# Recovery-Based System Planning (Part 1 and 2)

# (2005)

### Part 1 – Needs Assessment and Transformation Recommendations

Each implementation step of Proposition 63 is an opportunity to develop recovery principles and practices for that step. If we take advantage of all the opportunities, in a few years we will transform our system in California, and we will create blueprints and models for recovery-based transformation elsewhere, too. We should begin by using recovery-based principles throughout our planning.

The California Department of Mental Health wants Proposition 63 plans to be based on needs (both met and unmet) and capacity to meet those needs. Traditionally, we determine needs by calculating how many people have certain illnesses, at certain severities. From that we calculate the need for treatment services like clinic visits, crisis services, and hospital beds. That's not a recovery-based approach.

From a recovery point a view, people can be divided into three groups, 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 (HAP) who wouldn't go to our 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.

Here is an example of how these stages could be used to assess my community's needs and present capacities, and to make highly focused transformation recommendations based on our present problems. Your community will probably have some differences. I also offer services that the Mental Health Association has developed, either at our MHA Village integrated services program or at the Project Return: The Next Step consumer-run program, as possible models.

Stage 1: Unengaged

Entrance to stage:

- Identification of need for mental health services

Recovery goal:

- Trust, hope, goal setting, and planning

Common needs:

- Crisis management
- Charity/"entitlements"/quality of life support services and advocacy – housing, financial, employment, education, substance abuse treatment, physical health, community integration, family strengthening
- Engagement into treatment and thoughtful triage
- Recovery support – acceptance, sanctuary

Present capacity:

- Hospitals, emergency services, long-term locked treatment
- Police, jail
- Co-located mental health workers in social service settings – welfare office, housing, Social Security, education, homeless assistance, vocational rehabilitation, courts, police teams
- Primary health care settings

Present problems:

- These programs often provide crisis management without engagement or charity without engagement. It is rare to see even two of these functions integrated, although the vast majority of people need all three together.
- Virtually all present capacity is short term, episodic settings.
- Some people appear to be "persistently unengageable." They might be appropriate for involuntary outpatient treatment. Opponents of this coercive approach claim, rather persuasively, that if there was better engagement there might not be "persistently unengageable" people left to coerce.

Transformation recommendations:

- Integrate the three service needs into long-term community-based settings.
- Create a close link between settings where people are currently seen briefly to integrated settings where they can get longer, proactive services.

MHA Village Models:

- Outreach and Engagement and Fast Track programs

Stage 2: Engaged, but poorly self-directed

Entrance to stage:

- Engagement with mental health services
- Collaboration in own recovery

Recovery goal:

- Empowerment, self-responsibility

Common needs:

- Mental health treatment, often including crisis management
- Quality of life support services and advocacy – housing, financial, employment, education, substance abuse treatment, physical health, community integration, family strengthening
- Recovery support – acceptance, sanctuary, healing, self-responsibility, attaining meaningful roles in the community

Present capacity:

- "Structured" programs and environments – IMDs, board and care facilities, day treatment
- ACT teams
- Integrated Service programs – ISAs, AB 2034 programs

Present problems:

- Most of these people are being treated in outpatient clinics that lack the capability to intensively coordinate care, resulting in too many dropouts, erratic service utilization, frequent crisis, and poor outcomes.

- Programs that rely on structure and limit choices to make it easier to coordinate services are generally ill-suited to promoting empowerment and self-responsibility.

- Only the ACT teams and Integrated Service programs have substantial capability to do assertive outreach to re-engage people when they disengage.

Transformation recommendations:

- Transform structure-based cultures to recovery-based cultures.
- Add ACT and integrated services capabilities to clinics so people can be triaged to the level of service they need.

MHA Village Models:

- Neighborhoods, Transition Age Youth Team

Stage 3: Self-responsibility

Entrance to stage:

- Has ability to coordinate services
- Sets and pursues quality of life goals with minimal assistance
- Self-directs crisis management

Recovery goal:

- Community integration, attaining meaningful roles, graduation from system

Common needs:

- Mental health treatment, often including self-directed crisis management
- Quality of life support resources and advocacy – housing, financial, employment, education, substance abuse treatment, physical health, community integration, family strengthening
- Recovery support – acceptance, sanctuary, healing, self-responsibility, attaining meaningful roles in the community, self-help, giving back, graduation

Present capacity:

- Outpatient clinics

- Private psychiatrists, HMOs
- Self-help programs
- Wellness Centers

Present problems:

- Although these people are "high functioning," they often have needs beyond maintenance mental health treatment, but the system often doesn't have additional services for them. It is rare to have good accessibility to quality of life resources.
- We don't provide them the services they need in an integrated way, so it is difficult for them to be self-directed. It is rare for one program to integrate mental health services, recovery support, and quality of life resources.
- Programs have difficulty responding to crisis in empowering, responsive ways. They usually send people in crisis back to the same crisis services "unengaged" people go to where they are treated inappropriately.
- Graduation from the system is a rare outcome and generally not promoted.

Transformation recommendations:

- Integrate needed services into one program, including self-directed crisis management.
- Create effective linkages into these programs and out of them.

MHA Model:

- Wellness Center

Many programs care for people, but do not help them progress through these stages. If we expect people to progress through the stages, we need to be especially attentive to the transition points: identification, engagement, empowerment, and graduation.

There are an enormous number of people outside this schema before identification and after discharge. We assume that the "before identification" people don't need mental health treatment and the "after discharge" people no longer need treatment, but both groups are more complicated than that.

The "before identification" group includes numerous "normal" people. However, it also includes people who have serious mental illnesses, but for a variety of reasons have never been identified. These people should be a target for the Prevention and Early Detection programs.

In addition, there are many people who have requested mental health services, but are turned away because they aren't in the "target population" of people with serious mental illnesses. This screening process was created more than about two decades ago to focus services on the most needy by removing the "worried well" from caseloads. My remembrance is that Los Angeles County's system removed about half of the people it served at the time, but we were never able to increase the number of people with serious mental illnesses served because of ongoing budget cuts. There is an ongoing, serious, realistic concern that if this screening is reduced, the underfunded system would be overwhelmed by too many people in need. It is hard to be welcoming when the main job is to turn away as many people as possible.

The screening tool is diagnostically based, "Major Mental Illness on Axis I," rather than disability based, so people with primary post-traumatic stress, anxiety, eating, personality, and substance abuse disorders are to be screened out regardless of level of impairment. Many times this screening is done cursorily, even over the phone, without regard to what services might, or might not, be available for them outside the mental health system. Very rarely is a true diagnostic assessment, needs assessment, and community based service plan done. The net effect is that the "before identification" group includes a substantial number of needy people with mental illnesses who are "rejected" and end up unserved anywhere. We generally don't keep track of who we reject.

The "after discharge" group has six sets of people: 1) people who move away, 2) people who move outside the public sector for their mental health care, 3) people who become disengaged and are lost to follow-up, 4) people whose problems improve and no longer feel in need of services, although they didn't recover, 5) people who recover and graduate, and 6) people who we discharge because of unacceptable behavior (usually violence, substance abuse, non-compliance, or stealing).

If we consider each of these sets individually, quite a number of needs emerge – transfer coordination, assertive re-engagement, relapse prevention education, graduation services, specialized programs for unsafe people – along with possible system transformations. It is likely that if we followed our discharges, few of them would be "no longer in need."

With very limited "positive flow" in our system – people moving to lower levels of service and even graduating – and with new people coming to our doors every day in need, programs are nearly always "full." The belief underlying many of these groups' problems is that the system only survives because of an ability to turn away and discharge people in need.

Very little attention and resources are spent on these groups because of our guilt feelings over our role in creating them, and because we believe that attending to their needs would create more work rather than less. There is no belief that either better assessments or community service planning on the one hand, or better transfer coordination, assertive re-engagement, or graduations on the other hand would payoff. Changing this belief is an important, often unrecognized, piece of overall system transformation.

Therefore, a complete planning process requires two more stages:

Stage 0: Unidentified

Entrance to stage:

- Experiencing distress, disruption, or wanting help with life
- Being in a high risk group
- Experiencing early warning signs

Recovery goal:

- Prevention, increased self-awareness, and decreased stigma and avoidance of help

Common needs:

- Welcoming and acceptance in destigmatized, initial mental health contacts
- Screening for mental illnesses, risk factors, and warning signs
- Collaborative diagnostic assessment, needs assessment, and community- based service planning, whether eligible for mental health services or not
- Quality of life support resources and advocacy – housing, financial, employment, education, substance abuse treatment, physical health, community integration, family strengthening

Present capacity:

- Mental health public awareness, education, and screening campaigns
- Mental health help lines – referrals, suicide prevention, NAMI, MHA, etc.
- Telephone and walk-in screening at many mental health programs
- Outreach programs – homeless, police, jail, etc.
- Co-located mental health workers in social service settings – welfare office, housing, Social Security, education, homeless assistance, vocational rehabilitation, courts

Present problems:

- There is extremely limited funding to spend time with people who are not already identified clients of the mental health system. As a result, almost all programs have essentially eliminated these services. Services tend to be provided by charitable agencies often detached from the overall system.

- There is insufficient awareness of and collaboration with other community mental health and social service agencies to make realistic plans and referrals.
- The present diagnostically-based screening tool excludes many people who are the neediest, is not responsive to the community's social needs, and is easily distorted (often for humane reasons, but may lead to incorrect diagnoses and treatments as a result).
- Cultural factors have a profound impact on help-seeking behavior and stigma generally and require high levels of specialization to be successful.

Transformation recommendations:

- Create funding streams for these services to be integrated into present programs, probably from a combination of Prevention and Early Detection and Adult System of Care funds.
- Increase collaboration with other community-based agencies.
- Change the screening criteria for eligibility for public funded mental health services from a diagnostically based tool to an impairment and social disruption based tool.
- Increase culturally specialized programs.

MHA Village Models:

- "No wrong door," outreach and engagement, phone screening/triage, (We provide a quick response as well as active referrals for individuals who do not have serious mental illnesses.)

Stage D: Discharged

Entrance to stage:

- Discharge from services – people who: 1) move away, 2) move outside the public sector for mental health care, 3) become disengaged and are lost to follow-up, 4) improve and no longer feel in need of services, although they didn't recover, 5) recover and graduate, and 6) are discharged because of unacceptable behavior (violence, substance abuse, non-compliance, stealing)

Recovery goal:

- Depending on situation, transfer between providers, re-engagement, or

graduation and relapse prevention

Common needs:

- Facilitation of service transfers, which includes planning, supported contact, transfer of records, and management of relationship changes
- Assertive re-engagement services
- Re-entry services
- Quality of life support resources and advocacy – housing, financial, employment, education, substance abuse treatment, physical health, community integration, family strengthening
- Specialized services for people who cannot be treated safely in other programs and are discharged or refused services as a result

Present capacity:

- Modest discharge planning services in many programs
- Assertive re-engagement in ACT and integrated services programs
- Jail and prison services, forensic state hospitals beds, Conditional Release Program, Parole Outpatient Clinic, long term locked treatment

Present problems:

- Most programs do not have a vested interest in improving their discharge programs or re-engaging drop-outs, because they are not usually responsible for assisting people later on if there are problems. Their responsibility to serve people is episode-based, not lifetime-based.
- There is a pervasive lack of belief in true recovery, graduation, or the ability for people to become independent of the mental health system. Also, unfortunately, many of our other values and practices, like acceptance, re-engagement, and lifetime-based responsibility, can conflict with promoting graduation. As a result, many programs and practices tend to hinder these achievements rather than promote them.
- The specialized programs available are either accessed through the criminal justice system or acute hospitals, both generally unreliable partners because of their own overriding concerns. This is another, though very different, possible niche for involuntary civil commitments, but considerable police support will be

needed to make it safe and effective.

Transformation recommendations:

- More programs, especially in Stage 1 and 2, should have "no fail," lifetime based responsibility enrollments. These programs would have to incorporate facilitated transfers, assertive re-engagement, and monitored discharges in their practices.
- Create an inspirational cohort of successfully recovered graduates.
- Track unsafe people, so they aren't repeatedly discharged only to be readmitted by other unaware programs and so specialized plans and

programs can be specifically developed for them.

MHA Village Models:

- "No fail," lifetime-based responsibility enrollments, facilitated transfers, assertive re-engagement, monitored discharges
- "Main Street" program to facilitate flow, successful discharges, and graduation

As we progress in our planning and implementation, there will be a tendency to want to rely on doing things in familiar ways. We want to respect the expertise we've accumulated over the years. We don't want to "reinvent the wheel." But if we only do things in familiar ways, we will only generate familiar plans and programs. We will invent only wheels, and we want more than that. Hopefully, this paper has demonstrated a format for a recovery-based planning process that you can use in your community.

## Part 2 - Building Programs

As we've begun using the Recovery-Based System Planning tool, we've found that many people have trouble visualizing what these various levels of transformed services would look like and tend to suggest more of what they're doing at present. While some of this may reflect resistance to change, much of it is probably simply lack of personal exposure and experience. How can we realistically expect people to create programs they've never seen?

Even at MHA and the Village we've only built models of some of these programs and many are still evolving as we learn what works. Besides which, the goal isn't to create lot's of Villages. It's to create transformed recovery-based systems uniquely suited to the community they're in. I think it's realistic to expect a proliferation of exciting new program ideas none of have ever seen before over the next decade. Already as I've been doing planning workshops, I've seen novel ideas emerge: I especially liked a "one stop- shop," therapeutic family center that enrolls families instead of clients into a variety of family agencies and services and a mental health funded "unemployment insurance" plan for people who risk getting off Social Security to support them in case they lose their job until they get a new job or get back on SSI/SSDI. Wouldn't it be fun to try to create those programs? Before I get too carried away

imagining even more possibilities (How about a consumer run transportation business to help people get around rural counties or a cooperative effort to provide agricultural jobs?), I'd like to share some of what we have learned at the Village.

We've had 15 years of experience creating "no fail," integrated clinical and support services primarily for "Stage 2: Engaged, but poorly self-directed" people. Over time we were asked to include "high-utilizers," people in state hospitals and IMDs, homeless people, and jail diversion. Many of them are "Stage 1: Unengaged" people and we had to improve our welcoming and engagement services. For two years we've had a special "Fast Track" team adding intensive case management to our Outreach and Engagement Program working on engagement. As time has gone on we noticed that many of the people we've worked with at the Village have improved substantially becoming "Stage 3: Self-Responsible" people, but very few have "graduated." Two years ago we created "Main Street" to encourage graduation and last year we opened a "Wellness Center" for people in Stage 3 to move on to, creating new openings in our ISA programs and flow in our system.

For most people in the standard system, even that progression will seem foreign. Most point to enormous case loads and virtually no support services and can't visualize how they'd get to anything like where we're at. Maybe a few new specialized services could be built if there's really going to be new money, but entire system transformation seems impossible. I've found that the more details I can give people to work with, both personal practice and program design, the more realistic system transformation becomes for them. Then they more enthusiastically plan our futures.

Here are some details:

In the same way that our present mental health system prescribes certain programs based upon people's diagnosis and case management / rehabilitation needs, a transformed system would base its programs upon people's recovery stage and quality of life goals. Keep in mind that every service is designed to help the person grow into the next stage. Everything is "transitional" but rarely strictly "time limited." Transitions can be gradual and some staff will work with consumers in multiple stages moving forwards alongside them as they progress.

<u>Program Differentiation</u>:

<u>Employment</u>:

Stage 1: day labor, "work for a day – house for a day"

Stage 2: agency businesses, supported employment including job development and coaching, group placements, supported mental health employment

Stage 3: non-disclosure competitive employment job development, competitive mental health employment

Housing:

Stage 1: hospitals, IMDs, vouchers, SROs, crisis residential, family

Stage 2: Board and Care, drug treatment programs, sober living, supported housing, master leases, IHSS, family

Stage 3: independent living, home ownership

Finances:

Stage 1: small grants and loans

Stage 2: interim funding, rental subsidies, payee, grants and loans, agency savings accounts

Stage 3: grants and loans, community bank accounts

Substance Abuse:

Stage 1: harm reduction, motivational interviewing, DDA meetings, referrals

Stage 2: harm reduction, motivational interviewing, DDA meetings, drug treatment and detox programs, sober living, 12 step work

Stage 3: relapse prevention, ongoing 12 step work, giving back

Therapy:

Stage 1: engagement, empathy, crisis, drop-in groups

Stage 2: supportive, strengthening, cognitive, relationship, "corrective emotional experiences", drop-in groups

Stage 3: appointment based individual or group, dynamic, uncovering, self-help (including creating WRAP, advanced directives)

Medication:

Stage 1: med exploration, med trials, high flexibility and accessibility

Stage 2: med management, long acting injections, high flexibility and accessibility

Stage 3: self- management, regular appointments

Social:

Stage 1: "accepting" environment in the program, peer outreach, staff organized activities

Stage 2: peer networking, supported socialization

Stage 3: community development and integration

Education:

Stage 1: exposure

Stage 2: supported education, agency classes

Stage 3: career development

Crisis response:

Stage 1: outreach, crisis walk-in, meet practical needs while engaging, collaborate with coercive services diverting when possible

Stage 2: home visits, crisis walk-in, 24 hour emergency hotline, peer run warm line, coordinate support services in the community, "life coaches"

Stage 3: peer support, peer run warm line, coordinate natural supports in the community, utilize self-directed crisis plans (WRAP, advanced directives)

Program designers may notice that their programs have some of these services only available in certain forms, so that they're forced to mismatch recovery stage and service, or that they only have some of these services, in which case they're unlikely to promote successful outcomes in the areas they're missing.

The needed services are so varied that it is rare for one funding source to pay for everything that's needed. Unfortunately, administrators will have to combine multiple funding sources (e.g. MediCal, HUD, Voc Rehab, and MHSA) with multiple accountability requirements to create the integrated services people really need. (My image is of an old fashioned TV with lots of tangled wires plugged in the back, all to get the whole package one good cable can give, with the MHSA acting as a "wild card" plug providing services no other plug can.) It is possible to collaborate with other agencies to provide more services, but usually not in Stage 1, only when facilitated by a case manager in Stage 2, and independently coordinated by the consumer using referrals only in Stage 3.

People are usually in the same stage for every service they're receiving, because their stage reflects how far they've come in recovery, not how far they've pursued any particular goal area. These stages are not intended to be used as prerequisites for each other. People should use whatever stage's services they're in at the time. Some people may resist moving on even when they are able.

Notice also that these aren't the only services possible to offer. This is just a list of what we've tried at the Village. I had an interesting conversation with a woman in a planning workshop trying to apply my recovery planning stages to assist the battered Hispanic women she works with (Unengaged – collocate a mental health worker and a recovered peer at the church where these woman come to talk to the priest and at the ER where they come for medical treatment for their beatings. Engaged but not self-coordinating – have a mental health worker stick with these woman in a motivational interviewing

approach when they return to their men and, when they're ready, walk alongside them through the steps necessary to escape the abuse and recover. Self-Responsible – have a work sheet of the steps to take and the resources available and a recovered peer to offer support along the way.)

When planning programs, it's important to focus not just on what's done, but also how it's done. The values behind the practices are crucial. Some values, like consumer inclusion, hope, empowerment, choice, self-determination, pursuing quality of life goals, experiencing non-patient roles, and individualization of services are important throughout treatment and some are more important in certain stages of recovery.

Value differentiation:

Stage 1: Unengaged

- There's "No Wrong Door": People shouldn't be expected to understand our system design well enough to go to the right place for what they need themselves. Every entry into the system ought to lead to every service and it's the responsibility of whoever greets them as they come in the door to get them successfully to the right place.
- Everyone is welcoming: Too often we focus on our tasks of gate keeping and rationing, before we make new people feel welcome. If new people are seen as unwelcome additional burdens by staff they are unlikely to greet them with open arms.
- Create a "counterculture of acceptance": Most people with serious mental illnesses (and substance abuse) experience a lot of rejection from our community. To be helpful, our programs need to accept people that outsiders may not. This is not to say we should tolerate being abused or injured, but many people need a sanctuary of sorts, a place to let down their walls and work on recovering.
- A good treatment is built on a good relationship: Use everything possible to build relationships including charity (e.g. listening, respecting, doing things for people, self-disclosure, sharing non-clinical time and activities).

Stage 2: Engaged, but not self-coordinating

- Support, don't care-take: Staff are often needed intensively to facilitate people getting services and their needs met. This is done with the person not for them, while teaching them the skills to be able to think it through themselves and do it themselves. People will often prefer things being done for them, but that doesn't promote self-responsibility and recovery.
- Services are mobile: Their lives, their problems, and their goals are in the community not in our offices, so we need to be out there too. Build skills by doing things together where they need to be done, not by talking about how they're done in the office.
- Services are accessible: These people have serious problems coordinating things, including our appointments. The needed flexibility usually requires a team working together so there's a better chance someone is available
- Integrate services into a "one-stop shop": Having personal relationships with multiple service staff makes it more likely they'll actually access the services they need.
- Be a "no fail" program: Instead of rejecting people or taking over their lives when they do things wrong, focus on how they can learn from their missteps and what changes they need to

make. Instead of closing their case when they don't show up, do assertive re-engagement. Go out and find them.

Stage 3: Self-Responsible

- Create natural, community supports and roles: It's important to work ourselves out of a job. We want to help people find friends to support them, to find places to belong besides with us, to have more meaningful roles in their lives than being good patients.
- Promote self-help: We should teach people skills to manage a variety of symptoms and to get their needs met and connect them to other people in recovery who can support each other.
- Encourage people to "give back": No longer should they be just "consumers" of services. They can give back to our programs and to others in need. They can be role models bringing hope to others. Some even pursue mental health employment.
- Encourage mental health advocacy: Not everyone will want to promote the recovery movement or even disclose their illnesses outside our programs, but those who chose to can have a profound impact on stigma and the community's perception of mental illnesses.
- Create "graduation" rituals and services: It's important to have a positive exit from the system (even for people who continue to take medications), but there are serious personal issues for both the people taking the risk of moving on and for the caring staff they leave behind that need to be addressed. We need to remember that full recovery is far more common, and far more realistic, than we imagine.

Our traditional system creates very little flow and as a result our case loads go up and up and we have to rely on increasingly draconian rationing to keep ourselves afloat. A recovery system with its pervasive emphasis on growth and movement forwards can create much more flow. This helps both by moving people to higher levels where they do more for themselves and by "graduating" people. Flow and rationing are inversely related. The more flow we create the less rationing we need. The less flow we create the more rationing we need. While it may be easier to give a man a fish than teach him to fish, only the teaching creates self sufficiency and flow.

When all is said and done we will only build these programs, incorporate these values, and create flow if we believe recovery is possible. That's what makes this is a recovery based-system.