

APPENDICES

Domain Self-Assessment Checklists

Glossary of Recovery-Oriented Language

Examples of Strength-Based Conceptualizations

Source Documents from DMHAS Initiatives

The following principles were drawn from the *Practice Guidelines for Recovery-Oriented Care for Mental Health and Substance Use Conditions, Second Edition*, released in 2008 by the Connecticut Department of Mental Health and Addiction Services. Taken together, these principles offer a thumbnail sketch of the degree to which a system, organization, or program provide high quality and recovery-oriented services and supports.

Recovery-Oriented Care for Mental Health and Substance Use Conditions ...

is consumer and family-driven

- ❖ People in recovery and families are actively and meaningfully involved in the evaluation, design, planning, implementation, and monitoring of mental health services.
 - ❖ People in recovery and families comprise a significant proportion of boards of directors, steering or advisory boards, or other governing bodies, committees, and work groups.
-

is timely and responsive

- ❖ Systems invest significantly in prevention and health promotion approaches and a range of interventions are used to enhance protective factors, develop the resources and capabilities needed to maintain healthy lifestyles, and foster wellness.
 - ❖ Focused efforts are made to identify and intervene early with youth and young adults.
 - ❖ Practitioners offer swift access to a wide range of services which are welcoming, can be accessed from many different points, and have a low threshold for entry into care.
-

is effective, equitable, and efficient

- ❖ People in recovery and families are able to make informed choices from among an array of those interventions known to be effective for their particular condition(s).
 - ❖ Administrators monitor the treatment outcomes and satisfaction of individuals based on race and ethnicity, gender, gender identity, sexual orientation, trauma history, and socio-economic background and implement changes in services and service delivery to address disparities.
 - ❖ Competency-based training is coupled with on-going mentoring support, supervision, recovery-oriented case conferences, and opportunities for peer consultation.
-

maximizes use of natural supports and settings

- ❖ 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.
 - ❖ 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.
 - ❖ 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.
-

is person-centered

- ❖ People in recovery and families have maximum opportunity for informed choice and decision-making in their own care.
- ❖ 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.
- ❖ Practitioners actively partner with individuals and families in shared decision-making, creating integrated and collaborative recovery plans.
- ❖ 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.
- ❖ Recovery plans consider not only how the individual can access supports, but encourage an active role for the individual including how the individual can give back to others.
- ❖ 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.
- ❖ A discussion of strengths is a central focus of every assessment, care plan, and summary. The diversity of strengths that can serve as resources for recovery planning is respected.
- ❖ 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.
- ❖ 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, efficacy, and connections with others.
- ❖ Opportunities and supports are provided for the person to enhance his or her own sense of personal agency.
- ❖ Individuals are allowed 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.
- ❖ 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.

is safe and trustworthy

- ❖ Agencies make concerted efforts to avoid all involuntary aspects of treatment, and people request and receive supports and accommodations that help them to feel safe.
 - ❖ Individuals have their health care needs addressed and have ready access to primary health care services, including preventative health and dental care and health promotion.
 - ❖ Staff invite individuals to share their childhood and/or adult history of experiencing violence and abuse at a comfortable pace and also ask them what they will need in order to feel safer.
-

Domain #1. In consumer and family-driven care ...

I. 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 encourage individuals to exercise their responsibility and make meaningful contributions to their own care and to the system as a whole.

II. 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.

III. 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. In timely and responsive care ...

I. 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 made to help prevent youth and young adults from abusing alcohol, smoking, and using illicit drugs.

II. 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 look for organizational barriers or other obstacles to care before concluding that a person is ‘non-compliant’. Once identified, staff find 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, with 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 who have a special ability to make contact with and engage people into 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.

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

Service providers are to indicate their implementation of a minimum of 3 out of the 4 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 which allows for a high degree of individualization and a greater emphasis on the physical/social ecology of recovery.
 - Less emphasis 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.
-

Domain #3. In person-centered care ...

I. 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 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 which 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.

II. PLANNING IS STRENGTH-BASED AND EMPOWERING

Service providers are to indicate their implementation of a minimum of 12 out of the 14 bullets that support *Strength-Based and Empowering Planning* and provide specific action steps taken to support implementation of each.

- Person-centered 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. The diversity of strengths that can serve as resources for recovery planning is respected.
- 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 personal agency.
- Individuals are allowed 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 the mechanisms through which the individual can provide feedback, such as a protocol for filing a complaint or compliments regarding the provision of services.
- Recognizing the “dignity of risk,” administrators reward planning teams that encourage individual self-determination rather than those which 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.

III. `RELATIONSHIPS ARE CENTRAL

Service providers are 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, power, and connections with others.

IV. 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 one or two 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. In effective, equitable, and efficient care ...

I. 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, a flexible array 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.

II. 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 which may affect treatment and rehabilitation services and supports. Bilingual/bicultural staff are available to assess individuals both in their preferred language and within the context of their cultural heritage.

III. 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 on-going skill-building activities at the agency level.
 - Competency-based training is coupled with on-going 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 socio-economic 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.
-

Domain #5. In safe and trustworthy care ...

I. 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 preventative 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.

II. 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 invite individuals to share their childhood and/or adult history of experiencing violence and abuse at a comfortable pace and also ask them what they will need in order to feel safer.
 - Staff appreciate that understanding an individual's trauma history is an important part of assessing that person's relationships within his or her natural support network, at the same time recognizing that the process utilized in trauma screening may be more important than any of the specific content of the questions and answers.
 - 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 #6. In care that maximizes natural supports and settings ...

I. 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 primarily 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 clatches, 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 meaningful occupation that is meaningful to the person.

II. 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 integration, 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 *natural* 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, social-economic status, and their personal and family interests and activities.
-

Glossary of Recovery-Oriented Language

Creation of a recovery-oriented system of care requires practitioners to alter the way they look at mental health and substance use conditions, 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.⁶⁰ 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 the addiction self-help 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. In this case, recovery may be taking place in the presence of an enduring illness or condition, rather than following upon its absence. 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.

⁶⁰Credit 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: the strategy of complete and enduring cessation of the 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 in recovery play in their own treatment, rehabilitation, recovery, and life. Within the health care 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 health care 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 condition contributes to their posing imminent risks to others or to themselves.

Citizenship: a strong connection to the rights, resources, roles, responsibilities, and relationships that society offers 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 impairments 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 of being able to make informed choices, 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.

Cultural Competence: is knowledge, data and information from and about individuals and groups that is integrated and transformed into clinical standards, skills, service approaches, techniques, and marketing programs that match the individual’s culture and increase both the quality and appropriateness of health care and health outcomes. As a multidimensional construct, cultural competence can be conceptualized from provider, program, agency, and health care system levels.

Culture: includes but is not limited to, the shared values, norms, traditions, customs, art, history, folklore, religious, and healing practices and institutions of a racial, ethnic, religious or social group that are generally transmitted to succeeding generations.

“Dignity of risk and right to fail”: a phrase coined by Patricia Deegan, an international leader of the mental health consumer/survivor movement, to emphasize the importance of people in recovery being able to make their own choices, and therefore their own mistakes, as this is a primary source of learning for all adults, including those with substance use and/or mental health conditions.

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 substance use recovery context, there are two different relationships to power. Among the culturally empowered (those to whom value is ascribed as a birthright), the erosion of competence often associated with substance use may be 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 may be marked by the assumption of power and control rather than an abdication 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 health care more responsive and person-centered.

In either community, empowerment is meant to be inspiring, energizing, and galvanizing. The concept of empowerment applies to communities as well as individuals. It posits that the only solution to the problems of substance use 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 health care 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 appreciated, however, are the hope- and pleasure-based experiences that appear to be even more effective in promoting recovery: 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 substance use 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 mental health conditions, and low social support. The most common example of moderated resolution can be found in people who develop substance use 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: are non-confrontational approaches to eliciting recovery-seeking behaviors 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 recovery and expressing confidence that they will recovery). As a technique of preparing people to change, motivational interventions are 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 mental health and substance use conditions 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 without professional intervention or involvement in a formal mutual aid group. Since people in this form of recovery neither access nor utilize formal health care 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 substance use, 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 health care 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 substance 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 substance use, or 2) the achievement of complete abstinence from substance use 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 mental health and/or substance use, this term is used to refer to someone else who has experienced first-hand, and is now in recovery from, a mental health and/or substance use condition.

Peer-Delivered Services: any service or support provided by a person in recovery from a mental health and/or substance use condition for which their personal history of recovery is relevant and shared. This includes, but is not limited to, the activities of peer specialists or peer support providers (see below), encompassing also any conventional health care 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 psycho-social 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 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 health care services and supports such as respite care, transportation to and from health care appointments, recovery education, and advocacy.

Peer Specialist: a peer (see above) who has been trained and employed to offer peer support to people 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 health and/or substance use condition and who offers services and/or supports to other people with mental health and/or substance use conditions who are considered to be not as far along in their own recovery process.*

Person-Centered Care: 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 health and/or substance use condition and who has made progress in learning about and managing his or her 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 mental health and/or substance use conditions 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 stigma attached to substance use or mental health conditions by putting a human face on these conditions and by conveying living proof of the possibility of recovery.

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 as well as recovery supporters within the community. This concept is based on the belief 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 mental health and/or substance use conditions. Within the framework of recovery management, the “management” of the condition is the responsibility of the person with the condition. 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 mental health and/or substance use 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 strength-based orientation, and offer a wide spectrum of services and supports aimed at engaging people with mental health and substance use conditions into care and promoting their resilience and long term recovery from which they and their families may choose.

Recovery Planning and Recovery Plans: in contrast to a treatment or service plan, is developed, implemented, revised, and regularly evaluated by the person receiving care. Consisting of a master recovery plan and regular implementation/action plans, the recovery plan covers life domains in addition to mental health and substance use 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. 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 substance use and co-occurring mental health or other physical conditions.

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 health services and/or supports for mental health and/or substance use conditions, 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 mental health and/or substance use 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.

Worldview: is an individual’s perception of his or her relationship with the world; i.e., nature, institutions, people, and things. An individual’s worldview mediates his or her belief systems, assumptions, modes of problem solving, decision making, and conflict resolution style.

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 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.

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 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 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.

**Competencies for Providing Services to
Individuals with Co-Occurring Mental Health and Substance Use Disorders
Version 1.1**

Connecticut Department of Mental Health and Addiction Services

Basic:

1. Screen for mental health and substance use problems using standardized measures.
2. Form a preliminary impression of the nature of the presenting problems.
3. Use basic engagement skills. [Required]
 - Including stabilization, outreach, assistance with practical needs, building the therapeutic alliance, *not* working on changing substance use behavior in early engagement stages.
 - Able to use some basic motivational interviewing skills: asking open ended questions, making reflective listening statements, summarizing, and making statements of affirmation.
4. Use de-escalation skills when needed. [Required]
5. Knowledge of crisis management procedures. [Required]
 - Know the behavior/physiological signs for intoxication and withdrawal from various substances, and the signs of risk to self or others.
 - Follow the crisis management procedures if someone is intoxicated or in withdrawal from substances, and/or reporting suicidal ideation and/or homicidal ideation.
6. Knowledge of referral processes and use them assertively when needed.
7. Coordinate care assertively when multiple providers are concurrently involved in care.
8. Display patience, persistence and optimism. [Required]

Intermediate: (In addition to the competencies listed above)

9. Conduct integrated assessments.
 - Knowledgeable of the drug classes and mental health diagnostic categories used in the DSM IV.
 - Determine severity of disorders.
 - Knowledge of current street names of the various drugs.
 - Assess stage of change for both disorders.
 - Complete a functional assessment.
 - Document mental health and substance use disorder diagnoses.

10. Perform integrated and collaborative treatment (recovery) planning with a focus on shared decision making.
11. Conduct engagement, education, and treatment for both mental health and substance use disorders.
 - Use more advanced motivational interviewing strategies: developing discrepancy (e.g., using the importance ruler, decisional balance, and exploring personal goals and values); rolling with resistance (e.g., reflection, shifting focus, personal control, reframing); and how to offer information and suggestions.
 - Know the basic social learning theory concepts that underlie a Cognitive Behavioral Therapy (CBT) approach. Complete a functional analysis (behavior chain) and teach coping skills (e.g., rationale and guidelines, modeling, role plays, providing constructive feedback, and assisting consumers/individuals in recovery to practice exercises in their community).
 - Able to modify counseling strategies for consumers/individuals in recovery with a severe mental illness.
12. Use stage-wise treatment methods.
 - Use treatment strategies compatible with each stage of change for each disorder.
13. Understand the 12-steps used in AA/NA self-help groups, and assertively link people with co-occurring disorders to ones that are welcoming or specific to co-occurring disorders (e.g., Dual Recovery Anonymous).

Advanced: (In addition to both the basic and intermediate competencies)

14. Use integrated models of assessment, intervention and recovery.
 - Understand group processes and facilitate groups (e.g., process groups, social skills groups, stage-wise groups, interactive psychoeducation groups).
15. Provide interventions for families and other supports.
 - Work individually with families; facilitate a multi-family psychoeducation/support group.
16. Demonstrate an understanding of psychotropic medication.
17. Support quality improvement efforts, including a focus on incorporating new “best practices”, resources, and tools in the provision of integrated services for people with co-occurring disorders.

Primary Sources: CSAT, “Substance Abuse Treatment for Persons with Co-Occurring Disorders: TIP 42; DMHAS, *Integrated Dual Disorders Treatment (IDDT) Workgroup*; DMHAS *Co-Occurring Enhanced Program Guidelines Workgroup*.

Co-Occurring Enhanced Program Guidelines

Version 1.3 – September 2008

Connecticut Department of Mental Health and Addiction Services

Introduction

This document presents program guidelines to ensure responsiveness to the needs of individuals with co-occurring mental health and substance use disorders in treatment programs at all clinical levels of care. The intent of these guidelines is to provide direction, without being prescriptive, and to emphasize those factors that are of particular importance in the treatment of individuals with co-occurring disorders. These program guidelines are consistent with the larger context of a recovery-oriented system of care, and more detailed “Practice Guidelines for Recovery-Oriented Behavioral Health Care” that have been disseminated by the Connecticut Department of Mental Health and Addiction Services. This document begins below with some guiding *principles* for treating individuals with co-occurring disorders from two key publications in the field, followed by the DMHAS *guidelines* starting on the next page.

Guiding Principles in Treating Individuals with Co-Occurring Disorders

(CSAT, Treatment Improvement Protocol #42, 2005)

1. Employ a recovery perspective
2. Adopt a multi-problem viewpoint
3. Develop a phased approach to treatment.
4. Address specific real-life problems early in treatment.
5. Plan for the client’s cognitive and functional impairments.
6. Use support systems to maintain and extend treatment effectiveness.

Principles of Integrated Treatment

(Mueser, K.T., Noordsy, D.L., Drake, R.E., & Fox, L., Integrated Treatment for Dual Disorders, 2003).

1. Core value: Shared decision making
2. 7 Principles of integrated treatment:
 - **Integrated:** The same clinician (or team of clinicians) provides treatment for mental illnesses and substance use disorders at the same time.
 - **Comprehensiveness:** When needed, access to residential services, case management, supported employment, family psychoeducation, social skills training, training in illness management, and pharmacological treatment is available.
 - **Assertiveness:** Clinicians must make every effort possible to actively engage reluctant individuals in the process of treatment and recovery.
 - **Reduction of negative consequences:** Reduce the negative consequences of substance use, while developing a good working alliance that can ultimately help develop the motivation to address their substance use and mental health challenges.

- **Long-term perspective:** Recognizing that each individual recovers at his or her own pace, given sufficient time and support.
- **Motivation-based treatment:** Interventions must be motivation-based – that is, adapted to clients’ motivation for change.
- **Multiple psychotherapeutic modalities:** Including individual, group, and family approaches has been found to be effective.

Co-Occurring Enhanced Program Guidelines

Program Structure and Milieu

1. Agency mission statement and/or policy is inclusive of people with co-occurring disorders.
2. Program is licensed to provide both mental health and addiction treatment services.
3. Program displays, distributes, and utilizes literature and client/family educational materials addressing both mental health and substance use disorders.

Screening, Assessment, and Treatment Planning

4. As required by the Department of Mental Health and Addiction Services, the program uses standardized mental health and substance use screening instruments with established psychometric properties for routine screening for psychiatric and substance use symptoms.
5. The program performs a formal, integrated, and comprehensive assessment. Psychiatric, substance use and trauma history is reflected in the medical record, including longitudinal information about the interaction between an individual's mental health symptoms and substance use. The individual's stage of change for both disorders is documented. An integrated formulation of strengths, history, current symptoms, and other assessment information must be part of the assessment. The program documents both psychiatric and substance use diagnoses for people with co-occurring disorders.
6. The treatment/recovery planning process focuses on the recovery potential of an individual. It includes a focus on the co-occurring conditions, including co-occurring medical conditions, and incorporates stage of change principles. Relapse or non-adherence to medication or other treatment is not a cause for termination from the program. Co-occurring disorders are reflected as dual primary disorders, and a plan is developed in which each condition receives stage-specific and diagnostic-specific services concurrently. Treatment for mental illnesses, including psychotropic medications if deemed clinically appropriate, continues at the needed intensity even when individuals are actively using substances. Treatment for substance use disorders continues at the needed intensity even when individuals have psychiatric symptoms and are receiving interventions focused on their mental illnesses.

Services

7. Program has the ability and capacity to provide care to individuals with moderate to high symptom acuity, including those with a history of suicidal ideation. Program has the ability to provide care to persons with moderate to high severity of disability, including people with severe mental illnesses.
8. Through multiple modalities (e.g., individual, group) the program includes motivational interventions, addiction treatment, mental health treatment, education about the symptoms, course, and treatments for specific mental health and substance use disorders, and

information about the interactive nature of co-occurring conditions. Trauma-informed and trauma-specific services are an integral component.

9. Psychopharmacologic and addiction pharmacotherapy interventions are provided on-site, except for methadone or bupernorphine, which require specific federal approvals.
 - A psychiatrist or advanced practice registered nurse, with experience in prescribing for people with co-occurring disorders, must be available to provide psychiatric evaluation, psychopharmacologic and addiction pharmacotherapy (e.g., naltrexone, disulfiram) interventions, and medication monitoring.
 - For individuals with known substance dependence (active or remitted), the adjunctive use of benzodiazepines, addictive pain medications, or non-specific sedatives/hypnotics should be decided on a case-by-case basis, after careful consideration of alternative medications with reduced risk potential. The adjunctive use of these medications requires careful monitoring and close coordination between prescribing physicians. Medications with addiction potential should not be withheld from carefully selected individuals who demonstrate specific beneficial responses to them without signs of misuse.
 - The on-site prescriber will be available to staff for consultation, to participate in clinical team meetings, and provide staff in-services, as needed.
10. Peer supports for people with co-occurring disorders are available on-site or through collaboration (e.g., assertive linkage to 12-step groups that are welcoming to people with co-occurring disorders, alumni groups, All Recovery Groups at Recovery Centers sponsored by the Connecticut Community for Addiction Recovery (CCAR)).
11. Assessment and treatment incorporates families and friends. These interventions include, but are not limited to, family psychoeducation, multi-family groups, and family therapy, and incorporate a focus on co-occurring disorders.
12. Co-occurring disorders are addressed in the discharge planning process and aftercare planning. Program must be credentialed by DMHAS as a Clinical Recovery Check-up provider. Upon discharge, willing individuals are connected with recovery support services, including, but not limited to clinical recovery check-ups and telephone recovery support services.

Staffing

13. Written human resource policies incorporate the DMHAS list of staff competencies for providing services to people with co-occurring disorders. Status of attainment of these competencies must be documented for each direct care staff person, clinical supervisor and clinical director in the program. Documentation could include a recognized credential² for providing services to people with co-occurring disorders, or the equivalent in training and experience, copies of staff evaluations, training certificates, related credentials, verified employment history, and clinical supervision that documents development of the

² Connecticut Certification Board, National Association of Social Workers, American Psychological Association's College of Professional Psychology, American Society of Addiction Medicine, American Academy of Addiction Psychiatry.

competencies to serve individuals with co-occurring disorders. In addition to attainment of the COD competencies, the following is required of the program:

- At least one staff member has mental health licensure (i.e., LCSW, LPC, LMFT, licensed psychologist) and at least one staff member has addiction treatment licensure (i.e., LADC);
- Clinical supervisors must be licensed or certified in either the addictions or mental health fields;
- Agency clinical directors must be licensed Master's prepared professionals (or higher degree).

14. On-site, documented clinical supervision sessions, including a focus on co-occurring disorders, are provided, including a minimum of two hours of face-to-face clinical supervision for every four weeks worked for staff without a professional license. One of these hours can be in a group supervision format. Licensed (non-medical, non-prescribing) direct care staff will receive at least one hour for every four weeks worked in either a group or individual format.
15. Program has a written training plan. The plan needs to include how the program will assist staff in maintaining and enhancing their competencies to provide services for people with co-occurring disorders through the use of current literature, films, other medium, in-service trainings, and external trainings. The plan needs to include training in specialized treatment approaches and pharmacotherapies.

Quality Assurance

16. Program has a written quality assurance procedure, and evidence of its implementation, for identifying the percentage of clients with co-occurring disorders and some outcome indicators (e.g., critical incidents, level of functioning, treatment completion, improvements since admission).
17. Program has a written procedure for self-monitoring their adherence to these co-occurring enhanced program guidelines over time.

Primary Sources: DMHAS, "Commissioner's Policy Statement No.84 on Serving People with Co-Occurring Mental Health and Substance Use Disorders"; Mark P. McGovern, Ph.D., *Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index*; Mueser, K.T., et al., "Integrated Treatment for Dual Disorders"; CSAT, "Substance Abuse Treatment for Persons with Co-Occurring Disorders: TIP 42"; Kenneth Minkoff, M.D., "Psychopharmacology Practice Guidelines for Individuals with Co-Occurring Psychiatric and Substance Use Disorders".

Co-Occurring Enhanced Program Guidelines Workgroup: Jim Baker, United Services; Asher Delerme, Chemical Abuse Services Agency (CASA); Rick Fisher, DMHAS; Ron Fleming, Alcohol and Drug Recovery Centers (ADRC); Julienne Giard, DMHAS; Bill Gilbert, Community Prevention and Addiction Services (CPAS); Waldemar Gracia, Institute for the Hispanic Family; Rhonda Kincaid, DMHAS; Rob Lambert, Connecticut Counseling Centers; Susan Niemitz, Hartford Behavioral Health; Jim O'Dea, Backus Hospital; Kate Powell, SWCMHS, DMHAS; Alyssa Rose, CT Community Providers Association (CCPA); Nic Scibelli, Wheeler Clinic; Lauren Siembab, DMHAS; Kathy Ulm, Rushford Center; Phillip Valentine, Connecticut Community for Addiction Recovery (CCAR).

Community Connections: Roger D. Fallot, Ph.D. and Maxine Harris, Ph.D.

March, 2006

Introduction

Over the past fifteen years, there has been growing acknowledgement of several interrelated facts concerning the prevalence and impact of trauma in the lives of people in contact with various human service systems. We advocate for trauma-informed service approaches for a number of reasons.

•**Trauma is pervasive.** National community-based surveys find that between 55 and 90% of us have experienced at least one traumatic event. And individuals report, on average, that they have experienced nearly five traumatic events in their lifetimes. The experience of trauma is simply not the rare exception we once considered it. It is part and parcel of our social reality.

•**The impact of trauma is very broad and touches many life domains.** Trauma exposure increases the risk of a tremendous range of vulnerabilities: mental health problems like posttraumatic stress disorder, depression, excessive hostility, and generalized anxiety; substance abuse; physical health problems; interpersonal struggles; eating disorders; and suicidality, among many others. Trauma thus touches many areas of life not obviously or readily connected with the experience of trauma itself. This broad impact makes it particularly important to understand the less evident links between trauma and its sequelae.

•**The impact of trauma is often deep and life-shaping.** Trauma can be fundamentally life-altering, especially for those individuals who have faced repeated and prolonged abuse and especially when the violence is perpetrated by those who were supposed to be caretakers. Physical, sexual, and emotional violence become a central reality around which profound neurobiological and psychosocial adaptations occur. Survivors may come to see themselves as fundamentally flawed and to perceive the world as a pervasively dangerous place. Trauma may shape a person's way of viewing and being in the world; it can deflate the spirit and trample the soul.

•**Violent trauma is often self-perpetuating.** Individuals who are victims of violence are at increased risk of becoming perpetrators themselves. The intergenerational transmission of violence is well documented. Community violence is often built around cycles of retaliation. Many of our institutions—criminal justice settings, certainly, but also schools and churches and hospitals—are too frequently places where violent trauma is perpetuated rather than eliminated.

•**Trauma is insidious and preys particularly on the more vulnerable among us.** People who are poor, who are homeless, who have been diagnosed with severe mental health problems, who are addicted to drugs, or who have developmental disabilities—all of these groups are at increased risk of violent victimization.

•**Trauma affects the way people approach potentially helpful relationships.** Not surprisingly, those individuals with histories of abuse are often reluctant to engage in, or quickly drop out of, many human services. Being vigilant and suspicious are often important and thoroughly understandable self-protective mechanisms in coping with trauma exposure. But these same ways of coping may make it more difficult for survivors to feel the safety and trust necessary to helpful relationships.

•**Trauma has often occurred in the service context itself.** Involuntary and physically coercive practices, as well as other activities that trigger trauma-related reactions, are still too common in our centers of help and care.

Growing awareness of these facts regarding trauma has led to calls for the development of both trauma-informed and trauma-specific services. Human service systems become **trauma-informed** by thoroughly incorporating, in all aspects of service delivery, an understanding of the prevalence and impact of trauma and the complex paths to healing and recovery. Trauma-informed services are designed specifically to avoid retraumatizing those who come seeking assistance. They seek “safety first” and commit themselves to “do no harm.” The recently completed SAMHSA-funded Women, Co-Occurring Disorders, and Violence Study has provided evidence that trauma-informed approaches can enhance the effectiveness of mental health and substance abuse services. By contrast, **trauma-specific services** have a more focused primary task: to directly address trauma and its impact and to facilitate trauma recovery. An increasing number of promising and evidence-based practices address PTSD and other consequences of trauma, especially for people who often bring other complicating vulnerabilities (e.g., substance use, severe mental health problems, homelessness, contact with the criminal justice system) to the service setting.

This Self-Assessment and Planning Protocol and its accompanying Trauma-Informed Program Self-Assessment Scale attempt to provide clear, consistent guidelines for agencies or programs interested in facilitating trauma-informed modifications in their service systems. It is a tool for administrators, providers, and survivor-consumers to use in the development, implementation, evaluation, and ongoing monitoring of trauma-informed programs.

Overview of the Protocol and Scale

The Self-Assessment and Planning Protocol is divided into six domains; they address both services-level and administrative or systems-level changes. In each domain, there are guiding questions for a collaborative discussion of a program's activities and physical settings, followed by a list of more specific questions and/or possible indicators of a trauma-informed approach. Many of these questions and indicators are drawn from the experiences of human service agencies that have previously engaged in this self-assessment. Discussions of trauma-informed program modifications constitute an opportunity to involve all key groups—administrators, supervisory personnel, direct service and support staff, and consumers—in the review and planning process. In our experience to date, the more inclusive and fully representative these discussions are, the more effective and substantial the resulting changes.

Following the questions and indicators are brief notes linking the Self-Assessment and Planning Protocol to the Trauma-Informed Self-Assessment Scale. The structure and format of the Program Self-Assessment Scale are similar to those of “fidelity scales” commonly used to assess the extent to which a service model is actually being implemented as intended (e.g., consistent with a plan or a manual). Both administrative and clinical experience suggests that attributes of the system “as a whole” have a very significant impact on the implementation and potentially the effectiveness of any specific services offered. This instrument reflects current thinking about those program characteristics—at both the services and systems level—most likely to provide the sort of context in which people with trauma histories may become engaged in chosen services most helpful to their recovery.

The Self-Assessment Scale is intended primarily for the use of programs to assess their own current practices and/or to track their progress in relation to a specific understanding of trauma-informed services (Harris & Fallot, 2001). We recommend that programs beginning this review process complete the Scale at the time of their initial overall self-assessment. Its patterns may be helpful in prioritizing areas for change. Subsequent dates for completion of the Scale may be scheduled based on the key timelines in a trauma-informed program implementation plan. Self-monitoring can therefore be built into the change process. Some programs may choose to have the assessment completed by raters from outside the program. Outside raters would need access to administrative and clinical records and also be able to conduct interviews and/or focus groups as necessary to gain a complete picture of the agency's operation.

Part A: Services-level Changes

Domain 1. Program Procedures and Settings: “To what extent are program activities and settings consistent with five guiding principles of trauma-informed practice: safety, trustworthiness, choice, collaboration, and empowerment?”

This section of the protocol can be used to assess the extent to which formal and informal procedures and the physical environment in a human services program are trauma-informed and to plan corresponding modifications in service delivery practices. Consumer-survivors should be actively involved in the review process as should support staff, direct service staff, supervisors, and administrators.

Step One: Identify Key Formal and Informal Activities and Settings

- A. List the sequence of service *activities* in which new consumers are usually involved (e.g., outreach, intake, assessment, service planning). Think broadly to include informal as well as formal contacts. For example, consumers may be greeted and given directions by a number of people prior to formal service delivery.
- B. Identify the *staff members* (positions and individuals) who have contact with consumers at each point in this process.
- C. Identify the *settings* in which the various activities are likely to take place (e.g., home, waiting room, telephone, office, institution).

Step Two: Ask Key Questions about Each of the Activities and Settings

(See list of questions for Domains 1A-1E following Step Four)

Step Three: Prioritize Goals for Change

After the workgroup has reviewed services and has developed a list of possible trauma-informed changes in service delivery procedures, these goals for change should be prioritized. Among the factors to consider in this prioritizing are the following: (1) feasibility (which goals are most likely to be accomplished because of their scale and the kind of change involved?); (2) resources (which goals are most consistent with the financial, personal, and other resources available?); (3) system support (which goals have the most influential and widespread support?); (4) breadth of impact (which goals are most likely to have a broad impact on services?); (5) quality of impact (which goals will make the most difference in the lives of consumers?); (6) risks and costs of not changing (which practices, if not changed, will have the most negative impact?).

Step Four: Identify Specific Objectives and Responsible Persons

After goals have been prioritized, specific objectives (measurable outcomes with timelines for achievement) can be stated and persons responsible for implementing and monitoring the corresponding tasks can be named.

Domain 1A. Safety—Ensuring Physical and Emotional Safety

◆ Key Questions: *“To what extent do the program’s activities and settings ensure the physical and emotional safety of consumers and staff? How can services be modified to ensure this safety more effectively and consistently?”*

Sample Specific Questions:

- Where are services delivered?
- When are they delivered?
- Who is present (other consumers, etc.)? Are security personnel present? What impact do these others have?
- Are doors locked or open? Are there easily accessible exits?
- How would you describe the reception and waiting areas, interview rooms, etc.? Are they comfortable and inviting?
- Are restrooms easily accessible?
- Are the first contacts with consumers welcoming, respectful, and engaging?
- Do consumers receive clear explanations and information about each task and procedure? Are the rationales made explicit? Is the program mission explained? Are specific goals and objectives made clear? Does each contact conclude with information about what comes next?
- Are staff attentive to signs of consumer discomfort or unease? Do they understand these signs in a trauma-informed way?
- What events have occurred that indicate a lack of safety—physically or emotionally (e.g., arguments, conflicts, assaults)? What triggered these incidents? What alternatives could be put in place to minimize the likelihood of their recurrence?
- Is there adequate personal space for individual consumers?
- In making contact with consumers, is there sensitivity to potentially unsafe situations (e.g., domestic violence)?

Domain 1B. Trustworthiness—Maximizing Trustworthiness through Task Clarity, Consistency, and Interpersonal Boundaries

◆ Key Questions: *“To what extent do the program’s activities and settings maximize trustworthiness by making the tasks involved in service delivery clear, by ensuring consistency in practice, and by maintaining boundaries that are appropriate to the program? How can services be modified to ensure that tasks and boundaries are established and maintained clearly and appropriately?”*

Sample Specific Questions:

- Does the program provide clear information about what will be done, by whom, when, why, under what circumstances, at what cost, with what goals?

- When, if at all, do boundaries veer from those of the respectful professional? Are there pulls toward more friendly (personal information sharing, touching, exchanging home phone numbers, contacts outside professional appointments, loaning money, etc.) and less professional contacts in this setting?
- How does the program handle dilemmas between role clarity and accomplishing multiple tasks (e.g., especially in residential work and counseling or case management, there are significant possibilities for more personal and less professional relationships)?
- How does the program communicate reasonable expectations regarding the completion of particular tasks or the receipt of services? Is the information realistic about the program's lack of control in certain circumstances (e.g., in housing renovation or time to receive entitlements)? Is unnecessary consumer disappointment avoided?
- What is involved in the informed consent process? Is both the information provided and the consent obtained taken seriously? That is, are the goals, risks, and benefits clearly outlined and does the consumer have a genuine choice to withhold consent or give partial consent?

Domain 1C. Choice—Maximizing Consumer Choice and Control.

◆ *Key Questions: “To what extent do the program’s activities and settings maximize consumer experiences of choice and control? How can services be modified to ensure that consumer experiences of choice and control are maximized?”*

Sample Specific Questions:

- How much choice does each consumer have over what services he or she receives? Over when, where, and by whom the service is provided (e.g., time of day or week, office vs. home vs. other locale, gender of provider)?
- Does the consumer choose how contact is made (e.g., by phone, mail, to home or other address)?
- Does the program build in small choices that make a difference to consumer-survivors (e.g., When would you like me to call? Is this the best number for you? Is there some other way you would like me to reach you or would you prefer to get in touch with me?)
- How much control does the consumer have over starting and stopping services (both overall service involvement and specific service times and dates)?
- Is each consumer informed about the choices and options available?
- To what extent are the individual consumer’s priorities given weight in terms of services received and goals established?
- How many services are contingent on participating in other services? Do consumers get the message that they have to “prove” themselves in order to “earn” other services?
- Do consumers get a clear and appropriate message about their rights and responsibilities? Does the program communicate that its services are a privilege over which the consumer has little control?
- Are there negative consequences for exercising particular choices? Are these necessary or arbitrary consequences?

- Does the consumer have choices about who attends various meetings? Are support persons permitted to join planning and other appropriate meetings?

Domain 1D. Collaboration—Maximizing Collaboration and Sharing Power

◆ **Key Questions:** *“To what extent do the program’s activities and settings maximize collaboration and sharing of power between staff and consumers? How can services be modified to ensure that collaboration and power-sharing are maximized?”*

Sample Specific Questions:

- Do consumers have a significant role in planning and evaluating the agency’s services? How is this “built in” to the agency’s activities? Is there a Consumer Advisory Board? Are there members who identify themselves as trauma survivors? Do these individuals understand part of their role to serve as consumer advocates? As trauma educators?
- Do providers communicate respect for the consumer’s life experiences and history, allowing the consumer to place them in context (recognizing consumer strengths and skills)?
- In service planning, goal setting, and the development of priorities, are consumer preferences given substantial weight?
- Are consumers involved as frequently as feasible in service planning meetings? Are their priorities elicited and then validated in formulating the plan?
- Does the program cultivate a model of doing “with” rather than “to” or “for” consumers?
- Does the program and its providers communicate a conviction that the consumer is the ultimate expert on her or his own experience?
- Do providers identify tasks on which both they and consumers can work simultaneously (e.g., information-gathering)?

Domain 1E. Empowerment—Prioritizing Empowerment and Skill-Building

◆ **Key Questions:** *“To what extent do the program’s activities and settings prioritize consumer empowerment and skill-building? How can services be modified to ensure that experiences of empowerment and the development or enhancement of consumer skills are maximized?”*

Sample Specific Questions:

- Do consumer-survivor advocates have significant advisory voice in the planning and evaluation of services?
- In routine service provision, how are each consumer’s strengths and skills recognized?
- Does the program communicate a sense of realistic optimism about the capacity of consumers to reach their goals?
- Does the program emphasize consumer growth more than maintenance or stability?
- Does the program foster the involvement of consumers in key roles wherever possible (e.g., in planning, implementation, or evaluation of services)?

- For each contact, how can the consumer feel validated and affirmed?
- How can each contact or service be focused on skill-development or enhancement?
- Does each contact aim at two endpoints whenever possible: (1) accomplishing the given task and (2) skill-building on the part of the consumer?

Domain 2. Formal Services Policies

Key Question: “To what extent do the formal policies of the program reflect an understanding of trauma survivors’ needs, strengths, and challenges?”

Some Possible Indicators:

- ◆Policies regarding confidentiality and access to information are clear; provide adequate protection for the privacy of consumers; and are communicated to the consumer.
- ◆The program avoids involuntary or potentially coercive aspects of treatment—involuntary hospitalization or medication, representative payeeship, outpatient commitment—whenever possible.
- ◆The program has developed a de-escalation or “code blue” policy that minimizes the possibility of retraumatization.
- ◆The program has developed ways to respect consumer preferences in responding to crises—via “advance directives” or formal statements of consumer choice.
- ◆The program has a clearly written, easily accessible statement of consumer rights and grievances.

Domain 3. Trauma Screening, Assessment, and Service Planning

Key Question: “To what extent does the program have a consistent way to identify individuals who have been exposed to trauma and to include trauma-related information in planning services with the consumer?”

Some Possible Indicators:

- ◆Staff members have reviewed existing instruments to see the range of possible screening tools.
- ◆At least these minimal questions are included in trauma screening:
 - Have you experienced sexual abuse at any time in your life?
 - Have you experienced physical abuse at any time in your life?
- ◆Screening avoids overcomplication and unnecessary detail so as to minimize stress for consumers.

- ◆ The program recognizes that the process of trauma screening is usually much more important than the content of the questions. The following have been considered:
 - What will it mean to ask these questions?
 - How can they be addressed most appropriately—for the likely consumers, for the service context, time available, prior relationship, possible future relationship, at various points in the intake/assessment process?
- ◆ The need for standardization of screening across sites is balanced with the unique needs of each program or setting.
- ◆ The screening process avoids unnecessary repetition. While there is no need to ask the same questions at multiple points in the intake or assessment process, there is often a good rationale for returning to the questions after some appropriate time interval.

Part B: Systems-level/Administrative Changes

Domain 4. Administrative Support for Program-Wide Trauma-Informed Services

Key Question: “To what extent do program or agency administrators support the integration of knowledge about violence and abuse into all program practices?”

Some Possible Indicators:

- ◆ The existence of a policy statement or the adoption of general policy statement from other organizations that refers to the importance of trauma and the need to account for consumer experiences of trauma in service delivery.
- ◆ The existence of a “trauma initiative” (e.g., workgroup, trauma specialist).
 - Designation of a competent person with administrative skills and organizational credibility for this task.
 - Chief administrator meets periodically with trauma workgroup or specialist.
 - Administrator supports the recommendations of the trauma workgroup or specialist and follows through on these plans.
- ◆ Administrators work closely with a Consumer Advisory group that includes significant trauma survivor membership. Consumer-survivor members of this group identify themselves as trauma survivors and understand a part of their role as consumer advocacy. They play an active role in all aspects of service planning, implementation, and evaluation.
- ◆ Administrators are willing to attend trauma training themselves (vs. sending designees in their places); they allocate some of their own time to trauma-focused work (e.g., meeting with trauma initiative representatives, keeping abreast of trauma initiatives in similar program areas).

- ◆ Administrators make basic resources available in support of trauma-informed service modifications (e.g., time, space, training money).
- ◆ Administrators support the availability and accessibility of trauma-specific services where appropriate; they are willing to be creative about finding alternative reimbursement strategies for trauma services.
- ◆ Administrators find necessary sources of funding for trauma training and education (this sometimes requires going outside the usual funding mechanisms in a creative way).
- ◆ Administrators are willing to release line staff from their usual duties so that they may attend trainings and deliver trauma services. Funding is sought in support of these activities.
- ◆ Administrators participate actively in identifying objectives for systems change.
- ◆ Administrators monitor the program's progress by identifying and tracking core objectives of the trauma-informed change process.
- ◆ Administrators may arrange pilot projects for trauma-informed parts of the system.

Domain 5. Staff Trauma Training and Education

Key Question: "To what extent have all staff members received appropriate training in trauma and its implications for their work?"

Some Possible Indicators:

- ◆ General education (including basic information about trauma and its impact) has been offered for all employees in the program with a primary goal of sensitization to trauma-related dynamics and the avoidance of retraumatization.
- ◆ Staff members have received education in a trauma-informed understanding of unusual or difficult behaviors. (One of the emphases in such training is on respect for people's coping attempts and avoiding a rush to negative judgments.)
- ◆ Staff members have received basic education in the maintenance of personal and professional boundaries (e.g., confidentiality, dual relationships, sexual harassment).
- ◆ Clinical staff members have received trauma education involving specific modifications for trauma survivors in their content area: clinical, residential, case management, substance use, for example.
- ◆ Clinical staff members have received training in trauma-specific techniques for trauma clinicians.

◆ Staff members offering trauma-specific services are provided adequate support via supervision and/or consultation (including the topics of vicarious traumatization and clinician self-care).

Domain 6. Human Resources Practices: “To what extent are trauma-related concerns part of the hiring and performance review process?”

Key Question: “To what extent are trauma-related concerns part of the hiring and performance review process?”

Some Possible Indicators:

◆ The program seeks to hire (or identify among current staff) trauma “champions,” individuals who are knowledgeable about trauma and its effects; who prioritize trauma sensitivity in service provision; who communicate the importance of trauma to others in their work groups; and who support trauma-informed changes in service delivery.

◆ Prospective staff interviews include trauma content (What do applicants know about trauma? about domestic violence? about the impact of childhood sexual abuse? Do they understand the long-term consequences of abuse? What are applicants’ initial responses to questions about abuse and violence?)

◆ Incentives, bonuses, and promotions for line staff and supervisors take into account the staff member’s role in trauma-related activities (specialized training, program development, etc.).

Addendum A: Possible Items for Consumer Satisfaction Surveys

(Items are worded to be consistent with a Likert response scale from “strongly disagree” to “strongly agree;” specific items and wording should be tailored to the program’s goals and services)

Safety

- When I come to [program], I feel physically safe.
- When I come to [program], I feel emotionally safe.

Trustworthiness

- I trust the people who work here at [program].
- [Program] provides me good information about what to expect from its staff and services.
- I trust that people here at [program] will do what they say they are going to do, when they say they are going to do it.
- The people who work here at [program] act in a respectful and professional way toward me.

Choice

- [Program] offers me a lot of choices about the services I receive.

- I have a great deal of control over the kinds of services I receive, including when, where, and by whom the services are offered.
- People here at [program] really listen to what I have to say about things.

Collaboration

- At [program], the staff is willing to work with me (rather than doing things for me or to me).
- When decisions about my services or recovery plan are made, I feel like I am a partner with the staff, that they really listen to what I want to accomplish.
- Consumers play a big role in deciding how things are done here at [program].

Empowerment

- [Program] recognizes that I have strengths and skills as well as challenges and difficulties.
- The staff here at [program] are very good at letting me know that they value me as a person.
- The staff here at [program] help me learn new skills that are helpful in reaching my goals.
- I feel stronger as a person because I have been coming to [program].

Trauma Screening Process

- The staff explained to me why they asked about difficult experiences in my life (like violence or abuse).
- The staff are as sensitive as possible when they ask me about difficult or frightening experiences I may have had.
- I feel safe talking with staff here about my experiences with violence or abuse.

Prepared by: Roger D. Fallot, Ph.D. and Maxine Harris, Ph.D.
 Community Connections
 October, 2002; May, 2003; March, 2004; February, 2005; March, 2006

For further information, please contact:

Roger D. Fallot, Ph.D.
 Director of Research and Evaluation
 202.608.4796 (voice)
 202.608.4286 (fax)
rfallot@ccdc1.org

Rebecca Wolfson Berley, MSW
 Coordinator of Trauma Education
 202.608.4735 (voice)
 202.608.4286 (fax)
rwolfson@ccdc1.org

Community Connections
 801 Pennsylvania Avenue, S.E.
 Suite 201
 Washington, DC 20003

TREATMENT GUIDELINES
GENDER RESPONSIVE TREATMENT OF WOMEN
WITH SUBSTANCE USE DISORDERS

CORE WOMEN'S PROGRAM GUIDELINES

March 2007 Revision
Connecticut Department of Mental Health and Addiction Services
Women's Services Practice Improvement Collaborative
Guidelines compiled by *David J. Berkowitz, Ph.D.*

Core Women's Program Guidelines

The following guidelines are considered core women's program guidelines. They are extracted from the larger group of Treatment Guidelines for Gender Responsive Treatment of Women with Substance Use Disorders. While all the treatment guidelines are important for an effective program, these core women's program guideline areas are features of the program that are fundamental for women's programs in particular. All the guidelines are important for a high quality program, however the core guidelines are meant to be those that are particularly critical and specific to the unique needs of women in these programs.

1. Assessment and Engagement

- a. Capacity to include/welcome children throughout assessment process.
- b. In addition to assessment of mental health and substance abuse, assessment must include: relational context, parenting, trauma, grief/loss, domestic violence, safety, sexuality, life skills, vocational, spiritual, cultural, legal issues, gambling, housing, healthcare insurance needs.
- c. Assessment must be conducted in a manner that is sensitive to a history of possible sexual abuse and domestic violence and use an appropriate tool to explore these issues, with evidence of sensitivity to re-traumatization.
- d. Physical health screening that is gender specific is part of assessment with criteria for securing a full medical assessment if not completed within one year.

2. Recovery Planning

- a. Recovery plans should include:
 - i. Trauma, grief/loss, and/or PTSD
 - ii. Domestic violence
 - iii. Safety
 - iv. Parenting and reunification plan if appropriate
 - v. Relationships/sexuality

3. Clinical Treatment Program Design

- a. A therapeutic environment model must be evident that is safe, inviting, non-institutional, homelike, welcoming, with appropriate cultural features.
- b. Approaches must be respectful, supportive and empowering, not authoritarian, attacking or demeaning.
- c. Treatment should include psycho-educational input on the impact of gender on development and functioning in society including the strengths associated with gender.
- d. Treatment in all-women groups and/or with women therapists and counselors must be available at different stages/levels of treatment. This requirement is particularly relevant to co-ed programs.
- e. Opportunities are available for significant others or client identified supports to participate in and assist with the client's recovery.
- f. Program works to maintain, preserve or rebuild the client's attachment to her child(ren) being sensitive to the client's choice.
 - i. Individualized services should address:
 - 1. Practical needs, including housing, financial, transportation, child care, vocational training, education, job placement
 - 2. Parenting education and child development
- g. There should be evidence of efforts to arrange services for other family members if needed.
- h. Program collaborates appropriately with DCF's or other outside agency's assessment of client's parenting ability (with client permission).

4. Recovery Supports

- a. Use of peer supports within the program should be established clearly (e.g. women in more advanced levels of treatment mentoring those beginning).
- b. Client should be assisted to connect to local family support and/or advocacy groups prior to discharge.

5. General program environmental features

- a. Program environment/setting must be safe and secure.
- b. Physical setting of the program must be warm, inviting and comfortable.
- c. There should be a majority of women staff members.
- d. There must be comfortable play space for children in the program and areas for mothers and children to interact naturally, as well as age-appropriate activities designed for children.
- e. Mothers can bring children to the program and a supervised safe setting is provided for the child with age appropriate activities.(Program reserves the right to screen for safety in these situations).

- f. When children are present in the program, program staff will observe parent child interaction and assist in building parenting skills.
- g. Protocols are in place for care of children who are at the program, including emergency procedures, health management and interruptions in parent's ability to provide adequate care.

6. Staff competencies and training

- a. The program must include staff with demonstrated competencies in women's issues, cultural issues, substance abuse, mental health, co-occurring, trauma and child/family.
- b. There must be written policy in place regarding physical contact and boundaries between staff and clients, and between clients, to prevent re-traumatization.
- c. A comprehensive staff training program must be in place with the following elements:
 - i. Current theory of women's development from childhood through adulthood
 - ii. Unique characteristics of women with mental health and substance abuse issues
 - iii. Key values and principles in working with women
 - iv. Impact of cultural issues on gender specific programming
 - v. The role of trauma and issues of re-traumatizing
 - vi. Sexuality
 - vii. Sexual abuse
 - viii. Family violence
 - ix. Gambling
 - x. Parenting

7. Program Evaluation

- a. Process evaluation should be in place to insure appropriate utilization of gender responsive treatment services and elements as identified in these guidelines.
- b. Outcome measurements specific to women's programs include:
 - a. Improved family relationships
 - b. Parenting and reunification with child
- c. In addition to the above two measures, the WSPIC Women's Outcome Workgroup identified the following additional measures for women leaving a residential program.
 - i. Alcohol/drug recovery/sobriety
 - ii. Educational attainment
 - iii. Employment
 - iv. Housing
 - v. Criminal justice recidivism

These Guidelines were developed by the Women's Services Practice Improvement Collaborative, sponsored by the Connecticut Department of Mental Health and Addiction Services, with participation of the provider community, Advanced Behavioral Health, The Women's Consortium, Connecticut Community for Addiction Recovery. Please do not disseminate or modify these guidelines without the consent of Terry Nowakowski, Assistant Director of Statewide Services, CT DMHAS, e-mail: Terry.Nowakowski@po.state.ct.us. May 2006.

Primary Sources: DMHAS, "Women's Services: Developing Preferred Practices in Programming and Services, Literature Review of Best Practices"; CSAT, "Comprehensive Treatment Model for Alcohol and Other Drug-Abusing Women and Their Children" and "Practical Approaches in the Treatment of Women Who Abuse Alcohol and Other Drugs; Covington, "Helping Women Recover: Creating Gender-Responsive Treatment"; Covington and Bloom, "Gender-Responsive Treatment and Services in Correctional Settings"; Boyle, White, Corrigan & Loveland, "Behavioral Health Recovery Management: A Statement of Principles"; DMHAS, Draft Standards of Practice for Recovery-Oriented Behavioral Health Care.

Treatment Guidelines Committee: Robyn Anderson Turner, Director of Women's Services, ADRC; Colette Anderson, Northwest Mental Health Authority; David Berkowitz, Executive Director, Wheeler Clinic; Maureen Biggs, Midwestern Council on Alcoholism; Holly Bristol, Program Director of Outpatient Services, The Connection, Inc.; Donna Brooks, Unit Director, STARR Program, CVH; Delores Brown, Program Director, Project Courage; Miguel Caldera, M.D., Executive Director, Crossroads; Cinda Cash, Director of Community & Provider Relations, Connecticut Women's Consortium; Alyse Chin, Healthcare Operations, DMHAS; Sean Cronin, Manager, Health Care Systems, DMHAS; Lisa DeMatteis-Lepore, The Connection, Inc.; Barbara Geller, Director of Statewide Services, DMHAS; Joan Huskins, Program Manager, Morris Foundation; Valeria Leal, Women's Program Administrator; DMHAS; Terry Nowakowski, Assistant, Director, Statewide Services, DMHAS; Karen Ohrenberger, Director Project SAFE, DMHAS; Diane Potvin, Windham Recovery Community Center Director, CCAR; Victoria Sherman, Advanced Behavioral Health; Maggie Young, Director: Women's Residential Services, Liberation/Families in Recovery

Sample Top 2 Recovery Indicators for each DMHAS Initiative

DMHAS Initiative	Recovery Indicators	Level	Recovery Domain
Gender Initiative	▪ % of agency service plans which include an assessment dedicated to the exploration of strengths	Agency	Person-Centered
	▪ % of people who agree with item: “The goals written in my plan reflect the life domains that are most important to my recovery”	Individual	Person-Centered
Trauma Initiative	▪ % of agency/program activities that encourage and incorporate the involvement of people in recovery and their families	Agency	Consumer and Family Driven
	▪ % of people that report being involved in their own recovery/care planning to a satisfactory degree	Individual	Person-Centered
Co-Occurring Initiative	▪ % of agencies that adopt/follow “zero-reject” policies which do not require individuals to attain or maintain clinical benchmarks before they are supported in pursuing recovery goals such as employment.	Agency	Person-Centered
	▪ % of people that agree with the following: “I am able to work with a peer mentor, if I want to”.	Individual	Consumer and Family-Driven
Recovery and System Transformation Initiative	▪ % of membership on board of directors, advisory boards, or steering committees made up of persons in recovery	Agency	Consumer and Family-Driven
	▪ % of people that agree with the following: “I was an active and vocal participant in my recovery/service planning meeting”	Individual	Person-Centered
Cultural Competence/ Health Care Disparities Initiative	▪ % of agencies that report staff participation in yearly cultural competence training	Agency	Timely and Responsive
	▪ % of people that agree with the following: “If I want, my clinician or case manager will help me get folk/healing remedies or services that are used in my culture to deal with mental illness”.	Individual	Timely and Responsive
Preferred Practices	▪ % of agencies that report implementing evidence based practices.	Agency	Timely and Responsive
	▪ % of people who report that they were given a copy of their recovery plan	Individual	Person-Centered
Health Promotion and Wellness	▪ % of agencies that are able to link individuals with services within three days of having sought care	Agency	Timely and Responsive
	▪ % of recovery/service plans which include an assessment dedicated to the exploration of strengths	Agency	Person-Centered

NOTES