

I first met Bruce Anderson as a consultant to the Village. Originally coming from Alaska and in more recent years flying in from his home on Vashon Island outside of Seattle he has provided us, and many other social service programs and systems, ongoing wisdom, support, and uncomfortable prodding. I have probably integrated more teachings from him, including story creating and telling, relationship maps, core gifts, community welcoming, and cultural competency, than from any other single individual. We've both brought our separate talents and have worked hard trying to make this massive undertaking a success.

There have been a number of elements to the effort, but this piece describes our efforts to empower clinic staff directly and get them to create and take action in their own programs. The domains and goals were created by a group process Bruce facilitated. I wrote this paper based on our collective efforts.

Creating a Recovery Transformation Plan

(2005)

At some point, to transform our system, we have to stop planning and discussing, and actually do something different in our day to day work. Naturally, we hesitate at that point. On the one hand, it seems that any single change is tied to so many other needed changes that it's impossible to do anything. On the other hand, it's impossible to change everything at once.

Our approach is to begin by making a set of focused changes that are spread across all the domains that need to be addressed for change to endure. We've chosen to focus on eleven goal areas within four domains of change. We've chosen these goal areas both because they are practical and because they're likely to lead to true transformation. Every staff member is expected to choose one of the domains and their included goal areas to work on, while including consumer and family involvement. Each clinic has the freedom to approach these goals as they think best. You must make concrete plans for each goal area, including outcomes, timelines, and needed support. Clinics are encouraged to learn from each other, but we expect all plans to be unique.

Here is an overview of the domains and goal areas:

Staff Transformation	Organizational Structures and Processes
<ol style="list-style-type: none">1) Develop and enhance staff belief in recovery2) Energize and instill hope in staff	<ol style="list-style-type: none">5) Collect and use Quality of Life and Recovery Based outcomes6) Develop structure to promote client flow and graduation from services7) Build strong teamwork8) Build relationships with administration

Staff-Consumer Interactions	Available Services / Capacity
3) Develop welcoming environments 4) Develop successful strategies to work with challenging individuals	9) Develop quality of life support services 10) Collaborate with other social services 11) Develop community belonging

Which box looks good to you?

Here’s some background and ideas to help you get started:

Staff Transformation:

It’s clear that the heart of any program is the staff. Our system is certainly in need of major changes, but if, in the end, we change the system and don’t change ourselves, nothing will really change.

1) Develop and enhance staff belief in recovery

Recovery is so different from what any of us were taught in school, what we were trained to do, what MediCal requires, what the system has been set up to deliver, what our professional organizations espouse, and what we’ve personally experienced in our work, that it’s hard to visualize. With such a contrary background, it’s hard to believe recovery is regularly possible, let alone to make major changes to promote it.

We need to create a positive background on the fly. There is good research data. There are compelling speakers describing their own recoveries. There are programs promoting recovery that are true believers. There are probably even good examples of recovery and your ability to promote recovery in your past and present work. Calling up and reconnecting with people who left the clinic doing well can also be inspiring. Choose what you want to do.

Another very different kind of experience that builds belief in recovery is to work alongside people with serious mental illnesses in recovery, not as limited “consumer staff” with limited roles and expectations, but as full colleagues.

2) Energize and instill hope in staff

Recovery work is very emotionally intense work because it relies so heavily on personal relationships to be effective. It also requires lots of supported risk taking and giving up considerable control and structure to people with a psychiatric diagnosis. Most of the staff concerns are connected to this combination of increased investment and decreased control. Trying to minimize risks or retain control will seriously handicap recovery efforts. Therefore we’re left with trying to strengthen staff.

Fortunately, most staff have a lot of untapped strengths. The current system seriously restricts staff and attempts to create productivity by turning staff into assembly line workers. There are substantial emotional strengths from life experiences that have been cut off as “unprofessional” that can be tapped into. There are also lots of other strengths people have (for example dancing, hiking, spirituality, child rearing, charity work, athletics, politics, etc.) that can also be tapped into.

We also have a tendency to focus our attention on negative events and crisis creating a daily atmosphere of “impending disasters waiting to happen” instead of focusing on celebrating positive outcomes and pleasant surprises. Instilling a hopeful culture will lead to more willingness to take risks and decrease control.

Staff-Consumer Interactions:

The majority of our success and failure (including medications) depends on staff-consumer interactions. Although there are many people with whom we establish good working relationships, with many others we don't. We struggle engaging some people, others drop out without much benefit, and others fight with us throughout. Even though part of us is grateful not to have even more people to deal with, this dissatisfaction and aggravation takes its toll.

3) Develop welcoming environments

We have developed a host of practices designed to keep us from getting overwhelmed by new clients, to keep us from getting hurt by all these strangers coming in, and to make sure everything is adequately documented to bill efficiently. These practices are seriously handicapping our ability to engage new people in positive relationships and need to be systematically re-evaluated and changed. Even people we will turn away should be initially welcomed.

Once people are known to us, we need to share our program and our building with them. The traditional model where the office belongs to the doctor, or other professional, and the patient comes to visit, waiting patiently outside with the other visitors until they are allowed in needs to be transformed into a shared environment that can serve as a safe sanctuary, a place of acceptance and healing, a place to connect with others who care about each other; in sum a recovery community. Remember the old “therapeutic milieu”? Remember when groups were part of creating larger relationships and not the only place to connect in an impersonal clinic?

4) Develop successful strategies to work with challenging individuals

A small number of people create an enormous portion of the problems in any program and take lots of time and energy away from everyone else. Some of these people are essentially “unengaged” in treatment despite being given lots of treatment. They are frequently brought in by others coercively or come in demanding in crisis requiring immediate attention. Others are “engaged, but not self-coordinating.” They are trying to improve their lives, but everything is always a mess. Substance abuse and poor usage of medications are frequently part of the picture. Sometimes homelessness, jailings, or frequent hospitalizations complicate things further. These people do not do very well in the traditional,

appointment based, outpatient clinics they are often in. They never get enough support, in an ongoing, intensive, proactive, flexible way to improve enough to be “self-responsible” enough to be well treated in an appointment based clinic.

A number of strategies including ACT teams, walk-in clinics, harm reduction, motivational interviewing, payee programs, medication management, and assertive outreach have been developed to work with them.

Organizational Structures and Processes:

Many staff feel like they are working all alone or with a few trusted colleagues, fighting oppressive bureaucracies and auditors, relatively weak and unheard, powerless to effect major changes. Few have experienced the increase in power that comes from being in a system where the structure and processes are in alignment with what they value. Systems work better when everyone is going the same direction instead of where everyone is building small, walled off, embattled areas of their own.

5) Collect and use Quality of Life and Recovery Based outcomes

Our present system has virtually no outcome measures. Instead it measures “units of service” and analyzes chart notes. We will only be able to impact that system when we can replace it with a reliable outcome accountability system. It is important for us to measure what we want to create, quality of life and recovery, so we’re going in the same direction. Measurements have a way of making things real.

Quality of Life measurement tools have been developed by the AB2034 program to assess housing, employment, income, legal status, education, and involuntary treatment (conservatorship, hospitalization, and institutionalization). These are very powerful political measurements and saved the funding of the AB2034 program from the governor’s blue pencil. They will be included in the MHSA funded programs. The forms are easy to fill out, and it may be possible for people to fill out their own forms when they come into the clinic.

A recovery based outcome tool, the Milestones of Recovery (MORS) has been developed at MHA-LA and is getting substantial attention. Several of the clinics have already begun rating the “stage of recovery” of their clients to focus on their recovery needs. It is also reliable and easy to use and can help assess case load needs and individual progress.

It is crucial that any data that is collected is returned to the staff and consumers that collected them to be used. Otherwise any measurement tool is just another added paperwork burden to be resented. A feedback loop must be built in.

6) Develop structure to promote client flow and graduation from services

The most dangerous problem that transformation faces is the overwhelming case loads. We have a system where more people come for help everyday and very few people leave successfully. Over time, any such system will become overwhelmed. There is no staffing level large enough to avoid that fate.

That is not to say that we don't need more staff. We do. But unless we create flow we will never catch up.

Every service must be designed to be transitional (though not necessarily time limited) and there must be a set of "next steps" that people progress to if they do well. This can range from outreach services achieving engagement; then the person moves on to case management; then to outpatient therapy achieving self-help coping skills and natural community supports; and then the person moves on to self-help support without a therapist or case manager. A "flow map" of the overall program should be created. (Note that it's not a linear map and people unfortunately sometimes flow backwards.)

A crucial feature of the map is that there must be destinations outside of the clinic entirely. This may include private MediCal or Medicare providers, HMOs, sliding scale therapists, self-help programs, other social service agencies, community supports and no treatment needed at all. (At the Village, we were unable to identify or develop adequate outside destinations and resorted to creating an independent Wellness Center as a graduation destination. It is likely that DMH will create Wellness Centers in every service area to meet this need.)

Flow and graduation generates an impressive amount of distress and conflict among staff, clients and families. It is likely that after the organizational structure and processes group does its job and creates a structure for flow and graduation, the staff transformation group will need to address the issues that emerge.

7) Build strong teamwork

Teams are not included in this list of initial goal areas as a fashion statement. Strong teams are crucial to the ability to lower boundaries without ethical violations, to take on multiple roles with multiple clients, to insure physical safety in unlocked environments, to expose ourselves to painful emotions encountered in close relationships with clients without being overwhelmed, and to be accessible for walk-ins, work in the community, and keep appointments responsibly all at once. Our teams must include multi-disciplinary expertise including non-professionals, consumers and families, and social support specialists. We must also include multi-experiential backgrounds to engage a variety of difficult people and to have cultural diversity and competence. The plan in this goal area must go beyond generic team building to address all of these crucial needs.

8) Build relationships with administration

There is a longstanding mistrust and distancing between line staff and administration. Staff tends to have trouble believing that any initiative is real, let alone that they will get the ongoing administrative support needed to implement transformation. Administration tends to have trouble believing that staff will actually implement any changes without being ordered to do so and being told specifically what to do. Nonetheless, the best work plans are likely to come from the staff that has to implement them and the best motivation comes from empowering staff. The plan in this goal area needs to address how administration and staff can come closer together, trust each other more, and work collaboratively, being sensitive to each other's needs and pressures.

Available Services / Capacity:

Many staff express a frustration that they can't help people achieve quality of life goals without the needed services and capacity. What good is it to help someone get motivated to get their own apartment or a job if there aren't any apartments or jobs available? Our tendency is to return to dealing with mental health where we aren't so dependent on things we don't have and can't control. Unfortunately, that leaves the clients with nothing.

9) Develop quality of life support services

It's been shown repeatedly that mental health services on their own rarely lead to quality of life achievements like income, housing, employment, or education. This is partly because people with serious mental illnesses often need ongoing support along with skill building to "choose, get, and keep" these things, and partly because there are pervasive shortages of opportunities in our community. Therefore, services need to include skill building, support, and community development for each of these achievements.

Generally skill building and support staff should be integrated into the service teams so they have relationships with the clients and their services are easy to access, while community development staff need to spend most of their time in the community creating relationships with landlords, employers, educators, etc.

10) Collaborate with other social services

There are a variety of social service agencies designed to assist people with improving their quality of life. Some of these are well known to us (for example, SSI, Voc Rehab, HUD, county health services, GR, substance abuse services, and regional centers) and some are more obscure (for example, IHSS, meals on wheels, dial a lift, disabled student services at community colleges, family preservation services, mental health advocacy services, and library literacy classes). A good plan will increase the number of social services being used by our clients.

Unfortunately, most of these services have serious problems of their own and are difficult for people with mental illnesses to access or use successfully without accommodations. Many of them have developed specific mental health programs as a result (for example, GR's NSA program, HUD's shelter-plus program, the Voc Rehab- DMH co-op program, dual diagnosis programs, and collocated MH workers at the jail). Utilizing these services is a strategy for expanding what would be possible with direct clinic staff alone, but personal relationships are the glue that makes programs like this work, and we need to invest in assigning staff to make those relationships.

11) *Develop community belonging*

Perhaps the most challenging goal area is to develop community belonging. Yet, true recovery requires people attaining meaningful roles that are not “service recipient.” Staff, families, and even the clients themselves all tend to have problems visualizing our clients in these other roles. Making things worse, many staff are also uncomfortable working in the community outside of our provider roles. Community development is a rare skill. Part of this plan should be making a “community map” of potentially welcoming places in our community (for example YMCA, bowling leagues, churches, volunteer organizations, Park and Recreation classes, and singles’ groups)

The available services/capacity group has the difficult job of determining how to create new services and capacities. Three general strategies are available: First, they can re-allocate existing staff and resources. Transformation requires both creating some new services and destroying some old services. It may be that with a change in mission some services are lower priority than they used to be. Second, they can leverage resources from other community agencies. Using volunteers is an example of this (for example mentors or ComPeer), but even volunteers require an investment of staff to coordinate them. Third, they can make specific requests for upcoming MHSA resources.

Now which group looks good to you?

It’s been about a year since we began this process. Staff in each clinic has met about once every couple weeks and many have begun including consumers in their meetings. While there’s been ongoing resistance, there have also been concrete accomplishments. Some have been small things like having Armenian language magazines in the lobby at San Fernando MH (although this might not seem small to me if I spoke only Armenian and hesitantly walked into that clinic and got the encouraging message that I was expected). Some have been quite large things like redesigning the intake process or including a consumer greeter in the lobby to explain what’s going on and recruit for self-help groups.

Unfortunately, about six months into the process DMH was faced with an unexpected \$50 million “structural deficit” and for reasons unclear to me targeted the transforming clinics for especially large cuts in pre-existing personnel. This had a crippling effect on morale, the relationship with administration, and the process in general. We’ve struggled on and on most days I’m still hopeful.

Overall, I’ve been impressed with the power of the “domain work” and recommend it to other programs who want to empower their staff to support and create recovery based transformation.