Consumer-Centered Practice: An Implementation Case Study

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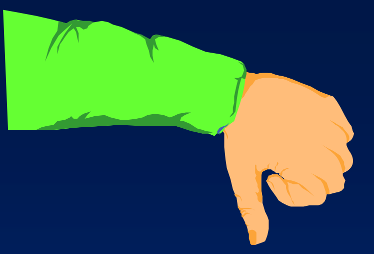
Who are we? - We're

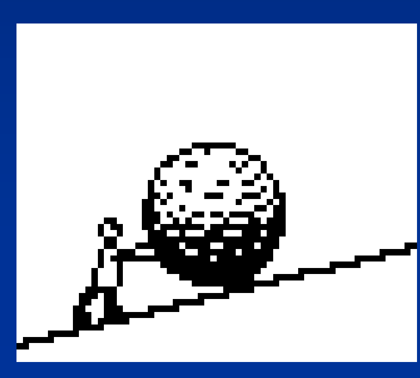
- CT Substance abuse and mental health authority
- 70,000 people in care annually
- 3,600 employees, two hospitals, 15 LMHAs
- $560 million/year operating expenses
- Contracts with 250 non-profit agencies
- Prevention (all ages)
- Treatment (age 18+)
- **RECOVERY IS OUR BUSINESS**

“addicts”



“a chronic, relapsing disease”

“severe persistent mental illness”



What message are we conveying?

Doesn’t anybody ever get better?

Typical service response

Symptoms

Remission

Acute symptoms

Discontinuous treatment

Crisis management

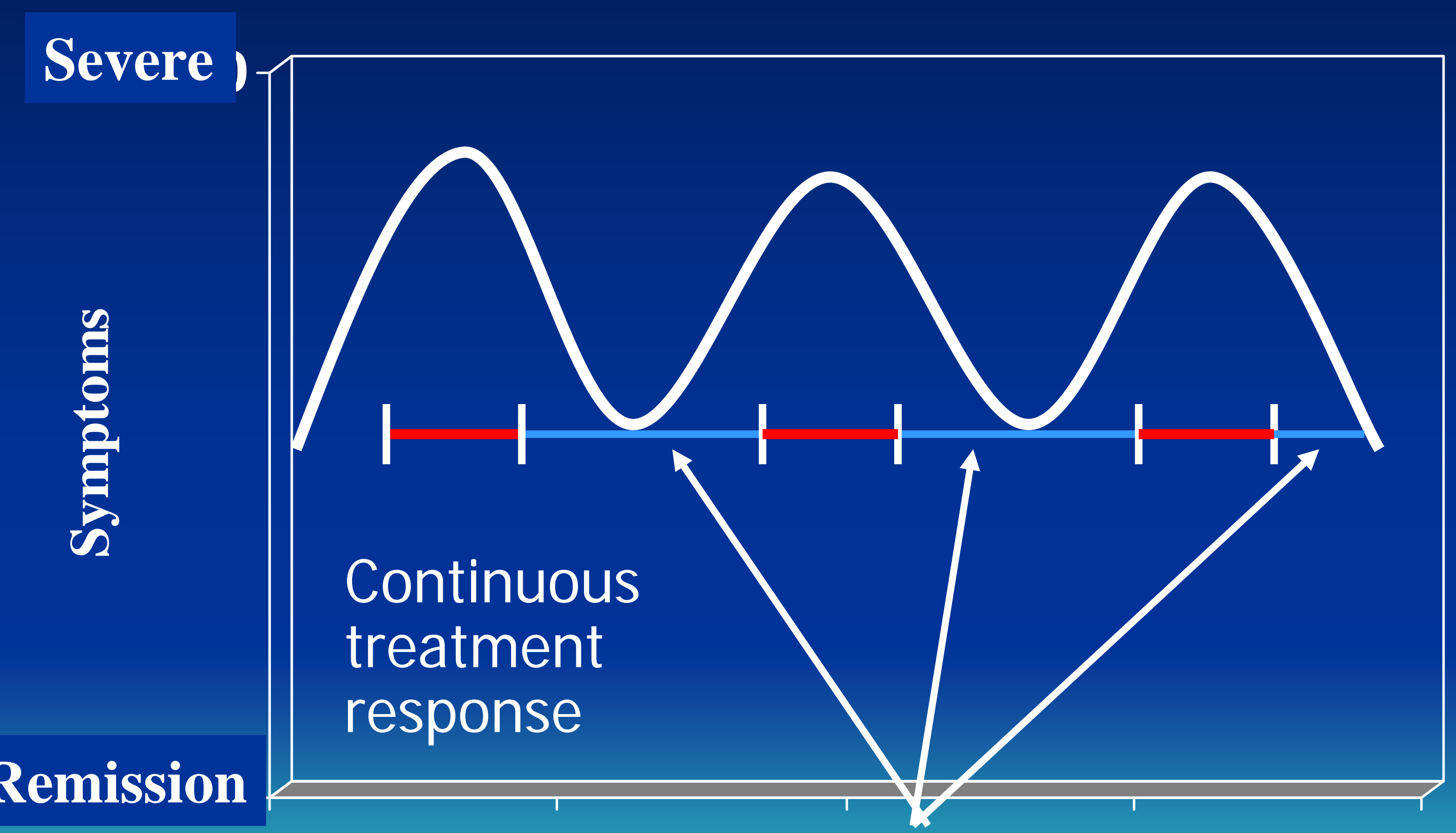
Recovery “From” vs. Recovery “In”

- Recovery “from” mental illness involves the amelioration of symptoms and other deficits associated with the disorder to a sufficient degree that they no longer interfere with daily functioning, allowing the person to resume personal, social, and vocational activities within what is considered a normal range.

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

- A “Recovery-oriented system” values the importance of BOTH recovery FROM and recovery IN mental illness… our mission to assist people in *regaining a meaningful, constructive, sense of membership in the broader community.”*

Recovery-oriented response



Promote Self Care, Rehabilitation

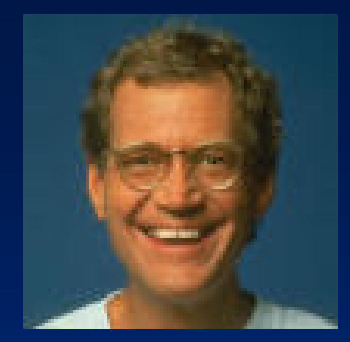
Single Overarching Goal: A Value-Driven, Recovery-Oriented Healthcare System

How do you get there???

What might get in your way…

- Anticipate concerns and address the tough questions, early on and throughout…
- Often these relate to "systemic" level issues that providers feel are, to some extent, beyond their control
- Align with provider community. Do not overlook organizational context and barriers while trying to "fix" individual providers…
    - *"When you pit a bad system against a good performer, the system always wins…(Rummler, 2004).*
- Pay attention to the "Top Ten Concerns About Recovery"

The Top 10 Concerns About Recovery



<u>Concern # 5</u>: *Who's going to pay for it? Medicaid can only pay for active treatment.*

<u>Recovery perspective</u>: Medicaid has been used in many creative ways.

<u>Strategy</u>: Use federal dollars to fund whatever they can, and use general fund dollars to fund other services that are not reimbursable under Medicaid.

The Top 10 Concerns About Recovery

Concern #3: *Recovery conflicts with other DMHAS initiatives. There are too many conflicting and fragmented efforts.*

Recovery perspective: Each initiative is compatible with a recovery perspective

Strategy: For example, person-centered planning should be part of Integrated Dual Diagnosis Treatment. In order to be recovery-oriented, services must be culturally competent.

The Top 10 Concerns About Recovery

<u>Concern #2</u>: *Recovery devalues the role of professionals. Recovery can appear anti-treatment or anti-provider in tone.*

<u>Recovery perspective</u>: Recovery moves behavioral health much closer to other medical specialties where the Doctor presents "treatment choices."

<u>Strategy</u>: Recovery-oriented care requires a higher level of professional knowledge and expertise.

Multi-level Change Efforts

System

(Policy)

Recovery-Oriented
Value- Driven

Program

(Provider)

Best Practices
and Innovative
Programs

Organizational
and Programmatic
Design

Practitioner

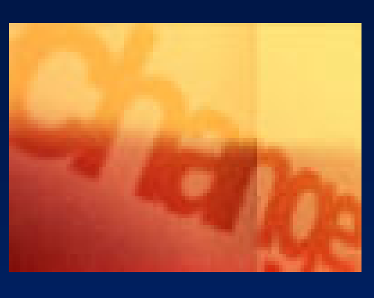
(Clinical)

Convey Hope and
Respect

Culturally
competent

Fidelity
to model

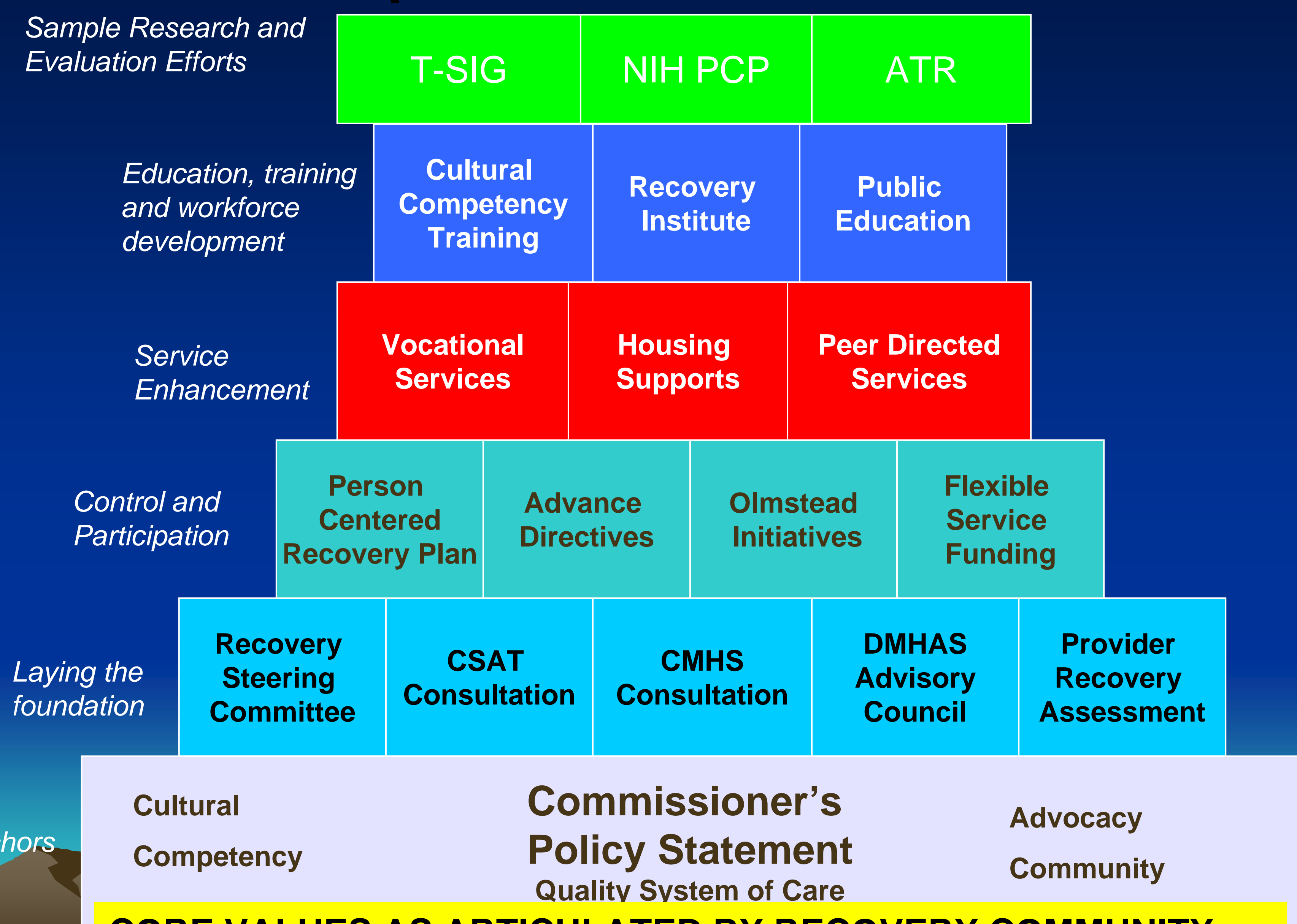
Workforce
Development



Strategies for Change

- Ground all efforts in a commitment to listen and respond to the voice of recovery community
  - in policy development, e.g., CORE RECOVERY VALUES as the foundation which has informed all subsequent building blocks, including the Commissioner’s policy
  - in service design and delivery, e.g., peer specialist model
  - in research and evaluation, e.g., DMHAS/Yale NIMH grant
  - in training and educational efforts, e.g., CT Recovery Institute (teachers & learners)
- Use technology transfer strategies to identify develop, implement, and sustain “best practices”
- Incorporate existing initiatives
- Re-orient all systems to support recovery
- Transition to recovery-oriented performance outcomes in non-punitive approach

CT Implementation Process

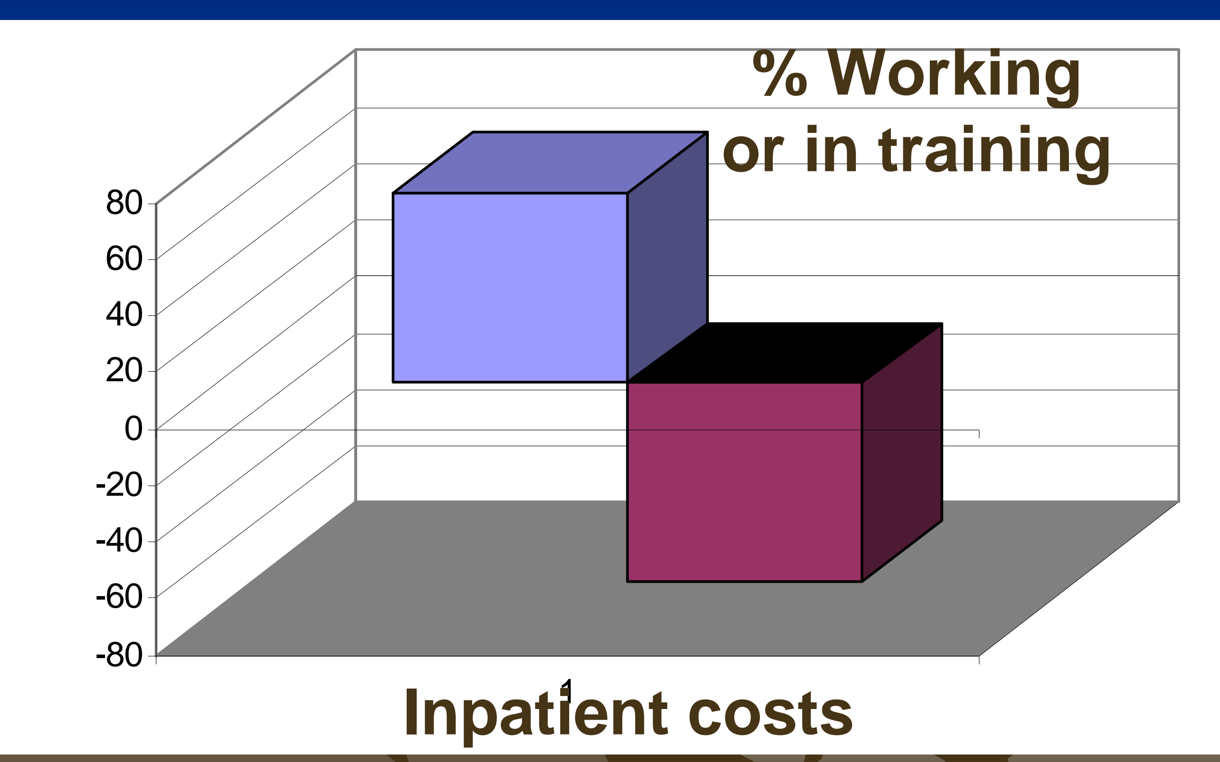


Systems Change & What Works: Lessons Learned

1. *Emphasizing community life and natural supports*
2. *Recognizing that people in recovery have valuable and useful contributions to make*
3. *Using multiple forms of "evidence" to guide policy*
4. *Using a combination of approaches to address cultural needs and elimination of health disparities*
5. *Establishing clear service expectations for providers and monitoring outcomes*
6. *Using "Practice Management Tools" adapted from the private sector to improve outcomes for people using public sector services*

Lesson 1:
Focus on community life and natural supports – Example 1: Supported Housing and Employment

More people working, less inpatient costs

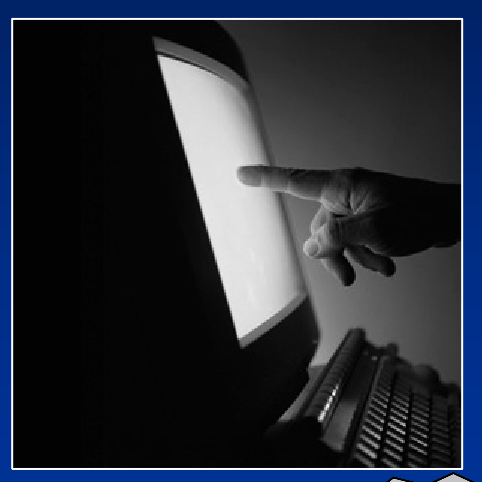


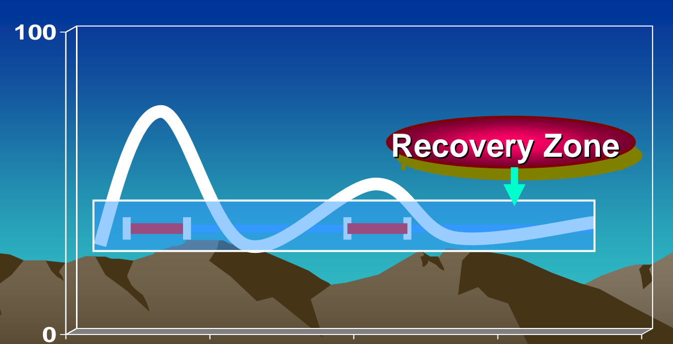
DMHAS established new supportive housing units for over 550 people with psychiatric or substance use disorders. Over 60% of these people are now working or in training, and their inpatient costs have decreased 70%.

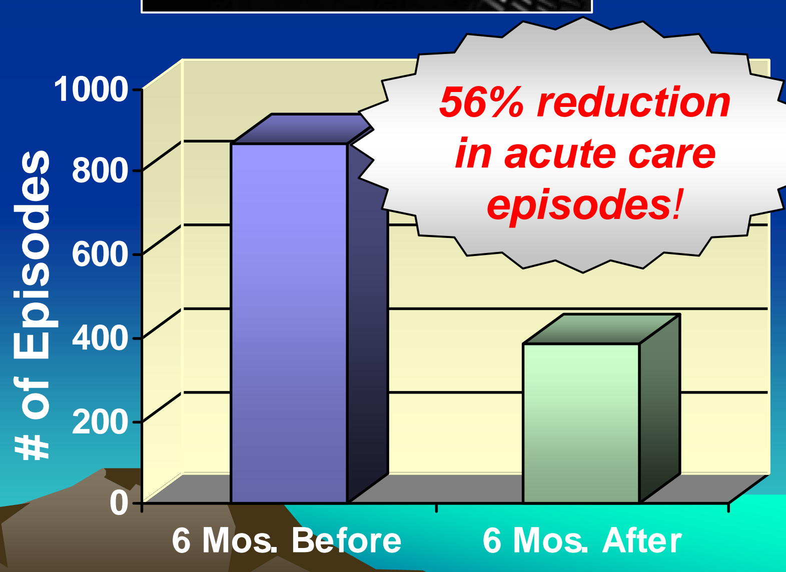
Based on a Corporation for Supportive Housing study, these supportive housing units are projected to generate over $140 million in direct and indirect economic benefits for the state.

Lesson 1: Focus on community life and natural supports – Example 2: Specialized Intensive Supports

- ASO identifies people with 3 or more acute hospital admissions within 90 days
- Recovery manager initiates contact while person is still in hospital
- Recovery plan developed to fill support gaps
- Recovery manager helps with transition to community care



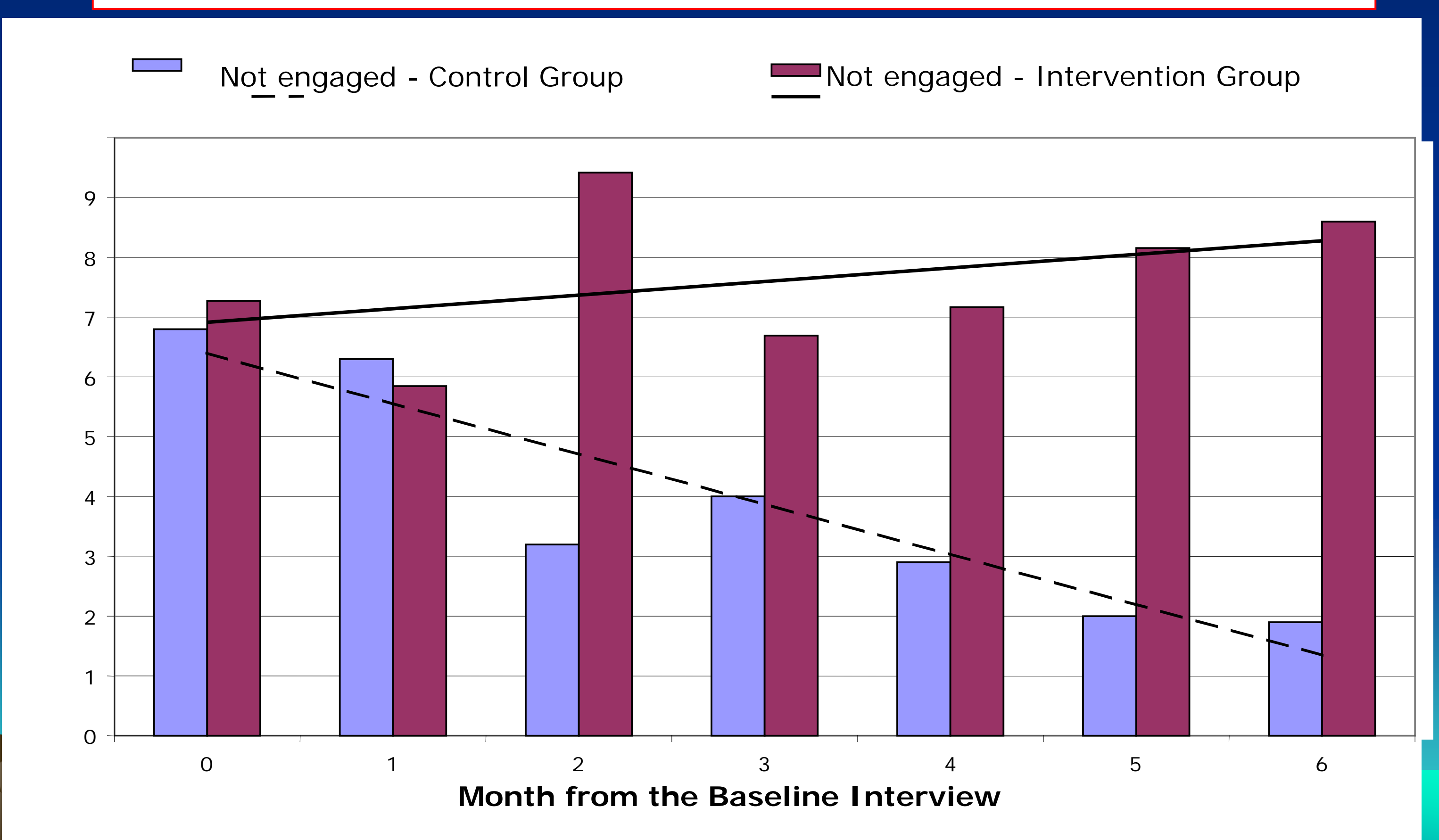




Lesson 2:
People in recovery make valuable contributions

Peer Engagement Specialist Initiative

Agency Contacts for the Least Engaged Clients



Source: 2002 Annual report to CT Legislature

Lesson 5: Necessity of Clear Expectations and Guidelines

- Provider Recovery Self-Assessment
- Consumer survey and language required by contracts
- Recovery-oriented performance measures
- Recovery-Oriented Practice Guidelines
  - Primacy of participation
  - Promoting Access and engagement
  - Ensuring Continuity of care
  - Employing Strength-based assessments
  - Community mapping and development
  - Identifying and addressing barriers to recovery
  - Functioning as a recovery guide
  - **Offering Individualized recovery planning**

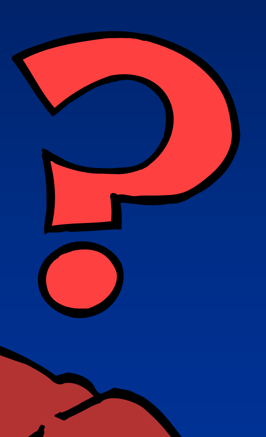
Person-Centered Planning: A Window of Opportunity for Change

- *…The plan of care will be at the core of the consumer-centered, recovery-oriented mental health system. The plan will include treatment, supports, and other assistance to enable consumers to better integrate into their communities and to allow consumers to realize improved mental health and quality of life.*
  - *New Freedom Commission Report on Mental Health, 2003*
- Overarching Principles:
  - Self-directed to maximum extent
  - Natural supporter involvement
  - Strengths-based
  - Community inclusion and integrated settings
  - Setbacks natural in path to self-determination

- **SAMHSA National Consensus Initiative on PCP**
  - www.psych.uic.edu/uicnrtc/cmhs/pfcphome.htm

Why do we need "Practice Guidelines"… for PCP?

Don't we already do this??



- *"If everybody's doing it, how come nothing is getting done??"*

  Joe Marrone, ICI

- *"You keep talking about getting me in the 'driver's seat' of my treatment and my life… when half the time I am not even in the damn car!"*

  Person in Recovery

- **So, no, we don't "already do this."**
  - **Not according to consumer/survivors…**
  - **and not if you take a close look at concrete implementation strategies.**
  - **"old wine…new bottles"**

The Utility of Practice Guidelines

- **Promote increasing accountability among providers and system as a whole (*You'll know you're doing it when…*)**
- **Provide a road-map for trainees/providers who WANT to make changes, but they feel un/under-prepared – C-H-O-W**
- **Assist in prioritizing state training & consultation objectives**
- **Educate consumers and families re: what they can/should expect from supporters and the system at large**

Guidelines can be a useful blueprint for desired change!

The mechanisms of OUR learning…

- Highly active and vocal consumer/survivor recovery community
- Experiences of diverse and skilled provider community
- DMHAS/Yale Recovery Training Institute, including COEs
- Extensive reviews of qualitative and quantitative research
- Links to federal SAMHSA PCP Initiative and review of "best-practice" programs
- Collaborative R&E Thru Public/Academic Partnership

EMPOWERMENT & CITIZENSHIP

MANAGING SYMPTOMS

ASSUMING CONTROL

OVERCOMING STIGMA

REDEFINING SELF

INCORPORATING ILLNESS

FINDING A NICHE IN THE COMMUNITY

RENEWING HOPE & COMMITMENT

BEING SUPPORTED BY OTHERS

See: http://www.dmhas.state.ct.us/recovery.htm.

Collaborative Research & Evaluation

- NIH-funded R01, *Culturally Responsive Person-Centered Care for Psychosis* (PI: Larry Davidson, Ph.D. and Thomas Kirk, Jr., Ph.D.)
- Awarded to Connecticut DMHAS; carried out in collaboration with the Yale Program for Recovery and Community Health
- Overarching aim is to examine a model of person-centered care which incorporates much of what has been learned in recent years regarding the effectiveness of **self-directed wellness strategies, community integration programs, peer-support services, and collaborative treatment planning.**

Design, Interventions, & Outcomes

- N = 360 African American or Latino/a participants
- New Haven (CMHC) and Bridgeport (SWCMHS)
- Randomized to 1 of 3 conditions
  - IMR
  - IMR + PCP
  - IMR + PCP + CI
- Qualitative and quantitative methodology (BL/6/18)
- Illness self-management, satisfaction with services, QOL, clinical and functional status, community inclusion, empowerment, relational networks

The Power of “Peer Services”

- The Federal Action Agenda makes explicit the SAMHSA/CMHS commitment to explore consumer-driven and consumer operated approaches to achieving recovery and community integration
- *“The peer-to-peer model is an exceptional example of the innovative ways in which we can help the system overcome its own barriers. Peer-support programs are not just empowerment programs. They are an expression…and an example…of the way the system is going to have to fundamentally change to foster healing relationships, and create an environment conducive for recovery.”* Kathryn Power
- Survey of Organized Consumer Self-Help, Webcast series on self-directed recovery, first ever national Consumer Direction Initiative Summit, emerging research priority, Federal resource kit on peer-supported recovery.

The "Nuts and Bolts" of PCP

The *practice* of PCP can only grow out of a *culture* that fully appreciates recovery, self-determination, and community inclusion.

Can change what people "do"… but also need to change way people feel and think (hearts and minds).

Plan: (a written document)

Process: (a way of doing)

Product: (multi-dimensional outcomes)

Philosophy: (a way of thinking & feeling)

The Details: Key Practices in Implementation

- **Make continuous use of strengths-based assessment strategies**
  - A discussion of strengths is a central focus of every assessment; Strengths are conceptualized broadly; Responses are recorded verbatim; All assessments are shared with the individual; Diagnostic "catch-all" labels are never used as a means of describing an individual (Language as a foundation for change)

- **Adhere to person-centered principles in the process**
  - Providers actively partner with the individual in all planning meetings; Individual has control of meeting logistics including invitees (and "non-invitees"); Goals are based on the individual's unique interests and strengths; Interventions are clearly related to the attainment of these stated goals; in the case of youth, special attention to family perspective with child assuming control as he/she matures; Plans are written together and person ALWAYS has a copy, TRANSPARENCY and leveling the playing field

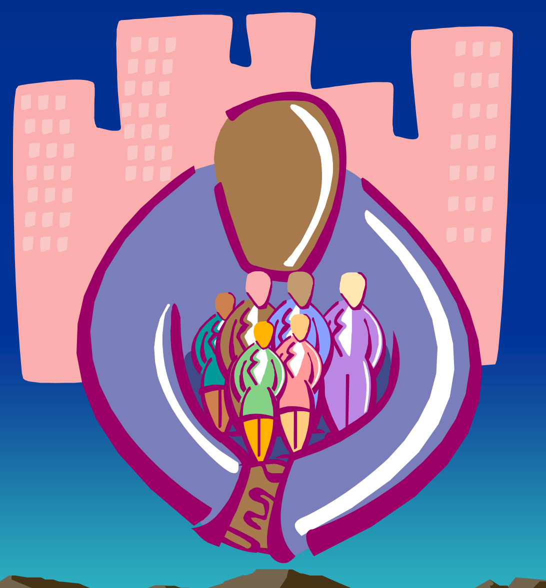
The Details: Key Practices in Implementation

- **Recognize the range of contributors to the planning process**
  - Providers acknowledge the value of the individual's existing relationships; Plan identifies a wide range of both professional supports and alternative strategies; Individuals are not required to attain, and maintain, clinical stability or abstinence before they are supported in pursuing recovery goals

- **Value community inclusion**
  - The focus of planning and care is on how to create pathways to meaningful and successful community life as the person defines it; Plans respect the fact that services and professionals should not remain central to a persons' life over time; A-B-C-D as a tool for facilitating inclusion; Interventions do not duplicate supports found naturally in the community; Ultimate goal is transformation of lives – systems transformation is only a means to that end, and it is NOT enough.

Community Life: What does it have to do with *Recovery??*

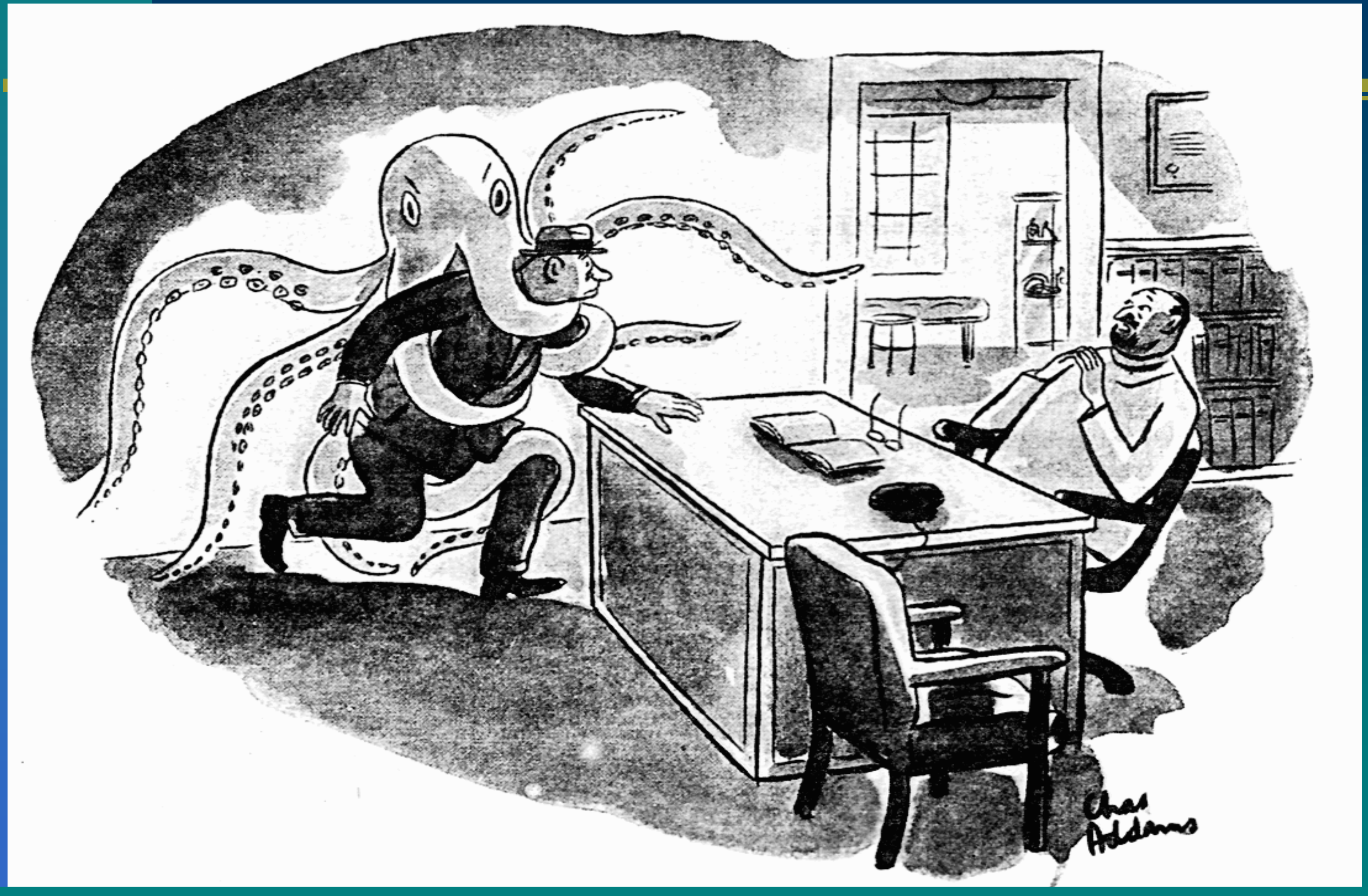
EVERYTHING! If we listen to the voice of people in recovery…



- *Part of healing and recovery is the ability to participate as full citizens in the life of the community.* (Walsh, 1996)

- *There is this little pub down the street that I just love. I like to go there and have a tonic and lime and just chat with the patrons. I am not sure what it is about that place?? But it makes me feel good. Maybe…maybe it's a lot like 'Cheers' – you know, a place where everybody knows my name… I am just Gerry, period. Not "Gerry the mental patient…"*
  - (Man in recovery on finding his niche…)

Missing the Obvious



"Now just sit down and tell me what seems to be the trouble…"

CAUTION

A word of caution…

- Building a life in the community is NOT a task that comes AFTER discharge. Rather, it must be an integral part of recovery-oriented, person directed care throughout the entire support process!! (“While” not “Then”)

  - So, how can you do this as a direct support provider? A few tools include:
    - Building Circles of Support
    - Supported Community Living
    - Asset Based Community Development

But how do we deal with stigma?

- Just as meaningful community life is not what comes AFTER recovery, it is also not something that service systems can, or should, artificially create FOR people.
  - Sheltered workshops rather than real jobs for real pay
  - Movie nights at the mental health center rather than passes to the local theatre
  - Construction of health and fitness facilities on the grounds of mental health agencies rather than negotiation of reduced rates to the local gym
  - The “social skills group” not speed dating, e.g., clozaril clinic and social horizons
  - Referral to the “current events group” and not Barnes & Noble

Despite good intentions, providing a “one stop shop” inadvertently contributes to the development of chronic “patient-hood” as well as the perpetuation of discriminatory and unethical practices on the part of community members.

- Instead:
  - Community education
  - Provider education re: recognizing instances of discrimination, understanding relevant disability laws, and utilizing state/local resources (e.g., P&A, EEOC, AU).
  - This same type of knowledge must be built among people in recovery so that they can protect themselves by recognizing and rectifying experiences of discrimination.
  - Collaborate with and leverage local resources, e.g., GED/adult ed.

Stigma and discrimination are NOT a reason to deny people access to, or to “protect” people from, the potential joys of community life!

The Details:
Key Practices in Implementation

- **Demonstrate a commitment to both outcomes and process**
  - Expectations for successful outcomes in a broad range of quality of life dimensions (e.g., in areas such as employment, social connections, community membership, etc.) are high AND personally-defined; Process tools (quality indicators, checklists) are flexibly applied to promote quality care.

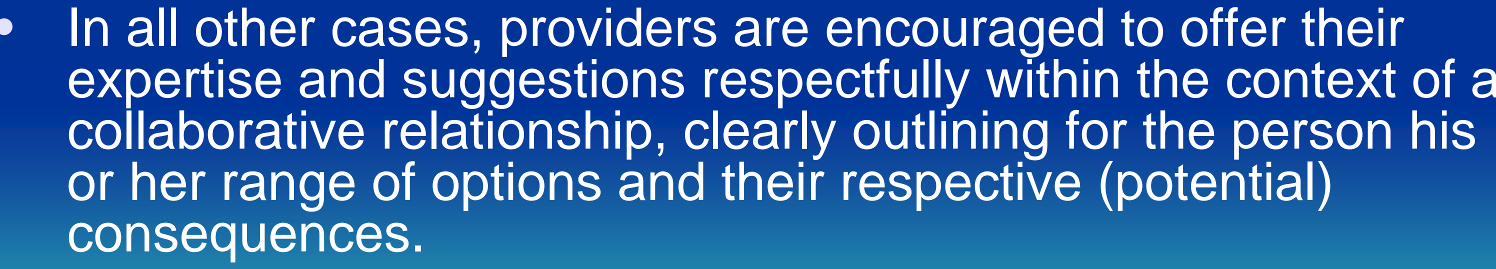
- **Understand and support human rights such as self-determination**
  - Prior to imposing power or restrictions, providers try multiple ways of engaging the individual; they support the dignity of risk and sit with their own discomfort as the person tries new experiences that are necessary for growth and recovery, working with the person to outline the range of options and their potential consequences (and fruits!); People are encouraged to write their own crisis and contingency plans

Practice Implications: Dealing with "*RISK*"

- People are presumed competent and entitled to make their own decisions. They are encouraged and supported to take risks and try new things. (RISK)

- Person-centered care does not take away the provider's right, and responsibility, to take action to protect the person or the public in the event of emergency or crisis situations, but limits the authority of providers to narrowly defined circumstances as defined by statutory laws. (SAFETY)

RISK
v.
SAFETY



- In all other cases, providers are encouraged to offer their expertise and suggestions respectfully within the context of a collaborative relationship, clearly outlining for the person his or her range of options and their respective (potential) consequences.
  - Sit with and support the "dignity of risk" (Deegan, 1996)
  - Encourage psychiatric advance directives

Manuscript available for download at:
www.**dmhas**.state.ct.us/documents/**practiceguidelines**.pdf

TOOLS AND RESOURCES

Practice Guidelines for Recovery-Oriented Behavioral Health Care

Connecticut Department of
Mental Health and Addiction Services

TOOLS AND RESOURCES…
Automated Recovery Plan

- Incorporates Recovery Principles
  - Encourages planning in multiple domains beyond symptom management
  - Elicits consumer satisfaction which in turn drives formulation of plan
  - Provides opportunity for prioritization
  - Allows consumer to build a “recovery team”
  - Utilizes a strengths-based model
  - Prompts a recovery dialogue between the consumer and the provider
  - Uses consumer-friendly language
  - Specifies clear action steps and encourages all members of the team to contribute to those steps
- Supports Accreditation and Third-Party Billing Requirements
- Generates Aggregate Planning and Quality Improvement Data

For more information, contact daniel.wartenberg@po.state.ct.us

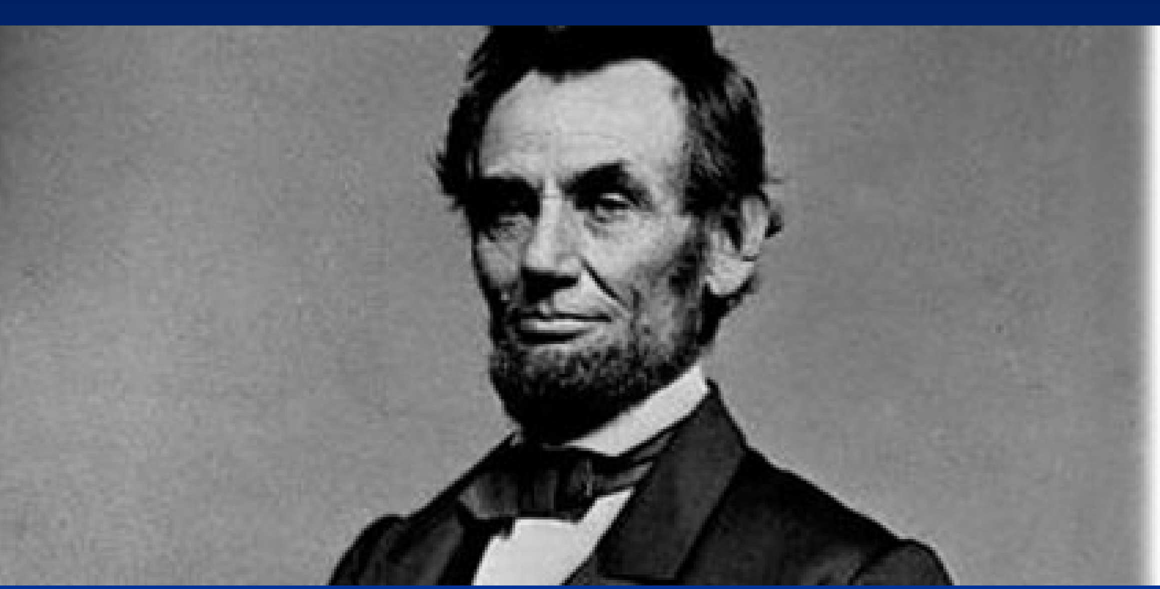
OTHER TOOLS AND RESOURCES…

- Language Considerations and Tips
  - e.g., Front-line staff/"in the trenches" / Direct support staff providing compassionate care; low-functioning / symptoms of illness interfere with…; suffers from / lives with; clinical case manager / recovery guide
- Educational Handout: *Your Treatment Plan & Meeting: Making it work for you and your recovery!*
- Consumer/Provider Tickle List: *PCP: How do we know if we're moving in the right direction?*
- PCP Peer Supporter Brochures

Lessons Learned (Some the hard way…)

- Address organizational barriers, BUT… also take a good hard look at the "internal" barriers. (Often, the former is a red herring – e.g., "keys")
- The dangers of "good intentions." Stepwise progress is good but not enough!
- Take the time and make it stick! Avoid Train and Run…while offering on-site consultation/technical assistance. A front-end investment for long-term gain.
- Prioritize action steps and GET OUT OF THE GATE!!
- Implementation requires flexibility, innovation, and a continuous commitment to learn from all stakeholders!
- Avoid "perpetuating pessimism." Given the opportunity with one-on-one guidance from consultant team and given user-friendly tools that support the work…many clinicians embrace new ways of thinking/doing.
- And for those who don't… IT IS NOT A CHOICE! These are fundamentally civil/human rights issues that can not be ignored/delayed

Recovery Delayed is Recovery Denied



Failed, failed, failed.
And then...