3 Recovery Implementation Tools

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DOMAINS OF TRANSFORMATION

(Ken Wilber)

	INSIDE	OUTSIDE
I	VALUES EMOTIONS	BEHAVIORS PRACTICE
WE	CULTURE MISSION	SYSTEMS PROGRAMS

DOMAINS OF RECOVERY PROGRAMS

	INSIDE	OUTSIDE
I	**Values:** HOPE, GROWTH, and RESPECT	**Practices:** ENGAGEMENT, EMPOWERMENT, REHABILITATION, SHARED RESPONSIBILITY, and TEACHING
WE	**Culture:** WELCOMING, HEALING, RECOVERY, and COMMUNITY INTEGRATION	**System:** INDIVIDUALIZATION, INTEGRATED SERVICES, FLOW PROMOTION, and RELATIONSHIP BASED SERVICES

Milestones of Recovery Scale (MORS)

Tracking individual's progress in attaining recovery

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Tracking Recovery

Challenges:

- Everyone's recovery is different - individual process
- Recovery is subjective – different people value different outcomes
- Recovery for the person is not directly correlated to reduction of their illness
- Recovery is non-linear.

Technical adaptation: We'll track correlations of recovery, not recovery itself.

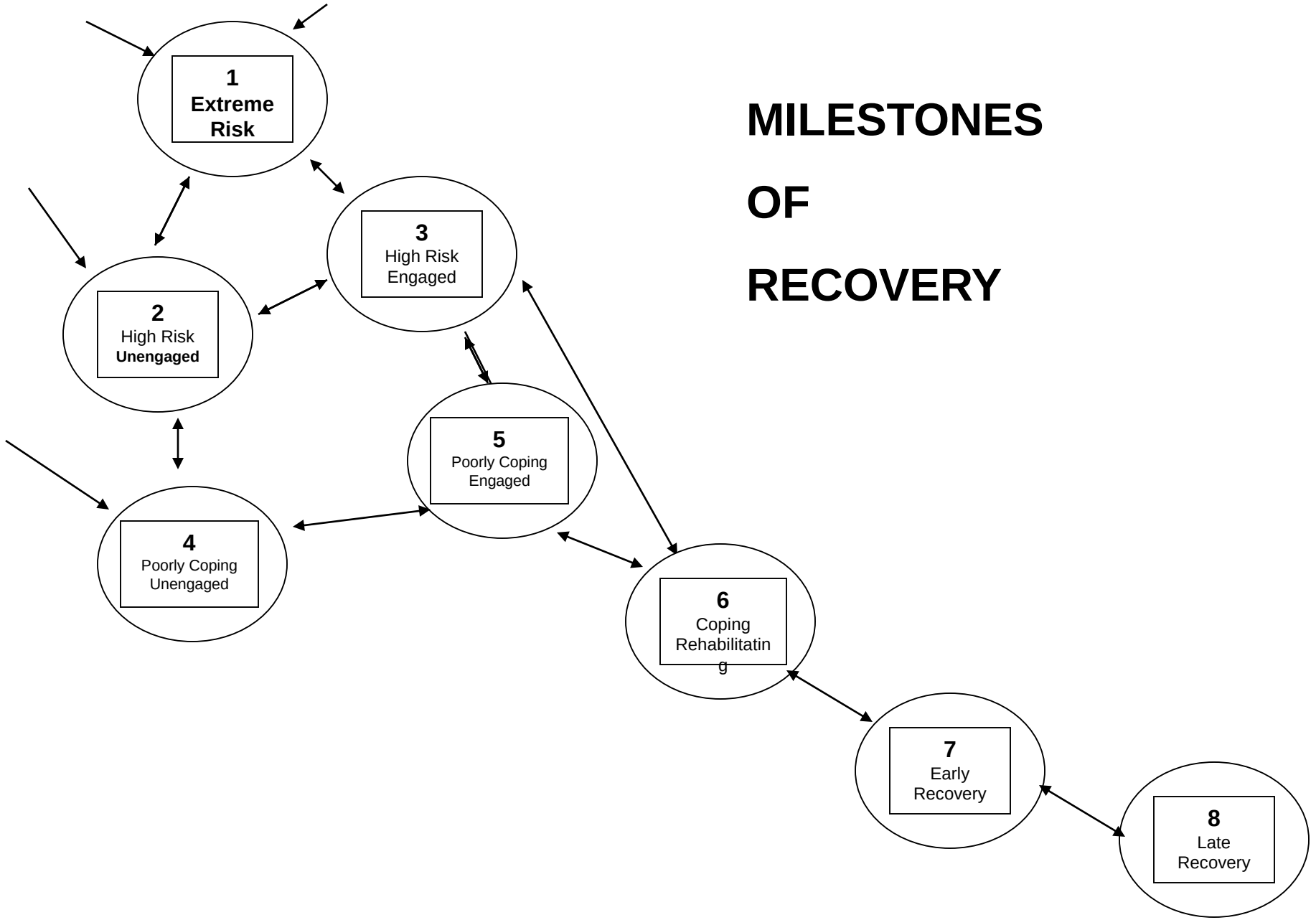
Three correlates together create a reasonably universal map:

1. Level of Risk
2. Level of Engagement
3. Level of Skills and Supports

8 MILESTONES OF RECOVERY

1. Extreme Risk
2. High Risk / Not Engaged
3. High Risk / Engaged
4. Poorly Coping / Not Engaged
5. Poorly Coping / Engaged
6. Coping / Rehabilitating
7. Early Recovery
8. Advanced Recovery

MILESTONES OF RECOVERY



Uses of the MORS

- Assist with your service delivery decisions
- Creates a picture of your caseload and the overall program
- Assist in choosing services to connect people to
- Assist in promoting flow
- Assist in system design

MORS Based Needs Determination

MORS 1: Risk reduction

MORS 2: Risk reduction and engagement

MORS 3: Risk reduction and motivation

MORS 4: Engagement

MORS 5: Motivation to build skills and supports to pursue meaningful roles

MORS 6: Building skills and supports within responsible, meaningful roles

MORS 7: Building community integration and self reliance

MORS 8: Self directed

Stage of Recovery	Care taking services	Growth oriented services
“Extreme risk” (MORS 1)	•Seclusion •Restraints •Chemical sedation	•Trauma informed •Identifying triggers •Increase self control
“Unengaged” (MORS 2,4)	• Forced treatment • Protection • Benefits establishment • Acute stabilization	• Outreach and engagement • Peer bridging • Concrete quality of life goals • Relationship building
“Engaged, but poorly self-coordinating” (MORS 3,5,6)	• Structure • Making decisions for people • Case management • Chronic stabilization	• Supportive services • Skill building • Personal service coordination • Collaboration building
“Self responsible” (MORS 7,8)	• Benefits retention • Maintenance therapy and medication	• Community integration • Self-help • Peer support • Wellness activities • Growth promoting therapy

Altering Crisis Response Depending on Stage of Recovery

Just because it's a "crisis" doesn't mean it's extreme or even high risk. The same crisis should be handled differently depending on where the person is in the recovery process:

- If they're in **"extreme risk" (MORS 1)** the main goals are harm reduction and protection, being "trauma sensitive", using coercion reluctantly, not wasting suffering, and welcoming them back
- If they're **"unengaged" (MORS 2,4)** the main goals are engagement with others and the recovery process
- If they're **"engaged, but poorly self-coordinating"(MORS 3,5,6)** the main goals are to recognize patterns, learn changes needed to make suffering not recur, skill building
- If they're **"self responsible" (MORS 7,8)** the main goals are to mobilize personal coping skills and natural supports, and build confidence in self directed care

Person-Centered Levels of Service (Recovery Based Spectrum of Care)						
Extreme risk	Unengaged		Engaged, but not self coordinating		Self responsible	
Locked setting	Outreach and engagement	Drop-in center	Intensive case management	Case management team	Appointment based clinic	Wellness center
Extreme risk (1)	High risk, unengaged (2) Poorly coping, unengaged (4)		High risk, engaged (3)	Poorly coping , engaged (5) Coping, rehabilitating (6)	Coping, rehabilitating (6) Early recovery (7)	
1:1 supervision Legal interventions Community protection Acute treatment Engagement	Welcoming Charity Evaluation and triage Documentation Benefits assistance Accessible medications Drop-in services		Case management Integrated services Accessible medications Supportive services Direct subsidies Rehabilitation		Appointment based therapy “Medications only” Wellness activities (WRAP) Self-help Peer support Community integration	

Recovery Based Culture Report

Assessing programs and practices that contribute to key recovery values

https://drive.google.com/file/d/1CNOttT2w4F2nOVEg5P9DiJD2DtCprO_O/view

Evaluating Cultures is Tricky

An anthropologist's view - "Man is an animal suspended in webs of significance he himself has spun. I take culture to be those webs, and the analysis of it to be therefore not an experimental science in search of law but an interpretative one in search of meaning."

But how will we know a recovery culture if we see one? We need to identify observable indicators of the cultural values we want to support.

We built on the example of "handicapped accessibility" by transforming it to "psychosis accessibility"

Seven Key Dimensions of a Recovery Based Culture

1. Welcoming and Accessibility
2. Growth orientation
3. Consumer inclusion
4. Emotionally healing relationships and environments
5. Quality of life focus
6. Community integration
7. Staff recovery

Tracking Building Recovery Culture

	Not Exploring	Exploring	Emerging	Maturing	Excelling
Welcoming and Accessibility					
Growth Orientation					
Consumer Inclusion					
Emotional Healing					
Quality of Life Focus					
Community Integration					
Staff Morale and Recovery					

Welcoming and Accessibility Example

Welcoming and Accessibility

Recovery programs are fundamentally relationship based. We try to "meet people where they are at." We realize most people with serious mental illnesses don't accept any services and that symptoms, stigma, trauma, low motivation, and negative treatment experiences can all be obstacles to getting help.

	Not Yet Explored	Exploring	Emerging	Maturing	Excelling
Hours	☐	☐ Program only open 9 - 5	☐ Staff can keep program open after hours for crisis	☐ Staff regularly flex hours to be available for services and activities after hours or on weekends and holidays	☐ Program open hours are based upon an assessment of the demographics and needs of the clients
Welcome / Greeting into program	☐	☐ Office staff and security greets all clients in friendly manner at the door	☐ New clients are shown around the building and introduced to a variety of staff and programs	☐ Clients are volunteer or paid greeters and "internal navigators" helping access program services	☐ Rituals are practiced to introduce new clients to the program's community
Where services take place	☐	☐ Staff can make emergency home / field visits	☐ Initial face to face visit can take place in the community	☐ Staff provide mobile care services, "in home services" not just in emergencies	☐ Arrangements can be made to work with people outside of the building – e.g. if they are too paranoid, disrupts other clients, steals
Reduce barriers to services	☐	☐ Staff refer to multiple services within the program	☐ Clients choose services they want to participate in	☐ Can begin with services directed towards any goal, even if not taking meds or clean and sober	☐ Able to serve clients who don't "admit" they have a mental illness or substance abuse problem even with active symptoms
Walk-ins	☐	☐ Walk-ins available for emergencies or hospital referrals	☐ Accommodate walk-ins for first appointment and missed appointments	☐ Staff work as teams to accommodate walk-ins and outreach lost clients - including home visits	☐ Everyone accessible for drop-ins, not just "on-call" person
After hour system	☐	☐ After hours call system is operated by a third party	☐ Staff willing to work on-call are identified	☐ After hours coverage by staff who know the clients	☐ Staff proactively reach out to at risk clients beyond 9-5

Consumer Inclusion Example

Consumer Inclusion

Recovery is a collaborative process that requires ongoing effort and commitment from the person who is recovering. Recovery is built upon the strengths inside a person that enable them to overcome, not upon the strengths of the staff's caretaking or even treatment. Recovery is most clearly seen from the client's point of view. Recovery programs emphasize client inclusion and active participation – "nothing about us without us."

	Not Yet Explored	Exploring	Emerging	Maturing	Excelling
Treatment/ service choices	☐	☐ Treatment planning includes clients' words and goals and signed by clients	☐ Clients can choose what services they want to participate in	☐ Informed client choice of service options	☐ Client is author of treatment plan with collaboration actually writing it
Treatment / Service collaboration	☐	☐ Staff solicits input from clients about their treatment / services	☐ Guided collaborative client choice of services (e.g. type of therapy, medications with psychiatrist / budget choices with staff payee)	☐ Widespread tools to help clients "negotiate" with psychiatrists and other staff (e.g. Shared decision making tools)	☐ Widespread tools to help clients take ownership and responsibility for own wellness (e.g. WRAP)
Treatment / service Autonomy	☐	☐ Forms to help clients think through what they want and what services would lead to those goals	☐ Staff continue to follow clients as they try paths the staff don't approve of	☐ Active staff support for client goals and services that aren't the choice the staff would've made	☐ Broad implementation of Advanced directives both in the program and with local hospitals and ERs
Client choice of service provider	☐	☐ Client can talk to supervisor if they have complaints to change staff	☐ Client may choose provider within program based on list with staff's traits, skills and interests	☐ "Open enrollment" – clients can periodically change staff and psychiatrist to another available staff of their choice without having to give justification	☐ Possible to "hang out" without intake observing to see they can trust program and watch staff to choose who they want to work with
Involvement with consumer movement and fighting stigma	☐	☐ Consumer movement speakers and literature available	☐ Clients involved in larger consumer movement activities including advocacy (e.g. state capital trips, letter writing campaigns)	☐ Active support for clients to become leaders in and be hired by the consumer movement	☐ Clients host consumer run advocacy and community education / anti-stigma efforts

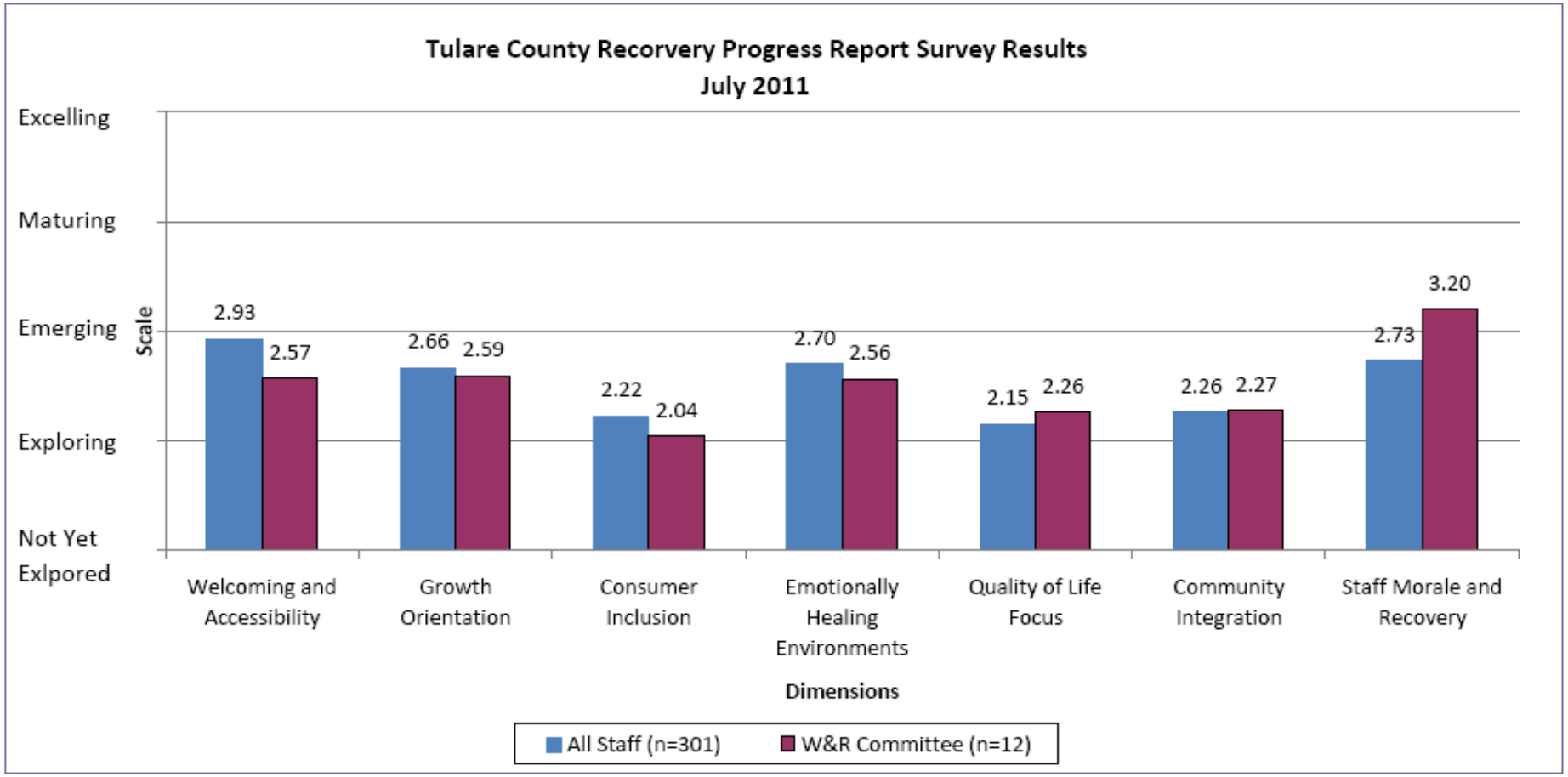
Administering the tool

Different people have different perspectives, and see different things - even when we tried to make an objective tool

The Recovery Progress Report can be administered to three audiences:

- Staff via online survey
- Consumers and Family Member via focus groups
- Wellness & Recovery Committee via onsite review

Example Findings



Creating Plans to Move Forwards

The Wellness & Recovery Committee reviewed overall results and developed a 2-year strategic plan with the following three initiatives:

- Education, Training, and Employment
- Peer Support
- Integration Across Systems and Supports

Activities:

- Peer run support groups
- Community garden project
- Pilot case staffings with consumer and support person inclusion
- Consumer staff involvement on committees
- Mental health awareness month participation
- Consumer greeter program
- Newsletter
- 5K fitness
- Recovery Champion Awards

Champion Awards

Nominate Someone Today

The Wellness & Recovery Champions would like to welcome their first annual Champion Awards, to be presented during the May 30, 2013 Mental Health Awareness Month *Friends and Family* Picnic at Mooney Grove Park from 10am to 3pm.

There are two type of Champion Awards (1) to recognize the personal wellness and recovery achievements of those impacted by mental illness who have been engaged in services for at least one year, are actively engaged in their wellness and recovery, and have made impressive growth in an area of their wellness and recovery; and (2) to recognize individuals who have made considerable strid
wellness and recovery transformation to the mental health

If you would like to nominate someone for either category, please complete the r
side of this flyer and submit according to the instructions. Nominations will be
Recovery Champions adhoc group.

Saturday training and gardening

Our training group grows weekly!!

Volume 1 Issue 5 — March 2013

The Trestle

Recovery Champion's Newsletter

"WE ARE THE BRIDGE"

SPECIAL EDITION

INSIDE THIS ISSUE

- Special Edition
- Bridgework
- Peer Platform

Thank You for Asking…

That is the name of the now famous PAC video ible on Mental ates, clients, er Specialists, Mentors, and Family members, it we are the bridge, the glue, and one another's re a voice in our community and we made a posi- a video without uttering a word.

speaks in volumes the words which we could not and stigma which is everywhere in society. This vid- ing point in our fight against stigma, prejudice, ad- crimination. We all matter and deserve to be treated

ESDAY'S AT TEN WORKGROUP

Recovery Staff Development Assessment

Assessing and promoting career-long staff development

https://drive.google.com/file/d/17Nd9JILGclQUGYnaTI-e5sy5cwjEwdEz/view

Recovery Based Administration is Crucial

Recovery programs have largely been developed by “outsiders” in isolated “bubbles”.

Most recovery staff complain that they can’t practice recovery within their programs and systems.

We should treat staff the same way we want them to treat our patients.

For recovery practice to be widely and effectively implemented, it needs to be embedded in recovery-based systems and supported by recovery-based administration and supervision.

Stages of Recovery Based Careers

- **Student / Intern**: Dialogue and relationship skills, Understanding impact of illnesses, Professional identity, Usefulness in goals, Poverty services
- **Early Career**: Collaborative medication, Trauma effects, Strengths based, Team work, Shared responsibility with clients, family impact
- **Mid Career**: Collect stories from “practice”, Develop “art” of treatment, Emotional engagement with stability and without burnout, community engagement, leadership
- **Late Career**: Numerous long term relationships / stories, Experience / patience, Mentoring, legacy

Where are you developmentally?

Where are your staff?

What are your most common challenges / barriers to development?

Recovery Staff Development Assessment

	Not Exploring	Exploring	Emerging	Maturing	Excelling
Student/Intern					
Dialogue and relationship skills					
Understanding impact of illnesses,					
Usefulness in goals					
Poverty services **Early Career**					
Mid Career					
Late Career					

Dialogue and Relationship Skills

We have to "meet people where they're at" – often untrusting, unengaged, unmotivated, and irresponsible

- Can you have a "normal caring" conversation with someone without fear and without resorting to hiding behind professional distance, boundaries, and paperwork tasks?
- Can you put them and their needs ahead of your own self-interest and self-protection to commit to being there when they really need you?
- Can you keep working with them when they're not doing what you want them to and having serious problems as a result without getting frustrated and punitive?

"I can tell you really care about me. I'm not just another case to you."

Understanding Impact of Illnesses

"Do you really want to know?"

- Can you go beyond identifying "signs and symptoms" and naming conditions to understanding what it's like to have the experiences they're having?
- Can you understand not just what you would feel in their situation and how you'd react, but what they're feeling and how they're reacting?
- Can you move beyond compassion to empathy?

These understandings are the foundation of true person-centered, client-driven services.

Managing Risk and Staff Growth

Staff can only take the risks needed to learn and grow in a culture of trust and security.

Supervisors must manage insecurity without creating a culture of defensiveness

Our traditional practice trains staff to make them “prepared and likely to succeed” and then monitors their performance using “fear based” accountability

Recovery based practice gets staff “motivated and excited” so they will learn by doing/ “bumbling together” with their peers and supervisors in a “failure tolerant” environment

Field-based supervision

In the same way that recovery services value in-vivo side-by-side learning, growing while pursuing concrete tasks instead of talking about what to do in therapy, recovery-oriented supervision includes field-based supervision – experienced staff teaching by working alongside less experienced staff.

Who is “excelling ”at each recovery based skill to be able to model and teach them in-vivo?

THANK YOU!

Check out my book

Journeys Beyond the Frontier:

A Rebellious Guide to Psychosis and Other Extraordinary Experiences

at Amazon books and Kindle

Look for my articles and videos at
www.markragins.com

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