

B. Recovery-Oriented Care is Timely and Responsive

The 1999 U.S. Surgeon General's *Report on Mental Health*²⁴ suggested that for every one person who seeks specialty mental health care for a diagnosable mental health condition, there remain two individuals, with similar conditions, who will neither gain access to nor receive such care. This report was followed by a supplement on culture, race, and ethnicity, which further identified lack of access to care as an even more formidable obstacle to recovery among people of color.²⁵ While this situation may seem dire, the proportion of people who access and receive care to those who are in need of such care is even worse in the case of substance use conditions, with approximately one out of seven people actually receiving active substance use treatment. And the story does not end with access. Once they access care, many people with mental health and substance use conditions do not stay in treatment or rehabilitation long enough to benefit from the care offered, with as many as 50% of people not returning after an initial intake visit. These facts clearly warrant the attention of the health care system to enhancing access, engagement, retention, and outcomes through a focus on increasing the timeliness and responsiveness of care while at the same acting to reduce stigma, discrimination, and other barriers.

As we noted in the introduction, it is optimal to foster wellness, enhance protective factors, and promote healthy living prior to the onset of mental health and substance use conditions. Given the current state of our science and society, this is not always possible, of course; nor perhaps will it ever be possible to prevent all mental health and substance use conditions. In the case of those individuals who are at high risk for or who do develop a condition, a first crucial issue therefore is that of access.

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Access to care involves facilitating swift and uncomplicated entry into care, and can be increased through a variety of means. These include: 1) conducting outreach to persons who may not otherwise receive information about services or who may avoid institutional settings where services are provided; 2) establishing numerous points of entry into a wide range of treatment, rehabilitative, social, and other support services. For example, a public health nurse working with a homeless outreach team facilitates a person's entry into health care, a clinician might help the person gain access to vocational services and entitlement income support, and, with

²⁴U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

²⁵U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

the person's permission, all of these service providers meet with or talk to each other regularly to coordinate their work with the person; and 3) ensuring that information about services is linguistically appropriate and made readily available and understandable to people through public education and information, liaison with other agencies, links to self-help groups, and other venues.

Access to care also involves removing barriers to receiving care, including bureaucratic red tape, intimidating or unwelcoming physical environments and program procedures, scheduling requirements and modes of service provision that conflict with the life situations and demands of persons with mental health and substance use conditions. It also means that access to care goes far beyond mere

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eligibility to receive services to the care being acceptable to those individuals for whom it is intended. Finally, access to care involves moving away from certain philosophies of treatment previously adhered to by some practitioners—including hitting bottom (e.g., “Addicts can’t be helped until they hit bottom and have lost everything”) and incrementalism (e.g., “We can’t house people with addictions until they’ve been in recovery for 6 months”)—and toward stages of

change approaches, recognizing that addressing basic needs, employment, and housing can enhance motivation for treatment, rehabilitation, and recovery.

Engagement into services is closely tied to access. Engagement involves making contact with the person rather than with the diagnosis, building trust over time, attending to the person's stated needs and, directly or indirectly, providing a range of services in addition to clinical care. The process of engagement benefits from new understandings of motivational enhancement, which see people standing at various points on a continuum from pre-readiness for treatment to being in recovery, rather than being either motivated or unmotivated. Engagement also involves sensitivity to the thin line between persuasion and coercion and attention to the power differential between the service provider and the person receiving or potentially receiving services, and the ways in which these factors can undermine personal choice. Finally, methods of ensuring engagement are integrated within and are part of providing good clinical and rehabilitative care, not adjuncts to them.

Once engaged in care, people will assess the ***timeliness of services*** they receive based on several considerations. One dimension of timely care is waiting times, such as delays in scheduling appointments, visiting practitioners, and entering hospital emergency departments. Racial, ethnic, and socioeconomic disparities exist within each of these indicators of timeliness, such that many people of color and people who are poor wait longer for health care than others. As just one example,

compared to non-Hispanic whites, African Americans experience longer waits in emergency departments and are more likely to leave without being seen.²⁶

Another aspect of timeliness includes perceptions of inadequate care and unmet need; areas which unfortunately demonstrate similar disparities. For instance, people with lower education and income and Hispanics/Latinos are more likely to report unmet health care needs and more difficulties obtaining care.²⁷ Such access to care goes far beyond mere eligibility to receive services to the care being acceptable to those individuals for whom it is intended.

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Once engaged into care, people in recovery and their loved ones evaluate the extent to which the services are **responsive** to their wants, needs, and preferences, including their cultural preferences. Some indicators of responsiveness include the extent to which they feel that their providers listen carefully, explain things in a way that they understand, demonstrate respect for what they say, and spend enough time with them. Racial and ethnic differences have also been found documented in each of these domains. For example, Hispanics/Latinos are more likely than non-Hispanic Whites to report that their providers did not “explain themselves clearly” or “listen carefully” and to be significantly less satisfied with their mental health treatment. Moreover, whereas African Americans report being more satisfied than Whites with the responsiveness of their health care, the quality of the care they receive across a variety of health conditions is inferior to that received by Whites. Given these findings, it is perhaps not surprising that African and Hispanic-origin Americans are more likely than Whites to leave treatment prematurely, perpetuating a demoralizing cycle of diminished access, unmet needs, and poorer outcomes.

As one dimension of providing timely and responsive care, it therefore becomes incumbent upon practitioners to be attentive to these types of disparities and to provide culturally responsive and competent care. Issues of disparities are also addressed in Section D as an aspect of equity. In this section we focus less on the identification and redress of such disparities and more on how care can be timely and responsive in the case of each individual and/or family. In this case, in addition to

²⁶ Institute of Medicine, Board of Health Services Policy, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. *Unequal treatment: Confronting racial and ethnic disparities in Health Care*. Washington DC: Institute of Medicine; 2003.

²⁷ Wells, K., Klap, R., Koike, A., & Shelbourne, C. (2001). Ethnic disparities in unmet need for alcoholism, drug abuse, and mental health care. *American Journal of Psychiatry*, 158, 2027-2032.

access and engagement, a final component of quality care is the *continuity* which practitioners can provide across episodes, programs, and agencies. This is important as recovery in both substance use and mental health, in the sense in which we are using it in this document, refers to a prolonged or long-term process. It does not refer, that is, to an acute phenomenon such as recovery from the flu or from a broken bone. This is not to say that substance use or mental health conditions cannot also be acute in nature. Many people do, in fact, experience one episode of mental illness or a short-lived period of substance use and do not develop prolonged conditions to begin with. For such people experiencing only one acute and delimited episode of either substance use or mental illness, however, the notion of recovery may not have much relevance.

For those individuals for whom being in recovery is a meaningful goal, the nature of their struggle with a mental health and/or substance use condition is likely to be sustained. In such cases—which, it should be acknowledged, comprise a significant segment of Connecticut citizens receiving care from DMHAS-funded programs—an acute model of care is not the most useful or appropriate. Particularly in terms of system design, prolonged conditions call for longitudinal models that emphasize continuity of care over time and across programs. Consistent with the principles under-girding the “new recovery movement” in substance use, the long-term nature of addiction and mental illness suggests a number of parameters for developing new models of care that go beyond loosely linked acute episodes²⁸. These are included below.

You will know that you are offering timely and responsive care when:

At the System/Agency level

- B.1.** Systems invest significantly in prevention and health promotion approaches to lessen the burden of disease and disability on the individuals served, the service system itself, and society at large.
- B.2.** A range of interventions are used to enhance protective factors, to help individuals, families, and communities to develop the resources and capabilities needed to maintain healthy lifestyles, and to foster wellness both prior to and following onset of mental health and/or substance use conditions.
- B.3.** Focused efforts are made to identify and intervene early in youth and young adults experiencing the early warning signs of, or being in the early stages of developing, a mental health condition.

²⁸White, W. (2001). The new recovery advocacy movement: A call to service. *Counselor*, 2(6), 64-67.

- B.4.** School and community-based educational and other health promotion efforts are made to help prevent youth and young adults from abusing alcohol, smoking, and using illicit drugs.
- B.5.** Practitioners can go where people are, rather than insisting that people come to their programs or agencies. Services and structures (e.g., hours of operation and locations of services) are designed around the needs, characteristics, and preferences of the people receiving services, including race, ethnicity, culture, age, and linguistic preference.
- B.6.** Practitioners provide, or can help the person gain swift access to, a wide range of services. People can access these services from many different points. In a “no wrong door” approach to providing care, individuals can also self-refer to a range of service options (e.g., specialized rehabilitation supports) without the need for referral from a primary clinical provider. In addition, individuals can access DMHAS-funded rehabilitation programs without being mandated to participate in clinical care. To manage resources responsibly, self-referrals will be subject to admission and oversight and also may need approval by a licensed entity to satisfy reimbursement and accreditation needs.
- B.7.** There is not a strict separation between clinical and case management functions though there may be differences in expertise and training of the people providing these services. Services and supports address presenting clinical issues, but are also responsive to pressing social, housing, employment, and spiritual needs. For example, employment is valued as a central element of recovery. Skill building and promoting employment are competencies included in all staff job descriptions, including clinicians, with only those people who have the most complex or profound needs being referred to specialized programs.
- B.8.** The assessment of motivation is based on a “stages of change” model, and services and supports incorporate motivational enhancement strategies which assist practitioners in meeting each person at his or her own level. Training in these strategies is required for all staff in order to help move people toward recovery. As a result, providers recognize that establishment of a trusting relationship often is necessary before they can be effective in helping individuals to change substance use behaviors and/or learn to better manage a mental health condition.
- B.9.** Staff actively look for signs of organizational barriers or other obstacles to care before concluding that a person is non-compliant with treatment or unmotivated for care. Once identified, staff remove or find ways to overcome these obstacles. Examples include offering safe, welcoming,

and child and family-friendly waiting areas, having on-site child care available during appointments, making parking available, planning access to public transportation, and providing information and links to referrals in several languages based on local community needs.

- B.10.** Agencies have “zero reject” policies that do not exclude people from care based solely on symptoms, substance use, or unwillingness to participate in prerequisite activities. For example, vocational agencies do not employ screening procedures based on arbitrary “work readiness” criteria; such criteria have limited predictive validity regarding employment outcomes. In addition, such procedures suggest that individuals must maintain stability or abstinence before they can pursue a life in the community, when, in fact, employment may often be a path through which people become stable in the first place.
- B.11.** Staff have an “open case” policy which dictates that a person’s refusal of services, even despite intensive and long-term outreach and engagement, does not require that he or she be dropped from the “outreach” list. This person may still accept services at another time. Committee structures and supervision are in place to evaluate the fine line between assertive outreach versus potential harassment or coercion. In addition, the agency establishes guidelines regarding what defines a person as being in “active” treatment versus “outreach,” and considers how such definitions impact program enrollment, documentation standards, 30 day drop out lists, case load definitions, and reimbursement strategies.
- B.12.** From an administrative perspective, the system is structured based on a commitment to and practice of motivational enhancement, with reimbursement for pre-treatment and recovery management supports. This structure includes flexibility in outpatient care, including low-intensity care for those who do not presently benefit from high-intensity treatment.
- B.13.** Agencies do not exclude individuals with self-injurious behaviors from services or require elimination of these behaviors before treatment can commence. Rather, appropriate care is offered for these issues.
- B.14.** Outpatient substance use treatment clinicians are paired with outreach workers to capitalize on the moments of crisis that can lead people to accept treatment and to gain access to their appropriate level of care. These teams work from a framework of patience, persistence, and hope.
- B.15.** Mental health professionals, substance use specialists, and people in recovery are placed in critical locales to assist in the early stages of

engagement, e.g., in shelters, in courts, in hospital emergency rooms, and in community health centers. Agencies develop and establish the necessary memoranda of agreement and protocols to facilitate this co-location of services.

- B.16.** Agencies employ staff with first person experiences of recovery who have a special ability to make contact with and engage people into services and treatment.
- B.17.** Housing and support options are available for those who are not yet engaged in recovery, but who may begin to engage in their own recovery if housing and support are available to them.
- B.18.** The availability of sober housing is expanded to make it possible for people to go immediately from residential or intensive outpatient treatment programs into housing that supports their recovery.
- B.19.** Services are designed to be welcoming to all individuals and there is a low threshold (i.e., minimal requirements) for entry into care. There also is an emphasis on outreach and pre-treatment recovery support services that can ensure that individuals are not unnecessarily excluded from care. If a person is denied care, they are connected to appropriate alternatives including an appointment at another agency. Eligibility and reimbursement strategies for this group of individuals (outreach and pre-engagement) are established and refined as necessary over time.
- B.20.** People have a flexible array of options from which to choose and these options allow for a high degree of individualization and a greater emphasis on the physical/social ecology (i.e., context) of recovery.
- B.21.** The overall focus of care shifts from preventing relapse to promoting recovery. Services are not primarily oriented toward crisis or problem resolution, e.g., detoxification and stabilization. There is a full array of recovery support services, including proactive, preventive supports and post-crisis, community-based resources such as adequate safe housing, recovery community centers operated by people in recovery, sustained recovery coaching, monitoring, and early re-intervention.
- B.22.** Outcomes tracking is influenced by the system's commitment to ensuring continuity of care. For example, less emphasis is placed on a review of the short-term outcomes of single episodes of care and more emphasis is placed on recovery roadmaps that highlight the long-term effects of service combinations and sequences on those outcomes

valued by the person such as quality of life domains including satisfaction with housing, relationships, and employment.

- B.23.** The range of valued expertise is expanded beyond specialized clinical and rehabilitative professionals and technical experts to include the contributions of multiple individuals and services. These individuals may include peers in paid or volunteer positions, mutual aid groups, indigenous healers, faith community leaders, primary care providers, and other natural supports. Of particular importance is knowledge of the 12-Steps used in AA/NA self-help groups and assertively linking people with groups that are welcoming to their specific needs and preferences. Valuing and incorporating such community resources in ongoing care planning is essential to decreasing dependence on formal health care and assisting the person to develop a more natural recovery network. In this spirit, the community, rather than an agency or program, is viewed as the context for sustained recovery.
- B.24.** New technologies (e.g., tele-medicine and web-based applications and self-help resources) are incorporated as service options to enhance illness self-management collaborative treatment relationships.
- B.25.** Access to housing, employment, and other supports that make recovery sustainable is enhanced. This includes changing policies and laws that restrict people's access to employment and home ownership, such as having a criminal record for non-violent, one-time, drug-dealing offenses or offenses related to a mental health condition.
- B.26.** Policy formulation and legislative advocacy at the administrative level is coupled with on-going efforts to work collaboratively with a variety of state systems to ensure continuity of care, e.g., with the Department of Correction to put into place plans for re-entry or with resources such as Oxford Houses and rental assistance for people with substance use conditions coming out of jails and prisons.
- B.27.** Advocacy efforts are extended beyond institutional policies and procedures to the larger community, including stigma-busting, community education, and community resource development activities in order to facilitate sustained recovery and community inclusion,
- B.28.** Agencies adopt a set procedure for informing people of changes in care of treatment/rehabilitation provider, hours of operation, or service and support options in advance. During these transitions, people are offered a choice and a voice in what happens next with their care.

At the Practitioner/Person in Recovery Level

- B.29.** The central concern of engagement shifts from: “How do we get this person into treatment?” to: “How do we nest the process of recovery within this person’s natural environment?” For example, people have often asked for meeting places and activities to be available on weekends, especially for those who are in the early stages of their recovery.
- B.30.** Continuity of care, especially for individuals with trauma histories, means a shifting of the services offered to the individual and not a transfer of the person from one program to another, requiring changing care providers or settings. This is particularly critical for individuals for whom the presence of ongoing supportive relationships is perhaps the most essential aspect of healing. To the extent possible, screening processes within different programs and collaborating agencies also are shared to avoid unnecessary repetition of intrusive questions.
- B.31.** Staff plan proactively with people to identify and address potential barriers to access such as child or elder care, lack of transportation, changing job schedules, or physical disability or health issues that might pose obstacles.
- B.32.** Within the context of a responsive continuum of care, individuals work in collaboration with their recovery team to select those services from an array of options that meet their particular needs and preferences at a given point in time. Individuals are not expected or required to progress through a continuum of care in a linear or sequential manner. For example, individuals are not required to enroll in a group home as a condition of hospital discharge when this is determined solely by professionals to be the most appropriate level of care.

Example of how this might look in practice:

It has been customary to view resumption of ordinary community activities such as employment and education as requiring and following after symptom reduction and clinical stability in both substance use and mental health care. This requirement for a linear sequence of steps toward recovery is both not supported by research (i.e., recovery is not a linear process) and is unlikely to be responsive to the wishes and priorities of at least some, if not most, people accessing care.²⁹ For these individuals, it will be important for practitioners to be responsive to the person’s own

²⁹Ridgway, P. & Zippel, A. (1990). The paradigm shift in residential services: From the linear continuum to supported housing. *Psychosocial Rehabilitation Journal*,

goals and priorities as much as possible and to view resumption of ordinary activities as a vehicle *for* recovery rather than as its reward. The following story of Celeste³⁰ exemplifies this shift, as well as many of the other guidelines described above.

Celeste was a 38 year old woman with schizophrenia who experienced prominent hallucinations and paranoia. Although she expressed an interest in working, her first clinician was concerned with her psychiatric status and tried to get Celeste to focus first on taking medication and getting some relief from her symptoms. For her part, Celeste did not identify the hallucinations and paranoia that she appeared to be experiencing as “symptoms” and was very skeptical of and reluctant to take medications. Given her symptoms, the clinician believed that Celeste could not yet work and thus focused her efforts on psycho-education and on trying to persuade Celeste to give the medication a try. When Celeste brought up her interest in working, the clinician suggested she attend a skills group for people who were interested in, but not yet ready for, employment, hoping to address the sources of her difficulties before turning to Celeste’s stated desires to work.

Were Celeste’s disability related to her mobility or vision, it would be obvious that this approach would result in her not acquiring a job until she no longer needed to use a wheelchair or had regained her vision. As it was, Celeste was soon discharged from treatment due to her failure to attend scheduled meetings and her refusal to be evaluated by a psychiatrist. From her perspective, she found the clinician indifferent to her needs and wants, saw no change in her condition, and began to feel that the agency was simply trying to drug her into a state of passivity and hopelessness; evidence for which she unfortunately found in the agency’s waiting room among some of the older, more ‘chronic’, clients. She did not want to become one of them.

After refusing these services but showing up repeatedly in hospital emergency rooms due to persistent, harassing voices, Celeste was then approached by an outreach worker from the same agency who suggested that she could in fact work despite her disability. This clinician encouraged Celeste’s desire to work, and offered to help her find a job which interested her.

With frequent personal contact and assistance with transportation, Celeste then pursued and got a job working at a fabrics store. She then found, however, that hearing voices and feeling paranoid made it difficult for her to be comfortable at work, and asked her clinician if she could do anything to help. The clinician described pharmacologic and psychosocial approaches to symptom management and suggested to Celeste that she discuss these concerns with her family and with a psychiatrist or nurse practitioner at the agency, who might be able to suggest which medications in

³⁰ All names used in the stories included in this volume are fictional and do not refer to real people. While the stories are taken from experience, they involve the blending of multiple stories and details have been disguised to protect the privacy of each of the individuals involved.

particular could help with these difficulties. Celeste then disclosed to the clinician that she had been forcibly medicated during a previous hospitalization and that the idea of meeting with a psychiatrist brought back these painful and humiliating memories.

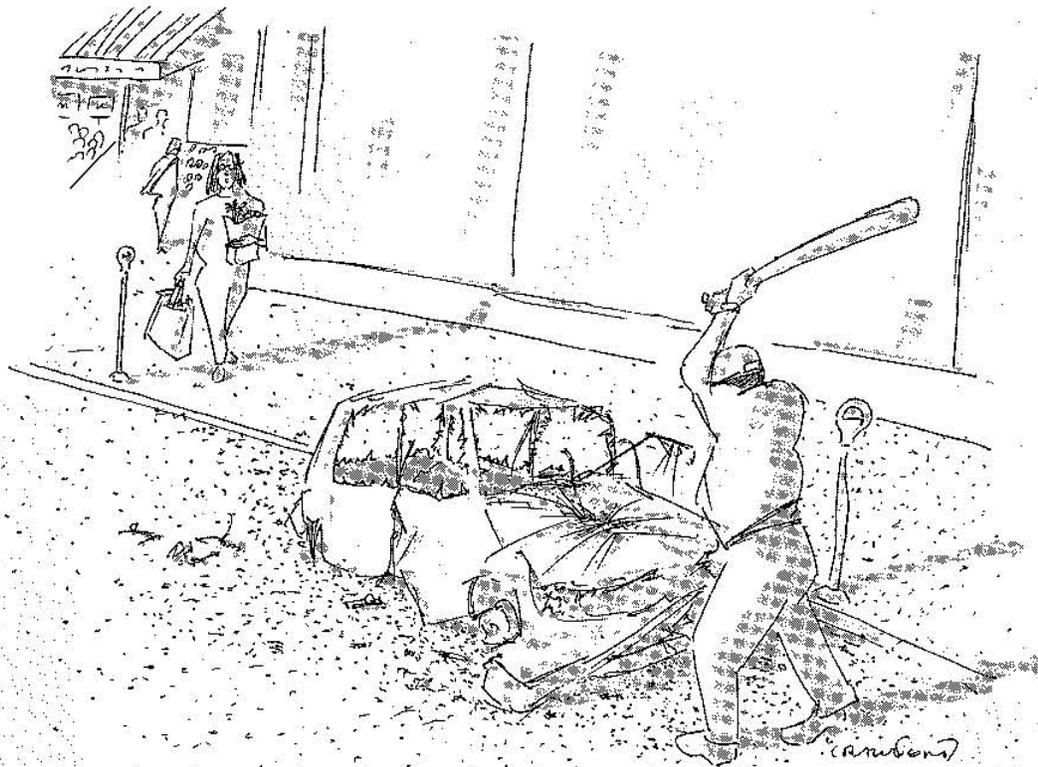
With encouragement, and after some reluctance, Celeste eventually chose to describe her situation to a nurse, who, based on Celeste's concerns about being "drugged," initially suggested a low dose of an anti-psychotic medication, explaining to Celeste that this would not make her too tired to work. Celeste found some relief from hearing voices due to the medication, and, less harassed by the voices, began to feel more comfortable at the store. She began to bring in some of her sewing projects and made friends with a few of her co-workers, finding that her paranoia significantly decreased accordingly. In her case, working turned out to serve several functions, including giving her a reason to use treatment and helping to offset her symptoms.

What you will hear from people in recovery when you are offering timely and responsive care:

- *I hated going to their building. Everybody looked at me as I was walking up the block like "Oh, I wonder if he's a patient there – crazy and on dope." So, I just never went. But, they came to me on my own turn and my own terms. Today, I think my case manager is the reason I'm still alive.*
- *I got help with the kinds of things that were most important to me – like getting my daughter back, and putting food on the table for her. Since they were willing to help me with that stuff, I figured "Hey, maybe I should listen to what they are telling me and try out that program they keep talking about." Today I've been clean for 9 months ...*
- *It used to be I was terrified of leaving detox. I'd go back to the same crappy environment and be back out on the streets in a matter of days. But, I got into some sober housing and it changed my life.*
- *Nobody wanted anything to do with me before. It was always "Come back and see us when you get serious about your recovery... when you've got some clean urines." But, then, this program tried to help me out with getting this job I had wanted for a really long time. Now, I am working part time and I've finally got a reason to try to be sober every day.*
- *People respected that I was doing the best I could. It was two steps forward one step back for a long time, but overall, I was moving in the right direction for the first time in as long as I could remember. But they stuck with me for the long haul. Now, I've been clean for 18 months, and someone still calls me every day to check in – even if its just to day "Hi, How ya' doin'?"*

- *I didn't get kicked out of the program because I had a dirty urine – it used to be that happened every week. This time, I had been clean for two months. My case manager reminded me of how good it was in those two months and I wanted to get back there.*
- *They knew I needed to work on my recovery AND my life at the same time. That meant getting a part-time job, paying off my debts, working on my marriage, and learning how to enjoy myself again and to do it all drug-free.*

The Importance of Not Overlooking the (not so) Obvious



“Still won't start?”

