The Council on Quality and Leadership

Brown Bag Series
Promoting Recovery Through Personal Outcome Measures® and Basic Assurances

WELCOME

Definitions of Recovery

Recovery Is….

"No longer viewing oneself primarily as a mental patient and reclaiming a positive sense of self"

- ***(Review of Recovery Literature: A Synthesis Sample of Recovery Literature 2000)***

Recovery is….

About having a high quality of life, moving beyond illness, stabilization and maintenance and having a life and a future that you want to live!

SAMHSA's Definition of Recovery:

(see facilitator's note, SAMHSA and Recovery*)

4 Dimensions of Recovery

Health
Home
Purpose
Community

8 Dimensions of Wellness

Emotional
Environmental
Financial
Intellectual
Occupational
Physical
Social
Spiritual

TIPS and TOOLS TO LEARN ABOUT RECOVERY

Personal Outcome Measures®

OUTCOMES: A Matter of Definition

Clinical Outcomes

- Cure and symptom reduction

Functional Outcomes

- Increasing functional status

Personal Outcomes

- Issues that matter most to people in their lives that enhance their health, wellness, quality of life and ultimately, recovery

What's So Different About Personal Outcomes?

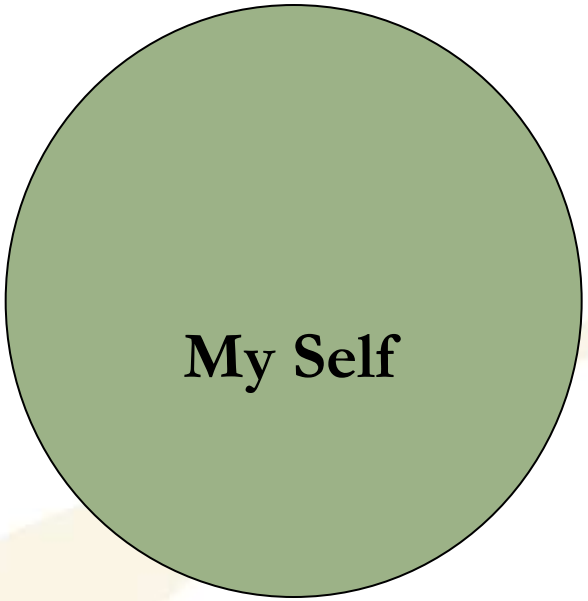
What Are Personal Outcome Measures (POM's)?

1. POM's are outcomes that are important to people, related to their quality of life

2. POM's are inclusive of recovery and "clinical" outcomes but they are not limited to them

3. POM's are defined by the **person**, not by clinical assessments, diagnostic labels, treatment providers or regulatory entities

4. POM's are broken down into 3 areas: "My Self," "My World" and "My Dreams"



POM:

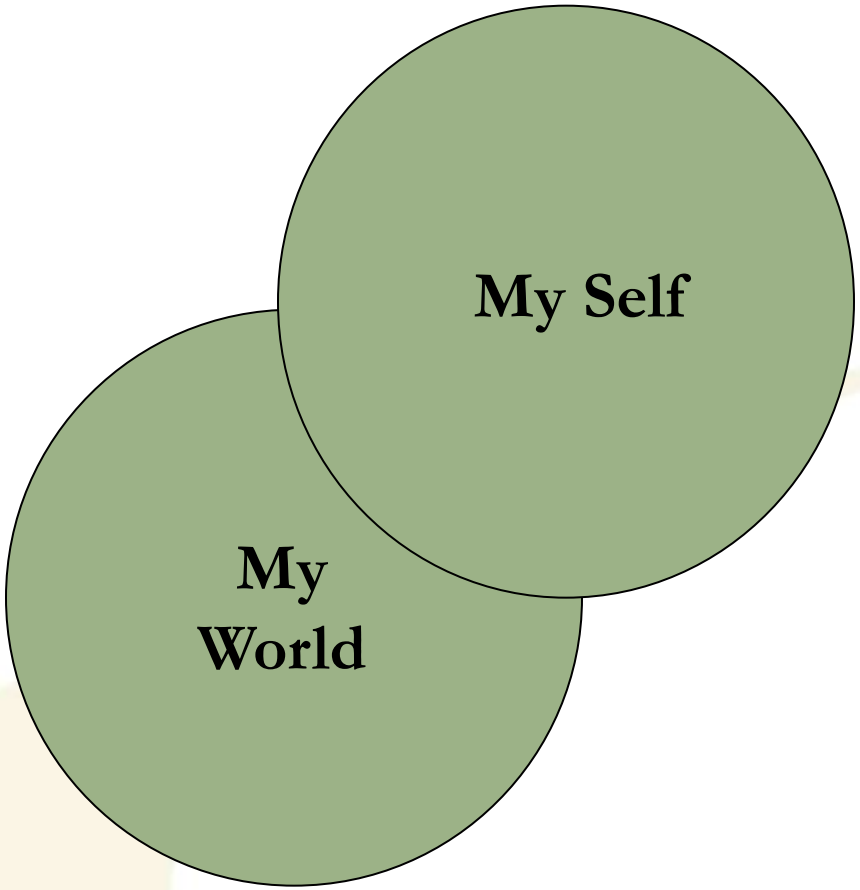
My Self is the personal, physical and environmental aspects of our lives which enable us to explore tomorrow's possibilities and choices

RECOVERY:

The Recovery Dimensions of Health and Community are synonymous with My Self

My Self

- People are connected to natural support networks.
- People have intimate relationships.
- People are safe.
- People have the best possible health.
- People exercise rights.
- People are treated fairly.
- People are free from abuse and neglect.
- People experience continuity and security.
- People decide when to share personal information.



POM:

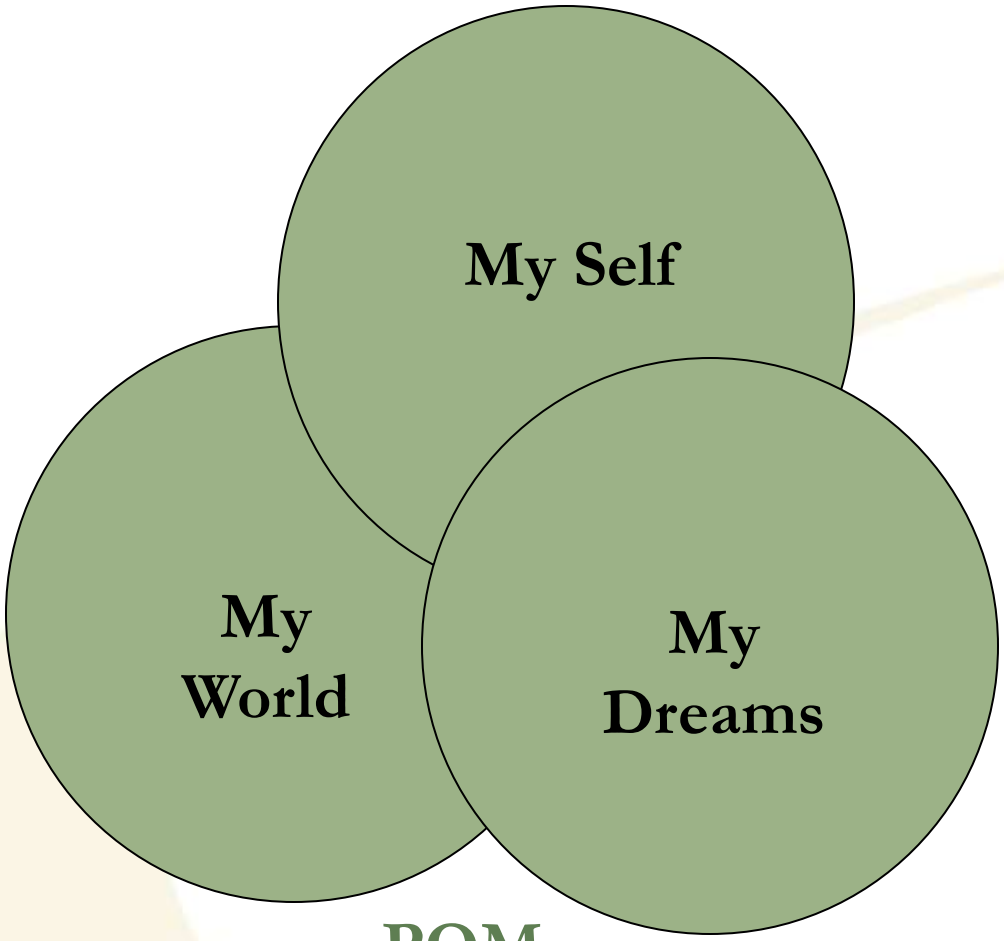
My World is the connectedness that occurs as we discover and react to people, places, choices and opportunities to have a life in the community

RECOVERY:

The recovery dimensions of Home, Purpose and Community are reflected in My World

My World

- People choose where and with whom they live.
- People choose where they work.
- People use their environments.
- People live in integrated environments.
- People interact with other members of the community.
- People perform different social roles.
- People choose services.



POM:

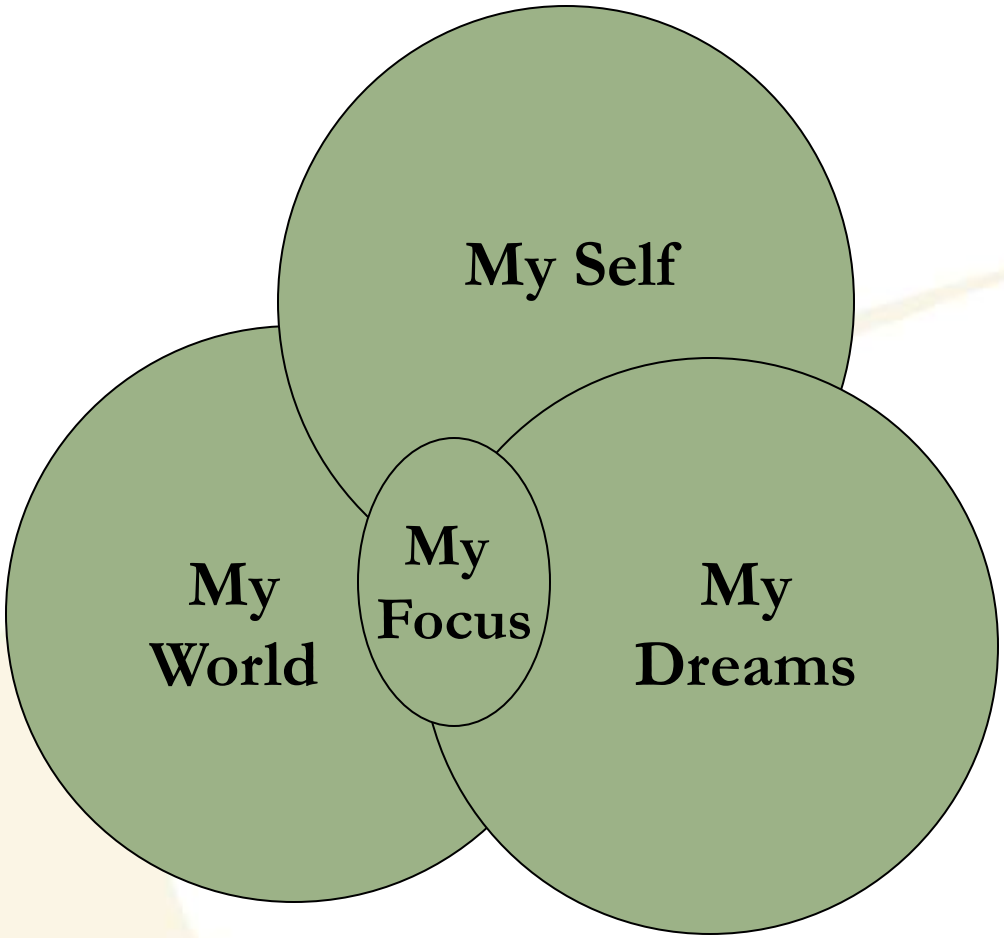
My Dreams include the discovery, choice and self-determination to determine how we want our lives (self and world) to be

RECOVERY:

Our personal definitions of recovery and the steps that we decide to take on that journey are examples of My Dreams

My Dreams

- People choose personal goals.
- People realize personal goals.
- People participate in the life of the community.
- People have friends.
- People are respected.



My Focus: What is most important to me now

Day Two:

Measuring with the Personal Outcomes (i.e. Decision Making)

Decision Making with Personal Outcomes

After you complete the learning/interview phase, two things are measured:

1. **Quality of Life: Is the Outcome for the person as defined by the person present?**

2. **Quality of Services: Are the individual supports present (being offered) for the person to attain his/her outcome?**

TOOLS FOR EVALUATION

PERSONAL OUTCOME RESULTS WORKSHEET

PERSON'S INITIALS:		
OUTCOME	OUTCOME PRESENT	INDIVIDUALIZED SUPPORTS PRESENT
My Self		
People are connected to natural support networks.		
People have intimate relationships.		
People are safe.		
People have the best possible health.		
People exercise rights.		
People are treated fairly.		
People are free from abuse and neglect.		
People experience continuity and security.		
People decide when to share personal information.		
My World		
People choose where and with whom they live.		
People choose where they work.		
People use their environments.		
People live in integrated environments.		
People interact with other members of the community.		
People perform different social roles.		
People choose services.		
My Dreams		
People choose personal goals.		
People realize personal goals.		
People participate in the life of the community.		
People have friends.		
People are respected.		

CQL's BA Companion Guide for Recovery-Oriented Behavioral Health Agencies

OVERVIEW

- CQL's Basic Assurances focus on Health, Safety and Human Security. While these are universal concepts, in practice, some nuances for ensuring Health, Safety and Human Security exist when providing recovery-oriented behavioral health services. This Companion Guide serves as a tool for CQL employees by offering guidance on the application of the Basic Assurances through the lens of behavioral health services

FACTOR 1: Rights Protection and Promotion

When reviewing rights protection and promotion of people with mental health and substance use challenges, at times, organizations restrict personal rights based on clinical decision making without due process or legal justification. For example, the right to review ones protected health information, chart or file, is often prevented due to a "clinical decision that reviewing the file would pose a threat, create stress or negatively impact the therapeutic relationship with the organization."

These type of restrictions must be reviewed to ensure that the individual's legal, human and clients rights are not being violated. Some areas to be aware of within behavioral health that may impact a person's rights include:

- A person's right to choose a different provider. Under threat of hospitalization or punitive discharge, people may be told that they cannot voluntarily choose different services or different providers.
- A person's right to refuse medications. Many behavioral health agencies require people to take medications as prescribed under penalty of involuntary commitment or discharge.

- A person's right to change representative payee or become their own payee. Often, organizations do not review payee status with people and provide them with the information to either change their payee or petition for control over their own finances.

- Termination of parental rights. Children may be removed from a home and placed in the state's custody or in foster care without due process because the parent(s) may have a mental health/substance use issue.

- Legal restrictions of rights. The courts may intercede and legally remove a person's right to carry or own weapons due to a criminal history. In these situations, ensure that the organization makes efforts to inform people of the legal process of rights restoration.

- Involuntary commitment. Involuntary psychiatric commitment represents one of the most frequent rights violations of people with behavioral health challenges. Review to ensure that organizations are making every attempt to prevent hospitalization when possible and to engage people in making informed decisions about their treatment by discussing the potential benefits and consequences of hospitalization.

- Coercion and threats. People with mental health/substance use challenges are vulnerable to coercion and threats. This may come in the form of "if you do not follow the rules, you will be discharged," or "if are not compliant with treatment recommendations, you will be hospitalized." Be aware of the subtle and overt ways that people's rights may be violated through coercion and threats.

When Help is NOT Helpful

"Help isn't help if it's not helpful. Help that is not helpful can actually do harm."

-Pat Deegan

"We must dare to talk about help because power, including the power to oppress, often disguises itself as help.

Power-disguised-as-help is used to silence disabled people.

Paolo Freire (1989) says that oppressive power submerges the consciousness of the oppressed into a culture of silence. Toxic help oppresses and silences people with disabilities."

Pat Deegan

Neglectful Help

Toxic Help

Helpful or Harmful: You Decide

- ✓ Telling someone you are working with that if they do not comply with taking their medications, they will be sent to the hospital
- ✓ Having an agency rule that states if a person doesn't follow the rules of the housing program, they will be kicked out
- ✓ Using cigarettes to control behavior
- ✓ Using level or point systems to reward and consequence attitude and behavior

Exploitation
Threats/Coercion
Forced Treatment
Over use of medication/sedation
Restraints/Seclusion
Aversive Conditioning
Lack of privacy/humiliation
Locking of cupboards, pantries, refrigerators
Lack of decision making- options that are important to the person
Behavior plans aimed at controlling behavior
Diet restrictions/other restrictions
Sleep times
Withholding- money, food, possessions
Preventing intimate relationships

How Can We Combat This?

1. Awareness of the Power Differentials

"Most people don't realize that they:

1. Have Power
2. Unknowingly Abuse It

Create Awareness!

http://www.springtideresources.org/sites/all/files/People_with_Disabilties_and_Caregivers_Wheel.pdf

2. Understand (and Choose Your Role)

Think about how you, the organization, colleagues and person served view your role. Which ones apply:

Monitor **EDUCATOR** Healer

Mentor Manager *Partner*

Supporter **Caretaker**

What is the difference between monitoring someone's "compliance" with treatment versus partnering with them to make decisions about what type of treatment they are interested?

What is the language that is used in each of these roles? What are the "tools" or approaches used as a monitor versus a partner?

3. Ask: What is Helpful and What is NOT?

…. And most importantly, LISTEN!

4. Have Empathy

The *Other* Side of the Desk

Have you ever thought just a wee little bit,
Of how it would seem to be a misfit,
And how you would feel if YOU had to sit,
On the other side of the desk?

Have you ever looked at the man who seemed a bum,
As he sat before you, nervous…dumb…
And thought of the courage it took to come,
To the other side of the desk?

Have you thought to yourself of his dreams that went astray,
Of the hard, real facts of his every day,
Of the things in his life that make him stay,
On the other side of the desk?

Have you thought to yourself, "It could be I,"
If the good things of life had passed me by,
And maybe I'd bluster and maybe I'd lie,
From the other side of the desk?

Did you make him feel he was full of greed,
Make him ashamed of his race or creed,
Or did you reach out to him in his need,
To the other side of the desk?

May God give us wisdom and lots of it,
And much compassion and plenty of grit,
So that we may be kinder to those who sit,
On the other side of the desk.

FACTOR 2: Dignity and Respect

- Dignity of risk is a key ingredient in recovery. Recovery-oriented organizations honor and respect each person's freedom to take risks even when the risk may be contrary to the treatment team recommendations. Among the risks that promote dignity include a person's decision to work, live in their own home rather than in congregate care or treatment setting.

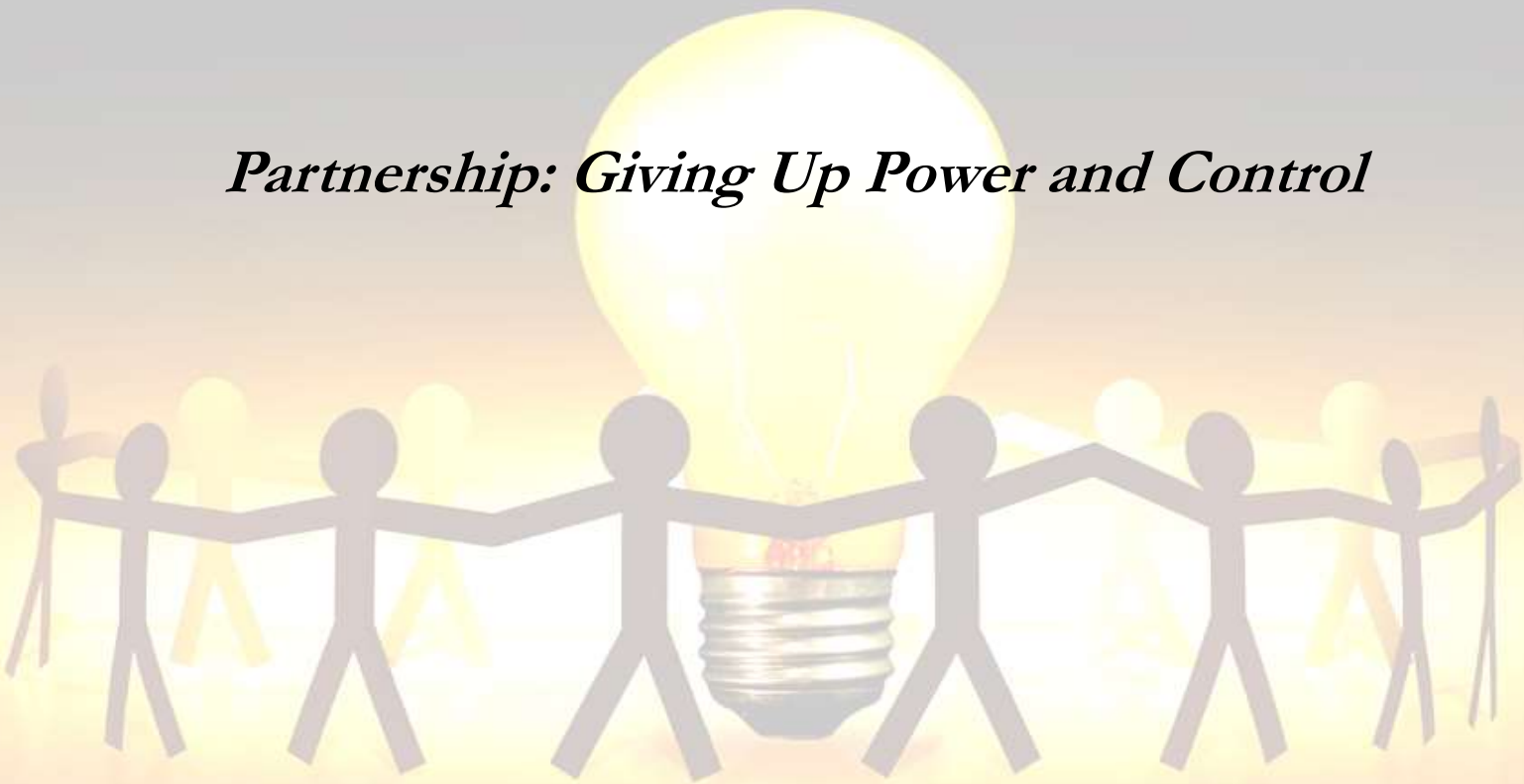
- Work: treatment providers can fear employment for people with mental health and substance use challenges due to concern over stress, relapse, and loss of benefits. Research demonstrates that the majority of people with behavioral health challenges want to work, yet, experience a very high rate of unemployment (approximately 80%). Behavioral health organizations that are well informed about employment as a path to recovery and a pathway out of poverty and pass this information along to the people they serve are demonstrating dignity and respect.

- Labeling: seeing people as individual's first, and their diagnosis last (if at all), is a hallmark of a recovery-oriented organization. When agency's see people through the lens of their clinical labels, disrespectful language such as "schizophrenics," "borderlines," "frequent flyers," "cutters," "bipolars," non-compliant," "manipulative" and "service resistant" are used throughout the organization. Rather than using labels, respectful organizations strive to understand each person's needs, wants, perspectives, and challenges and work to support him/her to overcome their challenges.

The Service Provider Culture

- Authoritarian
- Ethics/Boundaries
- "Know what's best"
- Decision makers
- "Mr/Mrs. Fix It"
- Safety and liability

Partnership: Giving Up Power and Control



"It is not our purpose to become each other; it is to recognize each other, to learn to see the other and honor him for what he is."

---Hermann Hesse

Dignity of Risk

The "dignity of risk" refers to the satisfaction of engaging in opportunities and new challenges that may entail an element of risk or may not be 'advisable' according to the dictates of others.

What Have You Risked?

Without Risk, Without Progress

The Mechanical Clock
The Printing Press
Immunizations and Antibiotics
The Automobile
Computers
The Photograph
Digital Video
Steel
Paper
Satellite Communications
Rubber

Modern Plumbing
The Telephone
Electricity
Television
Recorded Sound
Moving Pictures
Concrete
Plastic
Nuclear Power
The Internet
Air Conditioning

•Creating an organizational recovery culture

•Language MATTERS!

•How do you shift cultures and put values into action?

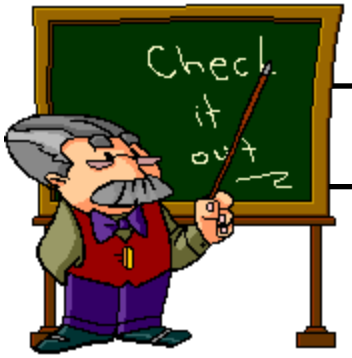
•One of the simplest ways to begin is by shifting the language that is commonly used in your organization

•Language Examples….

•The words that we choose to use are powerful. Words can inspire and motivate or can cut and scar.

•In behavioral health, "labels" are often used to communicate. Diagnoses are an example. However, there are also unintended consequences of labeling. They can be demeaning, discriminatory, stigmatizing and communicate a sense of helplessness and hopelessness.

Examples	Non-recovery labels
Diminishing	"borderlines," "frequent flyers," "cutters"
Catastrophizing	"suffers with," "afflicted by," "plagued with"
Patronizing	"my girls," "my people"
Demoralizing	"people like that don't get better," "low functioning"
Categorizing	"the mentally ill," "the Medicaids," "schizophrenics"



A point about “non-compliance”

“To call someone lazy, unmotivated or non-compliant is to admit that we don’t understand them”

-unknown

•Instead of labeling, try to understand people's experience

•Why does the person feel that the best way to express trauma is through self harm?

•What is the person communicating to us through his/her behavior?

•Are their subtle and not so subtle ways that we are communicating that people are helpless, sick, broken, hopeless, and/or in need of being taken care of?

Example: Recovery Language

ASHA

- http://www.asha.org/publications/journals/submissions/person_first.htm

Disability is Natural

- http://www.disabilityisnatural.com/images/PDF/pfl09.pdf

FACTOR 3: Natural Support Networks

- Family and friends can be vital to personal wellness and quality of life. Often people with MH/SA challenges become disconnected from relationships and are therefore surrounded only by paid service providers. Recovery agencies recognize, promote and honor the desire for people to develop relationships.

Examples include:

- AA/NA groups
- Support groups (NAMI, DBSA)
- On-line relationships, social media, blogs, etc.
- Friendships with peers both in and outside the recovery community
- Intimate relationships
- (Re)Connection with children

FACTOR 4: Protection from Abuse, Neglect, Mistreatment and Exploitation

Among the ways that organizations can prevent abuse, neglect, mistreatment and exploitation is through the awareness of the impact of trauma on mental health and then employ widespread use of trauma informed practices, processes and policies. All efforts to prevent abuse and neglect are made by organizations. This includes:

- Forced treatment
- Coercive treatment
- Seclusion and restraint
- Involuntary commitment

Trauma Informed Environment: Healing Place or Prison?

A lot of attention is being paid to the role of trauma in mental illness

Even more attention is being paid to the role of treatment in traumatizing or re-traumatizing people

Salem Hospital 2001-2005

- Eliminated use of locked seclusion
- Eliminated use of mechanical restraint
- Dramatically reduced use of involuntary medication
- Reduced use of routine medications by 30%
- Increased therapeutic contact
- Decreased injuries
- Decreased lengths of stay
- Increased financial performance

How'd They Do It?

- Understanding Trauma to:
  - Facilitate physiologic calm
  - Avoid triggering the fight/flight/freeze response
  - Encourage thinking, problem-solving, decision-making

- Seeking change from involuntary to voluntary—in all matters
- Involvement of those we served in all matters
- Listening to staff members
- Hard-wiring cultural change through policy, job descriptions, education, and evaluation
- Physical and social environments
- Language and vocabulary
- Assumptions and expectations

Steps Taken

- Trauma informed system and staff
- Recovery trained/competent staff
- Strategic planning
- Transparency
- Language and vocabulary
- Welcoming admission process
- Physical environment
- Social environment
- Listening to those we serve
- Response and debriefing S&R
- Celebrations

Becoming Healers

- Belief in recovery
- Development of community
- Effective leadership
- Trauma-sensitivity
- Listening well
- Leaning into service

Moving Recovery Into Practice:
Outcomes in a Randomized Trial of a Mental Health Consumer–Managed Crisis Residential Alternative to a Psychiatric Health Facility

- Use of seclusion and restraints:
  - Considered treatment failure
  - Experienced by many as traumatizing
  - Considered to have iatrogenic effects resulting in physical or psychological pain, or both ("Sanctuary Trauma")
- Critical to recovery: "Power over" vs. "power with"
  - Recovery tenets: "Power with" and collaborative relationships
    resulting in person-directed care

How They Did It

- Complete Advanced Directives (ADs) when doing well:
  - Will assist in getting what we know has—or believe will—work during times of vulnerability
  - ADs assist staff in supporting clients in resolving acute situations
  - By listening to client needs and implementing what clients know works for them, also puts people in charge of own recovery
- Adding peers to behavioral health workforce has made the team, more effective
- Peer providers in acute settings have same effect
- Trauma Informed training and skills

FACTOR 5 Best Possible Health

With research that indicates people with mental health issues die 15-20 years earlier than their cohort without mental health challenges, more attention is being paid to the integration of physical and mental health. Organizations that strive to ensure access to healthcare, routine screenings and exams, and the effective use of psychotropic medications are those that promote recovery. Among best practices include:

- Shared decision making. People have the information and supports necessary to make informed medical and behavioral health treatment decisions
- Primary care. People are connected with a health home and/or primary care provider to ensure that their healthcare needs are met.
- Psychotropic medications: Staff understand side effects of psychotropic medications and educate people served about recognizing these in themselves. Efforts to minimize the use of multiple psychotropic medications are made and agencies closely monitor the number and interaction of psychotropic medications. Staff are educated about medication complications such as weight gain, kidney issues, tremors, memory loss, impotence, and their impact on quality of life and related health issues.

The Eight Dimensions of Wellness

Shared Decision Making

Shared Decision Making and Medication Management in the Recovery Process
Patricia E. Deegan, Ph.D. and Robert E. Drake, M.D., Ph.D. Psychiatric Services November 2006

http://www.patdeegan.com/commonground/research

Dignity of Risk
http://www.thecouncil.org/base.aspx?id=614&cat=29&sec=r

In 2006, 24 community psychiatrists identified 12 barriers and 22 solutions to promoting recovery within their profession

Dr. Mark Ragins, MD

"Medical Collaboration"

"In medical school, I was taught to be a strong, helping professional, ordering medication for weak, helpless, dependent, sick patients, and then assessing their "compliance" with my regimen…. to advance recovery, I had to discard my white coat, my coat and tie, and even my professional distance."

"My role with medication has become that of a consultant. I listen to what members say helps them, educate them about their conditions and medications, and, as much as possible, prescribe the medications, they choose and then assess with them the results of our "collaboration….This is a rehabilitation/recovery model instead of an illness/treatment model."

Dr. Ron Diamond, MD

Traditional Approach to Medication

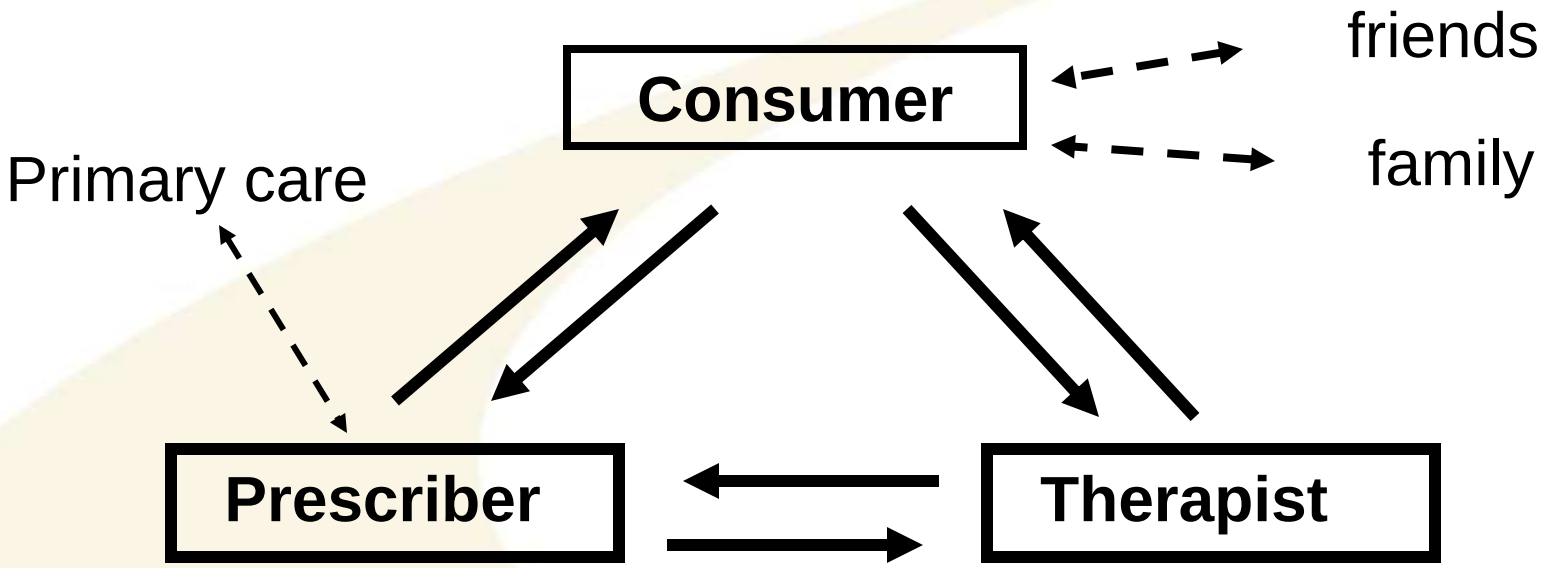
- Start with accurate diagnosis.
- Inform patient about the role of medication in treating the condition.
- Engage the patient regarding the need for medication adherence.
- Patient input is necessary, but prescriber's expertise is most critical.

Recovery Approach for Medication

- Medication is neither "good" nor "bad," but merely a tool that can address certain kinds of problems.
- Work with consumer to jointly understand the nature and impact of the problem.
- Work together to determine which solutions have been tried, what has worked, and what has not.
- Consider if medications would be a useful way to address some part of the problem.
- The prescriber has the most expertise about the medication; the consumer has the most expertise about the problem.

- The issue is not "compliance" or "adherence."
- The issue is ***effectiveness.***
  - = Is this medication being used in the most helpful way for dealing with the problem while causing the least risk and side effect burden?
- A consumer may choose to use medication other than as prescribed. This is a ***decision,*** not an error.
  - = What has gone into the consumer's decision?
  - = Respectful curiosity is helpful; lecturing is not.

In a Collaboration, We Are All "In Charge"



Who makes which decisions?

Medication

- Medication is NEVER a goal of treatment.
- Medication is a tool to help the consumer reach his or her goals.
- Medication always has a "meaning" that may be as important as pharmacology.
- Ambivalence about medication is normal.
- People *will* take medication if they feel it will help them.
- … and *will not* take medication if they feel it will not help.

Taking Medication Regularly

- Beliefs are important
  - **About the problem**
  - **About the solution**
  - **About whether medication will help**
- Relationships are important
  - **We take medication from people we trust**
- Hope is important: Why do anything if you feel it will not help and your life cannot get better?

FACTOR 6 Safe Environments

- In addition to safety of physical space, behavioral health agencies want to ensure that people can keep themselves safe from exploitation and violence and that people experience personal emotional safety. Among the indicators of agencies that foster safety, include:
- Use of individualized wellness, self-wellness management and crisis plans
- Supporting people to protect themselves through assertiveness, safety trainings, self-defense classes, first aid, cpr, etc.
- Teaching people how to use safety equipment and have their home equipped with working fire alarms, an evacuation plan and fire extinguishers

Shifting Our Focus

- from “illness” to WELLNESS and the Whole Person

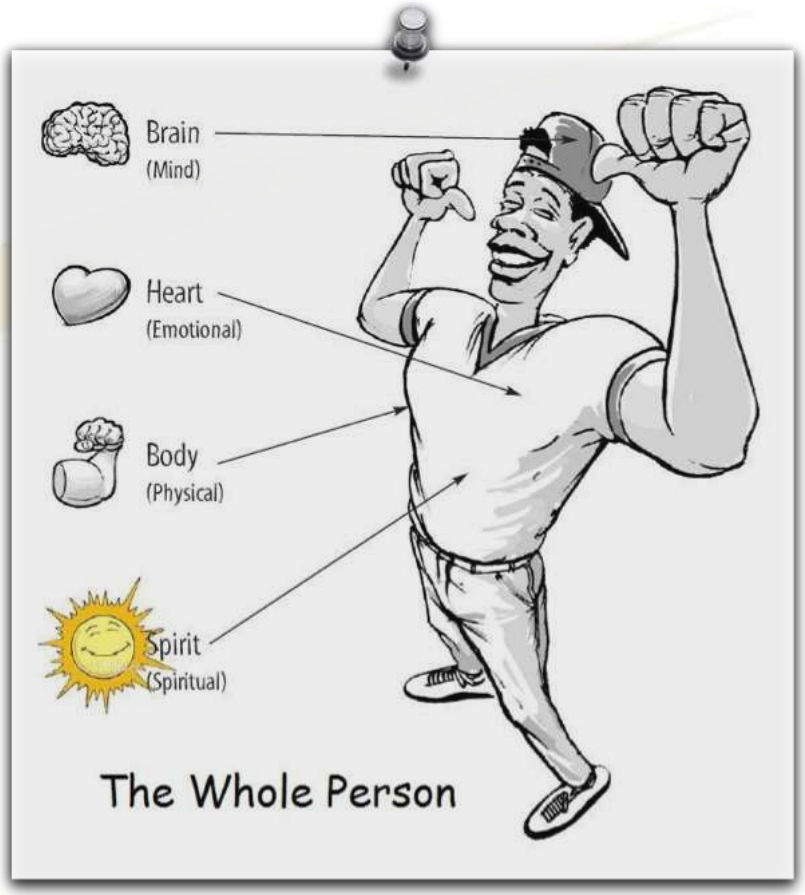


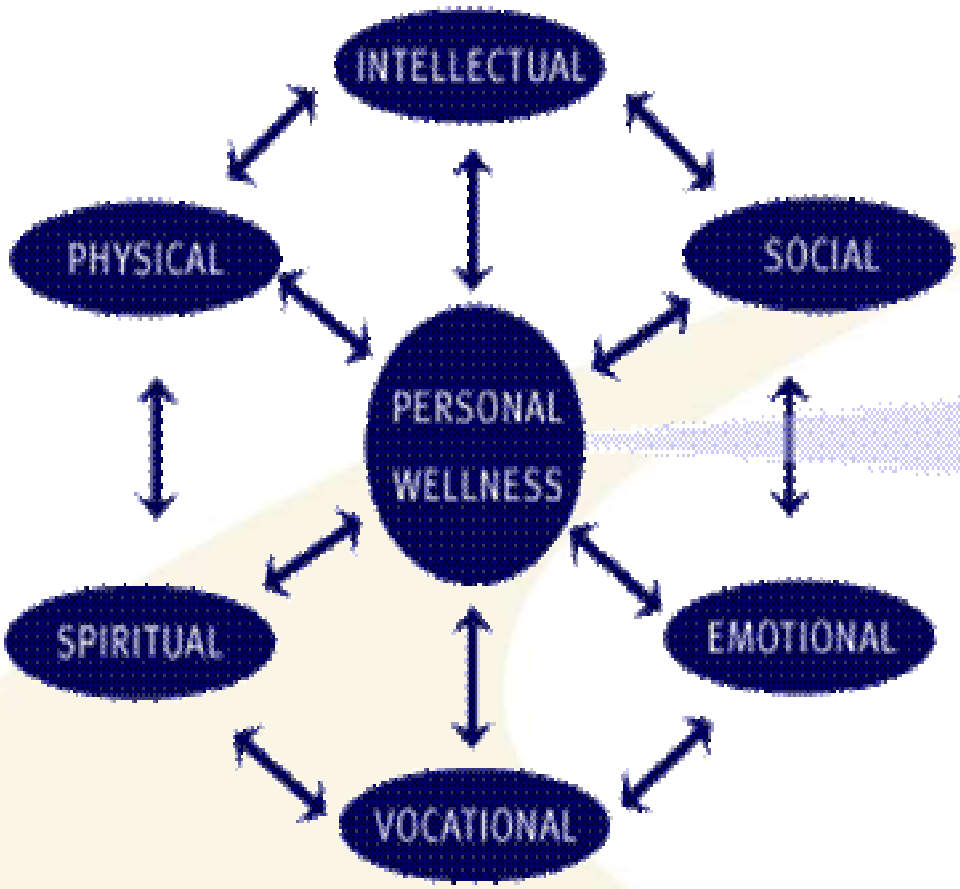
Image: Poster of “The Whole Person”

•Definition: Wellness Self Management

1. Feeling a sense of control over your life and your future, including control over your mental wellness;
2. Learning and practicing ways to effectively respond to life's challenges including physical and mental health issues;
3. Developing resiliency and reducing likelihood for relapse or re-hospitalization
4. Using self-care to enhance your mental and emotional wellness

•

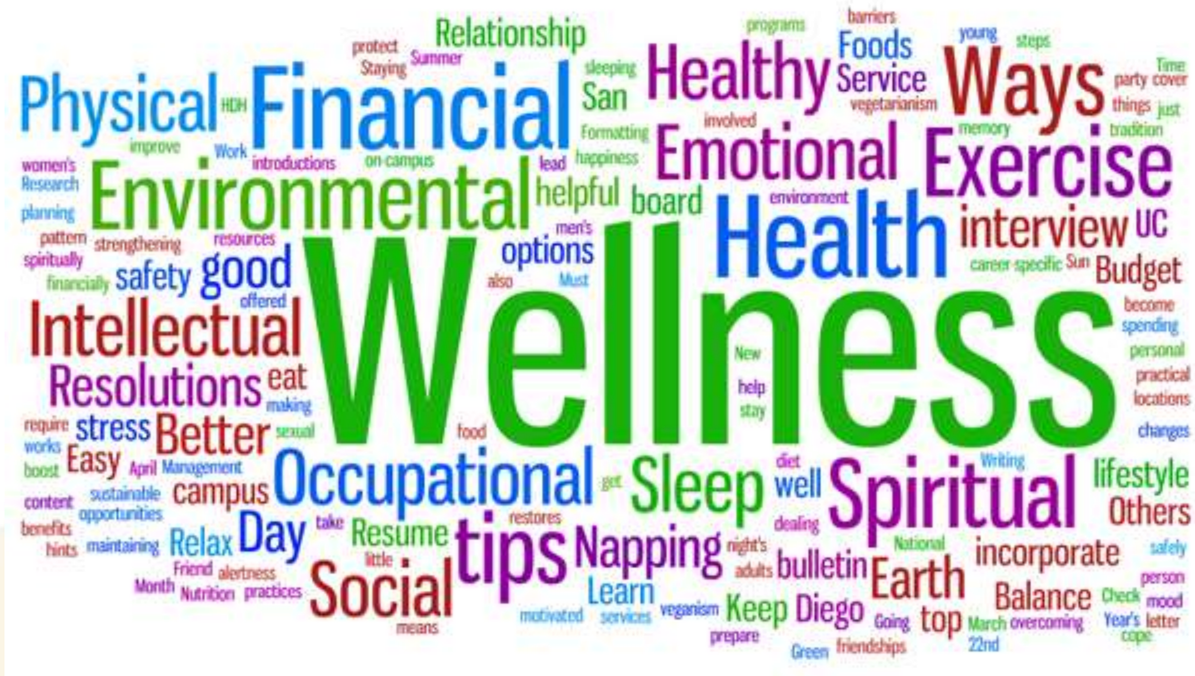
•Studies show that self-management of wellness facilitates recovery from mental illnesses. This is no different from a person learning how to manage diabetes or high cholesterol. It is about learning how it impacts you, what makes it worse, what makes it better, and applying the things that work for you.



Personal Wellness:

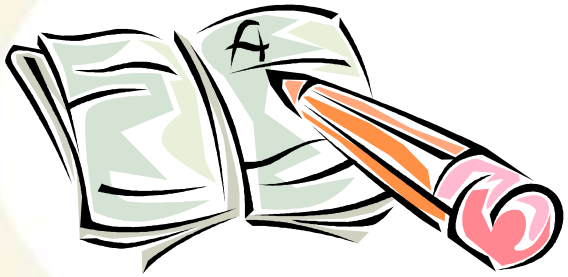
- Self Responsibility
- Optimism
- Self-Directed Approach
- Self Efficacy
- Choices

Montague, 1994



Wellness
Financial
Health
Environmental
Healthy
Ways
Emotional
Exercise
Physical
Intellectual
Occupational
Spiritual
Sleep
Social
tips
Resolutions
Relationship
Foods
Service
interview
good
options
helpful
board
Better
stress
safety
Easy
campus
Day
Relax
Resume
Napping
bulletin
Earth
incorporate
Balance
Learn
Keep
Diego
top
lifestyle
Others
Budget
San
UC
eat
well
protect
Staying
Summer
sleeping
programs
barriers
young
steps
Time
party
cover
things
just
tradition
memory
vegetarianism
involved
Formatting
happiness
lead
HDH
improve
Work
introductions
on-campus
women's
Research
planning
pattern
strengthening
resources
men's
environment
spiritually
financially
offered
also
Must
career
specific
Sun
become
spending
personal
practical
locations
changes
New
help
stay
making
require
sexual
food
works
boost
April
Management
diet
Writing
get
content
sustainable
opportunities
restores
dealing
benefits
hints
maintaining
take
little
night's
adults
National
safely
Friend
alertness
Month
Nutrition
practices
means
motivated
services
veganism
prepare
Green
friendships
Going
March
22nd
overcoming
Check
person
mood
Year's
letter
cope

The Wellness Self-Management Workbook



FACTOR 7: Staff Resources and Supports

- Recovery-Based research has yielded the positive impact of peer support on engagement, quality of life, reduction of hospitalization, empowerment, and recovery, among others. As a result, peer support has become a Medicaid billable service in many states, prompting behavioral health agencies to recruit, hire, train, supervise and retain qualified people in recovery from mental health and substance use issues to serve as mentors, navigators and Peer Support Specialists. Special considerations for organizations when employing peers include:

- Employing state Certified Peer Support Specialists (in states where certifications are offered)
- Employing peers with similar personal backgrounds as the individuals the agency serves (i.e. experience with homelessness, incarceration, hospitalization, etc.)
- Training for all staff on the peer role, what it is and is not, effective supervision of a Peer Specialist, ADA, etc.
- Training for the supervisor of the peer role on peer support, roles/tasks of peers, supervision, ADA, incorporating peers into the team, etc.

The POWER of Peer Support

- ***"When people do not see "recovery" as part of their lives, they need to be surrounded with possibilities of recovery."***

- **(Building a Foundation for Recovery: A Community Education Guide on Establishing Medicaid-Funded Peer Support Services and a Trained Peer Workforce. DHHS Pub. No. (SMA) 05-8089. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration**, 2005.)

A Person Fell in a Hole

A person experiencing emotional distress fell into a hole and couldn't get ou

A businessman went by. The person in the hole called out for help. The businessman some money and told him, "Get yourself a ladder." But the person could not find a la hole he was in.

A doctor walked by. The person said, "Help, I can't get out." The doctor gave him dru "Take this, it will relieve the pain," The person in the hole said thanks, but when the pil was still stuck down there, all alone.

A renowned psychiatrist rode by and heard the person's cries for help. He stooped and did you get there? Were you born there? Were you put there by your parents? Tell yourself, it will alleviate your sense of loneliness." So the person talked with him for fi then the psychiatrist had to leave, but he said he'd be back next week. The person than was still in his hole.

A priest came by. Again, the person in the hole called out for help. The priest gave him said I'll say a prayer for you. He got down on his knees and prayed, then left. The pers grateful; he read the Bible, but he was still stuck in that hole.

A Peer Mentor happened to be passing by. The person cried out, "Hey, help me, I'm s hole." Right away, the Peer Mentor jumped in the hole with him. The person in the "What are you doing? Now we're both stuck here." But the Peer Mentor said, "It's o been here before, and I know how to get out."

•Among the benefits associated with peer support include:

• improved self-esteem (Davidson et al., 2004)

• increased satisfaction with care (Solomon & Draine, 1995)

• improved engagement for traditionally alienated consumers (Rowe et al., 2007)

• improved social functioning (Davidson et al., 2004)

• increased access to resources and decreased stigma (Mowbray et al., 1998)

• greater gain in well being (Campbell, 2004)

• increased self-efficacy and enhanced employment (Van Tosh & del Vecchio, 2000).

•"*creates culture change in every aspect of treatment. They can make recommendations for improving forms and assessments, conduct interviews or do surveys to obtain information regarding consumer satisfaction. Their ability to relate to service recipients creates safety for that person to express themselves, which allows professional staff to devote time in areas where they are more needed.* (Paving New Ground, Peers Integrated into In-Patient Settings)

•FACTOR 8: Positive Services and Supports

•To be personal, effective and consistent with an individual's hopes, dreams and aspirations, planning must be done with the individual and his/her support team. Unfortunately, often the plans are completed by qualified professionals in isolation and do not reflect personal goals or quality of life. Recovery-oriented behavioral health agencies demonstrate their commitment to quality of life by:

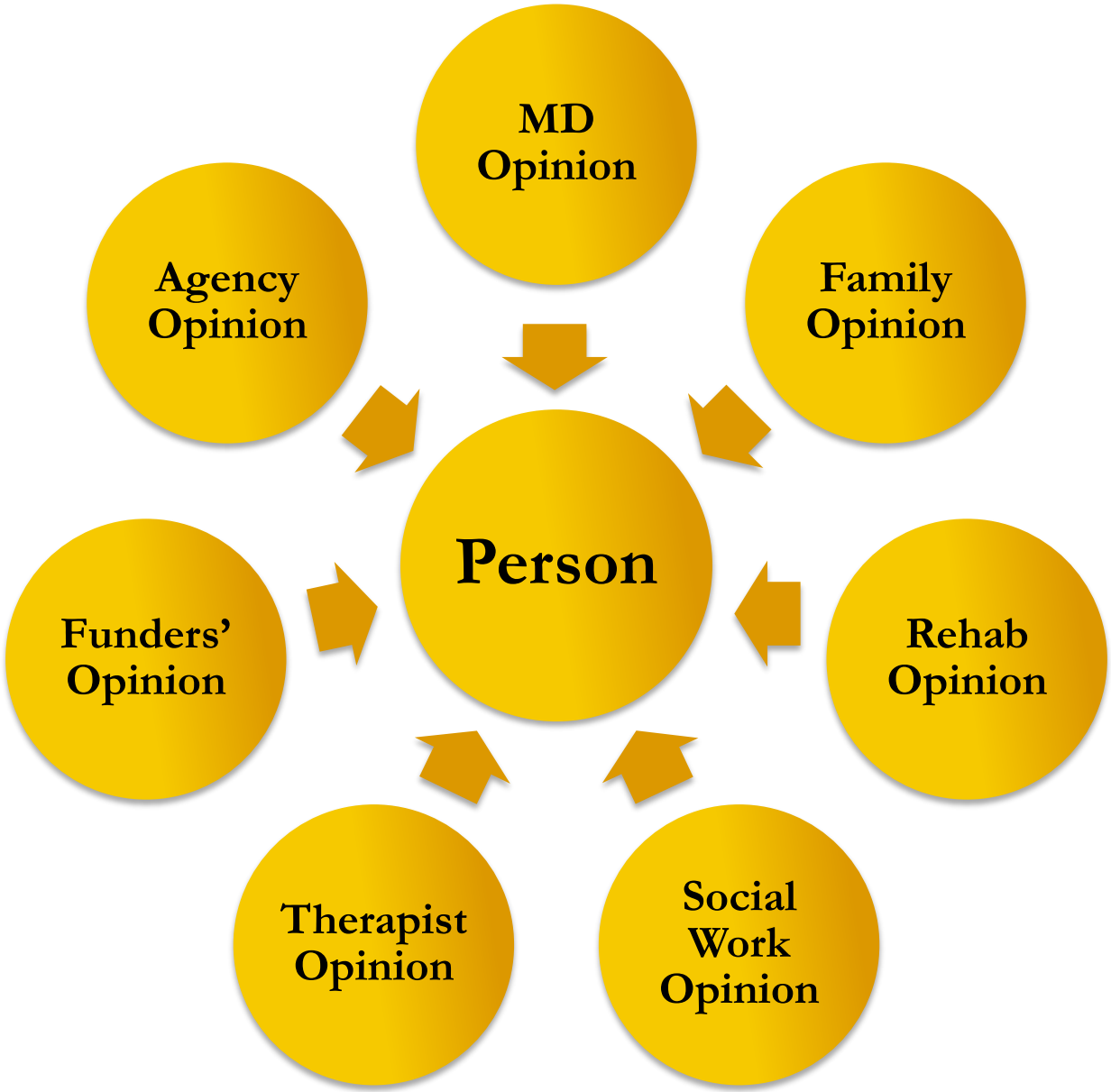
- Developing treatment/support plans with the person and his/her team
- Focus on various life domains, not simply mental health/substance use treatment and symptoms
- Include the role of community resources, the individual and his/her family and friends to advance recovery rather than solely treatment providers
- Use natural consequences rather than treatment imposed consequences to behavior

Moving from person-centered to person-directed

- Person-centered means that we provide services around you and your needs with your input

- Person-directed means you have decision making authority over your plan, services and life

•Person Centered



PLEASE question when the "goal" on someone's plan says…

"Have appropriate behaviors"

"Listen to staff more"

"Be compliant"

"Follow the rules of the group home"

"Be treatment compliant"

"Manage my outbursts"

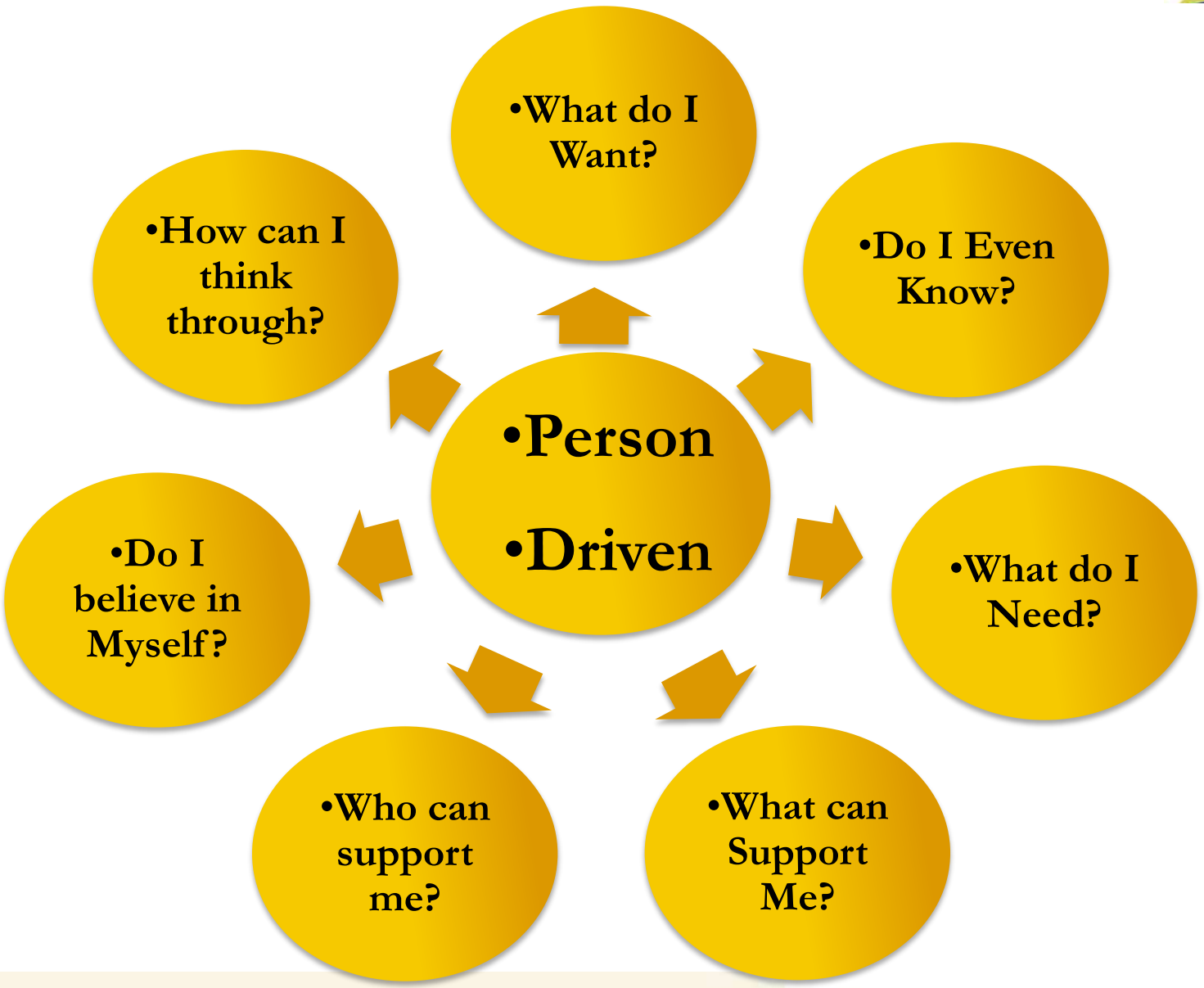
"Stop being sarcastic to staff"

"Maintain psychiatric stability as evidence by…"

"Take my medications"

"Shower daily"

- Who Is the Driver??


•What do I Want?
•Do I Even Know?
•What do I Need?
•What can Support Me?
•Who can support me?
•Do I believe in Myself?
•How can I think through?
•Person
•Driven

Person-Centered vs. Directed

Power with versus power over can mean the difference between wellness and illness

How do we put the power back in the hands of the individual through this process?

Getting in the Driver's Seat of Your Treatment: Preparing for Your Plan

FACTOR 9: Continuity and Personal Security

With the advent of managed care in behavioral health, the impact of continuity and security may be impacted for people supported. In part, this is due to the focus on short-term treatment options rather than long-term services. Further, people may receive specialized services from several behavioral health agencies, posing communication, consistency and continuity issues. Lastly, many of the housing options for people with behavioral health needs are temporary, transitional, or step wise housing in which the person is dislocated when 1) the funding ends, 2) if they are deemed "non-compliant" with treatment recommendations, and 3) if the time allotted for them to be in the service has ended. Despite these systems barriers, there is an expectation that organizations are striving for continuity and security through the following practices:

- Individualized, comprehensive and coordinated service planning that includes plans for consistency and continuity among the team
- Team meetings with the person and his/her family and friends occur to develop and update service plans
- Effective transition planning, prior to the end of a service that identifies with the person their next options and a plan to ease the transition out of the service and into the next phase of their life

Asset Development and Financial Literacy

- www.docstoc.com/docs/120690851/JudithCookNYAPRSAssetDevelopment

FACTOR 10: Basic Assurances System

In addition to the data sets that are common to organizations that serve people with disabilities, behavioral health agencies may have additional information to gather, analyze, and report. Among them may include:

- Results of diagnostic assessments such as GAF scores, LOCUS, CALOCUS, and ASAM criteria
- Proof of clinical, medical, and/or financial eligibility and medical necessity for each service provided
- Intervention/contact notes that describe the goal, intervention, response to the intervention and plans for follow-up
- Step-down/transition and discharge plans
- Relapse prevention plans, crisis plans and psychiatric advanced directives
- Identification of evidence-based practice used within the service delivery system
- Data on hospitalization, homelessness, veteran status, incarceration, trauma history, co-occurring mental health/substance use, history of suicidal ideation/attempts, legal involvement, incidences of restraint and/or seclusion (if applicable), involuntary commitment, safety issues (i.e. self-harm, homicidal thoughts/behaviors, etc.)

- Evidence of licensure, degree, certifications, and credentials for all clinical and medical staff
- Court documents in individual files
- Supervision plans including frequency and results of clinical supervision with a licensed clinician
- Data regarding utilization management and billing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