

Practice Guideline Domains for Recovery-Oriented Care

- A. Recovery-oriented care is consumer and family-driven
- B. Recovery-oriented care is timely and responsive
- C. Recovery-oriented care is person-centered
- D. Recovery-oriented care is effective, equitable, and efficient
- E. Recovery-oriented care is safe and trustworthy
- F. Recovery-oriented care maximizes use of natural supports and settings

A. Recovery-Oriented Care is Consumer and Family-Driven²²

An essential characteristic of recovery-oriented care is the primacy it places on the participation of people in recovery and their loved ones in all aspects and phases of the care delivery process. Beginning with the Federal Rehabilitation Act of 1973 and reaffirmed in 1990 in Public Law 99-660, federal and state governments have mandated the involvement of people with mental health and substance use conditions in all components of designing and implementing systems of community-based care. This mandate has been confirmed consistently in numerous federal and state statutes and regulations issued since, and forms the foundation of CT DMHAS' Recovery and System Transformation Initiative.

Recovery-oriented care requires that people in recovery be involved in all aspects and phases of the care delivery process, from the initial framing of questions or problems to be addressed and design of the needs assessments to be conducted, to the delivery and ongoing monitoring of care, to the design and development of new services and supports.

For the involvement of people in recovery and their families to be meaningful and substantive, it must go well beyond their signing off on provider-driven treatment plans or endorsing the replication of practitioner-driven models of care. Recovery-oriented care requires that people in recovery be involved in all aspects and phases of the care delivery process, from the initial framing of questions or problems to be addressed and design of the needs assessments to be conducted, to the delivery and ongoing monitoring of care, to the design and development of new services and supports. It is in this way that consumer and family-driven care is distinguished from person-centered care (discussed in Section 3 below). Consumer and family-driven refers to the involvement of people in recovery and family members in the process of designing, monitoring, and changing systems of care; it is a systemic principle that refers to the ways in which care as a whole is reformed. Person-centered care, on the other hand, refers to the care provided to each individual being based on his or her unique needs, values, and preferences. In this sense, person-centered care unfolds at the level of each person's individualized recovery plan. While perhaps an essential element of a consumer and family-driven system, ***person-centered care is not by itself sufficient to making care recovery-oriented or responsive. Changes are also required at the system level to make sure that the right types of services and supports are available to be included in individualized recovery plans.***

²² By "family" we include all of those persons who an individual identifies as being part of his or her family, i.e., his or her immediate, intimate social network, regardless of biological ties.

You will know that you are working toward providing consumer and family-driven care when:

At the System/Agency Level

- A.1.** People in recovery are involved in every aspect of the service delivery system from evaluation, development, and provision of services to staff training. People in recovery comprise a significant proportion of representatives to an agency's board of directors, advisory board, or other steering committees and work groups. Persons in recovery are provided orientation to their committee role by the chair, and actively contribute to the group process. Their involvement in these groups is reflected in meeting minutes and in decision-making processes.
- A.2.** The input of people in recovery is valued, as embodied in the fact that the agency reimburses people for the time they spend participating in service planning, implementation, or evaluation activities, providing peer support and mentoring, and/or providing educational and training sessions. Where system involvement is a mutually negotiated volunteer activity, people in recovery are reimbursed for out of pocket expenses that may be associated with their participation.
- A.3.** Initial program orientation is supplemented by ongoing availability of information and agency updates to people in recovery and their loved ones. This information is provided in a variety of formats (e.g., information tables, service directories, educational programs, newsletters, web postings, etc.) to enable people in recovery and their loved ones to make informed choices about treatments, rehabilitation, and supports and to provide meaningful input about program and agency performance. Feedback is regularly solicited from people in recovery and their loved ones regarding their informational needs.
- A.4.** Policies are established and maintained that allow people in recovery maximum opportunity for informed choice and decision-making in their own care. For example, people in recovery are able to a) access their records with minimal barriers, b) incorporate psychiatric advance directives in their recovery and crisis plans, c) secure the services of local or state advocacy services as necessary, d) request transfer to an alternative provider within agency guidelines, and e) participate actively in agency planning activities. These policies and procedures are highlighted on admission to an agency and are routinely publicized throughout the agency through newsletters, educational postings, Empowerment Councils, etc.

This process is particularly crucial within services such as “money management” in which the line between providing a service and infringing on a person’s rights can easily be blurred in the absence of clear programmatic guidelines and safeguards.

- A.5.** Measures of satisfaction with services and supports are collected routinely and in a timely fashion from people in recovery and their loved ones. These data are used in strategic planning and quality improvement initiatives to evaluate and make meaningful changes in programs, policies, procedures, and interventions. Feedback mechanisms are in place to inform people in recovery and their loved ones of changes and actions taken based on their input. When possible, these data are collected by people in recovery and/or their loved ones, so as to elicit more frank responses from people who may be reluctant to share criticisms directly with practitioners.
- A.6.** Formal grievance procedures are established and made readily available to people in recovery and their loved ones to address their dissatisfactions with services. People in recovery and their loved ones are fully informed about these procedures on a regular basis, and the frequency and focus of grievances are tracked to inform agency or program quality improvement processes. Finally, safeguards are in place to ensure there is no retribution for using the grievance process.
- A.7.** Administration ensures ethical practice through clinical supervision and pro-active human resource oversight. This oversight prohibits the use of coercive practices and holds all staff accountable for affording people maximum choice and decision-making in their own care.
- A.8.** Assertive efforts are made to recruit people in recovery for a variety of staff positions for which they are qualified. These include positions for which their personal experience of recovery make them uniquely qualified (e.g., peer support), as well as positions for which they are qualified by virtue of licensure (e.g., nursing, psychiatry) or other training or work experience (clerical, administrative, medical records, etc.). Assertive efforts include establishing mentoring programs for employees in recovery so they can advance in their skills and attain the necessary credentialing that will allow them to occupy a more diverse range of service or administrative positions.
- A.9.** Active recruitment of culturally diverse people in recovery for existing staff positions is coupled with ongoing support for the development of a range of peer-operated services that function independent of, but in collaboration with, professional agencies. This will help to ensure that

the recovery community's role is supported, while avoiding co-opting by transforming it into an adjunct service provider. As one example, recovery community centers operated by people in recovery—which are neither treatment centers nor social clubs—offer a valuable resource at the level of the local community. They are places where people who are interested in learning about recovery, how to access available services and supports, and local activities can meet with other non-professionals to learn about recovery first-hand and to find understanding and resourceful role models to talk to.

Agencies can demonstrate their support for peer-operated services by offering material and consultative support to emerging programs. For example, technical assistance or mentoring regarding business management, fiduciary support and/or attainment of 501(c)3 status, human resource practices, etc., can greatly facilitate the establishment and long-term viability of peer-operated services. Care should be taken to ensure capacity-building in peer-operated programs over time.

- A.10.** Self-disclosure by employed persons in recovery is respected as a personal decision and is not prohibited by agency policy or practice. Supervision is available to discuss the complex issues which can arise with self-disclosure.
- A.11.** Rather than being limited to agency functions (e.g., length of hospital stays, readmission rates), process and outcomes evaluation is a continuous process with expectations for successful outcomes being drawn from a broad range of quality of life dimensions (e.g., in areas such as employment, social relationships, community membership, etc.)²³. ***Maintenance of clinical stability alone is not considered an outcome, as recovery involves more than the absence of symptoms.***
- A.12.** Statistics on outcomes and satisfaction are made public so that individuals can make informed decisions about agencies and services that are effective for people who have similar needs and interests.
- A.13.** People in recovery are routinely invited to share their stories with current service recipients and/or to provide training to staff.
- A.14.** The agency offers to host regional and/or state events and advocacy activities for people in recovery and their loved ones, e.g., meetings of 12-step fellowships, Connecticut Community for Addiction Recovery, Advocacy Unlimited, NAMI CT, and Focus on Recovery-United.

²³Osher, T. & Osher, D. (2001). The paradigm shift to true collaboration with families. *The Journal of Child and Family Studies*, 10(3), 47-60.

A.15. In all phases of the care delivery process, agencies strive to achieve full transparency as it relates to informing and involving individuals in decisions that impact their care. For example, initial placement decisions across levels of care are made in collaboration with persons served and place an emphasis on honoring the person's expressed preferences. Discussions regarding placement include adequate information to ensure informed consent, but also more detailed material on the person's rights and responsibilities within each program.

At the Practitioner/Person in Recovery Level

A.16. Each person receiving care is provided with an initial orientation to agency practices regarding their rights, complaint procedures, treatment options for both mental health and substance use conditions, advance directives, access to their records, advocacy organizations (e.g., PAMI, Human Rights Commission), rehabilitation and community resources, and spiritual/chaplaincy services. Contact information on program staff and agency leaders is made available. Provision of orientation is documented in the person's health record.

A.17. Staff appreciate that many people in recovery may not, at first, share the understanding that they are key experts on the management of their own condition. Persons who have come to depend upon services and professionals to alleviate their distress may neither believe themselves capable of being an expert nor recognize that they are entitled to occupy such a role. Therefore, staff encourage individuals to exercise their responsibility and make meaningful contributions to their own care and to the system as a whole. For example, individuals are encouraged to become involved in local and state advocacy as a means of developing their confidence and skills in self-determination and collective action, agency efforts to enhance the participation of service users are widely publicized to the recovery community, and general education is offered regarding the necessity of active service-user involvement to achieve recovery outcomes. While people are to be encouraged to become involved at all levels of the system, not everyone will want to participate beyond the primary level of involvement, i.e., their personal recovery plan. As in other areas of choice and self-determination, this too is respected as a valid option.

A.18. Care planning is based on a shared decision making model in which persons in recovery and their loved ones view themselves as experts in determining their own needs, values, and preferences in relation to treatment, rehabilitation, and recovery supports. They seek information

about their concerns, review their options, ask questions about issues relevant to them, and make informed choices about their care. To support them in the process, decisional aids and other tools are made available to them so that their choices can be fully informed. As they progress in their own recovery, persons in recovery then offer feedback to practitioners about what they have learned about the opportunities and supports made available to them, the barriers to recovery they have encountered and overcome, and the ways in which practitioners' efforts have helped and hindered their own.

Example of how this might look in practice:

Staff of a hospital had been through training on recovery-oriented care in which the trainer had stressed the importance of including people in recovery and their loved ones on advisory councils, committees, and other workgroups. They were at first perplexed, however, and could not think of ways to include the people on their inpatient units in the work of the hospital. For people to require inpatient care at this point in time they either have to be acutely or severely disabled by their illness. How, in this state, could they be included in the management of the hospital?

As they were discussing this dilemma, it occurred to one of the staff that perhaps the principle of participation could be applied even at this earliest stage of the process. Rather than the staff trying to think of ways to include patients in the management of the hospital, they could ask people how they might like to be included and what ideas they had about their involvement. This strategy paid off almost immediately when, after asking a group of patients how they might like to be involved, one person asked the staff leader what kinds of groups the hospital had that they could join. The staff member began to describe some of the hospital's existing management structures and when she came to the quality improvement initiative, another person asked her what kinds of things this group did. The staff member used the example of medication errors and ways to reduce them as an example of an important quality improvement initiative currently underway. This example piqued the patients' interest and they quickly turned the conversation to beginning to suggest different strategies for reducing medication errors.

As a result of this discussion, patients were soon invited to brainstorm with the performance improvement team of the hospital about ways to reduce medication errors. The preferred strategy suggested by the patient representatives was for the nursing staff to ask each person to which she or he was about to administer a medication if, in fact, this was the person's correct medication(s). Not only would such a strategy provide an additional safeguard to patients taking medications given in error, but it also better prepared people to manage their own medications after discharge. This strategy was accepted by the performance improvement team and led

to a decrease in medication errors—and this prior to the time when JCAHO adopted its own policy of reviewing interventions with patients prior to administration.

What you will hear from people in recovery when you are working toward consumer and family-driven care:

- *You know, at first I thought, “What do I know or what could I possibly say at this meeting?” But then, I could tell that what I had to say made a difference. People were really listening to me. I finally got a place at the table!*
- *I knew I was in recovery when I could help somebody else that was in the same awful place I used to be. But I think about where I am today: healthy, and drug free, and being a real Grandma. And getting back to work as a peer provider makes me feel good; makes me understand I can do this. I can really do this. And if I can do this, anybody can. Folks get hope when they see me.*
- *I don’t have to hide who I am – even the part of me that isn’t well. Because it’s that part of me and all the things I’ve experienced as a client here – good and bad – that gives me ideas for how things could change.*
- *I just didn’t think my program was a good fit for me. I was sticking it out, but lots of other folks stopped showing up. But then, somebody came in and we had a great talk about what was working and what wasn’t in the program. And some changes actually got made. Things are a lot better now. The group is packed every week!*

The Importance of Not Overlooking the (not so) Obvious

