

Focus on the States: Implementing Recovery-based Care from East to West

By Robert Hennessy, Editor

When it comes to mental health, defining *recovery* may seem difficult. Defining *recovery-based care* in public mental health settings may be more difficult. While there are efforts underway across the country to transform mental health systems into environments that foster and encourage consumer recovery, it is challenging to focus on replicable commonalities. Most administrators will tell you that no two systems are alike. Funding streams vary as widely as the treatment methods, and it's always difficult to compare what works for a certain population with what works for another.

However, with the imprimatur of the President's New Freedom Commission on Mental Health's *Achieving the Promise* report, all states are sensing a need to begin or increase efforts to instill recovery-based care into their systems, and they need tangible guidance. Armed with a handful of emerging promising practices, and believing that there is an intrinsic logic to maintaining health systems that actually foster recovery, many states are skipping the "why transform?" part of the discussion, and have started asking "how do we do this?"

"How we do this" is a good question, with seemingly unlimited and sometimes controversial answers. The list of challenges is long and daunting. Many SMHAs are in financial straits; the average commissioner has been on the job for less than four years (with a median of just over 2 years); and the data on what actually constitutes recovery-based care are not yet robust enough to sway the skeptical.

With that said, one of the best ways to see if the water is warm is to observe those who have already plunged into the pool. From the local provider level in Arizona, to the state-wide perspective in Connecticut, the following anecdotal tales are intended to capture the experiences of two disparate mental health provider entities for the purpose of naming core values and methods that have survived the trial-and-error gauntlet of implementing recovery-based care.

A Desert Education

META Services, Inc., a state-funded vendor of Value Options, Inc., in Arizona, has immersed itself in recovery by literally transforming part of their service system into an educational experience for consumers. The result—consumers become students, and as students they *learn* how to recover.

"It's all about role transformation," said META President and CEO Eugene Johnson, CISW. "In this system, the consumers become students, and this helps people jump into recovery because being a student is a valued social role, and being a mental patient is not."

META's Recovery Education Center is a licensed, post-secondary educational institution. With classes on a range of topics including anger management, living with borderline personality

disorder, wellness workshops, and community living, META has created an academic environment that continues to maintain its system's therapeutic purpose.

As an example of the scope of this educational effort, for just one of META's classes—a WRAP-based¹, self-help class—the 2003 attendance was 18,600 students, with more than 200 ongoing classes per month in 20 locations, according to Johnson.

Where did META get the faculty, the curriculum, and the physical locations for such an enterprise? Value Options has a series of case management clinics around the area, so the classes are located where people are already receiving services. This space is provided for free to META. And one of the most significant parts of this process, according to Johnson, is that the curriculum was devised with the help of consumers.

Through an arrangement with the local community college, many of the Center's classes are eligible for college credit so that the students are able to achieve an associate's degree. In addition, most of the classes are taught by META-trained peer specialists.

Another aspect that keeps META in tune with recovery-based care is its staff makeup. According to Johnson, approximately half of the vendor's staff is made up of consumer providers—almost 170 people—many of them trained within META's own Peer Specialist training program.

The 70-hour, five-week course, started several years ago with an establishment grant through the Rehabilitation Services Administration, has graduated 500 peer specialists since 2001. The trainees were all existing consumers in the META system. In fact, the only requirements to enroll in the training program are that potential students have to be 1) receiving services in the system, and 2) willing to come to class.

“About 95% of the trainees graduate, and we find employment for about 68% of them,” said Johnson. “When people begin to work, they begin a whole new level of recovery. It has been transformational not just for the students, but for META's [non-consumer] staff members because as people get better, the whole staff has more hope.”

“The other thing that training and hiring peer support specialists does is change our level of accountability right away,” said Johnson. “We had to change how we write about people, what we are saying. We had to get rid of stigmas we weren't even aware of.”

META has created a variety of other successful programs, including a recovery housing program that recently graduated 104 students out of 120 enrolled, with 90% leasing apartments, and 70% of those renters free of entitlement programs.

¹ WRAP is an acronym for the Wellness Recovery Action Program, a self-help program developed by Mary Ellen Copeland that teaches individuals who experience psychiatric symptoms, their family members, supporters, and health care professionals how to reduce or eliminate psychiatric symptoms safely, simply, and effectively on a daily basis, and how to get well and stay well. These skills are taught complementary to, and not exclusive of, other treatments, including medication and rehabilitation supports (Campbell & Leaver, 2003).

However, META's transformation effort did not come without its share of challenges. When peer specialists are inserted into a traditional mental health system, it can ruffle some staff feathers. When META's existing staff were introduced to the first crop of peer specialists, Johnson heard a variety of complaints. Staff were concerned about confidentiality issues, fears about losing their jobs, jealousy, etc. "We had to find ways to acknowledge these fears," said Johnson. "It was kind of like having a new kid brother in the family."

Another issue that surfaced was the awkward possibility of peer staff needing psychiatric crisis services while on the job. "Our position was that we had to have understanding and flexibility," said Johnson. "Most of the people want to receive services from their peers anyway, not the psych staff, so we try to give them the choice, and then we help them get back to work."

"We've also had challenges around issues of ethics and boundaries; this happens whether we hire consumers or non-consumers," said Johnson. "However, the retention rates are pretty much the same with the regular staff. We've hired about 500 peer specialists, and we have terminated only about ten people."

Staff production is also measured by META management, and all staff are accountable. "These peer providers have to hit the same production that other staff do," said Johnson. "It's fee-for-service, and they have to handle their own paperwork. Our software monitors this, and we have business meetings just like anywhere else."

To help peer staff, META has designated team leaders to serve as mentors. "We have a career ladder that people can move up," said Johnson. Positions include recovery specialists, recovery coaches, team leaders, administrative positions, and faculty.

"We always find a way to maintain the 'peerness' of those services," said Johnson. "The credential of what peers bring is who they are. Their lived experience is what their contribution is. We don't want them being clinicians, using clinical jargon. We want them to tell stories. We want them to tell us who they are. We created this peer support role as a unique discipline, and the training just helps people bring their experience into a therapeutic recovery process," said Johnson.

"META Service has been able to create opportunities and environments that empower people to recover, to succeed in accomplishing their goals, and to reconnect to themselves, others, and meaning and purpose in life," said Leslie Schwalbe, deputy director of the Arizona Department of Health Services/Division of Behavioral Health Services. "META has made an outstanding effort in developing a comprehensive system of recovery-oriented services," she said.

System Recovery in the Northeast

"The average age of people who come into our system is about 35 years old," said Thomas Kirk, Ph.D., commissioner of the Connecticut Department of Mental Health & Addiction Services (DMHAS). "No matter who you are, at 35 years old, you have some kind of a life, for example, most people at 35 have a partner, or a family, maybe a job, a home. But these people who come

into our system have a psychological illness so devastating that it knocks them out of their life,” he said. “Our goal is to reunite people with their life.”

Connecticut has traveled down the path of instituting recovery-based care by reinventing their system based on the belief—and the right—to recovery from mental illness. From its executive team leadership and departmental mission, to its hospitals, local settings, and frontline providers, Connecticut has emerged as an example of progress in system transformation.

A few years ago, when Kirk’s term as commissioner was renewed, he and his executive team set a single, overarching strategic goal for the agency: “Developing and maintaining a value-driven, recovery-oriented healthcare system.” While this was by no means the start of recovery efforts in Connecticut, it was a symbol of how simple the basic ideology of recovery can be, even within the context of a business plan.

Kirk explains, “By ‘value-driven,’ I mean the highest quality of care at the most appropriate or realistic cost. When you look at your existing funding, you must ask, ‘Is the cost to be invested going to produce a measurable increase in the effectiveness of the service’s outcome?’” According to Kirk, this is a simple business question, a question that a CEO of a healthcare organization would ask to ensure his/her dollars are being expended in the most effective way. “Why shouldn’t state mental health agencies do the same?” he asked.

Kirk, along with his deputy commissioner Arthur Evans, PhD, and others, traveled across the state with the recovery message to visit as many providers as they could. Evans started to move the message forward by working with small groups of people, utilizing technical assistance resources to teach new outcome measures, as the measures are often different in a recovery system than a traditional system, according to Kirk.

They also entered into partnerships with educational institutions, notably Yale University, to conduct a Recovery Institute. “Yale developed courses for rethinking our services, including teaching motivational interviewing, being more effective at engaging people into care, new recovery principles, etc.,” said Kirk. Approximately 800 people have gone through the recovery institute, according to Kirk.

The DMHAS hosted all-day retreats, inviting the CEOs and senior clinicians from local mental health and substance abuse provider organizations to discuss the nuts and bolts of what it would take to transform the system from the ground level. From suggestions at these retreats, Kirk and his staff then met with the boards of directors from some of the organizations to share expectations and ideas for the effort.

Using a “Centers of Excellence” program, DMHAS solicited the state’s local providers and settings to have them share their recovery-related success stories. The department then identified local agency programs that featured promising practices in recovery-based cultural competence, peer support services, and effective engagement techniques, among others. The department offered these sites free consultation on sustainability while learning how each program worked.

The end result was a two-way exchange of ideas and information that highlighted exemplary programs along the way.

Now, the department uses these Centers of Excellence as models. “Through this effort, we are improving quality across our system, especially highlighting ideas and programs that help support recovery,” said Kirk.

In terms of reimbursement for some of these newer, recovery-based services, Kirk said his staff has worked hard to get federal technical assistance “to help identify service formats that will be more easily reimbursed or identified as eligible for federal entitlement.”

For instance, he cited a behavioral health program for people on general assistance. “It’s a basic needs program, but we were able to use the general assistance dollars to run recovery houses,” said Kirk. “The houses feature 20-bed residential units that a person can come to after inpatient stay for substance abuse or mental health services. They are relatively inexpensive to run, and the state was willing to invest in them for basic needs despite the fact that there’s no treatment. It’s just basic needs to help people move forward: transportation, some months of rent, tools for getting a job,” said Kirk. As long as they are in care, they are eligible for the program, as well as a shot at recovery *in* the community.

Kirk listed many obstacles to implementing recovery-based care, among them providers who mistakenly think they are already providing such care; a deficits-based intake system; the potential liability of consumer treatment choices; and a high commissioner turnover rate. However, Kirk, META’s Gene Johnson, and others interviewed for this Special e-Report feel there are as many effective tools and ideas as there are challenges. Some of those tools and ideas are recapped below.

- Identify the people and organizations in your system that are already working on recovery efforts, highlight them, then build up some friendly peer pressure to inspire others to catch up.
- Utilize peer support services in your clinical programs and consumers in recovery in your administrations. Nobody knows recovery better.
- The dollars put into staff training are a good investment. If possible, make training a necessity, not just a priority.
- Find your system’s “recovery heroes” and get them into the media and use positive media coverage to educate the public about recovery.
- Find a way to sustain services rather than having them be short-lived crisis services. Recovery is a journey, not a quick fix.
- Redo your language—from missions and goals, to forms and everyday paperwork—to reflect non-stigmatizing recovery nomenclature (visit <http://www.uspra.org/pdf/langGuidelines.pdf> for language guidance).
- Consider changing the role of consumers in the system to students, peers, or teachers. Making their role more valued by society is a huge step in helping people recover.

- Understand that this is a long-term project and that there is no single approach to implementing recovery-based care. One of the most important tasks for commissioners is to institutionalize this effort so that it is not driven by an individual person.
- Avoid being heavily ideological. Set “do-able” goals for the first year so you can see gains, then move on from there.
- Show concrete differences in how recovery-based care is provided/delivered, with specific examples of a recovery plan versus a treatment plan.
- Put a structure in place that will help to build the framework for recovery efforts, then get out of the way. The system’s consumers, providers, and other stakeholders will take it over, and you can serve as the effort’s biggest supporter.

“To me a recovery-oriented system helps the person to not only understand what his disorder is, but it also shows him how to manage it while using the tools of recovery,” said Kirk. “The tools can be medication, diet, therapy—any number of things to manage the illness. It is the consumer’s choice, and they have to be part of the journey. It’s not us doing it *for* them, it’s us doing it *with* them.”

For more information on META Services, visit www.metaservices.com. For info on the Connecticut Department of Mental Health & Addiction Services, visit www.dmhas.state.ct.us.

References

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