Toward a Recovery System of Care

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The Department endorses a broad vision of recovery that involves a process of restoring or developing a positive and meaningful sense of identity apart from one’s condition and then rebuilding a life despite or within the limitations imposed by that condition. A recovery oriented system of care identifies and builds upon each individual’s assets, strengths, and areas of health and competence to support achieving a sense of mastery over his or her condition while regaining a meaningful, constructive, sense of membership in the broader community.
Factors Influencing the New Recovery Movement in CT

- Addiction self-help movement
- Mental Health consumer/survivor movement
- Family movement - NAMI
- Advances in treatment approaches
- Recovery oriented research
- Mental health and addiction advocates
- Commitment of DMHAS leadership to recovery principles
Addiction Stakeholder Input and Participation

- Recovery Core Values – CCAR and AU
- Commissioner's Policy
- Addiction Dimensions of Recovery
- CSAT Consultation and Planning Retreat
- Recovery Institute Curriculum Development
- Recovery Advisory Group
Recovery Core Values
CCAR and AU

• Articulated core values for recovery system of care in four areas. Identified steps in each area that can be implemented in support of their recovery vision.

  – Direction
  – Participation
  – Programming
  – Funding/Operations
Voices of Recovery
Voices of Recovery

“Having hope”

“Choice”

“Getting well/getting better”

“Having same rights as others”

“Making changes, having goals, education”

“Doing everyday things”

“Get a job”

“Staying clean and sober”

“Starting over again”

“Having life goals”

“Be looked at as whole people”
DMHAS’ Recovery Vision

- Collaborative treatment process
- Promotes highest level of autonomy
- Driven by recovery outcomes
- MH and SA services are tools
- Culturally relevant
- Focusses on building recovery capital
- Individual and family participation
- Holistic and Hopeful
- Individual responsibility and control

Promotes highest level of autonomy
Barriers to Realizing our Vision of Recovery

• Focus primarily on symptom reduction or sobriety
• “Client” viewed passively as recipient of services
• Focus on “fitting into a program”
• Focus on client pathology and deficits
• Diminished role of self-help/community support
• Minimal individual and family voice or input in system
• Responsibility for change and control largely owned by programs
• Person’s growth and sense of self is “constrained by “illness”
Objectives of DMHAS
Recovery System of Care

• Assume, to the extent possible, individual responsibility and control over their personal recovery process
• Increase individual/family participation in all aspects of service delivery
• Expand recovery efforts to all aspects of individual’s lives—social, vocational, spiritual through direct services or linkage to natural helping networks
• Promote highest degree of independent functioning and quality of life for all individuals in our system
• Expand recovery capital (White) – personal assets, family and social support
Components of Connecticut’s Recovery Model

- Recovery vision
- Workforce development initiatives
- Consumer/Recovering Person service initiatives including self-help and mutual assistance
- Public education and anti-stigma campaign
- Initiatives to increase individual and family participation
- Resource reallocation strategies
- Policies and procedures to support recovery
Addiction Dimensions of Recovery (draft)

- Understanding behavior and impact on recovery
- Support of family and friends
- Hope, confidence and commitment
- Understanding and accepting self
- Community supports
- Maintaining recovery
- Promoting recovery
- Empowerment and citizenship
Principles to Guide Our Work

- Recovery is a reality
- There are many paths to recovery
- Recovery flourishes in supportive communities
- Recovery is a voluntary process
- Consumers and persons in recovery must be part of the solution

*From Bill White*
If we really believed in recovery, we would not:

- Create expectation that full recovery should be achieved from a single tx episode
- View prior tx as indicative of poor prognosis
- Discharge clients for symptomatic behavior
- Treat addiction in serial episodes of disconnected tx
- Relegate aftercare to an afterthought
- Terminate service relationship following brief intervention

*From Bill White*
Many Pathways to Recovery

• Natural - involves spontaneous remission, maturation, reorganization of self due to crisis
• Social – involves use of informal community resources, mutual aid
• Treatment – guided movement into recovery via mechanism of treatment

From Bill White
Recovery in a New Model

- Engagement - emphasis on outreach, pre-treatment support and no discharge for showing symptoms
- Motivation - emphasis on recovery priming
- Screening/assessment - strength-based focus that includes of family/kinship network
- Service goals - consumer-defined with focus on building recovery capital and meaningful life

From Bill White
Recovery in a New Model

• Service timing - focus on post-crisis recovery support activities; commitment to continued availability; continuum of recovery support services

• Service emphasis - sustained recovery coaching, monitoring with feedback and support, linkage to communities of recovery; early re-intervention

• Locus of services – nesting recovery in the community

• Service technologies - focus on service and support menus; high degree of individualization;

*From Bill White*
Recovery in a New Model

• Management of co-occurring - Concept of “serial recovery”; integrated model of care, multi-unit/agency models, inclusion of indigenous healers/institutions

• Service roles - prosumers in paid and volunteer support roles; emphasis on mutual aid; role of primary care physician

• Service relationship - (Partnership-Consultant Model). Less hierarchical, potentially time-sustained

From Bill White
Recovery in a New Model

- Consumer involvement - consumer involvement in all aspects of service focus on illness self-management. Use of consumers as volunteers & employees and in consumer-led support groups/services.
- Relationship to community - lessen reliance on professionals using indigenous supports; “the community is the treatment center”
- Aftercare - all care is continuing care; Role of guide or recovery coach.

From Bill White
Recovery in a New Model

- Service evaluation - Focus on long term effects of service combinations & sequences on client/family/community; Consumer-defined outcomes & review
- Advocacy - Emphasis on policy advocacy, community education (stigma) and community resource development; activist/community organization approach.

*From Bill White*
What We Are Doing
We are working on three levels:
- Conceptual/Philosophical
- Clinical Programs and Skills
- Administrative Policies and Infrastructure
Current Initiatives

- Information and Education (Newsletter)
- Advance Directives
- Recovery Institute
- Person Centered Planning Initiative
- Housing and Vocational Initiative
- CSAT/CMHS Consultation
- Preferred Practices Initiative
- Recovery Self Assessment
- Recovery Advisory Council
- Recovery Policy Work Group
- Recovery Work Group
Highlights of Progress to Date

- Developed Commissioner’s Recovery Policy
- Hosted 2 major recovery conferences
- Developed CT Recovery Model
- Initiated training through Recovery Institute
- Obtained consultation from CMHS/CSAT for development of recovery-oriented system
- Completed recovery system assessment
- Completed system wide consumer driven Voice Your Opinion satisfaction survey
- Supported continuation and expansion of peer operated services
Desired Outcomes of Recovery Initiatives

- Improved quality of life
- Improved treatment retention
- Meaningful social roles
- Increased consumer satisfaction
- Greater vocational participation
- Independent functioning
- Increased consumer participation
- Identification of best practices
- Increased use of peer support and self help
- Reduction in stigma
- Increased consumer satisfaction
- Improved quality of life
Next Steps

- Feedback regarding model development and training curriculum
- Identification of exemplary practices for Centers of Excellence
- Participation in advisory or work groups
- Policy changes to support recovery-oriented service system
Making Vision a Reality 2003 and Beyond

• Continue to implement recovery approaches through programming, funding opportunities and policy development
• Continue to refine and operationalize the concept across the entire service system
• Continue to identify and implement Recovery preferred practices
• Reorient all DMHAS systems (eg performance measures, fiscal policy, etc) to support a recovery oriented system of care
Supporting Providers Through Training and Education

- Train providers re recovery and the CT recovery model
- Identify best practices and transfer knowledge to provider system
- Develop centers of excellence for staff and program development
Recovery Institute

THREE LEVELS OF OFFERINGS

**Open Trainings:** To promote widespread knowledge of recovery paradigm. 5 regional session. 100 participants/session. *Begins February 03.*

**Intensives:** Skill based. Direct service staff, administrators/supervisors, persons in recovery. 25 participants/cohort. Multiple session trainings focused on development of recovery specific skills. *Begin March 03*

**Centers of Excellence:** Develop agency-based model programs. Provide training to staff, technical assistance to administrators. Phase 1- Program development. Phase 2- Use Centers as training/internship sites. *Begin September 03*
Core Curriculum

• *Open Trainings:*
  • Overview of Recovery and CT. Recovery Model.
• *Intensives:*
  1. Engagement/Motivational Enhancement
  2. Person-Centered Planning
  3. Core Clinical Skills
  4. Managing Your Own Recovery
  5. Mutual Support Programs
  6. Delivering Culturally Competent Recovery Services
Centers of Excellence

• Develop agency-based model programs. Provide training to staff and technical assistance to administrators.
• Phase 1 - Program development.
• Phase 2 - Use Centers as training/internship sites.
  Peer Run Programs
  Supported Community Living
  Case Management/Recovery Guide
  Outreach and Engagement
Objectives and Timelines
Recovery Institute

- Develop institute model completed
- Hire institute staff 12-02
- Present Level 1 trainings 2-03
- Present Level 2 trainings 3-03
- Start-up of Centers of Excellence 10-03
Benefits for Providers

- Improved treatment retention
- Increased consumer satisfaction
- Broadens community supports that complement traditional agency approaches
- Staff development through training in best practices
- Learning laboratories
DMHAS Recovery Vision

- Recovery must focus on enhancing all aspects of the person’s life—social, vocational, recreational, spiritual, and clinical.
- Recovery must be a collaborative process that recognizes hopes, wishes, and dreams.
- MH and SA treatment are important tools in a person’s recovery.
- Not all individuals recover equally but focus of recovery is to promote highest level of autonomy.
- Services must be individualized and focus on strengths.
DMHAS Recovery Vision cont.

- Individuals in recovery should participate in all aspects of service delivery, planning and evaluation to the fullest extent possible
- Services must be culturally relevant
- Recovery outcomes must drive the system
- Public education to combat stigma is essential to recovery
- Treatment approaches must focus on collaboration rather than coercion
- All service delivery must focus on enhancing quality of life
Mental Health Dimensions of Recovery

- Support of Family and friends
- Hope and Commitment
- Meaningful activities
- Incorporating illness
- Redefining Self
- Managing symptoms
- Overcoming Stigma
- Assuming control
- Empowerment and citizenship