

A Recovery Based Program Inventory

(2004)

Throughout the country there have been calls to radically reform the mental health system by making it recovery based. However, it has often been difficult to concretely describe and quantify the lofty ideals of the recovery movement. Even still, we must do so if we are going to catalyze the concrete as well as philosophical changes that are needed to truly transform most traditional programs. This inventory is an effort to translate the recovery vision into a practical program evaluation tool.

1) Recovery Beliefs and Implementation

A) Do staff and consumers believe recovery with severe mental illnesses is possible?

- What do they base that belief on?
- What are their expectations for outcomes and prognosis?
- What institutional “outcome stories” do they share?
- Do treatment plans and goals reflect expectations of growth and development, or protection, care taking and stability?
- Does staff carry hope for consumers until they are able to and have specific techniques for building hope within consumers?
- Does staff have a positive possible future image of the consumers they’re working with and do they help consumers build their own positive images?
- Is there an expectation, mechanism for, and/or regular process of “positive graduation”?
- Is there a positive exit from mental health services entirely?

B) Do staff and consumers believe in empowerment and self-determination?

- How much credibility is given to consumers’ decision-making abilities?
- Do treatment plans and goals reflect consumers’ decisions or staff decisions?
- How frequently are services not “freely chosen”:
 - Program requirements?
 - Involuntary hospitalizations?
 - Conservatorships?
 - Court ordered treatment?
 - Payeeships?
- Is there an expectation, mechanism for, and/or regular process of restoring free choice in these services?
- Do consumer decisions substantially effect their individual treatment and services:
 - Goal setting?
 - Services they use?
 - Medications?
 - Frequency of treatment?
 - Staff they use?
- Do consumer decisions substantially affect the overall program design and operation?

- Are program information and developments openly shared with consumers?
- Are consumers included in advisory boards, planning and quality management committees, research planning groups?
- Are there concrete program choices that reflect consumer input?

C) Do staff and consumers believe in self-responsibility?

- Are there “natural consequences” for behavior or “therapeutic consequences”?
- Is there an effort to shield people from legal consequences because they are mentally ill and therefore not responsible?
- Are consumers “permitted to fail” or protected/rescued from failure?
- Are consumers expected to behave responsibly without supervision?
- How much freedom are they given from supervision within the agency (to use phones, supplies, mail, be around staff possessions, etc.)?
- Is program safety based on separating staff from consumers and forcibly guarding them or an inclusive “community watch” approach?

D) Do staff and consumers believe people with severe mental illnesses can contribute meaningfully to our world?

- Are people with mental illnesses hired at all, in restricted consumer positions, and/ or as fully equal staff:
- Do they volunteer, receive reduced wages, and/or full pay?
- Does the program support community employment?
 - Fully paid, sheltered, and/or subsidized?
 - Enclave, protected, and/or “nondisclosure”?
- Are there roles in the program besides treatment recipient roles?
- Are consumers actively engaged to help each other?
- Do consumers co-lead and/or lead program activities?
- Are consumers kept within the program walls or supported within the community?
- Are community activities basically interacting with other consumers or with “normal” community members?
- Are there integrated, “non-disclosure” community activities?
- Do treatment plans and goals reflect meaningful community roles:
 - Employment?
 - Reconnecting with family?
 - Raising children?
 - Intimate relationships and marriage?
 - Spiritual involvement?
 - “Giving back” to others?

2) Recovery Relationships and Leadership

A) Are relationships between staff and consumers highly valued?

- Does the intake procedure emphasize relationship building or diagnostic assessments and paperwork?
- Is continuity of relationship maintained in the intake process?
- Are treatment assignments based on relationship fits?
- How are relationships built during treatment transitions:
 - In crisis?
 - In hospitalizations?
 - In staff vacations?
 - In staff departures?
 - In discharges?
- How many staff do consumers generally have relationships with?
- How much of the treatment activity is overtly relationship building in intent?
- Do administrators have relationships with consumers?

B) Does staff relate to consumers as people or relate to their illnesses?

- Do their interactions and notes reflect only illness concerns or include personal concerns?
- Are subjective experiences explored or only objective symptom checklists?
- Do goals reflect consumer's personal individuality or illness status?
- Are consumers assigned to and grouped into services based upon illness or personal factors?
- Does staff have other roles in the program besides their illness related roles when they interact with consumers?
- Are there program activities designed to encourage staff and consumers to interact away from their illness roles:
 - Are they outside the program grounds?
 - Are they outside normal working hours?
 - Are there different authority relationships?
- Is the language used by staff, with each other and with consumers, respectful and nonstigmatizing?

C) Are the barriers between staff and consumers minimized?

- Is there an atmosphere of staff and consumers sharing ownership of the program and living and working together or staff running the program for the consumers?
- Are there physical barriers between staff and members?
- Are there segregated bathrooms, lounges, telephones, work areas, eating areas, etc.?
- Is it hard to tell who is a consumer and who is a staff?
- Do interactions appear artificial and professional or real and personal?
- Is staff encouraged to share their personal experiences with consumers?
- Is staff encouraged to be emotionally expressive with consumers?
- Is there positive physical contact (e.g. hugs, pat on the backs, high fives) between staff and consumers?
- Does staff tend to treat consumers patronizingly?

- Is staff fearful and mistrustful of consumers?
 - Has there been significant harm done?
- Are consumers fearful and mistrustful of staff?
 - Has there been significant harm done?

D) Is staff treated the way we'd like consumers to be treated?

- Is administration hopeful about their staff?
- Does administration expect their staff to help consumers improve their lives?
- What outcomes do they hold staff accountable for?
- Is staff encouraged to make their own treatment decisions?
- Is staff given funds to spend directly on their consumers?
- Is staff encouraged to try new things?
- Is staff encouraged to take risks or is there a "culture of blame"?
- Is staff encouraged to be emotionally expressive with each other?
- Is staff encouraged and funded to build their own expertise?
- Is staff consulted as "experts" by their own administration?
- Are program information and developments openly shared with staff?
- Is staff included in advisory boards, planning and quality management committees, research planning groups?
- Are there concrete program choices that reflect staff input?
- Is staff expected to behave responsibly without supervision?
- Is staff encouraged to find meaningful roles in the program?
- Is staff encouraged to develop "complementary interests" in the community and share them with consumers?
- Is staff expected to grow both within the program and to move on to other opportunities?

E) Does the program's administration reflect recovery values?

- What is the mission statement of the program and how is it implemented?
- What issues does administration spend its time and leadership on?
- What issues does administration advocate for outside the program?
- How are competing pressures and auditors handled?
- How is risk management handled?
- Are administration desires forwarded through rules or values?
- Do internal funding choices reflect person centered recovery planning?
- Does programming and funding follow consumers as they grow?

3) Recovery Culture

A) Is welcoming widespread?

- How are inquiries about the program handled?
- Is there a "no wrong door" policy, finding help for everyone somewhere?
- Are there physical barriers to welcoming?

- Is there widespread staff accessibility:
 - Walk-ins?
 - Telephone calls?
 - Cross coverage?
 - After hours?
 - Comfort calls and crisis calls?
 - Family and others?
- Is there serious pressure to get rid of consumers and potential consumers?
- How are services rationed and how does that affect the culture?
- Are there substantial waiting lists?
- Are there program restrictions, exclusions or requirements, “hoops to jump through,” which restrict access?
- Does staff initiate extra contacts with consumers?
- Does staff seem genuinely happy to see consumers?
- Does staff reach out to dropouts and minimize “lost to follow-up”?

B) Is the program charitable?

- Does the program directly give people practical assistance:
 - Food?
 - Housing?
 - Transportation?
 - Clothing?
 - Mail?
 - Phone?
 - Storage?
 - Hygiene (showers, shave, laundry, hair cuts, etc.)
- Does the program indirectly give people practical assistance?
 - Referrals to local resources?
 - Assistance with applying for outside benefits (e.g. SSI applications, handicapped bus ID, disabled student’s office, Section 8 forms, medical and dental care, etc.)?
 - Accompany consumers to outside practical resources?
- Does the program develop outside practical resources?
- Is practical assistance always linked to treatment goals and requirements or can it be charity or engagement?

C) Does the program create a counter-culture of acceptance?

- How restrictive are the standards for “appropriate behavior” for consumers?
- How accepting is the program of “non-compliant” consumers:
 - Medication refusals?
 - Ongoing substance abuse?
 - Refusing to live in treatment settings?
 - Refusing to attend recommended groups?
- Are there punitive or exclusionary rules for inappropriate behavior or noncompliance?
- How are “bannings” handled?

- Is there a widespread effort to understand consumers' subjective experiences and the reasons for their behaviors?
- Is there widespread staff with personal experience with mental illness, substance abuse, homelessness, jailing, or other personal tragedies?
- Is there an inclusion in the program of socially undesirable consumers?

D) Is the program a safe sanctuary?

- Do consumers feel safe from the outside world within the program?
- Are consumers turned in to the police for criminal behavior they commit outside the program or only on the program grounds?
- How often are consumers involuntarily hospitalized for their behaviors?
- Is there physical violence within the program?
- Are the consumers protected from social stigma within the program or are they discriminated against, disrespected, and stigmatized within the program too?
- Do consumers feel safe enough to expose themselves emotionally to staff and to each other?
- Are consumers revealing shameful issues (e.g. childhood trauma, illiteracy, substance abuse, prostitution)?
- Are consumers able to learn from their mistakes?
- Is there a "no fail" policy?
- Why are consumers "86'd" from the program?
- Is there a sense of "spiritual acceptance" in the program?

E) Does the program embrace consumers' lives within it?

- Do consumers behave in the program like they do outside or act like patients within the program?
- Do consumers bring in their families, friends, lovers, and children to share with the program?
- Are consumer belongings, creations, and gifts widespread in the program?
- Do consumers share non-patient activities with the program?
- Is staff knowledgeable about consumers' lives?
- Does staff share ideas and resources relevant to consumers' outside lives with consumers within the program?
- Are "sensitive" parts of life openly included in the program:
 - Physical appearance?
 - Sexual feelings and behaviors?
 - Spirituality?
 - Child rearing?
 - Substance abuse?
 - Criminal behaviors?
- Does the program feel "full of life"?

4) Recovery Treatment

A) Is treatment focused on improving lives or treating illnesses?

- Are quality of life outcome data collected?
- Does goal setting reflect quality of life or clinical goals?
- Are there substantial services in the quality of life areas:
 - Housing?
 - Finances?
 - Employment?
 - Education?
 - Legal?
 - Physical health?
 - Substance abuse?
 - Social?
- Are services selected based on quality of life needs or clinical needs?
- Is there widespread staff with expertise in various life skills rather than mental health skills?
- Does staff “life coach” around practical skills and goals?

B) Is treatment integrated?

- Are services organized in teams working together or do staff pursue their own specialized goals and services?
- Is supervision organized around each consumer or by specialty service?
- Is there ongoing substantial communication between staff members, including the psychiatrist, to coordinate services?
- Does staff act as overlapping “generalists” doing “whatever it takes”?
- Are there substantial internal referrals because “that’s not my job”?
- Are there substantial external referrals because “that’s not our job”?
- Does all staff have an overall knowledge of the consumers they work with?
- Is substance abuse integrated into all staff services and relationships?

C) Does treatment utilize rehabilitation and recovery techniques and practices?

- Are services overall provided with a care taking or training emphasis?
- Are effective rehabilitation services provided:
 - Illness education and self management?
 - Supportive housing?
 - Supportive employment?
 - Family psychoeducation?
 - Supportive education?
 - Harm reduction and motivational interviewing?
 - Financial planning?
 - Supportive socialization?
 - Community integration?
- Is staff actively aware of the recovery stage, goals, and individual progress of the consumers they work with?
- Is staff actively aware of the “rehabilitation value” of their activities?

- Are consumers learning to manage their own lives through gaining recovery and life skills within a conscious framework of recovery promotion?
- Are consumers learning ways to manage symptoms?
- Are consumers learning ways of managing feelings?
- Are consumers learning ways to calm and center themselves (e.g. meditation, yoga, exercise)?
- Are consumers learning proactive ways of dealing with crisis (e.g. WRAP plans, advanced directives)?
- Are consumers building trust in their own decision-making and skills?
- Are consumers learning to find meaning in their suffering, to create wisdom from their pain?
- Are consumers preparing themselves to be independent of the program?

D) Does treatment build community supports and community integration?

- Does staff spend substantial time in the community, both with and without consumers?
- Does staff actively collaborate and build relationships with other social service agencies:
 - Social Security?
 - HUD and Section 8?
 - Vocational Rehabilitation?
 - Children’s Services?
 - Police, courts, jails, probation, and parole?
 - Disabled Students Services?
 - Welfare programs?
 - Medicaid/MediCal and Medicare?
- Does staff actively collaborate and build relationships with “community providers”:
 - Medical, dental, and eye services?
 - Schools and vocational training programs?
 - Employers?
 - Landlords and apartment management companies?
 - Board and Care operators?
 - Recreational programs and adult education?
 - Food providers?
 - Religious organizations?
 - Substance abuse treatment and sober living?
- Does staff actively collaborate and build relationships with self-help and consumer run services of various kinds?
- Does staff actively collaborate and build relationships in the community for consumers to have non-consumer roles?
- Does staff focus on replacing themselves with “natural supports” in the community?
- Does staff actively engage in mental health advocacy and stigma reduction activities?
- Does staff actively engage in improving the community?

Recently I visited Bonita House in Oakland because their consumer council had been using this tool to guide their discussions about what needed improvement about their own program. Before they discovered my inventory, they had been focusing on relatively superficial day to day items, like food and

bus passes. This inventory deepened the discussion dramatically by tapping into what they thought was really important. Their discussions had been slow. After eight or nine weeks they had only completed a page and a half of questions. Nonetheless, they'd gotten to the very sophisticated and deep place of trying to design a graduation process and celebration for their agency as a result of their discussions. The facilitator said he thought this self evaluation process was like painting the Golden Gate Bridge: By the time they got to the end of the questions it would be time to start all over again.

They enjoyed meeting me and sharing our ideas. You may be interested to know what their most heartfelt question of me was. They wanted to know if I really knew anyone who had actually recovered from schizophrenia and had a full life. Was recovery really possible? Hope requires role models.