Four Levels of Recovery Practice

(2009)

Increasingly mental health professionals are feeling pressure to participate in recovery transformation. After hearing presentations that generally combine some condemnation of the "medical model" with some praise of lofty recovery ideals, like hope, empowerment, individual journeys, overcoming illnesses, many professionals are left wondering, "So, what do you want me to do?" What usually follows depends heavily on who the recovery advocate is. Recovery practice seems to incorporate a bewildering array of practices ranging from medication collaboration and shared decision making, to rehabilitation, to supported employment and housing, to consumer run programs, to building resilience and protective factors, to cultural competence and trauma sensitivity. It can sometimes feel like recovery is being used as a vehicle to promote a set of fashionable, boutique practices that no one really has the time or resources to add to what they're doing already, instead of a coherent model for system redesign and transformation. This paper uses a four level model adapted from leadership practice to build a coherent model of recovery practice.

Leadership practice can be described as consisting of four levels:

1) **Direction** – Level 1 leadership is where a leader who knows what they want tells the person they're leading what to do and how to do it and expects compliance. A symbol level 1 leadership is a downward pointing arrow.

2) **Support** – Level 2 leadership is where a leader has an overall idea of what they want to go, but they expect the person they're leading to use their own ideas and talents to get there. A level 2 leader provides support, encouragement, skill development and resources to build on the capabilities of the person they're leading. A symbol for level 2 leadership is an upward pointing arrow.

3) **Linkage** – Level 3 leadership is where the leader doesn't provide support directly, but instead helps link the person they're leading to other people and resources so they can get the job done. A symbol for level 3 leadership is a triangle (between the person being led, the leader, and the linked resource). If a leader creates enough triangles around themselves they can form a network of triangle that interact synergistically.

4) **Networking** – Level 4 leadership is where the leader who has a network interacts with other leaders with networks to work on goals too large for either of them to achieve within their own sphere of influence. A symbol of level 4 leadership is interlocking webs of triangles.

Let's apply these four levels to mental health services and recovery practice:

1) **Recovery enhanced practice** – Most mental health practices exist primarily on the level 1 – directive. People in need come to trained experts to be told what to do to improve their problems and they expect to benefit if they follow instructions.

There are important advantages to - and indications for - practicing on this level including :

- It is what everyone – professionals, clients, families, the community, payers, politicians, etc. – expect and are, to a large extent, comfortable with. It overtly meets people's expectations of what being "taken care of" is supposed to be.
- It provides a clear path to bring professional training and research to bear on the person's problems – "Evidence Based Practice" – presumably leading to predictably good outcomes
- It allows individuals to be grouped into commonly offered services that are more easily monitored and paid for than highly individualized services.
- It allows providers and their administrators to create more "efficient" ways of delivering services because they control what services are delivered.
- It places responsibility clearly in the hands of the professionals who are expected to be able to make better - more objective, rational, altruistic, and informed - decisions than the impaired person being served would be able to make.

There are important disadvantages to practicing on this level including:

- It presumes that the professional will be able to effectively collect enough relevant information – including individualized factors – to make a comprehensive enough assessment to base effective service decisions upon.
- Many people inherently dislike and will have negative reactions to being told what to do, not infrequently, even discontinuing the service relationship as a result
- Many people will not obediently follow instructions they have not "bought into" for prolonged periods of time
- It doesn't provide any clear path to bring the person's strengths and supports – including their family, culture, and spirituality - to bear on their problems
- Individual professionals may create different service plans depending on their training and understanding of the person that can lead to fragmented teams or radical shifts in services when providers change (for example, major medication changes when someone goes into the hospital)
- Lack of adherence to the plan and/or lack of treatment success are likely to be viewed narrowly as the result of the illness and its associated impairments, often overlooking a wide variety of other possibilities not directly related to their illness
- If professionals get frustrated with people's lack of compliance and poor outcomes, they are likely to seek more "control" of the situation – most commonly structure and coercion – to more

readily implement needed services. Although this may be perceived as supportive by the professional (for example, when involuntary outpatient treatment is described as "assisted" treatment) this may be perceived as oppressive and traumatic, rather than caring and helpful, by the person seeking help and precipitate a loss of trust and either a destructive power struggle or a withdrawal form services.

- It may inadvertently lead to an increased passivity and dependency on the part of the person seeking help and their supports as decisions and responsibility are turned over to the professionals

The recovery movement has developed a series of practices designed specifically to address these disadvantages. These practices may appeal to those attempting to incorporate recovery within their current practice, to have recovery enhance the "medical model", without massive disruption. Prominent examples include:

- Shared decision making practices – including medication collaboration, shared goal setting and service plans, advanced directives, and some "chronic care" models
- Illness based psychoeducation – for the person to build their insight, understanding and "buy in", and for their family and even their community. Sometimes the "teacher" role is a more palatable instructive role than a mental health professional role
- Enhanced engagability, accessibility, and integration of services to reduce drop-outs – including collocating services, ACT teams, outreach and engagement services, and integrated service teams
- Personal (and family) treatment history collection and organization tools to give information to new professionals
- Cultural competency and spirituality trainings
- Trauma informed care – This can be used to help build "buy in" since many people more readily conceptualize their problems as traumatic than as an illness, and it can also be used to short circuit power struggles between professionals and the people they serve, most strikingly to achieve reduction of seclusion and restraints in hospital settings
- Inclusion of consumer staff to bridge between professionals and the people they're serving
- Recovery enhanced service triage and outcome tools – revised LOCUS

2) **Recovery based practice** – This level is a paradigm shift from level 1. On level 2 the task isn't to figure out how recovery can enhance services, but to figure out how services enhance recovery. Every treatment and service is evaluated on how well it promotes recovery. The goal isn't to treat illnesses, but to help people with illnesses build better lives. This represents a shift from "illness centered" services to "person centered" services. With that shift comes a shift in emphasis from

maximizing the professionals strengths in treating illnesses effectively to maximizing the person's strengths in overcoming their illness – a "strengths based" approach. Success is marked not by symptom relief but by overcoming crippling and dependency emerging from destruction with resilience and strengths. Treatment isn't something done to someone; it's done with them. The professional's responsibility is to provide information, skill building, helpful tools (like medications and coping skills), opportunities, and help develop the person's strengths. It is the responsibility of the person seeking help to actually use these services and to work on their own goals and recovery. As Home Depot puts it, "You can do it. We can help."

This level specifically attempts to address the disadvantages of level 1, but unfortunately creates its own set of disadvantages. Important advantages of practicing on - and indications for using - this level include:

- With many people it is far easier to build a shared plan built on a shared "insight" into problems in improving your life than on "insight" into their illness. People often work harder on pursuing life goals than on illness relief.
- Many people inherently like being supported and empowered more than being told what to do and taken care of.
- Many people do have substantial strengths and supports, of a variety of kinds, that they can use effectively to rebuild their life
- Many people do, over time, take increasing responsibility for their own lives and recovery and are much more successful when they do than when they waited for the professional to "fix" them.
- It is often easier to take advantage of the professional's authentic liking and caring about the person they are serving when the relationship is less limited by illness based professional functions and roles. This can be useful to improving the relationship – resulting in increased personal trust and disclosure and fuller assessments, stronger "placebo" effects and reduced side effects, more collaboration, more goal-driven risk taking, and less power struggles – and it can be useful in reducing staff feeling drained and burned out.
- Programs that include people's entire lives and not just their illnesses tend to be more filled with life themselves and more fun to work at and come to.
- Professionals benefit over the long run by not feeling compelled to take responsibility for things they can't control and are less likely to engage in power struggles and coercion.
- The person's own goals and plans can be used to integrate services provided by various professionals, both within a team and over time.

- A broader array of both barriers and skills and supports can be appreciated from a person-centered perspective than an illness-centered perspective often including additional sources of hope.

There are important disadvantages to practicing on this level including:

- It is far more difficult to implement, account for, pay for, and make "efficient processes" for highly individualized services driven by the person's goals as compared to a professionally driven "menu" of offered services.
- Most people - professionals, clients, families, the community, payers, politicians, etc. – are less familiar with, skilled at, and comfortable with empowering relationships than with care taking relationships.
- It is sometimes easier to give someone a fish than to teach them to fish.
- Removing strict illness-centered professional functions and roles requires a greater understanding of ethics and safety. Also, it is harder to hide a lack of authentic liking and caring about the person being served behind professionalism.
- Increased responsibility and decision making is shifted to the person being served in this level. Both sides may be uncomfortable with this.
- The person may have significant impairments in self-responsibility, decision making, problem solving, etc. – that may or may not be related to their illness – that require skilled support from the professional and assistance in learning from taking goal-directed risks and experiences (rather than deciding for them and protecting from goal-directed risks and experiences.)
- People may have goals, and request services to meet them, that are not within the expertise or capabilities of the professional's skills, program offerings, funding (for example, wanting a job or a medication to make them not feel distressed by their problems), or sometime they require something that the professional doesn't want to do or think would be beneficial. This can lead to a whole set of frustrations and power struggles.

The recovery movement has developed a series of practices designed specifically within this paradigm shift. Prominent examples include:

- Initial focus on welcoming instead of assessment – drop-in centers, peer outreach, peer "big brother-big sister" mentoring programs
- Programs with multiple roles for people besides "patients" or "clients" – clubhouses, psychosocial rehabilitation programs, consumer run programs, programs with "recovery cultures"

- Building resiliency and internal protective factors – some trauma based services, self esteem and body image building, "core gift"
- Programs that build self help and coping skills – rehabilitation programs, adaptations of CBT, DBT, and trauma treatments, WRAP, "personal medicine"
- Programs that develop steps of a personally directed recovery plan – dual recovery 12 step programs, Recovery Inc., PACE
- Peer run self help groups and programs – apartment finding clubs, recreational groups, support groups, job clubs, peer advocate support groups, NAMI
- Programs that "support" people pursuing their goals learning "in vivo" – supported employment, supported housing, supported education, job coaches, life coaches, peer life coaches
- "Client driven" service models - client goal driven services, programs for consumers to "purchase" services, Full Service Partnerships
- Person-centered triage and outcome tools – Quality of Life outcomes, MORS

3) **Community integration** - This level is a paradigm shift from level 2. As people pursue their own goals and rebuild their lives, many will seek a life outside the walls and relationships of the mental health system or even consumer run programs. Many will need services to achieve their goals that are beyond the expertise and capabilities. To address this, mental health professionals will need to leave their offices and programs and work side-by-side with people in the community. "Case management" services take on a prominent and sophisticated role in overall service delivery. Professionals will need to learn advocacy skills to use on behalf of people and how to teach self advocacy skills to people to use on their own behalf. They will need to find community resources and create personal relationships with other service and community agencies in order to facilitate accessibility and adaptations for people with mental illnesses. The professionals' responsibility shifts from providing relationships and services directly to meaningfully linking and nurturing relationships and services throughout the community, sharing the responsibility with the community. Rather than telling everyone to refer people with mental illnesses to professionals who "know how to deal with them", we can support those courageous and open minded and naturally helpful enough to support people with mental illnesses too. These "supported linkages" should be not just with documentation agencies or social services agencies, but also with "normal" community connections. Life shouldn't be centered on receiving as many services as possible.

Important advantages of practicing on - and indications for using - this level include:

- People are more likely to feel professionals care about them if they are actively involved in their lives outside the program and interact where they live and work.

- Plans are more likely to be successful when additional supports and resources outside of the strained mental health system are included. Professionals may feel less overwhelmed when they realize are not all people have to rely on. Other agencies may take on increasing responsibility when given support from mental health professionals.
- People have a better chance of displaying and increasing their personal strengths and achieving meaningful roles when they are outside the mental health program.
- People can feel dramatically less limited, oppressed, and stigmatized when they function outside the "segregation" of the mental health system.
- Behaviors that are adaptive within the mental health system, but maladaptive in the community are more likely to change. Self responsibility will more likely increase in the "real world".
- Loneliness, isolation, and desperate reliance on mental health professionals (by both people being served and their families) may be reduced with increased community connections

There are important disadvantages of practicing on this level, some of which are further extensions of the disadvantages on level 2. The disadvantages include:

- It is even more difficult to implement, account for, pay for, and make "efficient processes" for community integration. Staff who are out of the office are more difficult to keep track of and supervise. Holding other agencies, in other "silos" responsible for serving people with mental illnesses in adapted, effective ways is very difficult.
- Most people - professionals, clients, families, the community, payers, politicians, etc. – are less familiar with, skilled at, and comfortable with creating and nurturing linkages than with direct service relationships.
- It is sometimes easier to provide a service yourself than to link to someone else.
- Moving into the community requires even more attention to safety, ethics, and confidentiality. Professionals are likely to fell far safer and more comfortable and "in control" within their own programs than within people's communities. Professionals are likely to be unprepared or trained to deal with the actual dangers (and opportunities) in people's lives.
- Increased responsibility and decision making is shifted to the community in this level. The community may be uncomfortable with this. The community may respond with increased coercion and/or segregation, often through the police and justice system as a result. "If you won't take them away, we will."
- There is likely to be substantial stigma, prejudice, and outright rejection of people with mental illnesses in a variety of community agencies and settings. In the community we can't resort to protecting them by keeping them in "educated", "understanding" mental health settings

interacting just with professionals or peers (assuming those settings aren't also often stigmatizing, prejudiced, and rejecting too).

- Though not statistically more often than anyone else, people with mental illnesses do sometimes harm themselves or others. By expanding their relationships we expand those at risk (beyond the usual family, peers, and professionals) which will likely be frightening to the community and fanned by the media.

- Like professional staff, consumer staff and consumer run services may also be reluctant to leave their "segregated" comfort zone and move into "non mentally ill" roles and settings.

The recovery movement has also incorporated a series of practices designed specifically within this paradigm shift. Prominent examples include:

- Co-located staff in a variety of other agencies – Social security, welfare, children's services, schools, medical clinics

- Community integration specialists – job developers, housing developers,

- Models for community integration – developing "niches", finding "welcoming hearts"

- Police and jail education and collocated staff – MET teams, mental health and drug courts

- Individual linkages – COMPEER, "big brother – big sister", community volunteers and mentorship, SAMSHA's "What a difference a friend makes"

4) **Community development –** This level is also a paradigm shift from level 3. Instead of working to help people with mental illnesses be better able to get along in our community, we're working on making our community a better place for people with mental illnesses to get along in. The community becomes our "client". The network of people and resources in the mental health system interact and interlock with other networks who are also seeking to improve our community. We can't expect to eliminate trauma and illnesses, or even substance abuse, but we can work to strengthen our communities so the negative effects are minimized and people are supported to overcome them. We can also increase our community's tolerance, welcoming, compassion, acceptance, and inclusion of people with mental illnesses so they have the opportunity to recover. If mental health services are socially responsible "good neighbors", people with mental illnesses are more likely to be accepted in the neighborhood.

Important advantages of practicing on - and indications for using - this level includes:

- Many communities don't have already existing resources and supports for people with mental illnesses and the only way to get them is to develop them

- Many agencies are not "naturally" accessible to or adapted to people with mental illnesses and substantial relationships and formation of mutual interest are needed to influence them

- Mental health is a relatively weak "special interest" group on its own and needs allies to have influence. This process of forming alliances may have the added benefit of increasing exposure to people with mental illnesses and decreasing stigma.

- Some communities have relatively low "social capital" or opportunities for anyone, let alone people with mental illnesses, or are poorly functioning communities, and could benefit globally from community development

- There are sometimes existing political structures that could be used to benefit people with mental illnesses, but the mental health system doesn't have sufficient political influence to be able to use them. Partnering with other "political" groups (like disability groups, immigrants, minority groups, etc.) could overcome this ineffectiveness.

- There are major community resources in cultural traditions, alternative healers, and spirituality that can only be accessed and partnered with if substantial effort is made to build mutual appreciation and respect first.

There are important disadvantages to this level including:

- This work is far from the services mental health professionals are normally associated with. There is no community or political consensus that this is work mental health professionals should be supported with tax money to do. Payment and accountability systems generally don't exist.

- Mental health clinicians generally don't have training, expertise, or comfort in community development. Other professionals, including mental health professionals, who do this work are generally in non-clinical settings only minimally connected to clinical professionals and their work. This "internal" separation and lack of appreciation, relationships, trust, and collaboration handicap effective community development as part of recovery based practice.

- Desires to avoid stigmatization and rejection, often fortified by privacy and confidentiality rules, have promoted an overall practice of hiding mental health services and the people receiving services. Community development is fundamentally incompatible with our current treatment culture of shame and secrecy.

The recovery movement has some pioneers incorporating community development into their practice. Prominent examples include:

- Advocacy for changes in other social service systems – housing, social security, vocational rehabilitation, education

- Collaborative ventures – subsidized housing projects, Voc Rehab / DMH coop, Handicapped Habitat for Humanity projects, city redevelopment projects, hiring people with other disabilities in MH services

- Active participation in other community "causes" – cancer walk, health fairs, homeless census
- Active participation in community events and celebrations – local marathon, block party, neighborhood clean-up, local arts fair, Gay and Lesbian parade, acute disaster response
- Active participation in ongoing community activities - community garden, neighborhood watch, Meals on Wheels, farmer's market, school art programs
- Collaborative political causes and campaigns
- Building neighborhood "protective factors" – developing community capacity for trauma response and care, building "adult protective shield"
- Enhancing local cultural, healing, and spiritual strengths – creating partnerships and collaborative "safety nets"
- Mental health education and anti-stigma efforts

Practicing recovery on all 4 of these levels would be strikingly demanding and rare for any one person or even one program, at least at present. We are all part of this large vision, and we need to be, if people with mental illnesses are going to recover regularly in our communities.