system of care and for leveraging programs, resources, and ideas to create the most favorable outcomes for individuals, families, and communities. Through focus groups, webinars, and surveys, we received input and feedback from stakeholders that we then incorporated into the guidelines.

Using the Guidelines

These practice guidelines are organized into five domains and are a way to assess how each organization, public (yes, that means OAMHS too) and private, implements recovery-oriented practices and continually improves a recovery-oriented system of care.

At the end of the guidelines, you'll find **helpful self-assessment checklists for each domain, plus a table for providers for moving to a strength-based approach to care.**

This document is a **blueprint and a tool for helping people move forward in their lives.** It is also a working document that will be updated and revised as we learn what works and what doesn't work with recovery-oriented care. As the movement to a recovery-oriented system of care solidifies and as new information and findings become available, the guidelines will be adjusted and amended.

In truth, all of us - stakeholders, providers, and policymakers - are learning as we go along. Our hope is that this resource guide reflects our true values and core beliefs and helps to strengthen recovery-oriented care in Maine.

Practice Guideline Domains

Domain One: Recovery-Oriented Care Is Consumer Driven

A key component of recovery-oriented care is the importance it places on the participation of people in recovery in *all* aspects of the care-delivery process. **"Consumer driven" refers to the involvement and meaningful input of persons in recovery in the process of designing, monitoring, and changing systems of care.**

This involvement starts with the initial stages of identifying questions or issues to be addressed and carries through to every part of the planning of strategies and policies that affect the lives of individuals living with mental health issues.

> The motto "Nothing About Us Without Us," used by the disability-rights movement for years to call for full participation and equalization of opportunities for, by, and with persons with disabilities, is a rallying cry for mental health consumers claiming their rightful role.

Individuals know intimately through their own experience the results of service design, access to care, and coordination of services. This knowledge is invaluable to a system of recovery-oriented mental health care and support. For a mental health system to be consumer driven, it is essential that there is recognition of the many ways individuals give voice to their thoughts, ideas, and opinions—from participation in surveys and outcome tools to involvement in committees. The input from all these sources must be a part of system planning, implementation, and evaluation.

"Consumer driven" also refers to the way in which care as a whole system is reformed and is different from person-centered care. **Person-centered care happens at the individual level with a person's own unique needs, values, and preferences. It is consumer-driven, system-level changes that help insure the right types of services and supports are available to be built into an individual's own support or recovery plan.**

Domain Two: Recovery-Oriented Care Maximizes the Use of Natural Supports and Settings

An individual's well-being and recovery is greatly supported by opportunities to be present in a community and to participate as a community member.

Participation in meaningful activity and having an opportunity to contribute to the broader community are both cornerstones of recovery. The forms of participation can vary considerably, depending on interests, talents, and disability. However, many individuals identify employment as the single most critical ingredient in their recovery and their sense of belonging.

Giving back to one's community, whether through employment or some other form of productive activity, is both a right and a responsibility of citizenship. All individuals, no matter what level of disability, are capable of such meaningful, productive activity. **A recovery-oriented system of mental health care must communicate the belief that people with serious behavioral health conditions can, and should, be productive members of society.**

In a recovery-oriented system, promoting employment and career development must be a part of everyone's job and should begin with the individual's first contact with the public mental health system. Upon intake, all persons should receive information regarding the benefits of employment and be directed to local employment and education resources. All information routinely distributed by OAMHS should highlight employment and educational benefits and opportunities.

All services in a recovery-oriented system of care must respect the individual's right to self-determination. Consistent with this orientation, people should have the right to choose and change employment based on their self-defined interests and values.

Another major route to creating a well-rounded life is understanding a person's local community, including its opportunities, resources, and barriers, and using that knowledge to inform effective recovery planning. **Knowledge of community resources is required to support the individual's recovery and to avoid duplication of services already available.** It can be as simple as obtaining a gym membership instead of creating an exercise program within the mental health agency. This domain also addresses helping to open doors into communities for people who have often been labeled and experienced stigma and isolation instead of connection.

An additional route is through natural peer support. **Recipients of mental health care have often described their relationships with other peers, particularly in hospital settings, as the key to hope, survival, and recovery.** Sharing common experiences brings people together, creating meaningful lives. Engaging in naturalized relationships, peers frequently see what they have to offer and connect with each other in a way to more fully join the community at large.

Domain Three: Recovery-Oriented Care Is Person Centered

While consumer-driven, recovery-oriented care focuses on the assessment and change of the whole system of care, **person-centered care refers to the care provided to each individual based on unique needs, values, and preferences.** Person-centered care is not by itself sufficient to making care recovery oriented or responsive. Changes are also required at the system level to insure that the right types of services and supports are available.

Implementing person-centered care involves basing all treatment and rehabilitative services on an individualized, multidisciplinary recovery plan developed in partnership with the person receiving these services and any others that he or she identifies as supportive of this process. The goal of planning is to create, or maintain, a meaningful life in the community. **Practitioners develop a strength-based approach with the understanding that focusing solely on deficits, in the absence of a thoughtful analysis of strengths, disregards the most critical resources an individual has on which to advance his or her recovery.**

Person-centered care establishes a partnership among providers, individuals, and their families, as appropriate, to ensure that individuals have the education and support they need to make decisions and participate in their own care. Several different components need to be part of recovery-oriented care; one is the shift from deficit-driven treatment, care, and service planning to person-centered recovery planning. The second shift is orienting care and supports to the community areas in which the person wishes to participate.

Building on a strength-based assessment process, recovery planning encourages and expects the person to draw upon his or her strengths to participate actively in the recovery process. Improvement depends, in the end, on the resources, efforts, and assets of the individual, family, and community. **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 perceived failure of a person to display strengths may be due to a failure of the service system to adequately elicit information or to create opportunities and supports needed for these strengths to be displayed.

Individuals *and* service providers can find it confusing when there are plans created by different support organizations with seemingly no coordination. This is especially true of the coordination between mental health providers and physical health providers. Being part of a person-centered planning process means that partners are sought out to ensure that planning has relevance to the individual and his/her preferences and supports.

Over time, it is not uncommon for some individuals to lose touch with the healthier and more positive aspects of themselves and not be able to see beyond the "patient" role. When facing such circumstances, **providers must recognize that one of their first steps is assisting the individual to get in touch with their interests, talents, and gifts.**

Providers support the person's own hopes, encouraging individuals to pursue their goals even if doing so presents potential risks and challenges. It is crucially important 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 service and manage his or her recovery independently.

For example, an individual may identify returning to work as a primary recovery goal. Providers may advise against this step based on their concern that an individual is not work-ready or that employment will be too stressful. While such advice is based on good intentions, it sends a powerful message that can reinforce feelings of self-doubt and of inadequacy. **Providers support the dignity of risk and sit with their own discomfort as the person tries out new choices and experiences that are part of recovery.**

Domain Four: Recovery-Oriented Care Is Timely, Responsive, and Trustworthy

Timely care means swift and uncomplicated entry into service. Once engaged in service, people in recovery evaluate the extent to which the services are responsive to their wants, needs, and preferences, including cultural preferences. Some indicators of responsiveness include the extent to which they feel that their providers listen carefully, explain things in a way that they understand, demonstrate respect for what they say, and spend enough time with them.

It is vital that the provider pay careful attention to earning the trust of the person who is considering taking part in care, or unsure of or new to care. The engagement process requires the

cultivation of a trusting relationship. **Research demonstrates that a trusting relationship with a provider is one of the most important predictors of a positive outcome.**

In recognition of this fundamental role of interpersonal relationships in recovery, **providers go beyond doing no harm and ensuring safety to cultivating trusting relationships that the people being served view as helpful.** Determining what has been helpful to people managing distress in the past, and noting their preferences for how they would like to be treated in the future should they become distressed, is an essential step towards ensuring that care will be experienced as safe and trustworthy.

Domain Five: Recovery-Oriented Care Is Effective, Equitable, and Efficient

Quality is a foundation of the OAMHS-funded public mental health system. For care to be characterized as high quality, as well as having a recovery orientation, it is essential that it be effective, equitable, and efficient.

Effective **care** is that which has been shown to improve functioning and quality of life. It may be based on several different types and levels of evidence, and it reflects the best care a system can offer at any given point.

Equity ensures that care is provided to all those who would benefit from it. It speaks to the need to ensure that care does not vary in quality or effectiveness due to personal or social characteristics like gender, ethnicity, race, sexual orientation, religious affiliation, geographic location, or socioeconomic status.

Efficiency results from the thoughtful allocation and management of resources in such ways that maximize access and effectiveness and minimize barriers and wasted time. It is reasonable to suggest that it is more efficient to provide services in the least-restrictive, least-costly, and least-intensive setting possible, and that systems not re-create those settings that already exist in the broader community.

Afterword

The work of continuing to develop, refine, and implement practice guidelines for recovery-oriented care is a collaborative process. It will take all of us. As we continue to create a more detailed understanding of what recovery-oriented care looks like, we will use that vision to affect policy, contracts, program development, and evaluation. And as we understand more clearly what it means to have a system of recovery-oriented care, we will refine and evolve the processes to evaluate how services support recovery.

As OAMHS implements recovery core values and principles and establishes a conceptual and policy framework, **we look forward to working collaboratively to improve our system of recovery-oriented care.**

APPENDICES

A.   SAMHSA's New Working Definition of Recovery

B.   Domain Self-Assessment Checklists

C.   Moving to a Strength-Based Approach to Care

Appendix A: SAMHSA's New Working Definition of Recovery

A new working definition of recovery from mental disorders and substance-use disorders has been announced by the Substance Abuse and Mental Health Services Administration (SAMHSA). The definition is the product of a year-long effort by SAMHSA and a wide range of partners in the behavioral health care community and other fields to develop a working definition of recovery that captures the essential, common experiences of those recovering from mental disorders and substance-use disorders, along with major guiding principles that support the recovery definition. SAMHSA led this effort as part of its Recovery Support Strategic Initiative.

The new working definition of Recovery from Mental Disorders and Substance-Use Disorders is as follows:

> *A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.*

Through the Recovery Support Strategic Initiative, SAMHSA has also delineated four major dimensions that support a life in recovery:

- Health: overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way.

- Home: a stable and safe place to live.

- Purpose: meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society.

- Community: relationships and social networks that provide support, friendship, love, and hope.

Guiding Principles of Recovery

Recovery emerges from hope: The belief that recovery is real provides the essential and motivating message of a better future - that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them.

Recovery is person-driven: Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s).

Recovery occurs via many pathways: Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds - including trauma experiences - that affect and determine their pathway(s) to recovery. Abstinence is the safest approach for those with substance use disorders.

Recovery is holistic: Recovery encompasses an individual's whole life, including mind, body, spirit, and community. The array of services and supports available should be integrated and coordinated.

Recovery is supported by peers and allies: Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery.

Recovery is supported through relationships and social networks: An important factor in the recovery process is the presence and involvement of people who believe in the person's ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change.

Recovery is culturally based and influenced: Culture and cultural background in all of its diverse representations - including values, traditions, and beliefs - are keys in determining a person's journey and unique pathway to recovery.

Recovery is supported by addressing trauma: Services and supports should be trauma-informed to foster safety (physical and emotional) and trust, as well as promote choice, empowerment, and collaboration.

Recovery involves individual, family, and community strengths and responsibility: Individuals, families, and communities have strengths and resources that serve as a foundation for recovery.

Recovery is based on respect: Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems - including protecting their rights and eliminating discrimination - are crucial in achieving recovery.

Appendix B: Domain Self-Assessment Checklists

These domain self-assessment checklists are intended to provide guidance to providers as they periodically assess progress towards implementation of recovery-oriented care and practice. Results of the self-assessment can be used to create action steps towards implementation of the various domains of recovery-oriented care and practice. We encourage providers to include input from consumers and family members in their self-assessment process.

Domain 1: Recovery-Oriented Care Is Consumer Driven

A.   ACTIVE AND MEANINGFUL INCLUSION OF PERSONS IN RECOVERY

Service providers are to indicate their implementation of a minimum of 4 out of the 5 bullets that support *Active and Meaningful Inclusion of Persons in Recovery* and provide specific action steps taken to support implementation of each.

- ☐ People in recovery are actively and meaningfully involved throughout all aspects of service provision and comprise a significant proportion of boards of directors, steering or advisory boards, or other steering committees and work groups.

- ☐ People in recovery are reimbursed for the time they spend in planning, implementing, or evaluating services and/or in providing educational and training sessions.

- ☐ People in recovery have maximum opportunity for informed choice and decision-making in their own care.

- ☐ People in recovery are routinely invited to share their stories with current service recipients and/or to provide training to staff.

- ☐ Staff encourages individuals to exercise their responsibility and make meaningful contributions to their own care and to the system as a whole.

B.   SYSTEM/AGENCY LEVEL

Service providers are to indicate their implementation of a minimum of 5 out of the 7 bullets that support inclusion at the *System/Agency Level* and provide specific action steps taken to support implementation of each.

- ☐ Measures of satisfaction with services and supports are collected routinely and used in a timely fashion to guide strategic-planning and quality-improvement initiatives.

- ☐ Administration prohibits the use of coercive practices and holds staff accountable for affording people maximum choice and decision-making in their own care.

- ☐ Assertive efforts are made to recruit people in recovery for a variety of staff positions for which they are qualified.

- ☐ Active recruitment of culturally diverse people in recovery for existing staff positions is coupled with ongoing support for the development of a range of peer-operated services that function independent of, but in collaboration with, professional agencies.

- Self-disclosure by employed persons in recovery is respected as a personal decision. Rather than being prohibited by agency policy or practice, it is encouraged as a way to dispel stigma.

- Process and outcomes evaluation is a continuous process and is not limited to the absence of symptoms or maintenance of clinical stability.

- Statistics on outcomes and satisfaction are made public so that individuals can make informed decisions.

C. ACCESS TO INFORMATION/INFORMED CARE

Service providers are to indicate their implementation of a minimum of 2 out of the 3 bullets that support *Access to Information/Informed Care* and provide specific action steps taken to support implementation of each.

- Information is provided in a variety of formats to enable people in recovery and their loved ones to make informed choices and to provide meaningful input.

- Each person receiving care is provided with an initial orientation to agency practices regarding their rights, complaint procedures, advance directives, access to their records, rehabilitation and community resources, and spiritual/chaplaincy services.

- People seek information about their concerns, review their options, ask questions about issues relevant to them, and are offered decisional aids and other tools to enable them to make informed choices about their care.

Domain 2: Recovery-Oriented Care Maximizes the Use of Natural Supports and Settings

A. COMMUNITY PARTICIPATION AND CITIZENSHIP

Service providers are to indicate their implementation of a minimum of 3 out of the 4 bullets that support *Community Participation and Citizenship* and provide specific action steps taken to support implementation of each.

- People in recovery and other labeled and/or marginalized persons are viewed as citizens (i.e., rather than as clients), and are recognized for the gifts, strengths, skills, interests, and resources they have to contribute to community life.

- High value is placed on the less formal aspects of associational life that take place, for instance, in neighborhood gatherings, block-watch meetings, coffee klatches, salons, barbershops, book groups, knitting and craft circles, restaurants, pubs, diners, etc.

- 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.

☐ Practitioners appreciate that long-term recovery is enhanced by meaningful occupation. Work, whether volunteer or paid, offers people the opportunity to play social roles that are valued by their community. Rather than waiting until symptoms or substance use abate before attempting employment, many people find that their symptoms or use are actually reduced by working, as meaningful involvement is a healthier alternative to social isolation and empty time. Practitioners therefore actively encourage employment and meaningful occupation that is meaningful to the person.

B.   COMMUNITY COLLABORATION AND DEVELOPMENT

Service providers are to indicate their implementation of a minimum of 4 out of the 5 bullets that support *Community Collaboration and Development* and provide specific action steps taken to support implementation of each.

☐ Agencies provide both formal and informal supports aimed at increasing the engagement and contributions of a diverse range of people. Involvement of natural or community supports beyond family members can be facilitated by establishment of "community collaboratives." Collaboratives bring together, on a regular basis, leadership from agencies within the system of care as well as from the community at large. They focus on developing a shared vision to guide their work as well as on the capacity-building of services that promote long-term recovery, community inclusion, and career advancement, e.g., supported education/career retraining and employer consultation regarding reasonable workplace accommodations.

☐ Community leaders representing a range of community associations and institutions work together with people in recovery to carry out the process of community development.

☐ Asset maps and capacity inventories reflect a wide range of the gifts, strengths, skills, knowledge, values, interests, and resources available to a community through its individuals, associations, and institutions.

☐ Community development is driven by a creative, capacity-focused vision identified and shared by community stakeholders.

☐ Asset maps and capacity inventories include a range of options that recognize the connections people make based on their gender, race, ethnicity, sexual orientation, trauma history, religious affiliation, socioeconomic status, and their personal and family interests and activities.

Domain 3: Recovery-Oriented Care Is Person Centered

A.   CARE PLANNING IS COLLABORATIVE AND INCLUSIVE

Service providers are to indicate their implementation of a minimum of 5 out of the 7 bullets that support *Collaborative and Inclusive Planning* and provide specific action steps taken to support implementation of each.

☐ Practitioners actively partner with individuals in shared decision-making, creating integrated and collaborative recovery/care plans.

☐ The individual has reasonable control as to the location and time of planning meetings, as well as to who is involved.

☐ The language of the plan is understandable to all participants, including the person, his or her family and friends, and the non-professional or natural supports he or she has invited.

☐ Goals are based on the day-to-day life and unique interests, preferences, and strengths of the individual, and interventions are clearly related to the attainment of these stated goals.

☐ 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.

☐ The plan identifies a wide range of both professional resources and alternative strategies to support recovery, particularly those that have been helpful to others with similar struggles.

☐ Recovery plans consider not only how the individual can access needed supports, but also how the individual can, in turn, give back to others.

B.   PLANNING IS STRENGTH-BASED AND EMPOWERING

Service providers are to indicate their implementation of a minimum of 12 out of the 15 bullets that support *Strength-Based and Empowering Planning* and provide specific action steps taken to support implementation of each.

☐ Person-centered recovery/care plans encourage and highlight an active role for the individual.

☐ A discussion of strengths is a central focus of every assessment, care plan, and summary.

☐ Recognizes and respects a broad variety of strengths that can serve as resources for recovery planning.

☐ Practitioners interpret perceived deficits within a strength and resilience framework, as this allows the individual to identify less with the limitations of his or her condition.

☐ Strength-based assessments are developed through in-depth discussion with the individual as well as attempts to solicit collateral information regarding strengths from family and others.

☐ An individual may select or change practitioners within agency guidelines.

☐ People are offered a copy of their written plans, assessments, and progress notes.

☐ Practitioners encourage individuals to write their own crisis and contingency plans.

☐ Opportunities and supports are provided for the person to enhance his or her own sense of ability.

☐ Individuals have the right to make mistakes, and this is valued as an opportunity for them to learn.

☐ People are allowed to express their feelings, including anger and dissatisfaction, without having these reactions immediately or routinely attributed to symptoms or relapse.

☐ Language used is neither stigmatizing nor objectifying. "Person-first" language is used to acknowledge that the condition is not as important as the person's individuality, except in cases in which the person prefers otherwise. While the majority of people prefer to be referred to in first-person language, when in doubt the person is asked what he or she prefers.

☐ Information on rights and responsibilities of receiving services is provided. This information should include a copy of how the individual can provide feedback, such as a protocol for filing a complaint or posting compliments regarding the provision of services.

☐ Recognizing the "dignity of risk," administrators reward planning teams that encourage individual self-determination rather than those that focus primarily on containment.

☐ Individuals are presumed competent and entitled to make their own decisions. As part of recovery, they are encouraged and supported by practitioners to take risks and try new things.

C.   RELATIONSHIPS ARE CENTRAL

Service providers are willing to indicate their implementation of a minimum of 3 out of the 4 bullets that support the *Central Role of Relationships* and provide specific action steps taken to support implementation of each.

☐ Recovery is viewed as a fundamentally social process, involving supportive relationships with family, friends, peers, community members, and practitioners.

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

☐ 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.

☐ Interventions are aimed at assisting people in gaining autonomy, empowerment, and connections with others.

D.   CARE IS COMMUNITY-FOCUSED

Service providers are to indicate their implementation of a minimum of 5 out of the 6 bullets that support the *Community Focus of Care* and provide specific action steps taken to support implementation of each.

☐ The focus of planning is on how to create pathways to meaningful and successful community life as opposed to maintaining stability or abstinence from substance use or self-injury.

☐ 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 1 or 2 steps of recovery.

☐ Practitioners are willing to offer practical assistance in the community contexts in which people live, work, and play.

☐ Care is not only provided in the community but is also oriented toward increasing the quality of a person's involvement in community life.

☐ Efforts are made to identify sources of incongruence between the person and his or her environment and to increase person-environment fit.

☐ Practitioners are mindful of the limited resources available for specialized services and focus on community solutions before replicating services that are available in the community.

☐

Domain 4: Recovery Oriented Care Is Timely, Responsive, and Trustworthy

A. HEALTH PROMOTION AND EARLY INTERVENTION ARE EMPHASIZED

Service providers are to indicate their implementation of a minimum of 3 out of the 4 bullets that support *Health Promotion and Early Intervention* and provide specific action steps taken to support implementation of each.

☐ Systems invest significantly in prevention and health promotion approaches.

☐ A range of interventions are used to enhance protective factors, to develop the resources and capabilities needed to maintain healthy lifestyles, and to foster wellness.

☐ Focused efforts are made to identify and intervene early with youth and young adults.

☐ School and community-based educational and other health promotion efforts are put into practice to help prevent youth and young adults from abusing alcohol, smoking, and using illicit drugs.

B. ENGAGEMENT IS FACILITATED

Service providers are to indicate their implementation of a minimum of 6 out of the 8 bullets that support *Engagement* and provide specific action steps taken to support implementation of each.

☐ Staff looks for organizational barriers or other obstacles to care before concluding that a person is "non-compliant." Once identified, staff finds ways to overcome these obstacles.

☐ Assessment of motivation is based on a "stages of change" model, and care incorporates motivational enhancement to help practitioners meet each person at his or her own level.

☐ The system is structured based on a commitment to motivational enhancement, while ensuring reimbursement for pre-treatment and recovery-management supports.

☐ Outpatient substance use treatment clinicians are paired with outreach workers to capitalize on the moments of crisis that can lead people to accept care.

☐ Mental health professionals, substance use specialists, and people in recovery are placed in critical locales to assist in the early stages of engagement.

- Agencies employ staff with first-person experiences of recovery that have a special ability to make contact with and engage people in services and treatment.

- The availability of sober housing is expanded to make it possible for people to go from residential or intensive outpatient treatment into housing that supports their recovery.

- Services are designed to be welcoming to all individuals and there is a low threshold (i.e., minimal requirements) for entry into care, including housing and employment supports.

C. THERE IS A FLEXIBLE ARRAY OF OPTIONS OFFERED OVER TIME

Service providers are to indicate their implementation of a minimum of 4 out of the 5 bullets that support a *Flexible Array of Options* and provide specific action steps taken to support implementation of each.

- Practitioners provide, or can help the person gain swift access to, a wide range of services.

- People can access these services from many different points.

- People have a flexible array of options from which to choose that allows for a high degree of individualization and a greater emphasis on the physical/social ecology of recovery.

- Less emphasis is placed on short-term outcomes of single episodes of care and more emphasis is placed on recovery roadmaps that highlight the long-term effects of service combinations.

- Continuity of care, especially for individuals with trauma histories, means a shifting of the services offered to the individual and not a transfer of the person from one program to another, requiring changing care providers or settings.

D. RESPECT FOR AUTONOMY AND BODILY INTEGRITY

Service providers are to indicate their implementation of a minimum of 4 out of the 5 bullets that support *Respect for Autonomy and Bodily Integrity* and provide specific action steps taken to support implementation of each.

- Agencies make concerted efforts to avoid all involuntary aspects of treatment.

- Individuals have their health care needs addressed and have ready access to primary health care services, including preventive health and dental care and health promotion, both to enhance and promote health and to reduce reliance on crisis or emergency care.

- Policies and practices support healthy connections with children, family, significant others, and community.

- In the process of developing advance directives or upon admission, individuals are asked to describe the strategies or interventions that have worked well for them in the past to assist them in managing their distress. They also are asked to specify for the staff the ways in which they would, and would not, prefer to be treated should they become distressed during their stay within the care setting.

- Individuals request and receive supports and accommodations that help them to feel safe.

E.   TRAUMA-INFORMED

Service providers are to indicate their implementation of a minimum of 3 out of the 4 bullets that support care being *Trauma-Informed* and provide specific action steps taken to support implementation of each.

☐   Staff invites individuals to share their childhood and/or adult history of experiencing violence and abuse at a comfortable pace. Staff also asks them what they will need in order to feel safer.

☐   Staff appreciates that understanding an individual's trauma history is an important part of assessing that person's relationships within his or her natural support network, at the same time recognizing that the process utilized in trauma screening may be more important than any of the specific content of the questions and answers.

☐   Recommendations from individuals with trauma histories are aggregated and reviewed so services can be structured in a way that helps people feel safe.

☐   Training and resources on trauma-informed treatment are readily available to and utilized by practitioners, including training related to professional boundaries, confidentiality, dual relationships, and sexual harassment, as well as clinician self-care and vicarious trauma.

Domain 5: Recovery-Oriented Care Is Effective, Equitable, and Efficient

A.   PRACTITIONERS FOCUS ON UNIQUE NEEDS AND PREFERENCES

Service providers are to indicate their implementation of a minimum of 3 out of the 4 bullets that support *Focusing on Unique Needs and Preferences* and provide specific action steps taken to support implementation of each.

☐   Rather than a pre-established continuum of services, flexible arrays of supports are offered that each person can choose from at different points in time depending upon his or her phase of recovery and unique needs and preferences.

☐   The task of assisting people in pursuing employment and education is taken to be inherent to the responsibilities of the entire practitioner network, including those not specifically charged with work service or supported education activities.

☐   Self-directed funding opportunities are piloted both on a collective basis and through individualized budget programs.

☐   Recovery plans respect the fact that services and practitioners need not remain central to a person's life over time.

B.   CULTURAL AND LINGUISTIC COMPETENCE IS ENSURED

Service providers are to indicate their implementation of a minimum of 4 out of the 5 bullets that support *Cultural and Linguistic Competence* and provide specific action steps taken to support implementation of each.

- Practitioners make available and disseminate culturally relevant and linguistically appropriate information regarding local mental health and addiction services, as well as non-traditional and self-help resources in a wide variety of formats.

- Staff has and uses an available list of culturally and linguistically accessible services, along with qualified interpreters, within the facilities and throughout the community.

- The agency's educational materials are made available to individuals served and reflect the language and culture of those persons.

- The social and physical environment within the agency reflects the diversity and culture of the persons served. Waiting areas and offices display magazines, art, music, etc., reflective of the diversity of persons served.

- Initial and ongoing assessments include cultural factors that may affect treatment and rehabilitation services and supports. Bilingual/bicultural staff is available to assess individuals both in their preferred language and within the context of their cultural heritage.

C.   QUALITY IS ENSURED THROUGH TRAINING AND MONITORING

Service providers are to indicate their implementation of a minimum of 4 out of the 6 bullets that support *Training and Monitoring* and provide specific action steps taken to support implementation of each.

- Training initiatives regarding recovery-oriented care address the needs of people in recovery and families to develop their own capacity to self-direct their treatment and life decisions.

- An analysis of current staff competencies and self-perceived training needs guide the development of ongoing skill-building activities at the agency level.

- Competency-based training is coupled with ongoing mentoring support, clinical supervision, recovery-oriented case conferences, and opportunities for peer consultation.

- Agency leaders are involved in ongoing training so that there is consistency between proposed recovery-oriented practices and administrative structures.

- Agency administrators monitor the treatment outcomes and satisfaction of individuals based on race and ethnicity, gender, gender identity, sexual orientation, trauma history, and religious and socioeconomic background and implement changes in services and service delivery to address disparities.

- Processes for continual quality assurance and independent audits by people in recovery and families trained in recovery-oriented care are funded and coordinated.

Appendix C:
Moving from a Deficit-Based to a Strength-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. These examples may be used to consider how many common situations can be viewed quite differently from a recovery-oriented perspective. Providers, consumers, and family members can periodically assess their own language, thinking, and practice and ask: Is my approach deficit-based? Strength-based? Or somewhere in between?

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 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.

Presenting Situation	Deficit-Based Perspective		Recovery-Oriented, Asset-Based Perspective	
	Perceived Deficit	Intervention	Perceived Asset	Intervention
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, structured time, spending 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 50% 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's and his or her loved one's 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.
Person makes poor decisions	Person's judgment is impaired by mental health or substance-use condition; 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 setbacks. People are not abandoned to the negative consequences of their own actions, however, as staff stands 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.

Presenting Situation	Deficit-Based Perspective		Recovery-Oriented, Asset-Based Perspective	
	Perceived Deficit	Intervention	Perceived Asset	Intervention
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 online friends; plays online chess or belongs to collectors clubs; is a movie buff or enjoys religious programs on TV. 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.
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.

Presenting Situation	Deficit-Based Perspective		Recovery-Oriented, Asset-Based Perspective	
	Perceived Deficit	Intervention	Perceived Asset	Intervention
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 partici-pate in other treat-ments; 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 out-side 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 as 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 appoint-ment 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 music, giving them stern orders to leave him or her alone, or confines them to certain parts of the day when 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.