

## New Rules for Staff to Work By

(2006)

As I travel around the state conducting recovery based transformation workshops, I'm inevitably faced with an objection from the back of the room, "What you're telling us to do is against the rules. I'd get in trouble with my supervisor for that." Indeed when I looked at the personnel policies for Los Angeles' DMH, I realized I break a dozen rules before lunch. I am an outlaw.

Although it would ultimately involve sitting hour after hour in a workgroup debating every last word, I realized we'd have to rewrite the "rules" if transformation was going to have a chance. We have to bring our policies in line with a recovery based practice if we expect to succeed.

This document is the product of Chad Costello, David Pilon, and me from MHA joining a DMH Medical Director's work group including representation from unions, risk management, human resources, and the Office of Consumer Affairs. This is the final draft. It subsequently went through several layers of administrative approval to become official. I hope it will help guide others as you rewrite your rules.

No one told me when I was sitting in a college dorm room dreaming of changing the world, that to do that you have to sit in long administrative meetings writing bureaucratic parameters, but here they are.

DRAFT

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

OFFICE OF THE MEDICAL DIRECTOR

### 4.12 PARAMETERS FOR SERVICE RELATIONSHIPS IN A RECOVERY-BASED MENTAL HEALTH SYSTEM

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#### I. INTRODUCTION

The Department of Mental Health (DMH) has adopted concepts of the Recovery Model for the transformation of its delivery of mental health services. For the purposes of these parameters, recovery refers to both the process individuals go through as they rebuild their lives and to the mental health treatment movement focused on promoting individuals' recoveries. It includes an underlying belief that every individual can recover substantially, if not entirely, and deserves support to achieve their recovery. Although recovery is a uniquely individual process, each individual's progress can be described and tracked using a variety of descriptive tools. Generally this progress is conceptualized as moving through a series of stages, for example, hope, empowerment, self-responsibility, and attaining meaningful roles. These stages are flexible and fluid. They are fundamentally the same stages all individuals progress through as they recover from serious setbacks.

In adopting this model, DMH recognizes the role effective relationships between our staff (which includes volunteers and contract personnel) and the individuals we serve (individual) will play to accompany them through the stages of recovery. Staff must develop and use all their skill, education and talents to create and maintain caring, positive, and supportive relationships with individuals. DMH also recognizes that there may be new, substantial and complex risks inherent in such relationships.

**II. PURPOSE:** DMH has created these parameters to:

1. Support staff to manage potential risks successfully;
2. Serve as guidelines to understand recovery model concepts and the relationships essential to assist an individual through the stages of recovery successfully;
3. Clarify standard processes in the event of future legal actions,
4. Avoid misunderstandings for staff and individuals who may be unfamiliar with Recovery Model concepts;
5. Become aware of needs for staff training and performance improvement;
6. State the department's written intentions as a resource and training tool for staff, managers and individuals; and
7. Improve morale by establishing an opportunity for individuals and staff to participate in and review the parameters as they currently exist and may evolve.

**III. RELATIONSHIP TO EXISTING POLICY OR REGULATIONS:**

These parameters are not to be considered as a substitute for compliance with relevant existing Departmental or Agency Policies and Procedures (P&P,) Codes of Ethics and Conduct from individual licensing boards or regulations. Relevant Departmental or Agency policies include but are not limited to:

1. Ethics (See DMH P&P [100.1. Department of Mental Health Code of Ethics](#))
2. Compliance Policies and Programs (See DMH P&P [112.2 Compliance Program](#))
3. The Health Information Portability and Accountability Act (HIPAA) (See DMH P&P [500.1 to 500.10 HIPAA](#))
4. [Sexual Harassment Prevention](#) (See DMH P&P [605.2 Sexual Harassment Prevention-Anti-Retaliation](#))
5. Conflict of Interest (See DMH P&P [608.2 Conflict of Interest](#))
6. Organizational Codes of Conduct (See [DMH Code of Organizational Conduct](#))
7. Illness and Injury Prevention Programs (See DMH Illness & Injury Prevention Program)

**IV. PERTINENT RECOVERY MODEL CONCEPTS AND COMPONENTS**

1. Creating and Establishing a Recovery Milieu
2. Engagement and Understanding
3. Emotional Healing
4. Financial and Work Relationships
5. Medication Support
6. Psychosocial Rehabilitation
7. Substance Use and Abuse
8. Working in the Community
9. Working with Law Enforcement

## PARAMETERS ESSENTIAL TO THE UNDERSTANDING AND DEVELOPMENT OF SERVICE RELATIONSHIPS IN A RECOVERY MODEL

### 1. Creating and Establishing a Recovery Milieu

Individuals need a safe place to recover. This safe place must provide acceptance, understanding, hope, emotional and practical support, treatment and rehabilitation. It must also provide a base for increasing self-responsibility and achieving meaningful roles in the community. DMH expects all staff to work together to insure every program is a safe place in which recovery can occur.

- A. Creating a recovery milieu depends upon all staff, including clinical and non-clinical, creating caring, positive, and supportive relationships with everyone they meet, whether they are on their caseload or not. This creates a web of recovery-based relationships that serve as a powerful environment for all our services and protects both staff and individuals
- B. Program supervisors are responsible for creating and maintaining the recovery milieu in their program. Their leadership should emphasize hope, healthy usage of authority, healing, and community integration. Staff should contribute positively in each of these areas.

### 2. Engagement and Understanding

Staff is expected to develop enough trust with an individual to be able to engage them in treatment and understand both their mental illnesses and them as individuals.

A. Trust-building should rely on shared humanity in addition to emphasizing professional authority and expertise. Toward this end, staff is encouraged to use:

- 1) Therapeutic self-disclosure
- 2) Agency charity, i.e. the giving of resources to individuals to improve their lives without requiring them to do anything in return. Examples of agency charity include providing bus tokens, food, or clothing.
- 3) "Meeting individuals where they are" for example in terms of dress, in order to emphasize attempts to decrease the distance between us

- 4) Language, cultural competency and spiritual sensitivity
- 5) Using personal connections to individuals or places in the individual's life to enhance the original engagement and ongoing relationship. Examples of these connections may include circumstances in which you may already know the person or someone in their family, or have some shared interest or history, e.g. you went to the same high school or came from the same state.

B. Staff should be careful not to take advantage of this trust by taking over decision-making for an individual. Staff should instead focus on building a collaborative relationship by giving an individual choices and meaningful education about those choices.

C. When an individual shares their story with staff they place themselves in a vulnerable position. It is imperative that staff protect their story. Staff must respect confidentiality rights and keep information within the confines of the mental health system. However, personal confidentiality or exclusivity between an individual and a staff member is not a right and should be used cautiously and circumspectly. Keeping personal secrets may increase the risk of fragmented care, personal impropriety, and even danger, along with possible losses of staff accountability, documentation, and funding. Staff is expected to work as an integrated part of the entire mental health system, not as an individual practitioner.

### 3. Emotional Healing

One of the primary goals of mental health services is emotional healing. Individuals with mental illnesses often have substantial emotional distress. This distress can arise as a as a part of their illness, as a consequence of their illness, for example, stigma or the services received, or from other issues in their lives. Emotional healing can be either the direct reduction of the state of emotional distress or the improvement of underlying emotional traits that contribute to ongoing emotional distress.

At our most effective, our services should go beyond impersonal assessment, medication, case management, and placement to incorporate emotional healing. In general, to be healing requires skillful maintenance of relationships of substantial emotional depth. Traditionally, these relationships have been contained and protected within the controlled confines of therapy sessions. Staff is now expected to integrate healing throughout a variety of roles and settings.

A. High levels of personal emotional strength and awareness are a basis for the effective and safe promotion of emotional healing in others.

- 1) Staff may find themselves challenged by tragedies and traumas, both to an individual and to themselves. At these times, staff should make every possible effort to reestablish their emotional strength and seek personal healing. Both supervisors and team mates have a responsibility to ensure that all staff has personal and professional support in this effort. Supervisors are expected to help staff utilize all internal and external resources at their disposal.

2) Staff should not tolerate being abused, threatened, taken advantage of, or harmed sexually, emotionally or physically by an individual. Supervisors and teammates must act purposefully to protect staff and report such actions to their supervisors.

B. Staff may not demean, emotionally abuse, intentionally wound, or be physically aggressive or threatening to an individual regardless of the circumstances. The risk of these infractions should be reduced by staff knowing their own emotions. Staff can be clearer about the emotions involved by avoiding treating those individuals with whom they have previous or ongoing personal relationships. Supervisors and teammates must act purposefully to protect individuals and report such actions to the manager.

C. Physical contact between staff and an individual may often contribute to emotional healing, but it carries special risks. Staff absolutely must avoid all inappropriate touching or other sexual contact with an individual. Sexual attraction or “falling in love” by either the staff or an individual dramatically increases the risk of inappropriate and/or unethical behavior on the part of staff. Therefore, these emotions must not be kept private. When confronted with these situations, staff must make their supervisor and teammates aware of them. Therefore, situations in which there is likely potential for inappropriate behavior or allegations of inappropriate behavior, staff should discuss the situation with teammates and with their supervisor. Supervisors shall report these situations immediately to the program manager. The program manager, upon evaluation of the situation, should report when warranted to the DMH Human Resources Bureau (HRB) for possible reporting to the Los Angeles County Office of Affirmative Action Compliance. Decisions regarding further contact between the staff and the individual shall be based upon a consultation with the Manager and DMH HRB.

D. Persons with mental illnesses are valued by DMH in all staff positions because their life experiences afford them unique abilities to engage with, understand, and emotionally heal an individual. They must meet the same employment standards as staff without mental illnesses.

#### **4. Financial and Work Relationships**

Treating mental illness should focus on improving quality of life. As a result, mental health services include a wide range of social activities managing an individual’s money, using discretionary mental health funds, and assisting individuals in accessing other funds to improve their quality of life.

Staff control over financial and other resources creates a potentially problematic power differential between staff and an individual. Even when staff believes that they are acting in the best interests of an individual, there are risks of exploitation, withholding, and manipulation.

A. These risks shall be reduced by establishment and adherence to clear policies, sharing decisions with supervisors and teammates, having clear paths for an individual to air grievances, and by the keeping of transparent and accessible records.

- B. Staff may not get involved in personal financial dealings, e.g. the personal exchange of goods or services with an individual. Staff may not use a program participant's funds, discretionary mental health money or other program related funds for their own use.
- C. Staff who is serving as a representative payee is at particularly high risk for the development of a power differential and therefore may require additional physical protection. The same staff who is serving as a payee for an individual should not also have primary service coordination or emotional healing responsibilities for that same individual. Payees may use physical barriers for additional protection when needed, especially when handling cash. Payees should be in physical proximity of other staff and/or security staff when handling cash and interacting with an individual. Representative payee policies should include procedures for handling cash.
- D. With the approval of the manager, staff may operate in the role of "work supervisor" with an individual. These work experience, day labor, life coach, and peer supportive services jobs should all be temporary, part-time positions designed to promote an individual's growth while they perform needed work. Staff must be conscious of the additional risks inherent in these more complex relationships, and should make it clear to an individual that the true employer is the organization and not the staff person. Fulltime, permanent jobs should be separate from an individual's treatment team.

## 5. Medication Collaboration and Support

Although taking medications is not a prerequisite for an individual to receive services, medications are an important factor in recovery for many people. Medication collaboration is the process where the prescribing professional and an individual taking the medications work together to find ways of using medications that will benefit the individual. This is in contrast to a definition of medication compliance in which the prescribing professional orders the individual to take medications in the way they think best and an individual is expected to comply with those orders. It is expected that all staff, not just those whose scope of practice includes prescribing or monitoring medications, should be attentive to medication issues which they observe or are raised by an individual and respond within the context of the parameters that follow.

- A. Staff may assist an individual as they learn about their medications and the role medication plays in their lives. They should be able to provide competent guidance about additional credible sources of information about medication. Staff may also assist an individual to improve communication with their prescribing professional, and may use their relationship to increase medication collaboration. They may not, however, forward their own medication instructions or opinions about what an individual should do, unless their scope of practice includes medications.

- B. Staff may assist individuals in taking their medications as prescribed, for example by picking up medication(s) at the pharmacy, or helping them organize medication(s) into reminder boxes. However, they may not hand the medication(s) directly to an individual to take unless their scope of practice permits it. Examples of those with such a scope of practice would be a Medical Doctor, Registered Nurse or Licensed Psychiatric Technician.
- C. Staff may work with an individual to increase medication collaboration by a variety of means including the offering of incentives, or, with the individual's permission, involving other individuals in their support system. However, staff may not use coercive means or otherwise withhold services or funds that may be due to an individual, except when specifically permitted by law or statute.
- D. Staff may not, directly or indirectly, give an individual medication surreptitiously, intentionally mislead or misinform them about medications, or otherwise undermine informed consent, even if they believe they would be acting in an individual's best interests by doing so.

#### **6. Psychosocial Rehabilitation:**

The practices of psychosocial rehabilitation are essential components of services that promote recovery. Psychosocial rehabilitation is a service delivery philosophy that focuses on creating meaningful roles apart from the illnesses of an individual. For staff to take on these other roles successfully, they must also take on roles apart from the illnesses. Staff may find these other roles (for example customer, coworker, and house guest) less comfortable than their usual staff roles when they are less practiced in them, but these roles are not inherently more risky. They should continue to work on therapeutic goals including emotional healing while working in these multiple roles.

Among the important staff techniques used are goal setting, motivating, skill building, and applying these skills in the community, classically expressed as the "choose, get, keep" model. They should incorporate these practices into their relationships with an individual. It is preferable to do skill building in the actual community settings where the skill will be used instead of in classroom settings.

- A. Staff should support development of autonomy and independence in all domains, including finances, and refrain from doing things for an individual when they can do it for themselves. Encouraging individuals to provide for themselves and promoting growth are the ongoing underlying goals.
- B. Goal setting should be value-driven and consumer-centered. Goals should reflect the choices of an individual. Goals should also reflect socially promoted values such as increased independence in housing, employment, adherence to laws, responsible child rearing, safety and others. Staff

should be culturally competent, sensitive and respectful of personal choice in goal setting. However staff should not support illegal or socially destructive goals. Special sensitivity is needed when working on spiritually-oriented goals to make sure staff is truly supporting choices of an individual and not persuading them to make spiritual choices that staff may personally value. Staff may ask for another staff to work on a particular goal with an individual if it conflicts with their personal spiritual beliefs.

- C. Motivating individuals should be based upon understanding them well enough to promote their core drives and desires rather than upon coercion. Staff should maintain supportive relationships even when an individual makes choices that may result in serious consequences. Staff should help an individual take risks in a more prepared manner and to help them learn from the consequences of their choices.

## 7. Substance Use and Abuse

DMH is committed to serving individuals living with mental illnesses who are also using or abusing substances. Staff should be competent in the delivery of integrated substance abuse services (Co-occurring Disorders (COD) appropriate to their roles.

- A. To effectively serve individuals with both mental health and substance abuse conditions, staff must have the ability to provide services for each condition separately, the ability to integrate services for the two conditions, and the ability to provide services uniquely designed for dually diagnosed individuals. Staff who is considered to be COD competent have these abilities in all areas of service including engagement, assessment, treatment, rehabilitation, advocacy, and recovery.
- B. Staff must maintain a willingness to actively serve individuals who are using and abusing substances, and accept them wherever they are along the continuum of recovery. However, this does not imply condoning substance use or abuse. Staff should always maintain a goal of freedom from dangerous and addictive substances no matter how remote or unlikely it appears at the time. Staff must maintain relationships and continue to serve individuals who use and abuse substances.
- C. Staff must provide or consult with their supervisor in order to arrange for the provision of a full range of substance abuse interventions appropriate to the stage of recovery of the individual being served.
- D. Staff should assume advocacy roles for individuals when dealing with other groups or agencies that have exclusionary “no tolerance” policies. In these situations staff must pay special attention to individual choice and maintain confidentiality.

- E. Program restrictions and limitations on individuals should be based on the appropriateness of their behavior, rather than on the fact that they are continuing to engage in substance use or abuse. Substance use and abuse increases the risks in relationships, including unlawful behavior, violence, and unsafe sexual practices. There may be increased risk to staff directly involved with individuals using and abusing substances. Therefore, staff should exercise extra caution and discuss any concerns with their supervisor.
- F. Staff may not use any alcohol or illegal drugs or while working, even if they are at an activity where drinking would be appropriate, and even if the individual they are serving is drinking or using drugs. Under no circumstances should staff who are impaired by drugs, legal or illegal, interact with the individuals they serve.
- G. DMH values smoking cessation and supports efforts by both staff and individuals to stop smoking. Nonetheless, both staff and individuals are permitted to smoke during work wherever permitted by law. No staff members or individuals should be in any way coerced or pressured to expose themselves to secondhand tobacco smoke, and every effort should be made to maintain smoke-free environments. However, individuals should be permitted to smoke where lawful and where others are not involuntarily exposed to secondhand smoke.

## 8. Working in the Community

Working outside of traditional locations and in the community vastly increases staff effectiveness, but also increases a number of risks. For the purpose of these parameters, community is defined as the social, cultural and physical environment in our daily lives. This does not include treatment settings. For individuals with mental illnesses, community is the environment in which they have meaningful roles that are not solely defined by their mental illness and its treatment.

- A. Staff should serve people in the community, not just in crisis situations, but whenever it is likely to increase the effectiveness, intensity, or relevance of their service. Many times this will involve taking on friend, family, mentor, or teacher roles (for example while facilitating hosting a house warming party, attending an AA meeting with them, or attending someone's graduation). However, staff should be mindful that their primary responsibility is not socialization or transportation alone. Depending on each person's needs and choices, staff should be engaging, assessing, supporting charitably, emotionally healing, treating, training, rehabilitating, advocating for, or promoting integration into the community while working in a variety of roles. For example while going out to lunch with someone a staff may be building trust, feeding a hungry person, demonstrating caring and reliability, assessing medication side effects or functional literacy, assisting in vivo practicing of relaxation techniques, modeling social skills, introducing someone to a friendly waitress the staff knows, or working to get the restaurant to serve a strange looking person.

- B. Staff should pay special attention to confidentiality when working in the community and, within constraints of applicable laws, any disclosures should be based upon the personal choice of an individual.
  - 1) Staff should avoid identifying themselves to others as mental health workers until they have reached an agreement with an individual regarding disclosure. This may involve, for example, altering vehicles or clothing or removing identifying badges while working in the community. However, County identification badges must be carried on the person of the staff when providing services in the community.
  - 2) Staff should secure confidential documents until returned to the designated storage site.
- C. When staff are serving an individual in the community and interacting with the individual's family, friends or other community contacts, the staff's role is not necessarily to speak for that person or take responsibility for them. Staff should be prepared to assume different roles when interacting with various agencies and individuals to facilitate attainment of meaningful roles in the community.
- D. Staff working in the community should conceptualize their role as guide or mentor, rather than caretaker or protector of either the community or the individual. There are exceptions in emergency situations, but even when an individual is placed on an involuntary hold for treatment, relationships should follow these guidelines. Often these emergency contacts are an individual's first contact with the mental health system and therefore should be recognized and approached as important engagement opportunities.
- E. Community work may involve unique safety risks. Staff should not work alone when legitimate safety concerns are identified. In high-risk situations, staff should consult with their supervisor and/or call for police assistance to avoid endangering themselves and others. Staff should avoid physically restraining an individual in the community.
- F. Advocacy is a core component of recovery services. Staff is expected to fight stigma and advocate on behalf of individuals when working with other agencies and community members. Staff should expect support from their supervisors and by DMH in these efforts.

## 9. Working with Law Enforcement

DMH is making a strong effort to serve people who are struggling to be included in our community. Many of these people also have contact with law enforcement. Staff are encouraged to become directly involved with law enforcement issues when so desired by an individual in supportive, advocacy, and

collaborative roles (for example by visiting individuals in jail, collaborating with their probation officer, or providing clinical bases for sentencing determinations).

- A. Law enforcement and mental health systems have different basic missions that effect our collaborations. Mental health is primarily focused on helping individuals with mental illnesses have better lives, while law enforcement is primarily focused on increasing public safety. Sometimes these goals are in alignment, for example, when staff is trying to help someone escape a battering partner, and sometimes they are in conflict, for example, when someone staff is serving is trying to avoid criminal punishment.

- 1) In some situations, for example, the Duty to Warn Child or Adult Protective Services and court ordered treatment for Mentally Disordered Offenders, mental health staff are required to act as agents of public safety and should actively support law enforcement that carries the ultimate authority and responsibility. Staff should strive to provide services collaboratively rather than under court order unless directly required for public safety.

- 2) In some situations, for example, 5150 evaluations or involuntary treatment enforcement, law enforcement is acting as agents of mental health care and should actively support mental health staff that carries the ultimate authority and responsibility. In general, it is not law enforcement's role to directly promote or court order mental health treatment, except as it is reflected in increased public safety.

- 3) In most situations, mental health and law enforcement are acting relatively independently. In these situations mental health staff's focus should not be on either advocating for individuals to help them avoid legal responsibility and punishment (except in situations of legal insanity, clear diminished capacity, or mental incapacity to stand trial), nor on directly assisting law enforcement's efforts to increase public safety, but on supporting individuals to meet their legal responsibilities in the most constructive way possible, so that they can be included as responsible members of our community. This includes promoting legal responsibility when individuals perpetrate crimes against the mental health staff and programs serving them.

- 4) The above goals may, at times, run contrary to the desires of an individual. Staff should not support illegal desires, but should instead try to maintain a collaborative, emotionally healing relationship with the individual while promoting legal responsibility even during periods of disagreement or legal coercion.

- A. Because mental illness has specific legal implications there is a tendency for law enforcement to respond to the illness instead of the person. We have a responsibility to advocate for and collaborate directly to promote person-centered law enforcement responses.

- 1) When an individual with mental illness witnesses a crime or is a victim of a crime we should advocate and collaborate directly for them to be taken seriously as a member of our community with full rights.

2) When an individual with mental illness is contacted by law enforcement we should advocate and collaborate directly against a presumption of increased dangerousness or irrationality unless warranted by their behavior.

- B. Law enforcement agencies may have access to specific resources and support for individuals they serve. Being a client of the mental health system should not relieve law enforcement of their responsibilities to serve individuals themselves. Mental health staff should advocate for and collaborate directly to assist individuals in accessing these resources.

What's most remarkable to me about these policies is that it turned out to be possible to have policies that we believe will promote recovery that met the needs of risk management, human resources, the medical director's office, and even the union representative. They honestly worked hard collaborating with us to make it work.

I want to tell one last story about these meetings. One day the heavy set black woman who was the union representative and who had struggled with many of these policies said that she'd been thinking about what we'd said about hugging clients and that it didn't need to be forbidden. So she'd tried it. She hugged a client for the first time that week and it went pretty well. Maybe we were right. Maybe she'd even try that again.