This article incorporates several years of direct experience with system and program transformation especially with the Los Angeles County Department of Mental Health (DMH). We've been building the airplane as we've flown it. Key contributions were made by Bruce Anderson at Community Activators, Debbie Innes-Gomberg and her staff at DMH, and me, David Pilon, and others at Mental Health America of Los Angeles (MHA), and the numerous contributions from the line staff of DMH who have actually been in the airplane hammering away.

A Roadmap to Recovery Based System Transformation (2008)

Many people have been working hard for quite a while to promote a recovery based transformation in our mental health services. More people join the movement all the time. But, it's hard to tell if we're making progress or what are priorities should be. When is change just slow and when is "everyone is moving along at their own pace" fine? When should we be disappointed and pushing harder? Meanwhile, the rest of the pressures and demands we face in our jobs haven't gotten any easier. We still have overwhelming case loads, erratic damaging budget cuts, escalating documentation and billing requirements, political pressures, and the usual array of "crises of the week" to contend with. It's hard to keep our focus.

Building a Transformation Infrastructure:

Most public systems are designed for stability, not change. Most public systems are designed to be able to respond to other governmental funding and documentation requirements, not to their users' needs. Most public systems are designed for proposals to be spread top-down, not bottom-up. Most public systems don't have substantial leadership development programs and tend to be managed, not led. Most public programs manage risks to avoid exposure, not to promote innovation. No wonder transformation is so hard!

For transformation to move reasonably rapidly we need to work on changing these infrastructure features. Specifically we need to:

1) Have consistent, hands-on, reliable, focused leadership
2) Create a "learning culture" with small work groups creating innovative actions and learning what changes work – with a lot of administrative support
3) Improve the trust and communication between central administration and line staff in both directions.
4) Have a clear shared vision and goals and be mutually accountable for them.
5) Incorporate consumers widely, including hiring them

Leadership:

Most of the leaders of the recovery movement have been "outsiders." Many have spent years aggressively attacking the system. Those who work for the system are likely to be away from the central

power structure in the office of consumer affairs, training, protection and advocacy, employment services, etc. Effective leaders of system transformation will have to be accepted by the central power structure or part of it themselves. We now need our leaders to be "inside reformers" more than "outside revolutionaries." Establishing internal recovery leadership may be a challenge.

There needs to be widespread support for the transformation from administrators, some of whom may not be connected to clinical issues, to get them to make administrative changes to facilitate the transformation. They will need to be exposed to the central values of recovery if they are going to make decisions that consider a recovery impact. We have a one and a half day Recovery Oriented Leadership workshop focusing on hope, healing, authority, and community integration.

Line staff learning culture:

Most staff is used to a "change process" that consists of administration creating an initiative that staff is directed to implement. These staff have learned that, in general, if they wait out the current initiative, administration has no real implementation plan and will sooner or later move on to the next initiative without making them do anything differently. Staff has rarely, if ever, been asked to design the change and implement it themselves with administrative support. Consequently, they are unlikely to believe it if they are offered that opportunity. Many of them are "heart-broken early adaptors" who early in their careers did try to make improvements in their programs, but after a career of set backs, broken promises, and stifling inertia have bitterly given up. It takes a great deal of sensitivity and effort to motivate staff to participate in a true empowerment change process.

We designed a set of four "domain" groups for staff to divide into to form ongoing work groups pursuing innovations and improvements in their programs:

Staff Transformation	**Organizational Structures and Processes**
1) Develop and enhance staff belief in recovery 2) Energize and instill hope in staff	6) Collect and use quality of life and recovery based outcomes 7) Develop structure to promote client flow and graduation from services 8) Build strong teamwork 9) Build relationships with administration
Staff-Consumer Interactions	**Available Services /Capacity**

3) Develop welcoming environments 4) Develop successful strategies to work with challenging individuals 5) Include consumer volunteers and staff	10) Develop quality of life support services 11) Collaborate with other social services 12) Develop community belonging

The domains each describe a different approach to transformation and will likely appeal to different staff. Some people like focusing on their work culture, others on clinical practice, others on clinic structure and outcome measurement and others on community relationships. The "objectives" in each domain have been selected as actions that give the most transformational "bang for the buck" as well as being valuable, concrete accomplishments that can be observed and celebrated in their own right.

We have repeatedly noted special difficulties in the second objective to "energize and instill hope in staff." Many programs have very poor staff morale and energy, very little cohesiveness, and/or a pervasive culture of victimization. We have developed more focused approaches to help them create a more hopeful work culture.

If staff doesn't believe that the transformation is "real" and tries to stay on the sidelines, working hard on the seventh objective to "develop structure to promote client flow and graduation from services" can make it suddenly become very concrete and real. Los Angeles County DMH staff developed a structure for clinic redesign that each clinic is now determining how to best implement:

Recovery Based Clinic Redesign

Welcoming / Triage / Referral
Full Service Partnership
Strategic Services and Supports
Enhanced Engagement
Wellness Center

When clients are being reassigned, job duties changed and teams reorganized, transformation becomes very real and staff will want to get involved.

Other specific problems with transformation can be addressed by emphasizing the related domain group.

Line Staff – Administration Relationships:

One of the leader's most important ongoing responsibilities is to combat the negative views staff usually has about administration and administration usually has about line staff. One task is to get each to actually be considerate of each other's needs and take supportive actions. Another task is to get each side to be aware of and appreciative of what the other is doing positively. Facilitating better direct communication is a crucial aspect. Unfortunately, both sides tend to limit transparency to protect themselves. It's a sign of clear progress when both sides are more open in the other's presence.

We have facilitated program directors' meetings to promote communication in both directions. We have had administrative meetings devoted to addressing line staff concerns brought to them by program directors. We have had large meetings of "domain leaders" from multiple programs inspiring each other and presenting their achievements to administrative guests.

Shared vision, goals, and accountability:

The recovery vision is relatively easy to sell because for most people it solidly reflects their inner values and the reasons staff got into this field in the first place. Most of it is "common sense." After their initial defensive reactions, many staff experience recovery as a return to their roots and their profession's roots which have too often gotten distorted and lost along the way. The disagreements come when we try to translate that vision into a practical reality. That is one of the reasons why it is so important for the actual action steps to be designed by the people who are going to have to make them real.

The goals of this transformation work fall into two basic categories: Improved client outcomes and improved programs.

The recovery model prides itself on going beyond symptom relief to help clients get better lives. We have developed two major approaches and corresponding tools to track this: (1) Beginning with MHA's Village, DMH of the State of California has been tracking concrete quality of life outcomes since 1990. Our present tool tracks housing, jail, psychiatric hospitalization, employment, education, income / benefits, and legal status. (2) The Milestones of Recovery Scale (MORS) is a 1 – 8 rating of clients' progress in recovery using three correlates of recovery – risk, skills and supports, and engagement. Domain Objective 6 to "collect and use quality of life and recovery based outcomes" focuses not on reinventing these tools, but on incorporating them within the daily life of the program and using them to improve services. In our view, client outcome measurement is a strikingly underused tool for improvement and should largely replace chart audits. Measuring something and creating reports makes it important and creates focus.

"Measuring" improvement in programs as they become more recovery based has been illusive thus far. Many recovery advocates complain that programs are just changing their names and some of their language and paperwork and then calling themselves recovery based programs, without really transforming. We believe that tracking "fidelity" to the structure of an "Evidence Based Practice" is akin to doing chart audits to track clients; it tracks process, not outcomes. What program outcomes do we really want? How do we know if a program is really "recovery-based?"

Recovery is a culture and not a practice. Recovery is predominantly a value-driven movement. Both of these features make it hard to make recovery concrete enough to measure, but not impossible. After all, the "value" of handicapped accessibility has been painstakingly made concrete in the pages of the Americans with Disabilities Act. Agencies of all kinds are being held accountable for concrete actions that demonstrate handicapped accessibility every day. We are actively working to create a "Report Card" to make the key values of recovery concrete. Here is our present format:

Tracking Building Recovery Culture

	Exploring	Emerging	Maturing	Excelling
Growth Orientation				
Consumer Inclusion				
Emotional Healing				
Quality of Life Focus				
Community Integration				
Staff Recovery				

We're collecting concrete items to put in each box from a variety of people, especially line staff, to create a tool with items meaningful to the people who will be held accountable for using them.

If you try to connect the domain groups and their objectives on the one hand with the report card outcome values and their concrete indicators on the other, you'll probably discover that the domains are "means" to the outcome values "ends." For example, you can pursue Growth Orientation by focusing on staff's belief in recovery, by emphasizing skill building services, by building graduation into your structure, or by connecting with new roles in the community. Conversely, increasing the welcoming environment by creating a consumer volunteer position might promote growth, include consumers in new ways, improve staff's morale, and promote community activities. The two tools join together in the

concrete changes that are actually made. Accountability focuses in on that intersection: Did the program actually make concrete changes?

Incorporating consumers:

Recovery is experienced by our consumers as they overcome their illnesses and rebuild their lives. They are the ones who can best describe what recovery is like for them. We need to incorporate their voice and their view into everything we do: "Nothing about us without us." This also helps insure we include client service prominently in our decisions.

The process of incorporating consumers generally follows these steps:

- "Consumer movement" and first person recovery presentations
- Consumer councils and advisors
- Including consumers in domain groups
- Consumer volunteers
- Hiring consumers
- Consumer leadership

We are not including consumers out of charity or compassion. They are responsible not only to improve our programs and our services, but also to actively break down walls of segregation and stigma, altering how all of us view people with mental illnesses along the way. The first consumers to take any of these steps are groundbreakers. They are "Jackie Robinsons." A number of concrete things can be done both to support and supervise consumers to increase their chances of success.

We recently described what we've been doing to a district chief and he said, "That seems like an awful lot of work." Yes, it is.