The Village struggled for a long time with the concept of "consumer driven" before coming to the collaborative compromise of "value driven and consumer centered." Explaining this difference to people new to recovery often helps them not feel like we're not really recommending "turning over the asylum to the inmates." Even though our approach is still far more "consumer driven" than they're likely to be using or even considering using, this gives them a more comfortable place to start.

I wrote this paper recently for newer Village staff. I've heavily drawn on concepts we developed for system transformation that will be discussed in detail in later chapters, but tried to write it in a way that it speaks to everyday issues and insecurities. I tried to keep including the collaborative nature of the service relationship because it's so easy to return to a helpful expert – helpless client relationship. That's not the comfortable place I'm aiming for.

Recovery Based Service Coordination

(2006)

Recovery based programs pride themselves on treatment planning and service delivery that is "consumer driven." We don't assume we know what's best for people. We don't tell them what they have to do or limit our help to what we think is right. We try to support them as they find their own path to recovery.

But the day to day reality isn't that straightforward. We don't actually support every goal people might create – for example killing your family or using lots of drugs while we pay their rent and help them get off when the police catch them. We do try to persuade people do what we think would be helpful. Sometimes, like with payees or medication management or hospitalization we even coerce people. We do have some overall positive vision for what we're trying to accomplish that we're trying to sell to people.

Reality is closer to "value driven and consumer centered."

We have some values that are socially driven, like cost containment, not bothering the neighbors, helping out the police, and increasing the safety of our community. We need to promote these values to stay in business. We have some values that are Quality of Life driven like housing, staying out of jail and hospitals, finances, employment, education, physical health, etc. These values are incorporated into our Outcomes and we're held accountable for them. We also have some values that are recovery based. We want people to recover.

Service coordination at its best is an effort to promote those values along a path that is centered on each person's choices.

In the same way that traditional mental health programs prescribe certain treatments based upon people's diagnosis and case management / rehabilitation needs, recovery-based programs base their services upon people's recovery stage, quality of life goals, and society's needs. When we get into disagreements with the people we serve about what service they want, we can reground ourselves by

asking which of the three value sets is generating the conflict. Do we disagree about what would promote their recovery at this point? Do we disagree about how to pursue which Quality of Life goals at this point? Or do we disagree about what is socially acceptable?

Often we're least sure about where someone is in recovery and how to help them progress.

One useful way to track someone's recovery is by tracking three dimensions of recovery: 1) Risk – Presumably they're not very far along in recovery if they're at high risk for more damage. 2) Engagement – This doesn't mean "compliance with staff treatment and meds." This means connected with other people around the process of rebuilding. Presumably they're not very far along in recovery if they're seriously suffering but not connected with anyone trying to work to improve. On the other end, presumably if they're far along in recovery they don't need much professional help and can successfully live with natural supports. 3) Skills and supports – Presumably the more skills they have the better, along with the supports they need keep progressing.

As people progress in their recovery their service needs change in all three dimensions: Risk, Engagement, and Skills and Supports. Being aware of where people are in their recovery process can clarify how to handle common conflicts. For example, if someone wants you to drive them somewhere and you want a life coach to teach them how to take a bus to get there, it helps to know what their skills and supports are. This also applies for if they want to be their own payee and you don't think they're ready. On the other hand, if you want to hospitalize someone or give them a life coach for overnight crisis support and they think they can manage on their own, the issue isn't just skills and supports, but also risk. This may also apply for getting off medication management. When they complain that you used to buy them lunch and now you won't, it may be that there level of engagement has changed.

Note that these recovery based considerations do not give you authority to override the person's choices any more than clinical considerations did. They are a way of clarifying the collaboration for both of you.

Pursuing quality of life goals may require different services depending on someone's progress in recovery. It's not that they can't pursue certain goals, for example employment, until they've achieved more recovery. It's that the way to pursue their goal changes. For purposes of simplicity let's divide people into three groups based on the three dimensions, irrespective of their diagnosis: 1) "unengaged," 2) "engaged, but poorly self-directed," and 3) "self-responsible."

People who are "unengaged" generally do not collaborate in their recovery. They might refuse all treatment, come in irregularly during crises, only want charity and entitlements but not treatment, or be brought into treatment repeatedly or involuntarily for being dangerous or disruptive. People who are "engaged, but poorly self-directed" might want to collaborate in their recovery, but have trouble coordinating the services they need. They may miss appointments, take medications poorly, abuse substances, or have poor skills or support. They need someone to help coordinate their services. People who are "self-responsible" not only collaborate in their recovery, they can coordinate it.

The three groups are not dependent entirely on consumer traits. System traits, primarily "engageability" and "directability," also affect who is in which group. For example, there were many people who went to the Mental Health Association's Homeless Assistance Program who wouldn't go to a local mental health clinic to make appointments and get medications. However, when I started handing out pills at HAP's drop-in center, most of them wanted to take pills. They weren't really "medication resistant." They were "clinic resistant." When I changed the "engageability" of psychiatric services, many of them changed from "unengaged" to "engaged, but poorly self-directed." Similarly, it is far easier for consumers to coordinate their own services if they are available at one site in an integrated services program, instead of scattered in several separate systems.

Keep in mind that every service is designed to help the person grow into the next stage. For example, you can meet the housing needs of an "engaged, but poorly self-directed" person with a Board and Care by adding structure, making decisions for people, and taking care of their needs, but this is unlikely to lead to them growing into the "self-responsible" stage. On the other hand, supported housing where you provide for their needs in an apartment setting while training them to do it for themselves both meets their housing needs and is likely to lead to growing into the "self-responsible" stage. All services should be seen as "transitional" but rarely strictly "time limited." Transitions are likely to lead to the most conflicts as services change. It can sometimes help transitions if staff have been talking about them from the outset, so they're not surprises. Although transitions can be gradual, staff have to change to keep working with people moving forwards alongside them as they progress.

For each stage there is a key service delivery question: For "unengaged," it's "What's the engagement value of this activity?" For ""engaged, but poorly self-directed," it's "What's the rehabilitation value of this activity?" And for "self-responsible," it's "What's the community integration value of this activity?"

Services can be differentiated so people can successfully pursue their goals at any stage of recovery.

For example, an "unengaged" person doesn't have to become "self-responsible" before they can pursue employment. They can pursue employment right now with day labor or "work for a day – house for a day." An "engaged, but poorly self-directed" person can pursue employment with an agency businesses, supported employment including job development and coaching, group placements, or supported mental health employment. A "self-responsible" person can pursue employment with non-disclosure competitive employment job development or competitive mental health employment.

A similar recovery based spectrum of services can be made for housing, finances, substance abuse, therapy, medication, socialization, education, and even crisis response. As another example, the crisis response spectrum is: "Unengaged" people need outreach, crisis walk-in, meeting practical needs while engaging them, and us collaborating with coercive services diverting them when possible. "Engaged, but poorly self-directing" people need home visits, crisis walk-in availability, our 24 hour emergency hotline, a peer run warm line, coordination of support services in the community, and "life coaches." "Self-responsible" people need peer support, a peer run warm line, to coordinate natural supports in the community, and to utilize self-directed crisis plans (WRAP, advanced directives).

Services should be chosen by recovery stage, not by what's easiest to access at the time. Mismatching recovery stage and service, or lacking some of these services, make it harder to promote successful outcomes.

It is possible to collaborate with other agencies to provide more services, but usually not for "unengaged" people, only when facilitated by a case manager for "engaged, but poorly self-directed" people, and independently coordinated by the consumer using referrals only for "self-responsible" people.

A recovery program should pervasively emphasize growth and movement forwards. Some people may resist moving forwards, for example, preferring you to do something for them instead of learning to do it for themselves, or preferring to spend time at the Village where they feel safe instead of developing new roles and connections out in the community. If you're well grounded in understanding the process of recovery you'll be more confident it's the right thing to do to push them and you can have better teaching conversations about why you're pushing them even though they don't like it.

Some people may not be willing to take into account the risks involved, being engaged with you, or their skills and supports when they decide to move forwards anyway. If you're aware of these dimensions, you can help them learn if they don't succeed so they'll do better the next time. Or maybe you'll be surprised that they're further along in recovery than you thought. It may be that the effort they made to grow itself helped them progress in recovery too. People don't always have to be "ready" to move forwards. Oftentimes they learn and grow as they go.

There's a lot of skill involved in being a good recovery worker. It's not just "do whatever the consumer wants" or "do whatever you know is best for them.