Creating Recovery Possibilities

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Learning from the people we serve

I’m just old enough to remember when medicine was a practice, when we learned from our patients instead of memorizing research studies and literature reviews, practicing fidelity to “evidence-based practices”, and putting health information into computerized data bases with treatment algorithms to assess quality of services

We still need respectful curiosity

“Do you really want to know?”

Looking for hope

I was taught that hope was coming in the next biological breakthrough, the next medication – but that we'd have to do more public education, stigma busting, and decreasing patients' rights to refuse treatments, and rebuild some asylums to use them effectively.

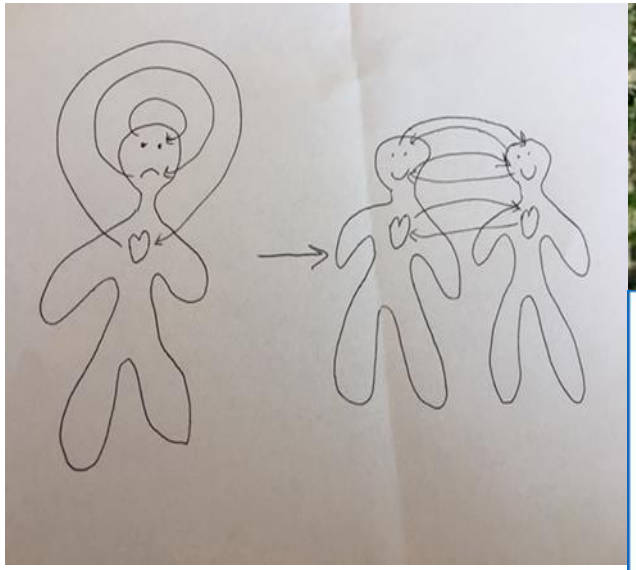
I was looking for alternatives:

- In medical school I saw a hospice, a 12-step program, and a clubhouse
- Some of the old, discredited psychoanalysts had hope, and maybe results
- RD Laing had an entirely different approach
- Skid row was energetically using new approaches – welcoming "guests", practical case management, "meeting them where they're at", outreach and engagement, med management

Hope in the lived experience of recovery and the programs they created:

Dan Fisher

https://power2u.org/dan-fisher/



Emotional CPR

National Empowerment Center

PERSONAL ASSISTANCE IN COMMUNITY EXISTENCE

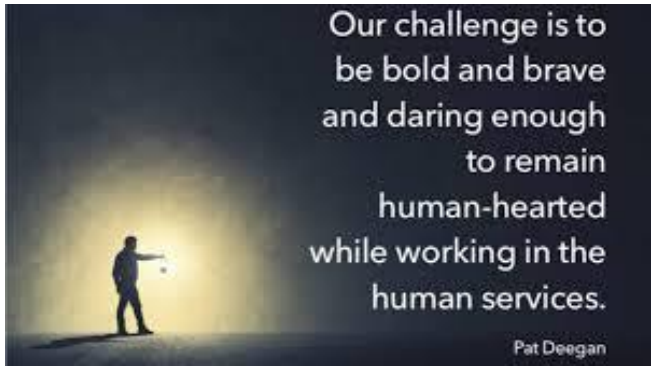
A Recovery Curriculum

Recovery at Your Own PACE

National Empowerment Center, Inc.
800-POWER-2-U (800-769-3728)
www.power2u.org

Patricia Deegan

https://www.commongroundprogram.com/about-pat-deegan



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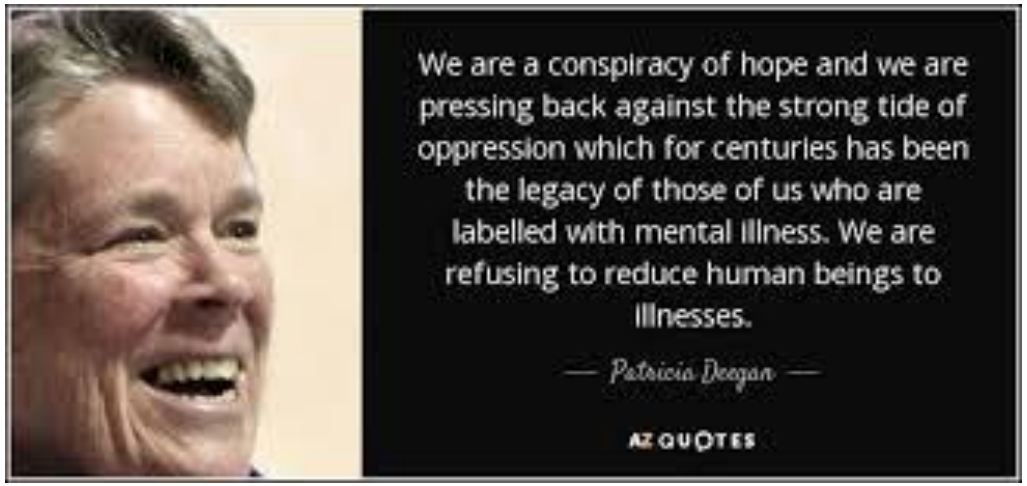


Hope in Research and Rehabiliation

What really happened to the people let out of the state hospitals?

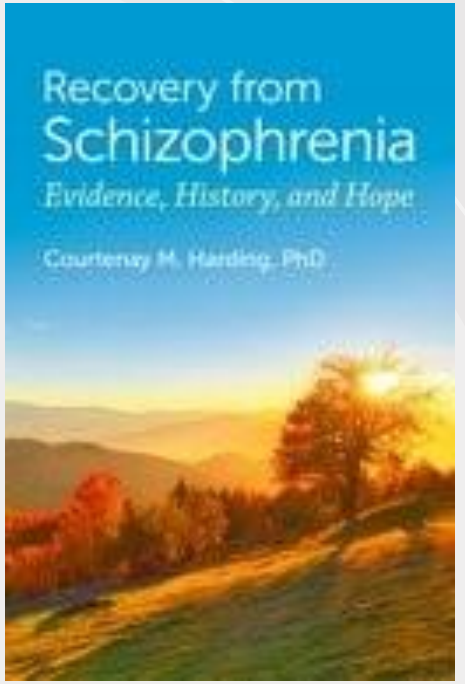
Vermont Longitudinal Outcomes 32 years after state hospital closure
Courtney Harding, et. al. 1987

TABLE 3. Results From the Strauss-Carpenter Levels of Function Scale for the 168 Subjects of the Vermont Study Who Were Alive and Interviewed

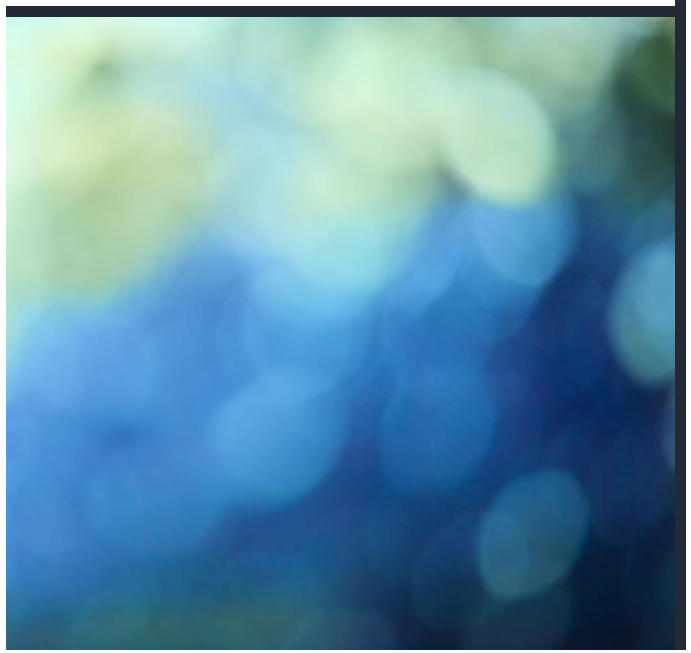
Area of Functioning	N	%
Not in hospital in past year	140	83
Met with friends every week or two	111	66
Had one or more moderately to very close friends	128	76
Employed in past year[a]	79	47
Displayed slight or no symptoms	121	72
Able to meet basic needs	133	79
Led moderate to very full life	128	76
Slight or no impairment in overall function	92	55

[a]Quality of work could not be rated; issues of confidentiality prevented visits to subjects' work sites.

- There is no condition identifiable with diagnostic criteria that reasonably reliably describes the deteriorating psychotic condition we call schizophrenia. They usually get better.
- Research limited to short time frames and objective, quantifiable symptom data can't see the full picture, and mislead us
- Recovery depends far more on what happens to people and the opportunities they're given, and especially hope, then on any symptom or medication response.
- Meds are most effective when used to rebuild your life and then stop them, then to stabilize your biochemistry for the rest of your life.



The Original Village 1990



- Combination of ACT and clubhouse together integrated within psychosocial rehab culture
- Combination of professional, paraprofessional, and peer staff working as teams
- No fee-for-service illness centered billing or funding – quality of life outcome accountability
- Strong community and political connections and support
- All services integrated and capitated, including crisis and inpatient, housing and employment
- Didn’t have to do anything “ the way it has always been done” – very limited bureaucracy
- “no fail” program for members

SERVICE EXPENDITURE PATTERNS: VILLAGE vs. COMPARISON GROUP (1990-1994)

	Village	Comparison Group
Service	Percent of Total	Percent of Total
Case Management	40.6	10.1
Day Treatment	0.2	1.0
Medications	11.2	10.2
Residential	0.3	2.1
Socialization	11.6	1.2
Outpatient Therapy	4.7	23.2
Vocational	25.1	1.3
Acute Hospital	5.1	27.9
Long Term Care	1.3	23.1

The normal system spent their money on hospitals, long term care, and therapy – professional illness centered services
The Village spent our money on case management, employment, and socialization – person centered services.

Village Outcome Highlights

- About 70% reduction in homelessness, hospitalization, incarceration
- About 65% reduction in institutional / group living (primarily to independent/ supportive living)
- About 400% increase in employment (75% tried some work in the first year)
- Increase in satisfaction with services among members and families
- No suicides in first 10 years (also massive decreases in attempts, threats, hospitalizations)
- About 2/3 of people with history of serious substance abuse were in serious recovery / entirely clean over time
- Outside auditor noted striking walk-in accessibility to staff and staff taking people's goals and dreams seriously and actively working on them
- Almost no drop-outs from program (but coupled with very few "graduates" led to "filling up" and repeated need to expand program size…until "flow" was systematized)

Over time outcomes shifted with funding changes, program changes, and especially outside changes – like recession and housing market and prison releases.

Many hopeful, effective recovery practices have been developed in the last 30 years…that aren't being funded or used much

- Psychosocial rehabilitation (supportive education, employment, housing, socialization, etc.)
- Housing first programs
- Peer run warm lines
- Living room crisis programs
- Harm reduction and motivational interviewing for substance abuse
- WRAP, "personal medicine", and advanced directives
- Open dialogue
- Voice Hearers Network groups
- Collaborative mental health / police teams and police "quality of life" teams
- CBT for psychosis
- Clubhouses (built on Fountain house model)
- Integrated substance abuse recovery
- Crisis residential programs (built on the "Soteria model")
- Mental health and drug courts
- Consumer and family greeters
- Peer bridgers (from institutions to the community)
- HeadSpace teen drop-in centers
- Core gift mentoring
- Trauma-informed inpatient care to reduce seclusion and restraints
- Moral CBT for ex-convicts
- Emotional CPR

What does this have to do with recovery? Why couldn't the "medical model" have done this?

- Medical model only funds clinical, illness centered services
- The medical culture requires people to act like patients with weakness they need professionals to help them with, often assuming they're helpless without us, rather than looking for and building on their inner strengths
- Professional ethics requires professional distance with strong boundaries and emotional separation
- Professional liability requires professionals take the risks and be responsible, not the people being served
- Medical model services are accountable for only clinical, symptom outcomes, not quality of life outcomes
- Medical model services require isolated, private, professionally responsible services, not community connected, public, socially responsible services

When we closed the state hospitals, we retained the same staffing patterns, treatments, culture, roles, and goals. It still isn't working and we're not adapting even though there are effective alternatives.

3 Essential Recovery Transformations

1. ***From Illness-Centered to Person-Centered:*** Moving from centering our efforts on the treatment of illnesses and the reduction of symptoms to a holistic service of people and the rebuilding of lives. ***Recovery is something a person does, not an illness.***
2. ***From Professionally-Driven to Client-Driven:*** Moving from professional directed relationships emphasizing informed compliance with prescribed treatments to individualized relationships emphasizing empowerment and building people's self responsibility. ***We don't do recovery to someone, recovery comes from within them.***
3. ***From Deficit-Based to Strengths-Based:*** Building for recovery upon each person's strengths, motivations, and learning from suffering rather than upon the competence of professionals and medications to reduce or eliminate the burden of their illnesses. ***People don't recover because we cure what's wrong with them, but because they build protective factors and resilience***.

We applied recovery to everything we did

- Capitated “designer care” funding
- Recovery and quality of life outcome accountability
- Recovery based administration, supervision, and staff development
- Recovery based culture and rituals
- Recovery based staff – client relationship parameters and practices
- Crisis response models
- Strengths-based community integration and community development
- Adapted programs to special populations

We envisioned an entire recovery-based system

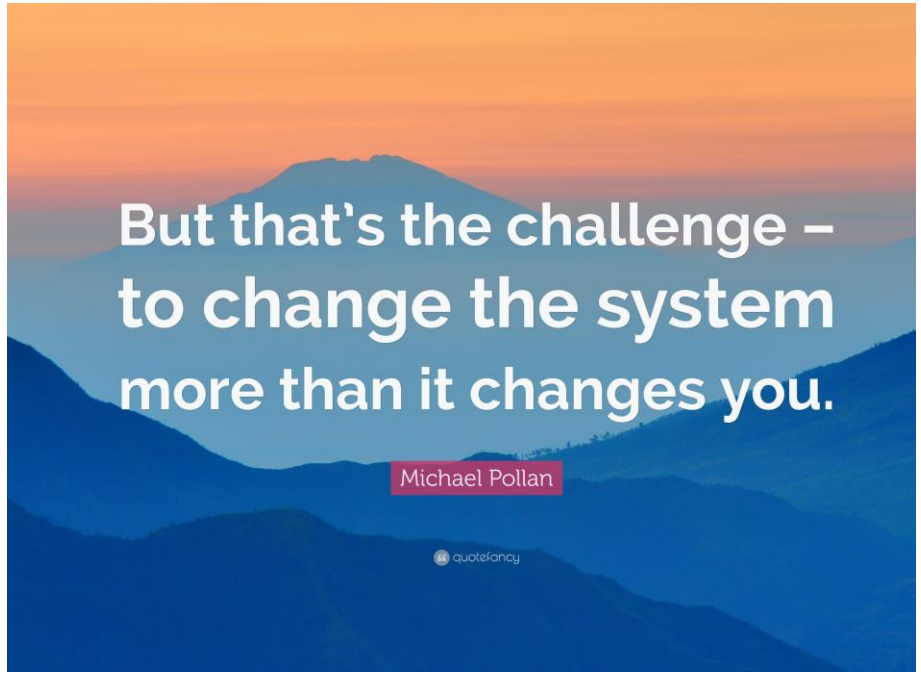
Person-Centered Levels of Service (Recovery Based Spectrum of Care)						
Extreme risk	Unengaged		Engaged, but not self coordinating		Self responsible	
Locked setting	Outreach and engage-ment	Drop-in center	Intensive case manage-ment (ACT)	Case manage-ment Team and Clubhouse	Appointment based clinic	Wellness center
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	

And we began to piece a system together

MHALA's Recovery Based System of Care in Long Beach			
System navigator (no wrong door)	Unengaged	Engaged, but not self coordinating	Self responsible
	Outreach and engagement Homeless Drop-in Center (HAP) Street Medicine Team (HIP) Housing – First Programs Welcoming Team (FSP)	Intensive case management (FSP) Less Intensive Case Management (FCCS/VHS)	Wellness center (enrolled or "social members")

MHALA and the Village tried to move from being an isolated “demonstration project” in a bubble to transforming the entire system

- Inspirational and instructional example - “immersion trainings”
- Wide-spread trainings, workshops, consultations, articles and books
- Defined and trained in recovery-based practices including “Jump Start” and “Mental Health Pipeline”
- Created recovery tools
- Leading role in passage of Mental Health Services Act in California and its implementation



Over time, we nurtured a lot of other recovery bubbles, some that continue to spread, but we didn't transform the system

For a recovery revolution to really succeed:

1. We need to spread a pervasive recovery narrative and vision
2. We need to reform government funding and how programs and staff are held accountable
3. We need places for people to connect with each other
4. We need to change who is doing the work, how they're trained and supported to avoid burnout
5. We need widespread community support and inclusion

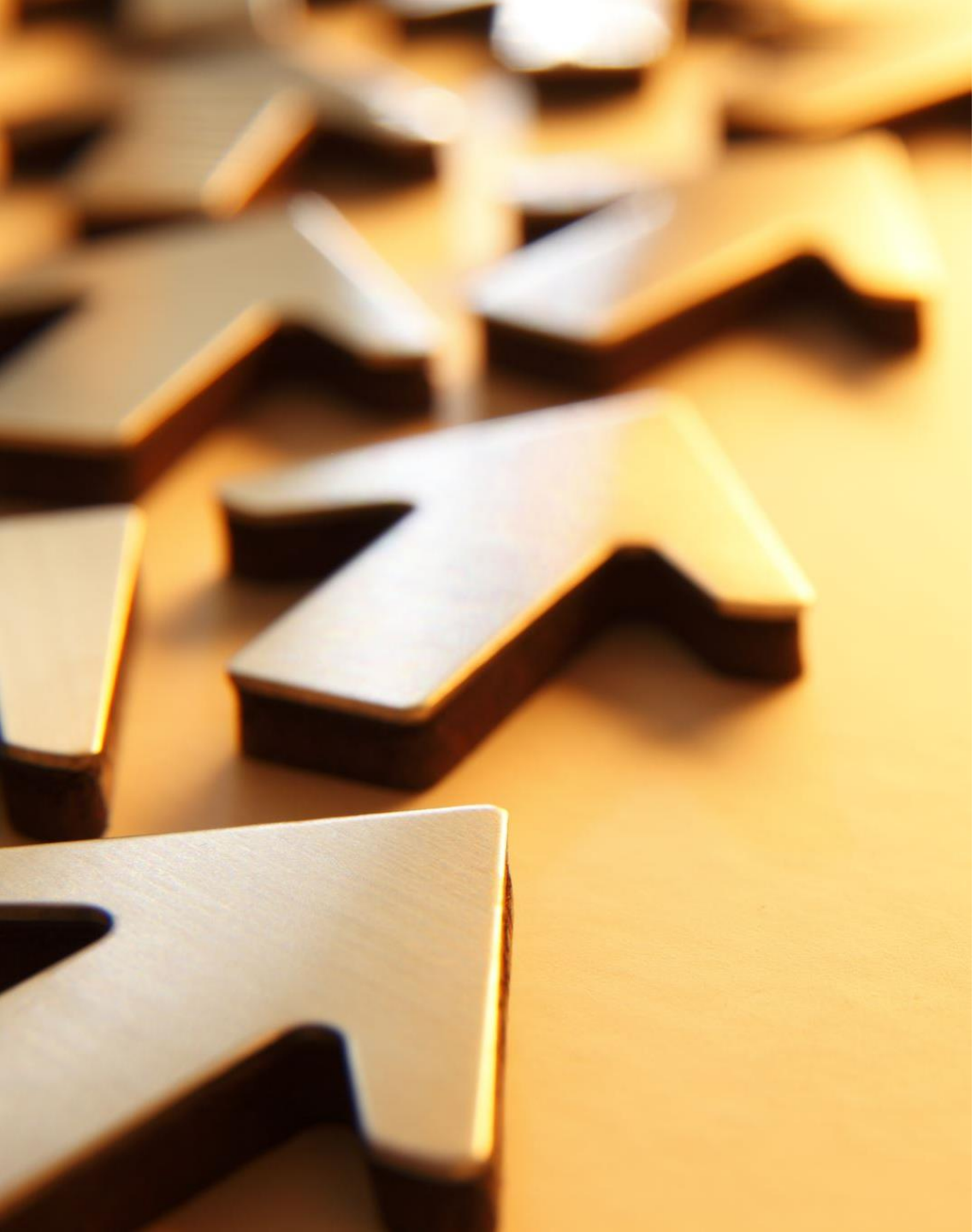
It's far easier to be Che Guevara throwing bombs than to be Nelson Mandela trying to build a just, integrated country.

It's more complicated than, "What's the one thing you'd do to help homelessness if you were the governor?" and nobody likes complicated.

Eventually our bubble popped… and there is no more Village

It's important to understand what forces changed us into something different:

- Illness centered funding and fragmented funding and accountability
- Loss of control over hospital
- Administrative risk aversion and prohibitions
- Gentrification – pushed out of neighborhood
- External events – recession and especially housing crisis
- New MHALA leadership that doesn't value recovery, welcoming, or shared authority
- Elimination of trainings and system change focus



Passing the recovery torch

- How do you feel boxed in by the current paradigms?
- What would you like to explore, beyond where we've gone?
- What things have you discovered and wondered about?
- What ideas do you have about how to explain things and help people?
- What new practices would you like to develop?
- Can you see and begin to create a new emerging vision and system?

Whatever you do, remember to include:

- Listening to and learning from the people we serve
- Building and sustaining hope
- Welcoming and inclusion on every level

and our three essential transformations:

- Person-centered
- Client –driven
- Strengths - based

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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