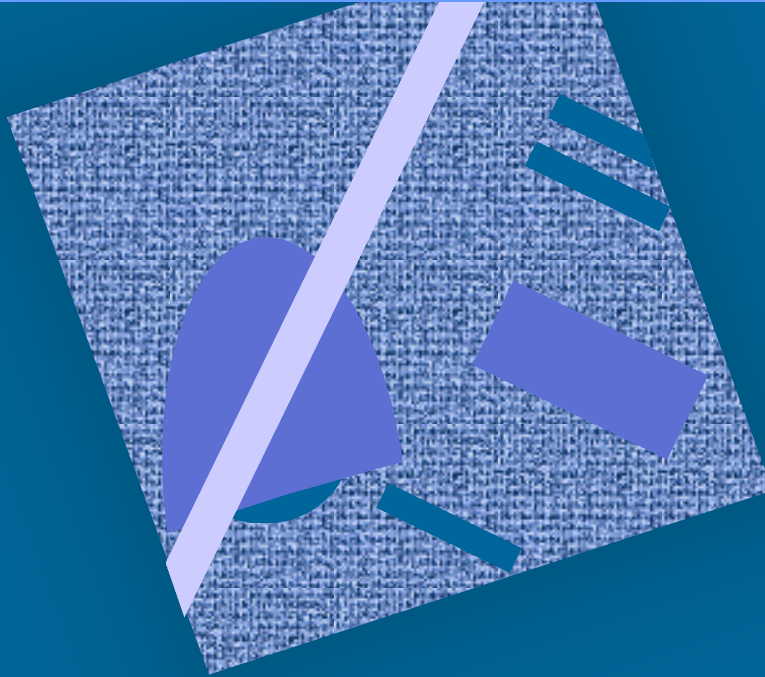


Recovery in Behavioral Health



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

March 29, 2004

Goals for the Retreat

- **Communicate overarching principles and goals of the Recovery Initiative**
- **Communicate draft standards and preliminary practice expectations**
- **Clarify major work tasks and implementation time frames**
- **Solicit feedback regarding the recovery initiative and implications for providers**
- **Identify opportunities for partnerships**

Why Focus on Recovery Now?

- **Blue Ribbon Commission**
- **Federal Emphasis and Expectation**
 - **President's New Freedom Commission**
- **Expectations of consumers and persons in recovery**
- **Expanding research base showing improved effectiveness of treatment**
- **Healthcare research demonstrating better outcomes when patients are involved in care decisions**
- **"It's the right thing to do"**

WHAT DOES RECOVERY MEAN TO YOU?

Freedom

Relationships

Autonomy

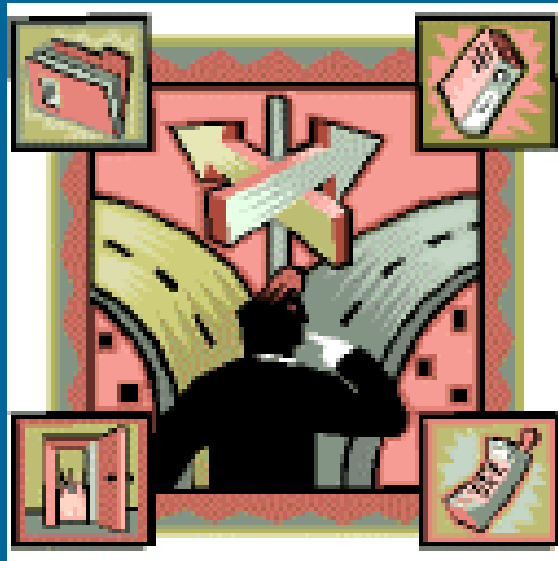
Hope

Independence

Getting Better

Trust

RECOVERY:



Multiple Pathways

The Many Views of Recovery

Primary Care & Everyday Life

Trauma

Addiction

Traditional 12 Step

Rational Recovery

Christian Recovery

Harm Reduction

Mental Health

Similar to Primary Care

Similar to Trauma & Addiction

Disability/Civil Rights

Overarching Tenets of Recovery Initiative

- **There are multiple viewpoints on recovery.**
- **Meaningful systemic change requires a broad consensus development process.**
- **Recovery has been promoted as the basic goal of behavioral healthcare for many years.**
- **Individualized recovery planning provides a holistic framework for integration of various other DMHAS initiatives.**

For those individuals for whom recovery does not mean cure, DMHAS has offered the following definitions:

- ***The Department endorses a broad vision of recovery that involves a process of restoring or developing a positive sense of identity and meaningful sense of belonging apart from one's condition and then rebuilding a life despite or within the limitations imposed by that condition.***
- ***A recovery-oriented system of care identifies and builds upon each person's assets, strengths, and areas of health and competence to support the person in managing his or her condition while regaining a meaningful, constructive sense of membership in the broader community.***

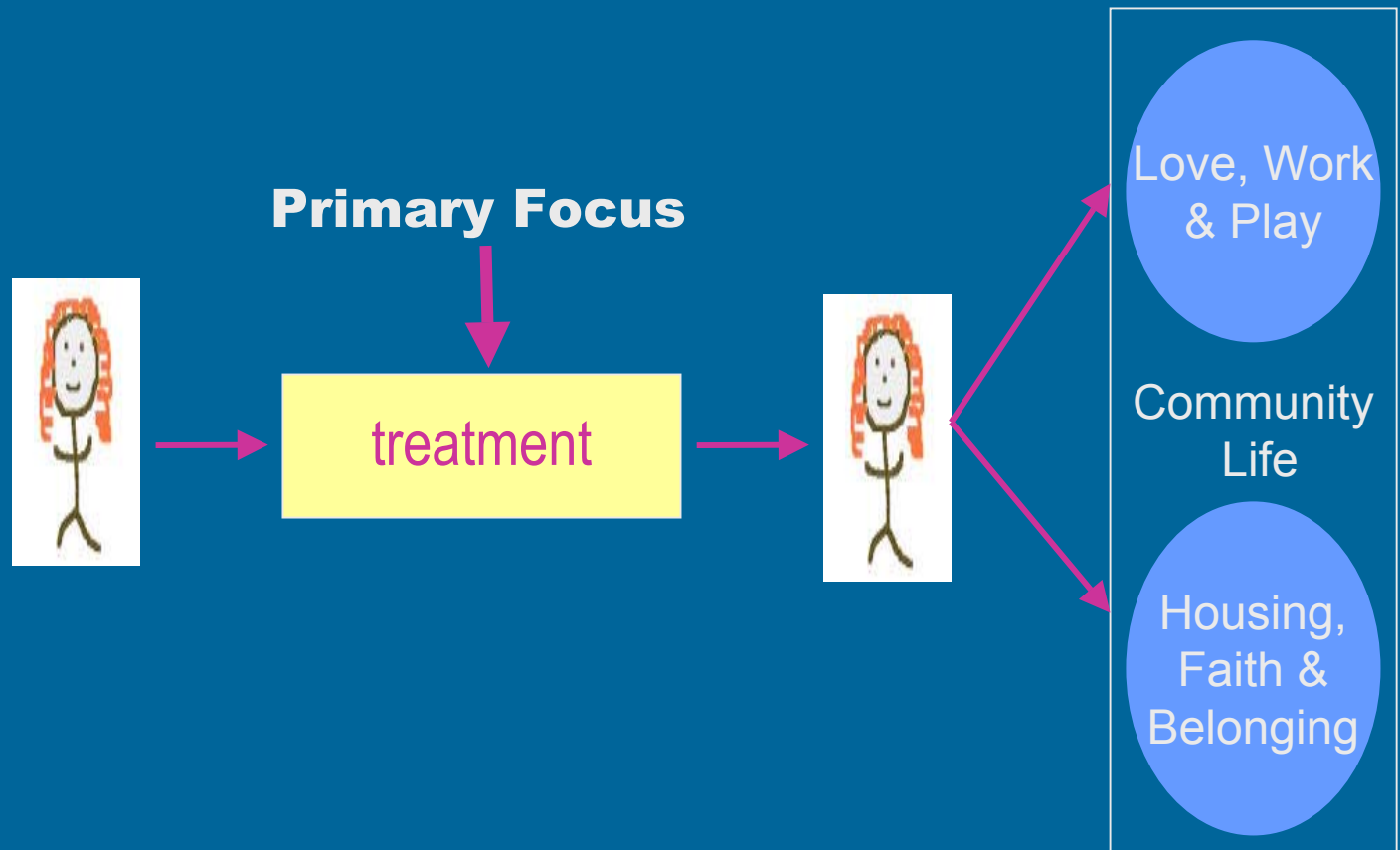
Highlights

- **Commissioner's Policy**
- **Hosted 2 major conferences**
- **CMHS and CSAT Consultation**
- **Vocational Consultation**
- **Recovery system self assessment**
- **Recovery Institute**
- **Centers of Excellence**

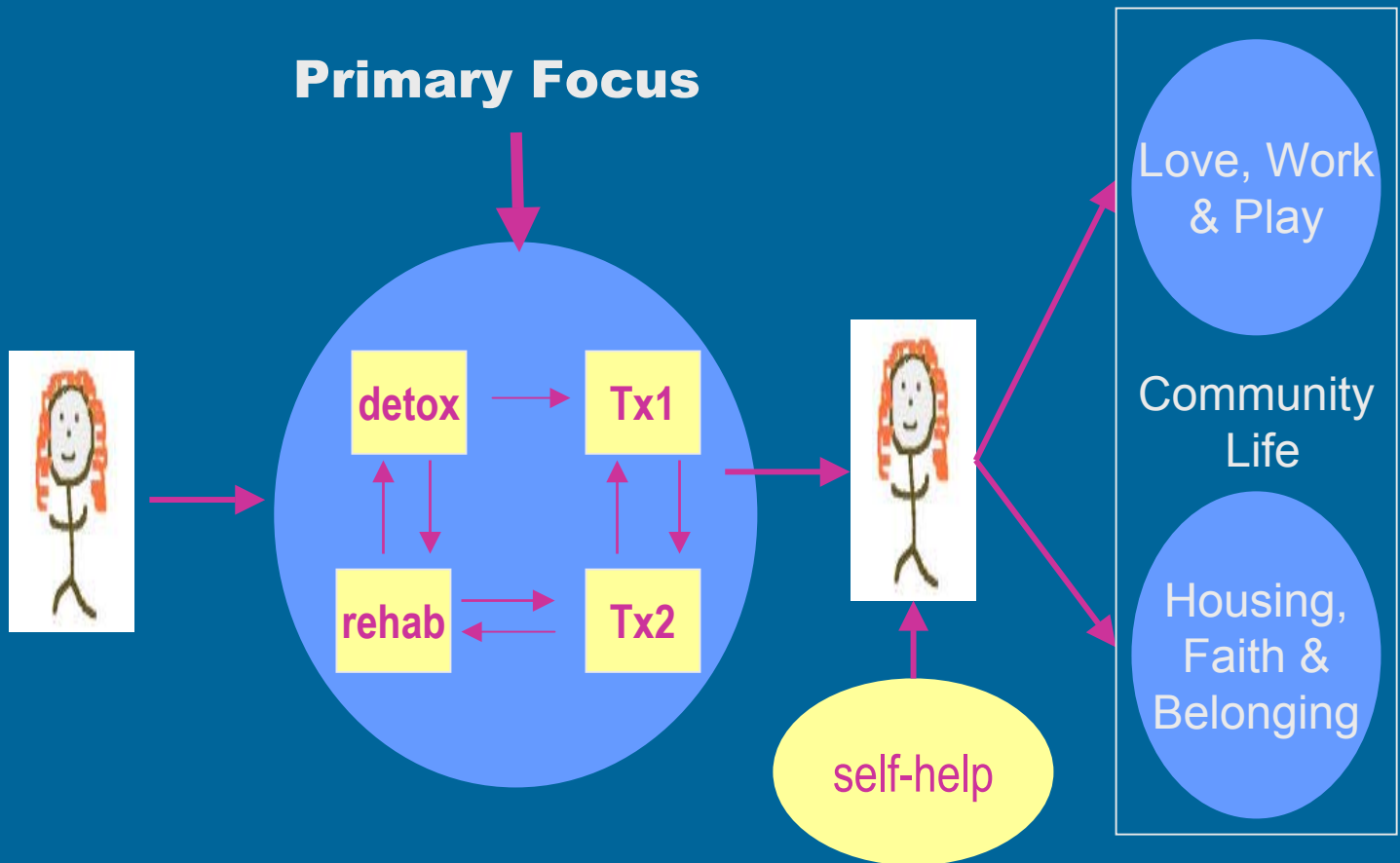
Additional Highlights

- **Advisory Groups**
- **Preferred Practices**
- **Olmstead Initiative**
- **Advance Directives**
- **Faith Initiative**
- **Communication Mechanisms**
 - **DMHAS website**
 - **Newsletter**
 - **Recovery documents**

Service System Progression: Model 1: Effective Treatment



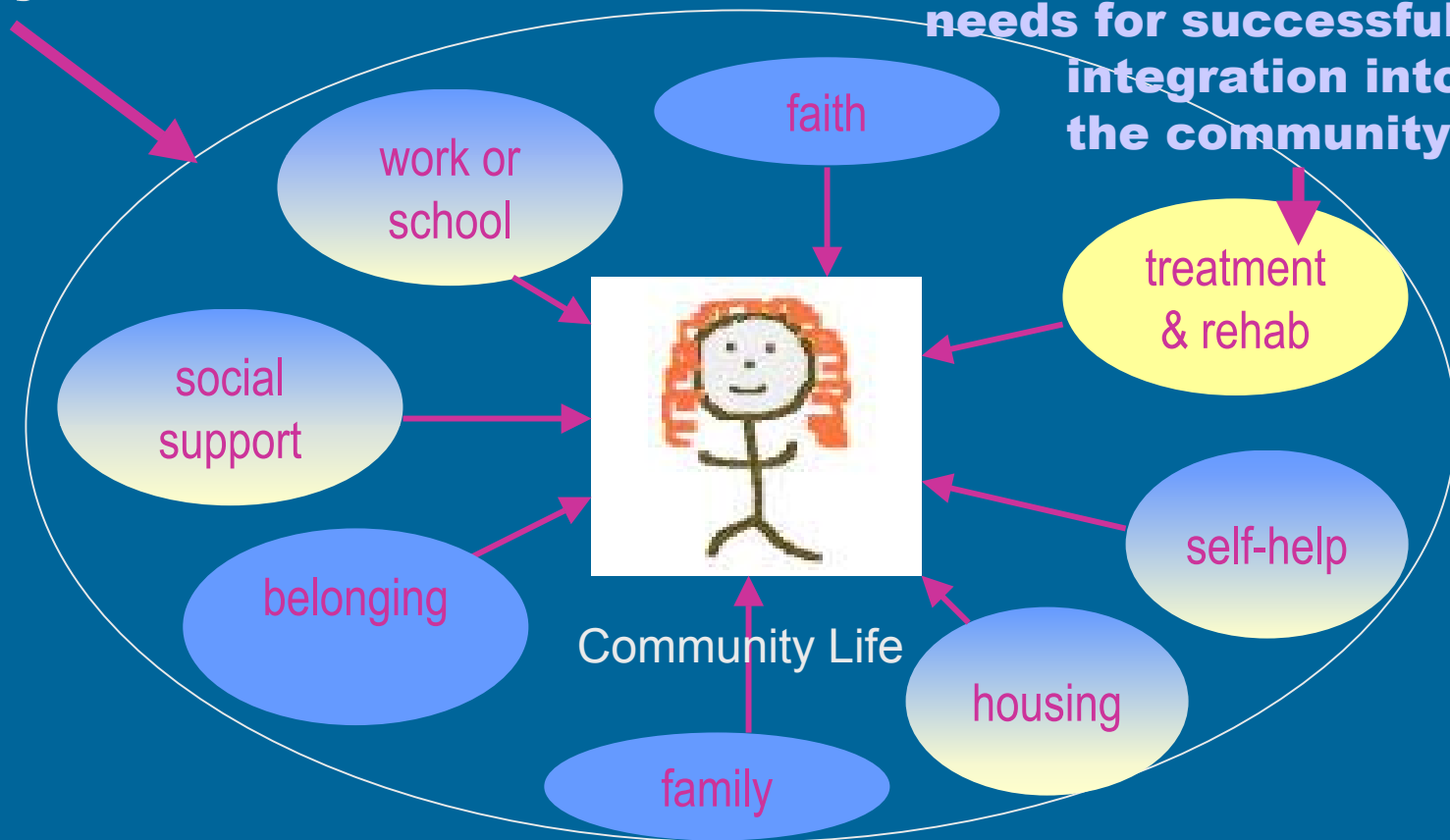
Model 2: Continuity of Care



Model 3: Recovery-Oriented System of Care

In this model, clinical care is viewed as one of many resources that one needs for successful integration into the community.

Primary Focus

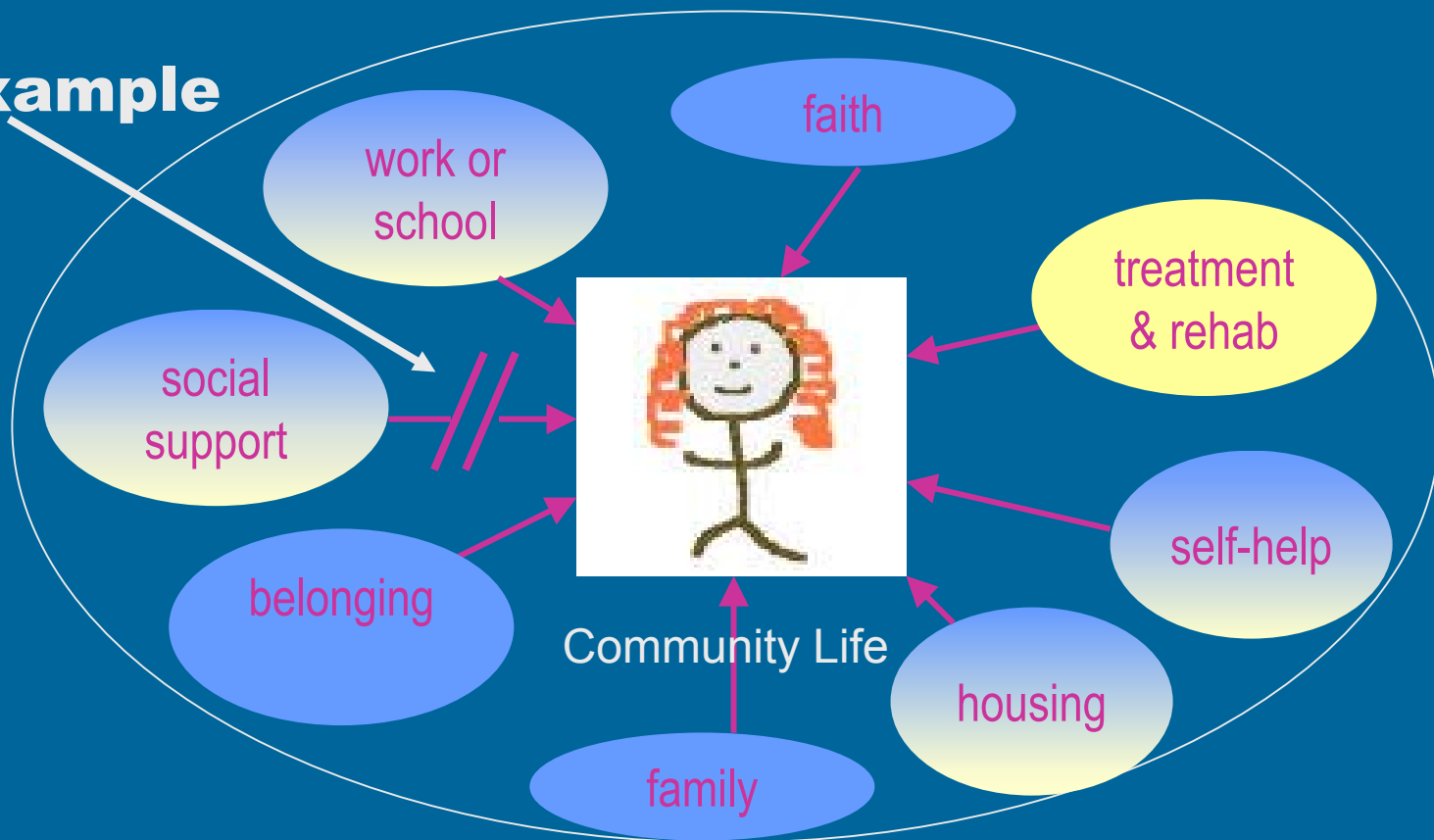


“You can do it. We can help.”*

Risk and Resilience Model

What connections are not yet in place for this person, and what needs to be done to establish or cultivate them?

For example



*Current motto of The Home Depot

We're Making Progress but we're not there yet

R
E
C
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Dependency

Natural supports

Frequent Involuntary Treatment

Advanced Directives

Self-determination

Self-help

Dignity and Respect

True choice of supports & services

Community movement

Intensive case management

Cultural competence

Where we've been

Moving toward a Recovery-oriented System of Care

Where we're headed

Alienation

Treatment = Medication

Ambulatory Detox

Empowerment

Stigma

Treatment Advances

Person = Case

Supported Housing

Early ID & intervention

Community integration

Provider determines treatment

Peer support & mentoring

Prevention
Peer-run businesses

The Top Ten Concerns about Recovery

- 10. Recovery is old news. It has been around in addiction for over half a century and in mental health for over a decade.**
- 9. Recovery is yet another responsibility being pushed onto already overburdened providers.**
- 8. Recovery means the person is cured, no longer using substances or battling the symptoms and deficits of the illness.**
- 7. Recovery in mental health is an irresponsible fad that glosses over real, enduring deficits and raises false hopes for people who already are suffering tremendously from their illness.**
- 6. Recovery only happens after, and as a result of, active treatment.**

Top Ten Concerns, continued

- 5. Recovery-oriented services will not be reimbursable under Medicaid.**
- 4. Recovery can only be implemented through the introduction of new services, which requires additional resources.**
- 3. Recovery conflicts with other DMHAS initiatives such as evidence-based practice, trauma, cultural competence, and co-occurring disorders.**
- 2. Recovery approaches devalue and diminish the role of professional intervention.**
- 1. Recovery increases provider exposure to risk and liability.**

#10. Recovery is old news.

Expressed concern: Recovery has been around in addiction for a half century and in mental health for over 20 years.

Recovery perspective: Many of the changes that have been recommended to promote recovery have yet to be implemented. New strategies also have emerged recently.

Possible strategy: Shift care from an acute model of treatment and aftercare to one of “recovery management.” Build on strengths, person-centered planning, stages of change philosophy, cultural competence, peer support, and outreach.

Strategy: Implement previously recommended changes and incorporate new recovery management approaches throughout DMHAS system.

- **Assertive outreach**
- **No discharge for relapse**
- **Use of stages of change philosophy**
- **Inclusion of family/ social networks**
- **Person-centered planning**
- **Building “Recovery Capital”**
- **From aftercare to disease management**
- **Move from program-based services to service and support menus**
- **Use of people in recovery as staff**
- **Cultural competence**
- **Use of peer support programs**

#9. Recovery is another responsibility that staff can and should provide.

Expressed concern: DMHAS is pushing its recovery initiative onto already overburdened providers.

Recovery perspective: The responsibility for recovery resides primarily with the person him or herself. A provider's responsibility is to support the person in this process by offering hope, information, tools, and other resources.

Possible strategy: Distinguish between recovery (what the person does) and recovery-oriented care (what we provide).

#8. Recovery means the person is cured.

Expressed concern: This is what recovery usually means in primary care and daily life.

Recovery perspective: This is not what it means for most DMHAS clients.

Possible strategy: Develop and implement models for recovery in addiction and mental health that allow for improved quality of life despite continued disability.

#7. Recovery in mental health is an irresponsible fad.

Expressed concern: Full recovery, in its usual sense, may be unattainable for some people who have more severe disabilities.

Recovery perspective: Many people improve over time, while others find ways to have quality lives despite continued disability.

Possible strategy: Even though some people may not recover fully, strategies do exist to promote their full inclusion in community life through the provision of community supports.

#6. Recovery only happens after, and as a result of, active treatment.

Expressed concern: Treatment works well for many people.

Recovery perspective: Many people do well without treatment. More importantly, recovery refers to a process, not a goal, of care. People seldom talk about “recovery,” but are clear in their desires for work, love, housing, and involvement in other activities.

Possible strategy: Reframe treatment and other interventions as tools to be used in the person’s recovery rather than as prerequisites to recovery.

#5. Recovery-oriented services will not be reimbursable under Medicaid.

Expressed concern: Traditionally, Medicaid has been based on a narrow definition of medical necessity.

Recovery perspective: Medicaid has been used in many creative ways by other states to fund recovery-oriented services.

Possible strategy: Use federal dollars to fund whatever it can fund, and use general fund dollars to fund other services that are not reimbursable under Medicaid.

#4. Recovery can only be implemented with new resources.

Expressed concern: There are some interventions that are not currently provided that will require additional resources, such as community support.

Recovery perspective: Although we don't have all the resources we need, not all of our current resources are funding recovery-oriented care.

Possible strategy: In a tight fiscal environment, it is even more important that we utilize only the most effective practices. In some cases, this will require new resources, but in others it requires using existing resources and staff differently.

#3. Recovery conflicts with other DMHAS initiatives.

Expressed concern: There are very few recovery-oriented services that can be described as evidence-based at this time.

Recovery perspective: Most people currently have little choice in their care.

Possible strategy: Emphasize the fact that the notion of *choice*—which is core to recovery—is only meaningful when people have a range of accessible and effective alternatives *from* which to choose.

#2. Recovery devalues and diminishes the role of professional intervention.

Expressed concern: Recovery comes from the advocacy community, and can appear anti-treatment or anti-provider in tone.

Recovery perspective: Far from devaluing professional knowledge or skill, recovery moves behavioral health much closer to other medical specialties, in which informed choice has been shown to improve outcome.

Possible strategy: View promoting recovery as requiring a higher level of professional knowledge and expertise, as these are the crucial tools the provider has to offer.

#1. Recovery increases provider exposure to risk and liability.

Expressed concern: Recovery does highlight the importance of client choice. Choice may conflict with risk management.

Recovery perspective: Risk is a real issue, and a recovery orientation does not translate into neglect of clients who choose not to follow provider advice. However, most people pose little to no risk, most of the time. In fact, they are more likely to be victimized than to victimize others. But for those people who do pose real risks, skillful risk assessment and management is even more crucial to promoting recovery.

Possible strategy: Appropriate use of risk assessment and management is in the best interest of everyone.

Characteristics of Recovery-Oriented Care

- **Fosters hope**
- **Encourages active participation of people in recovery at all levels of the system**
- **Conveys courtesy, dignity, and respect to all persons**
- **Promotes the rights and responsibilities of each person**
- **Is person-centered, strengths-based and community focused**
- **Is culturally-responsive**

Characteristics of Recovery-Oriented Care

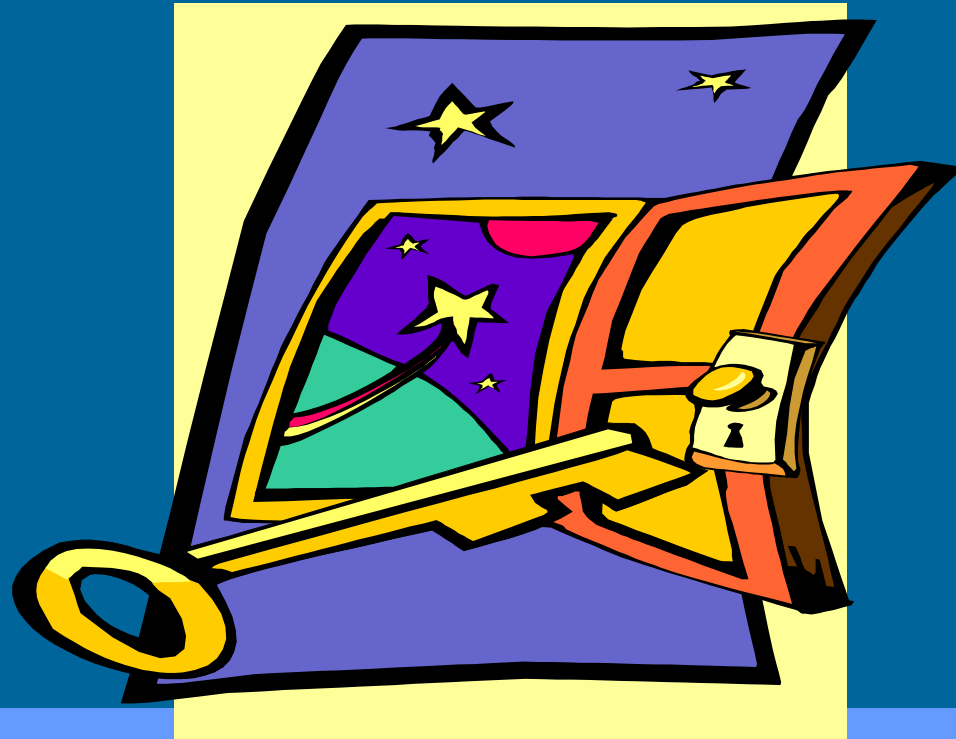
- **Offers multiple entry points for easy access**
- **Provides a menu of choices of effective services and supports**
- **Offers people an array of educational and informational materials**
- **Is relationally-mediated and allows for reciprocity in relationships**
- **Optimizes natural supports and community involvements**
- **Utilizes best practices**

Recovery Management



Moving Towards a
Recovery-oriented
System of Care

Recovery is what people do, treatment is one tool that some people may use to achieve it.



If we really believed addiction was a chronic disorder, we would not:

- 1. Create expectation that full recovery should be achieved from a single Tx episode**
- 2. View prior Tx as indicative of poor prognosis**
- 3. Extrude people in recovery for becoming symptomatic**
- 4. Treat addiction in serial episodes of disconnected TX**
- 5. Relegate aftercare to an afterthought**
- 6. Terminate the service relationship following brief intervention**

Recovery Management

- **time-sustained collaborative approach**
- **goal of stabilizing and managing substance use disorders**
- **people in recovery:**
 - **are at center of model**
 - **direct their recovery process**
 - **involved in the design, delivery and evaluation of services**

Recovery Concepts

- **Stages of Change: Developmental Models of Recovery**
- **Stages of Recovery and Service Needs**
- **Recovery Priming/Initiation versus Recovery Maintenance**
- **Serial Recovery: Accepting, Managing & Transcending Multiple Wounds/Limitations**
- **Peer-driven Models of Recovery Support**

Recovery Management Process

- **Engagement and Recovery Priming (pre-recovery/treatment)**
- **Recovery Initiation and stabilization (recovery activities/treatment)**
- **Recovery Maintenance (post-treatment support services)**



Treatment in Recovery Management

- **One of multiple pathways to recovery**
- **Preferred pathway:**
 - **for people with high severity or co-occurring problems**
 - **and low levels of natural supports or recovery capital**

Clinical Versus Community Populations

- 1. Higher personal vulnerability (e.g., family history, lower age of onset)**
- 2. Higher severity (acuity & chronicity)**
- 3. Higher rates of co-morbidity**
- 4. Greater personal and environmental obstacles to recovery**
- 5. Lower recovery capital (personal assets / family and social supports)**

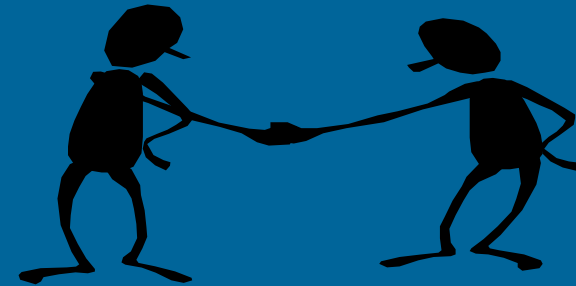
Acute Treatment Model Versus Emerging Recovery Management Model

**16 major differences in service
design and delivery**

- **Compare and contrast**
- **Desirability and effectiveness of
each model varies across
clinical populations**

1. Engagement

- **Traditional Model:**
 - high threshold of engagement
 - crisis intervention
 - isolated outreach
 - high extrusion
- **Recovery Management Model:**
 - low threshold (welcoming)
 - emphasis on outreach
 - pre-treatment recovery support services
 - low extrusion



2. View of Motivation

- **Traditional Model:**
 - **Pre-condition for treatment**
 - **absence defined as “resistance”**
 - **responsibility/blame– client**
- **Recovery Management Model:**
 - **Seen as outcome of services**
 - **emphasis on pre-action stages of change (“recovery priming”)**
 - **responsibility/blame--service milieu**

3. Screening and Assessment

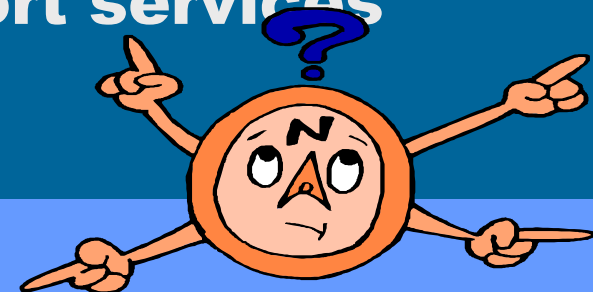
- **Traditional Model:**
 - **Categorical Intake Activity**
 - **Deficit-based (problems to treatment plan)**
- **Recovery Management Model:**
 - **Global, Continual (stages of change assumptions)**
 - **Strength-based (assets to recovery plan);**
 - **Inclusion of family/kinship network with people in recovery defining family.**

4. Service Goals

- **Traditional Model:**
 - professionally defined in treatment plan
 - focus on reducing pathology.
- **Recovery Management Model:**
 - defined by people in recovery in plan
 - focus on building recovery capital and meaningful life

5. Service Timing

- **Traditional Model:**
 - focus on crisis/problem resolution
 - Reactive
- **Recovery Management Model:**
 - focus on post-crisis recovery support activities
 - proactive;
 - commitment to continued availability;
 - continuum of recovery support services



6. Service Emphasis

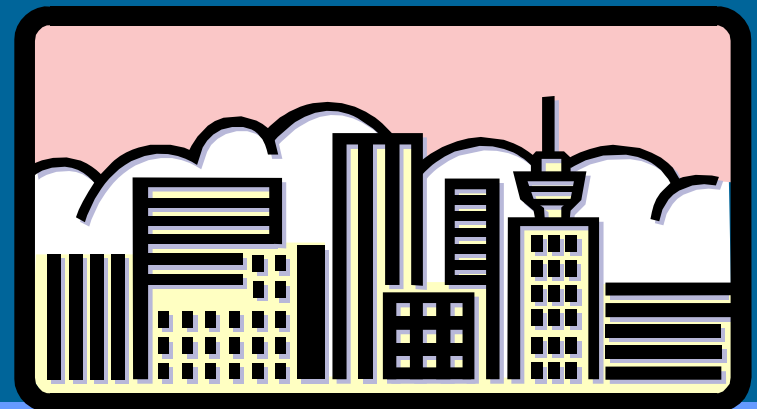
- **Traditional Model:**
 - detoxification and stabilization
- **Recovery Management Model:**
 - sustained recovery coaching,
 - monitoring with feedback and support,
 - linkage to communities of recovery
 - early re-intervention



From Bill White Chestnut Health Systems

7. Locus of Services

- **Traditional Model:**
 - **Institution-based--“How do we get the client into Treatment?”**
- **Recovery Management Model:**
 - **“How do we nest the process of recovery within the person’s natural environment?”**



8. Service Technologies

- **Traditional Model:**
 - focus on “programs”
 - limited individualization
 - biomedical stabilization
- **Recovery Management Model:**
 - focus on service and support menus
 - high degree of individualization
 - greater emphasis on physical/social ecology of recovery

9. Management of Co-morbidity

- **Traditional Model:**
 - **exclusion, extrusion, recidivism, iatrogenic injury; experiments with parallel/sequential tx**
- **Recovery Management Model:**
 - **concept of “serial recovery”**
 - **integrated model of care**
 - **multi-unit/agency models**
 - **inclusion of indigenous healers/institutions**

10. Service Roles

- **Traditional Model:**
 - specialization of clinical roles,
 - emphasis on academic/technical expertise
 - resistance to prosumer movement
- **Recovery Management Model:**
 - “adisciplinary”;
 - role cross-training
 - People in recovery in paid and volunteer support roles
 - emphasis on mutual aid
 - role of primary care physician

From Bill White Chestnut Health Systems



11. Service Relationship

- **Traditional Model:**
 - (dominator-expert Model).
 - hierarchical and time-limited
 - transient (staff turnover)
 - commercialized.
- **Recovery Management Model:**
 - (partnership-consultant Model)
 - less hierarchical
 - potentially time-sustained
 - continuity of contact
 - less commercialized.



12. Involvement of People in Recovery

- **Traditional Model:**
 - **passive role-- professionally prescribed**
 - **consumer dependency**
- **Recovery Management Model:**
 - **Involvement in direction of service policies, goal-setting, delivery, and evaluation.**
 - **focus on illness self-management.**
 - **people in recovery as volunteers & employees.**

13. Relationship to Community

- **Traditional Model:**
 - **community defined in terms of other agencies**
- **Recovery Management Model:**
 - **focus on how to diminish need for professional services**
 - **emphasis on hospitality and supports within the natural community**
 - **emphasis on indigenous supports; “the community is the treatment center”**

14. View of Aftercare

- **Traditional Model:**
 - aftercare as an afterthought (less than 30%) or maintenance for life.
- **Recovery Management Model:**
 - eliminate concept of “aftercare”:
 - all care is continuing care
 - emphasis on community resources
 - use of guide or recovery coach.

15. Service Evaluation

- **Traditional Model:**
 - focus on professional review of short-term outcomes of single episodes of care
 - recent emphasis on social cost factors-- impact on hospitalizations, arrests, etc.
- **Recovery Management Model:**
 - focus on long term effects of service combinations & sequences on people in recovery/family/community
 - outcomes & review defined by people in recovery

16. Advocacy

- **Traditional Model:**
 - **advocacy often limited to that related to institutional funding**
 - **marketing and PR approach.**
- **Recovery Management Model:**
 - **emphasis on policy advocacy**
 - **community education (stigma)**
 - **community resource development;**
 - **activist/community organization approach.**

Draft Domains for Recovery Standards

- **Prevention and early intervention**
- **Primacy of participation**
- **Access and engagement**
- **Continuity of care**
- **Individualized recovery planning**
- **Recovery support staff**

Draft Domains for Recovery Standards

- **Community inclusion**
- **Housing and Work**
- **Evidence-based practices**
- **Cultural competency**
- **Quality and performance**

Practice Guidelines:

Prevention/Health Promotion

- **Persons in recovery will:**
 - be able to access information re health promotion and treatment options
 - promote their own health and *Recovery Capital (resources available for recovery)*
- **Agencies will:**
 - provide community and consumer education
 - Utilize a range of community-based interventions to reduce risk factors and enhance resilience
 - encourage access to resources or info, conduct anti-stigma campaigns

Practice Guidelines:

Involvement

- **Persons in recovery/Family**
 - participate on Boards
 - participate in agency evaluations
 - participate in planning structures
 - know grievance procedures
- **Agencies**
 - offer peer-run services
 - hire peer staff
 - routinely evaluate consumer satisfaction and solicit ideas on how to improve care

Practice Guidelines:

Access and Engagement

- **Persons in recovery**
 - can access services through any door
 - are offered services where they live
- **Agencies use:**
 - a range of pre-engagement strategies
 - peer engagement specialists
 - specialized outreach strategies for difficult to engage populations
 - specialized procedures to rapidly admit people who relapse
 - admission criteria that don't exclude people based on prior tx failure, etc.

Practice Guidelines

Continuity of Care

- **Persons in recovery aren't discharged just for being more symptomatic**
- **Agencies link people in recovery to:**
 - **appropriate aftercare services upon discharge**
 - **self-help resources or natural supports**
- **Agencies have mechanisms for:**
 - **follow-up post-discharge**
 - **people returning for services**

Practice Guidelines:

Recovery Planning

- **Persons in recovery**
 - actively participate in the development of their recovery plans
 - sign all plans
 - attend all planning meetings
 - designate meeting participants
 - receive their plans
- **Providers:**
 - develop holistic plans that include wishes, interests, goals, etc.
 - regularly review plans with multi-disciplinary team (e.g., treatment, housing, work, natural supports)

Practice Guidelines:

Recovery Support Staff

- **Providers:**
 - offer people hope that recovery is “possible for me.”
 - work collaboratively to develop relapse-prevention plans and advance directives
 - assist persons in recovery with self-management strategies
 - help engage and maximize use of natural supports such as friends, family, and neighbors
 - promote autonomy and *Recovery Capital*
 - aid in skill development as well as symptom management and treatment

Practice Guidelines:

Community Inclusion

- **People in recovery can be assisted to connect to community resources**
- **Agencies:**
 - **identify and regularly update traditional and non-traditional resource directories**
 - **integrate program activities into community life**
 - **utilize community social, recreational, educational, vocational, faith resources**

Practice Guidelines:

Housing and Work

- **Agencies:**
 - **link people in recovery to safe affordable housing**
 - **offer a range of work and educational opportunities to all persons in recovery**
 - **eliminate work eligibility requirements**
 - **strengthen linkages to vocational and educational providers**

Practice Guidelines:

Evidence-Based Practices

- **People in recovery:**
 - **Provide information to help shape local adaptation of EBPs**
 - **Participate in program evaluations**
 - **Help interpret data**
 - **Provide ideas about promising practices that need more research**
- **Agencies implement and sustain recovery-oriented EBPs**

Practice Guidelines:

Cultural Competency

- **Agencies:**
 - **evaluate data to ensure that members of diverse cultural groups are receiving effective treatment**
 - **provide services and materials that are linguistically and culturally appropriate**
 - **establish and utilize relationships with local community institutions**
 - **identify and eliminate health disparities**
 - **conduct culturally competent assessments**
 - **maintain staff composition that reflects diversity of population served**

Practice Guidelines:

Quality and Performance

- **Agencies:**
 - regularly administer opinion and satisfaction surveys
 - collect recovery-oriented performance measures
 - have a Continuous Quality Improvement (CQI) process that seeks to eliminate barriers to recovery
- **Persons in recovery**
 - participate on CQI committees
 - inform service needs assessment
 - identify effective practices

And now . . .

- **What areas of the Recovery Initiative do you agree with?**
- **What aspects have yielded the greatest success?**
- **What aspects do you have the most difficulty with or not agree with? What might we leave out (even if just for now)?**
- **What barriers can you identify?**
- **What areas have presented the greatest challenges to you in your agency's recovery work?**

And now . . .

- **What else do we need to address? What else would you like to hear about?**
- **What will our biggest challenges be in communicating this to the field?**
- **What additional information or direction would assist you in this system change**
- **What else do we need to address? What else would you like to hear about?**

And now . . .

- **What is the process you recommend for obtaining regular feedback from you?**
- **What are the implications of this view for your area of responsibility?**
- **Do you agree with the direction for the coming year?**
- **What was not addressed?**

Major Objectives for Coming Year

- **Supplement existing performance measures**
- **Revise service profiles**
- **Incorporate service profiles, standards, outcome measures and policy changes into provider contracts. (Phase-in approach).**
- **Continue to ID service innovations and transfer to field through COEs**
- **Develop communication mechanisms to build stakeholder consensus**

Major Objectives for Coming Year

- **Incorporate recovery principles into all new funding opportunities**
 - **RFP's, RFQ's, Practice Improvements Collaborative, etc...**
- **Continue workforce development through the Recovery Institute**
- **Conduct a follow-up administration of Recovery Self-Assessment tool**
- **Develop performance standards for Recovery-oriented System of Care**
- **Develop and implement recovery plan review (complete at regular intervals)**

Discussion

