

C. Recovery-Oriented Care is Person-Centered

The Institute of Medicine defines patient-centered care as “health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients’ wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care.” In addition, patient-centered care is guided by the patient’s values and is personalized to ensure that practitioner instructions are properly understood and followed. Given the history of stigma that continues to accrue to both mental health and substance use conditions, several different components will need to be incorporated into recovery-oriented care to make it fully person-centered. Primary among these is the shift from deficit-driven treatment, care, or service planning to person-driven recovery planning. Essential to this shift is basing care on the person’s own goals and life circumstances, identifying and building on the person’s resources and strengths, and, finally, orienting care and supports to the community arenas in which the person wishes to participate.

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In accordance with the Connecticut General Statutes, as well as Federal and Joint Commission guidelines regarding the need for individualized care, all treatment and rehabilitative services and supports to be provided shall be based on an ***individualized, multidisciplinary recovery plan*** developed in collaboration with the person receiving these services and any others that he or she identifies as supportive of this process. While based on a model of collaboration and partnership, significant effort will be made to ensure that individuals’ rights to self-determination are respected and that individuals are afforded maximum opportunity to exercise choice in the full range of treatment and life decisions. The individualized recovery plan will satisfy the criteria of treatment, service, or care plans required by other bodies (e.g., CMS, CARF) and will include a comprehensive and culturally competent assessment of the person’s hopes, assets, strengths, interests, and goals in addition to a holistic understanding of his or her mental health and substance use conditions and other medical concerns within the context of his or her ongoing life.

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Typical examples of such life context issues include employment, education, housing, spirituality, social and sexual relationships, parenting, and involvement in meaningful and pleasurable activities. In order to ensure competence in these respective areas, including competence in addressing the person's cultural background and affiliations, the multi-disciplinary team may not be limited to psychiatrists, nurses, psychologists, social workers, and substance use counselors, but also include rehabilitative and peer staff, and, wherever possible, relevant natural supports, community representatives, and/or others identified by the person.

Building on a *strength-based assessment* process, recovery planning both encourages and expects the person to draw upon his or her strengths to participate actively in the recovery process. Focusing solely on deficits in the absence of a thoughtful analysis of strengths disregards the most critical resources an individual has on which to build in his or her efforts to adapt to stressful situations, confront environmental challenges, improve his or her quality of life, and advance in his or her unique recovery journey. As improvement depends, in the end, on the resources, efforts, and assets of the individual, family, or community, a recovery orientation encourages practitioners to view the glass as half full rather than half empty³¹.

Following principles that have been articulated at length by Rapp and others³², strength-based approaches allow practitioners to balance critical needs that must be met with the resources and strengths that individuals and families possess to assist them in this process. This perspective encourages practitioners to recognize that no matter how disabled, every person continues to have strengths and capabilities as well as the capacity to continue to learn and develop. The failure of an individual to display competencies or strengths is therefore not necessarily attributed to deficits within the person, but may rather, or in addition, be due to the failure of the service system and broader community to adequately elicit information in this area or to create the opportunities and supports needed for these strengths to be displayed.

While system and assessment procedures have made strides in recent years regarding inquiry into the area of individual resources and capacities, simply asking an individual what strengths they possess or what things they think they are "good at" may not be sufficient to solicit the information that is critical to the recovery planning process. For example, many people who have prolonged conditions will at first report that they have no strengths. Such a response should not be taken at face value, but rather to represent the years of difficulties and failures they may have endured and the degree of demoralization which has resulted. Over time, it is not uncommon for such individuals to lose touch with the healthier and more positive aspects of themselves and become unable to see beyond the "patient" or "addict" role.

³¹Saleebey, D. (2001). The diagnostics strengths manual. *Social Work*, 46, (2), 183-187.

³²Rapp, C.A. (1998). *The Strengths Model: Case management with people suffering from Severe and Persistent Mental Illness*. New York: Oxford University Press.

When facing such circumstances, practitioners conceptualize one of their first steps as assisting this person to get back in touch with his or her previous interests, talents, and gifts. The guidelines below are intended to assist practitioners in conducting a comprehensive, strength-based assessment that can help people to rediscover themselves as capable persons with a history, a future, and strengths and interests beyond their symptoms, deficits, or functional impairments. It is important throughout this process that practitioners maintain a belief in the individual's potential for growth and development, up to, and including, the ability to exit successfully from services and manage their recovery independently. Practitioners also solicit the person's own hopes, dreams, and aspirations, encouraging individuals to pursue their preferred goals even if doing so presents potential risks or challenges.

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For example, many people identify returning to work as a primary recovery goal. Practitioners may advise against this step based on their concern that an individual either is not “work ready” or that employment will be detrimental to his or her recovery (e.g., by endangering his or her disability benefits). While such advice is based on good intentions, it sends a powerful message to the individual and can reinforce self-doubts and feelings of inadequacy. Rather than discouraging the person from pursuing this goal, the practitioner can have a frank discussion with the person about his or her concerns while simultaneously highlighting the strengths that the individual can draw upon to take the first step toward achieving this goal.

In this vein, individualized recovery planning explicitly acknowledges that recovery entails the person's taking risks to try new things, and is enhanced by the person having opportunities to learn from his or her own mistakes and their natural consequences. This represents an important source of progress in the person's efforts to rebuild his or her life in the community that—similar to exercising one's muscles—cannot proceed without an exertion of the person's own faculties.

In order to orient the work of practitioners to assisting the person in rebuilding his or her life in the community, we suggest replacing the traditional language of “case manager” with the concept of *recovery guide*. The sentiment that “we're not cases, and you're not managers”³³ has been accepted increasingly as a fundamental challenge to the ways in which health care is conceptualized within a recovery-

³³Everett, B. & Nelson, A. (1992). We're not cases and you're not managers. *Psychosocial Rehabilitation Journal*, 15(4), 49-60.

oriented system. During this time, the predominant vehicle for offering services to many adults with serious conditions has evolved from the team-based and *in vivo* approach of intensive case management to the introduction of strength-based and rehabilitative forms of case management that attempt to shift the goals of care from stabilization and maintenance to enhanced functioning and community integration.

From the perspective of recovery, though even these inherited models of case management limit the progress that otherwise could be made in actualizing the shift from a deficit- and institution-based framework to a recovery paradigm. This paradigm calls for innovative models of community-based practice that move beyond the management of cases to the creation of a more collaborative model that highlights the person's own role in directing his or her life and, within that context, his or her own treatment (in much the same way that people, in collaboration with their health care professionals, make decisions about their own medical care for other conditions such as hypertension). One such model that is emerging within DMHAS is that of the community or recovery guide or mentor.

Rather than replacing any of the skills or expertise that practitioners have obtained through their training and experience, the recovery guide model offers a useful framework in which these interventions and strategies are framed as critical tools that the person can use in his or her own recovery. In addition, the recovery guide model, depicted below, offers both practitioners and people in recovery a recovery roadmap of the territory they will be exploring together.

Prior to attempting to embark with a person on his or her recovery journey, practitioners appreciate that the first step in the process of treatment, rehabilitation, or recovery is often to engage in a relationship a reluctant, disbelieving, but nonetheless distressed, even suffering, person. In this sense, practitioners recognize that most people will not know or accept that they have a substance use or mental health condition at first, and therefore will frequently not seek help on their own. The initial focus of care is thus on the person's own understanding of his or her predicament (i.e., not necessarily the events or difficulties which brought him or her into contact with care providers), and on the ways in which the practitioner can be of assistance in addressing this predicament, regardless of how the person understands it at the time.

It also is important to note that within this model, care incorporates the fact that the lives of people in recovery did not begin with the onset of their conditions, just as their lives are not encompassed by substance use or mental health treatment and rehabilitation. Based on recognition of the fact that people were already on a journey prior to the onset of their conditions, and therefore prior to coming into contact with care, the focus of care shifts to the ways in which this journey was impacted or disrupted by each person's condition(s). For example, practitioners strive to identify and understand how the person's substance use or mental illness has impacted on or changed the person's aspirations, hopes, and dreams. If the person

appears to be sticking resolutely to the hopes and dreams he or she had prior to onset of the condition, and despite of or without apparent awareness of the condition and its disabling effects, then what steps need to be taken for him or her to get back on track or to take the next step or two along this track? Rather than the reduction of symptoms or the remediation of deficits—goals that we assume the person shares with care providers—it is the person’s own goals for a life beyond or despite his or her condition that drive treatment, rehabilitation, and recovery planning and efforts.

Figure 6. Conceptual Model for the Recovery Guide



You will know that you are providing person-centered care when:

At the System/Agency Level

- C.1.** An individual may select or change practitioners within agency guidelines and is made aware of the procedures for doing so.
- C.2.** In the spirit of true partnership and transparency, all parties have access to the same bodies of information so that people in recovery can embrace and effectively carry out responsibilities associated with the recovery plan³⁴. People also are automatically offered a copy of their written plans, assessments, and progress notes.

³⁴Osher, T., & Osher, D. (2001). The paradigm shift to true collaboration with families. *The Journal of Child and Family Studies*, 10(3), 47-60.

- C.3.** Individuals are not required to attain or maintain clinical stability or abstinence from substance abuse or self-injury before they are supported by practitioners in pursuing such goals as employment.
- C.4.** Goals and objectives are driven by the person's current values and needs and not solely by commonly desired clinical outcomes, e.g., recovery is a process that may or may not begin with the individual understanding or appreciating the value of abstinence or of taking medications.
- C.5.** The focus of planning is on how to create pathways to meaningful and successful community life as opposed to maintaining stability or abstinence from substance use or self-injury. Person-centered plans document areas such as physical health, family and social relationships, employment or education, spirituality, housing, recreation, and civic and community participation unless such areas are not of interest to the person. Achieving interdependence with natural supports is a valued goal for many people who express a strong preference to live in typical housing, to have friendships and intimate relationships with a wide range of people, to work in regular employment settings, and to participate in school, worship, recreation, and other pursuits alongside other community members.³⁵ Such preferences often speak to the need to reduce time spent in segregated settings designed solely for people with a substance use or mental health condition.
- C.6.** Recovery is viewed as a fundamentally social process, involving supportive relationships with family, friends, peers, community members, and practitioners. Recovery plans respect the fact that services and practitioners should not remain central to a person's life over time and maximize the role of natural supports. Exit criteria from formal services are clearly defined. Given the unpredictability of illness, and life more generally, however, readmission also remains uncomplicated, with avenues clearly defined for people on discharge.
- C.7.** A focus on community is consistent not only with person-centered care but with the need for fiscal efficiency. Practitioners and people in recovery are mindful of the limited resources available for specialized services and focus on community solutions and resources first by asking "Am I about to recommend or replicate a service or support that is already available in the broader community?" At times this has direct implications for the development of interventions within recovery plans, e.g., creating on-site health and fitness opportunities such as

³⁵Reidy, D. (1992). Shattering illusions of difference. *Resources*, 4(2), 3-6.

exercise classes without first exploring to what extent that same opportunity might be available in the community through public recreational departments, YMCAs, etc. If natural alternatives are available in the community, individuals are informed of these opportunities and to the extent to which what is offered is culturally responsive and accessible, they are supported in pursuing activities in such integrated settings.

- C.8.** There is a flexible application of process tools, such as the Assessment of Person-Centered Planning Facilitation Integrity Questionnaire, to promote quality service delivery. Assuming attention is paid to the larger organizational culture, process tools can be helpful in defining the practice and then monitoring its effective implementation.³⁰
- C.9.** Language used is neither stigmatizing nor objectifying. “Person-first” language is used to acknowledge that the condition is not as important as the person’s individuality and humanity. Employing person-first language does not mean that a person’s condition is hidden or seen as irrelevant; but that it also is not to be the sole focus of any description.
- C.10.** Exceptions to person-first and empowering language that are preferred by some persons in recovery are respected. For instance, the personal preferences of some individuals with substance use disorders, particularly those who work the 12-Steps as a primary tool of their recovery, may at times be inconsistent with person-first language. Within the 12-Step Fellowship, early steps in the recovery process involve admitting one’s powerlessness over a substance and acknowledging how one’s life has become unmanageable. It is also common for such individuals to introduce themselves as: “My name is X and I am an alcoholic.” This preference is respected as a part of the person’s recovery process, and it is understood that it would be contrary to recovery principles to pressure the person to identify as “a person with alcoholism” in the name of person-first language. Use of person-first language is in the service of the person’s recovery; it is not a super-ordinate principle to which the person must conform. *While the majority of people prefer to be referred to in first-person language, when in doubt the person is asked what he or she prefers.*
- C.11.** Recognizing the “dignity of risk,” administrators reward planning teams that encourage individual self-determination rather than those which focus primarily on compliance and containment.

³⁰Osher, T., Osher, D. & Blau, G. (2005a). Family-driven Care: A working definition. Alexandria, VA: Federation of Families for Children's Mental Health. http://ffcmh.org/systems_whatish.htm.

- C.12.** Training and resources for developing individualized recovery plans, conducting strengths-based assessments, and serving as a recovery guide are readily available to individuals and practitioners.

At the Practitioner/Person in Recovery Level

- C.13. Core principles of “person-centered” planning are followed in the process of building individualized recovery plans.**
- C.13.1.** Consistent with the principle of “nothing about us, without us,” practitioners actively partner with individuals in shared decision-making, creating integrated and collaborative recovery plans. The individual is centrally involved in all planning meetings and/or case conferences regarding his or her recovery services and supports.
- C.13.2.** The individual has reasonable control as to the location and time of planning meetings, as well as to who is involved, including conserved persons who wish to have an advocate or peer support worker present. Planning meetings are conducted and services are delivered at a time that does not conflict with other activities that support recovery such as employment. The individual can extend invitations to any person she or he believes will be supportive of his or her efforts toward recovery. Invitations extended are documented in the recovery plan. If necessary, the person (and family or friends as relevant) are provided with support before the meeting so that they can be prepared and participate fully.³⁶
- C.13.3.** The language of the plan is understandable to all participants, including the person, his or her family and friends, and the non-professional or natural supports he or she has invited. Where technical or professional terminology is necessary, this is explained to all participants.
- C.13.4.** When individuals are engaged in rehabilitation services, rehabilitation practitioners are involved in planning meetings (at the discretion of the individual) and are given copies of the resulting plan.
- C.13.5.** Within the planning process, a diverse, flexible range of options is available so that people can access and choose those supports that will best assist them in their recovery. These choices and service options are clearly explained to the individual, and documentation reflects the options considered.

³⁶Osher, D. & Keenan, S. (2001). From professional bureaucracy to partner with families. *Reaching Today's Youth*, 5(3), 9–15.

- C.13.6.** Goals are based on the day-to-day life and unique problems, interests, preferences, and strengths of the individual, and interventions are clearly related to the attainment of these stated goals. Such goals may include safety, medical and dental care, income development including employment, relationships and sexuality, and children’s or family concerns such as parenting and/or reunification. In the case of children and youth, the unique goals of the family are also considered, with youth increasingly driving the process as they approach the age of maturity. In cases in which preferred supports do not exist, the team works collaboratively with the individual or family to develop the support or to secure an acceptable alternative.
- C.13.7.** Planning focuses on the identification of concrete next steps, along with specific timelines, that will allow the person to draw upon existing areas of strength to move toward recovery and his or her vision for the future. Individuals, including non-paid, natural supports who are part of the planning process, commit to assist the individual in taking those next steps. The person takes responsibility for his or her part in making the plan work. Effective recovery plans help people rise to this challenge regardless of their mental health or substance use status.
- C.13.8.** Information on rights and responsibilities of receiving services is provided at recovery planning meetings. This information should include a copy of the mechanisms through which the individual can provide feedback to the practitioner and/or agency, e.g., protocol for filing a complaint or compliments regarding the provision of services.
- C.13.9.** Teams reconvene as necessary to address life goals, accomplishments, and barriers. Planning is characterized by celebrations of successes, and meetings can occur beyond regular, established parameters (e.g., 6-month reviews) and crises (e.g., to prevent hospitalization or relapse).
- C.14. A wide range of interventions and contributors to the planning and care process are recognized and respected.**
- C.14.1.** Practitioners acknowledge the value of the person’s existing relationships and connections. In addition, interventions complement, rather than interfere with, what people are already doing to keep themselves well, e.g., drawing support from friends and loved ones.³⁷ When natural supports are actively engaged in the planning process, the action steps to which they are committed are written in the plan.

³⁷Osher, D. and Webb, L. (1994). *Adult Literacy, Learning Disabilities, and Social Context: Conceptual Foundations for a Learner-Centered Approach*. Washington, DC, U.S. Department of Education.

- C.14.2.** The plan identifies a wide range of both professional resources and alternative strategies to support the person’s recovery, particularly those which have been helpful to others with similar struggles. Information about medications and other treatments are combined with information about self-help, peer support, exercise, nutrition, daily maintenance activities, spiritual practices and affiliations, homeopathic and naturopathic remedies, etc.
- C.14.3.** Recovery plans consider not only how the individual can access and receive needed supports from the health care system and broader community, but how the individual can, in turn, give back to others. People have identified this type of reciprocity in relationships as being critical to building recovery capital and to the recovery process as a whole. Therefore, individuals are encouraged to explore how they can make meaningful contributions in the system or in the community, e.g., through advocacy, employment, or volunteering.
- C.14.4.** Person-centered plans reflect an integration of clinical care and/or rehabilitation services along with the use of natural supports, and encourage and highlight an active role for the individual. As such, the “interventions” section of individualized recovery plans include formal interventions but also action steps which have been offered by natural supports and those to which the individual has committed (see C.15.1.).
- C.15. The planning process honors the “dignity of risk” and “right to fail” as evidenced by the following:**
- C.15.1.** Unless determined to require conservatorship by a judge, individuals are presumed competent and entitled to make their own decisions. As part of recovery, they are encouraged and supported by practitioners to take risks and try new things. Only in cases involving imminent risk of harm to self or others is a practitioner authorized to override decisions of the individual. Person-centered care does not eliminate practitioners’ obligations to take action to protect the person or the public in the event of emergent or crisis situations, but limits the authority of practitioners to specifically delimited circumstances defined by relevant statutes.
- C.15.2.** In all other cases, practitioners are encouraged to offer their expertise and suggestions respectfully within the context of a collaborative relationship, clearly outlining for the person his or her range of options and possible consequences. Practitioners support the “dignity of risk” and sit with their own discomfort as the person tries out new choices and experiences that are necessary for recovery.

- C.15.3.** In keeping with this stance, practitioners encourage individuals to write their own crisis and contingency plans (such as psychiatric advanced directives or the crisis plans of the WRAP model). Ideally, such plans are directed by the individual but developed in collaboration with the entire team so as to share responsibility and resources in preventing or addressing crises. Such plans provide detailed instructions regarding preferred interventions and responses in the event of crisis, and maximize an individual’s ability to retain some degree of autonomy and self-determination at a time when he or she is most likely to have these rights compromised.³⁸ This plan is kept in an accessible location and can be made available for staff providing emergency care.
- C.16. Person-centered care identifies and builds on a person’s strengths and resources as evidenced by the following:**
- C.16.1.** A discussion of strengths is a central focus of every assessment, care plan, and case summary. Assessments begin with the assumption that people are key experts on their own recovery and that they have learned much in the process of living with and working through their struggles.
- C.16.2.** Initial assessments recognize the power of simple, yet powerful, questions such as “What happened? What do you think would be helpful? What are your goals in life?” Self-assessment tools rating level of satisfaction in various life areas can be useful ways to identify diverse goal areas around which supports can then be designed.
- C. 16.3.** Practitioners interpret perceived deficits within a strength and resilience framework, as this allows the individual to identify less with the limitations of his or her condition. For example, an individual who takes medication irregularly may be perceived as “non-compliant,” “lacking insight,” or “requiring monitoring.” This same individual, however, could also be seen as “making use of alternative coping strategies such as exercise and relaxation to reduce reliance on medications” or could be praised for “working collaboratively to develop a contingency plan for when medications are to be used on an ‘as-needed’ basis.” (Additional examples are provided in the Appendix)
- C.16.4.** While strengths of the individual are a focus of the assessment process, thoughtful consideration also is given to potential strengths and resources within the individual’s family, natural support network, service system, and community at large. This is consistent with the

³⁸Kendziora, K. T., Bruns, E., Osher, D., Pacchiano, D., & Mejia, B. (2001). *Wraparound: Stories from the Field*. Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

view that recovery is not a solitary process but rather a journey toward interdependence within one's community of choice.

- C.16.5.** The diversity of strengths that can serve as resources for the person and his or her recovery planning team is respected. Saleeby, for example, has recommended conceptualizing strengths broadly to include the following dimensions: skills (e.g., gardening, caring for children, speaking Spanish, doing budgets); talents (e.g., playing the bagpipes, cooking); personal virtues and traits (e.g., insight, patience, sense of humor, self-discipline); interpersonal skills (e.g., comforting the sick, giving advice, mediating conflicts); interpersonal and environmental resources (e.g., extended family, good neighbors); cultural knowledge and lore (e.g., healing ceremonies and rituals, stories of cultural perseverance); family stories and narratives (e.g., migration and settlement, falls from grace and redemption); knowledge gained from struggling with adversity (e.g., how one came to survive past events, how one maintains hope and faith); knowledge gained from occupational or parental roles (e.g., caring for others, planning events); spirituality and faith (e.g., a system of meaning to rely on, a declaration of purpose beyond self); and hopes and dreams (e.g., personal goals and vision, positive expectations about a better future)³⁹.
- C.16.6.** In addition to the assessment of individual capacities, it is beneficial to explore other areas not traditionally considered “strengths,” e.g., the individual's most significant or most valued accomplishments, ways of relaxing and having fun, ways of calming down when upset, preferred living environment, educational achievements, personal heroes, most meaningful compliment ever received, etc.
- C.16.7.** Assessment explores the whole of people's lives while ensuring emphasis is given to the individual's expressed and pressing priorities. For example, people experiencing difficulties with substance use or mental health often place less emphasis on symptom reduction and abstinence than on desired improvements in other areas of life such as work, safe housing, or relationships. For this reason, it is beneficial to explore in detail each persons' needs and resources in these areas.
- C.16.8.** Strength-based assessments ask people what has worked for them in the past and incorporate these ideas in the recovery plan. People are more likely to use strategies that they have personally identified or developed rather than those that have been suggested to them by others.

³⁹Saleeby, D. (2001). The diagnostics strengths manual. *Social Work, 46*(2), 183-187.

- C.16.9.** Guidance for completing a strength-based assessment may be derived from certain interviewing strategies employed within solution-focused approaches. For example, DeJong and Miller recommend the following types of inquiry: exploring for exceptions (occasions when the problem could have occurred but did not), imagining a future when the problem has been solved and exploring, in detail, how life would then be different; assessing coping strategies, i.e., asking how an individual is able to cope despite the presence of such problems; and using scaling questions (where the individual rates his or her current experience of the problem) to elucidate what might be subtle signs of progress.⁴⁰
- C.16.10.** Illness self-management strategies and daily wellness approaches such as WRAP⁴¹ are respected as highly effective, person-directed, recovery tools, and are fully explored in the strength-based assessment process.
- C. 16.11.** Cause-and-effect explanations are offered with caution in strength-based assessment as such thinking can lead to simplistic resolutions that fail to address the person’s situation. In addition, simplistic solutions may inappropriately assign blame for the problem to the individual, with blame being described as “the first cousin” of deficit-based models of practice.⁴² For example, to conclude that a person did not pay rent as a direct consequence of his or her “non-compliance” with medications could lead to an intrusive intervention to exert control over the individual’s finances or medication. Strength-based assessments respect that problem situations are usually the result of complex, multi-dimensional influences, and explore with the person in more detail the various factors that led to his or her decisions and behavior (e.g., expressing displeasure with a negligent landlord).
- C.16.12.** Strength-based assessments are developed through in-depth discussion with the individual as well as attempts to solicit collateral information regarding strengths from the individual’s family and natural supports. Since obtaining all of the necessary information requires time and a trusting relationship with the person, a strength-based assessment may need to be completed (or expanded upon) after the initial contact as treatment and rehabilitation unfold. While each situation may vary, the assessment is written up as soon as possible in order to help guide the work and interventions of the recovery team. Modular approaches to

⁴⁰DeJong, G. & Miller, S. (1995) How to interview for client strengths, *Social Work*, (40), 729-736.

⁴¹Copeland, M. (2002). *The depression workbook: A guide for living with depression and manic depression. Wellness Recovery Action Plan*. Oakland, CA: New Harbinger Publications.

⁴²Cowger, C.D. (1994). Assessing client strengths: Clinical assessment for client empowerment. *Social Work* 39(3), 262-268.

service delivery, billing, and reimbursement are considered by local and state administrative leadership, e.g., certain information is gathered in the first 24 hours with additional areas being assessed by the end of one week, one month, etc.

- C.16.13.** Efforts are made to record the individual’s responses verbatim rather than translating the information into professional language. This helps to ensure that the assessment remains narrative-based and person-centered. If technical language must be used, it is translated appropriately and presented in a person-first, non-offensive manner, e.g., avoiding the language of dysfunction, deficit, or disorder.
- C.16.14.** Practitioners are mindful of the power of language and carefully avoid the subtle messages that professional jargon has historically conveyed to people with mental health and/or substance use conditions and their loved ones. Language is used that is empowering, avoiding the eliciting of pity or sympathy, as this can cast people in a passive victim role and reinforce negative stereotypes. For example, just as we have learned to refer to “people who use wheelchairs” as opposed to “the wheelchair bound” we should refer to “persons who use medication as a recovery tool” as opposed to people who are “dependent on medication for clinical stability.” In particular, words such as “hope” and “recovery” are used frequently in delivery and documentation of care.
- C.16.15.** While important for certain purposes (e.g., treatment, reimbursement), practitioners avoid using diagnostic labels as “catch-all” means of describing an individual (e.g., “she’s a borderline”). Such labels yield minimal information regarding the person’s actual experience or manifestation of their condition. Alternatively, a person’s needs are not well captured by a label, but by an accurate description of his or her functional strengths and limitations. While diagnostic profiles are required for other purposes (e.g., decisions regarding medication, justification of level of care), strength-based assessment places limited value on diagnosis per se. In addition, acknowledging limitations and areas of need are not viewed as accepting one’s fate as “a mentally ill person” or “an addict.” Rather, identifying and accepting one’s current limitations is seen as a constructive step in the process of recovery. Gaining a sense of perspective on both strengths and weaknesses is critical in this process as it allows the person to identify, pursue, and achieve life goals despite the lingering presence of illness or disability.
- C.16.16.** Persons in recovery give thoughtful consideration to the strengths and resources available within their existing relationships (e.g., with family,

friends, neighbors, workplace, faith community, etc.) and incorporate these strengths and resources into their recovery plan, as appropriate.

C.16.17. Persons in recovery review their personal history for successes and periods of enhanced functioning they have experienced, as well as strategies they have used to manage difficult situations and to achieve goals. They build their recovery plans based in part on making use of these strengths and strategies to address new and future challenges.

C.16.18. Persons in recovery discuss their strengths and successes with others, including friends, family, and colleagues, as appropriate, in order to gain perspective and generate new ideas to support the recovery planning process.

C.17. Practitioners providing recovery-oriented care function as recovery or community guides as evidenced by the following:

C.17.1. The primary vehicle for the delivery of most mental health or substance use treatment is the relationship between the practitioner and the person in recovery. The care provided is grounded in an appreciation of the possibility of improvement in the person's condition, offering people hope and/or faith that recovery is "possible for me."

C.17.2. Practitioners convey belief in the person even when he or she cannot believe in him or herself and serve as a gentle reminder of his or her potential. In this sense, staff envision a future for the person beyond the role of "mental patient" or "addict" based on the person's own desires and values and share this vision with the person through the communication of hope and positive expectations.

C.17.3. Practitioners assess where each person is in relation to the various stages of change (e.g., pre-contemplation, preparation, etc.) with respect to the various dimensions of his or her recovery. Interventions are appropriate to the stages of change relevant to each focus of treatment and rehabilitation (e.g., a person may be in an action phase related to his or her substance use but be in pre-contemplation related to his or her mental health condition).

C.17.4. Care is based on the assumption that as a person recovers from his or her condition, the substance use or mental health condition then becomes less of a defining characteristic of self and more simply one part of a multi-dimensional sense of identity that also contains strengths, skills, and competencies. Services elicit, flesh out, and cultivate these positive elements at least as much as, if not more than,

assessing and ameliorating difficulties. This process is driven by the person in recovery through inquiries about his or her hopes, dreams, talents, and skills, as well as perhaps the most important question of “How can I be of help?”

- C.17.5.** Interventions are aimed at assisting people in gaining autonomy, power, and connections with others. Practitioners regularly assess the services they are providing by asking themselves: “Does this person gain power, purpose (valued roles), competence (skills), and/or connections (to others) as a result of this interaction?” and, equally important: “Does this interaction interfere with the acquisition of power, purpose, competence, or connections to others?”
- C.17.6.** Opportunities and supports are provided for the person to enhance his or her own sense of personal agency. For example, practitioners understand that medication is only one tool in a person’s “recovery tool box” and learn about alternative methods and self-management strategies in which people use their own experiences and knowledge to apply wellness tools that work best for them. Sense of agency involves not only feeling effective and able to help oneself but also being able to positively impact the lives of others. Practitioners can promote this by thoughtfully balancing when to do for someone, when to do with someone, and when to let someone do for him or herself. Knowing when to hold close and support and protect, when to encourage someone while offering support, when to let someone try alone and perhaps stumble, and when to encourage a person strongly to push themselves is an advanced, but essential, skill for practitioners to develop. While these are intuitive skills that all practitioners struggle to refine over time, prior to taking action it is often beneficial for practitioners to ask the question: “Am I about to do for this person something she or he could manage to do more independently?” Acting for another person when unnecessary, even with the best of intentions, can send messages of low expectations and incapacity.
- C.17.7.** Individuals are allowed the right to make mistakes, and this is valued as an opportunity for them to learn. People in recovery report that they have found meaning in adverse events and failures and that these have subsequently helped them to advance in their recovery. In accordance with this, practitioners recognize that their role is not necessarily to help people avoid adversity or to protect them from failure. For example, the re-experiencing of symptoms can be viewed as a part of the recovery process and not necessarily a failure or setback. The “dignity of risk” ensues following a thoughtful and proactive planning process in which practitioners work collaboratively with individuals to

develop relapse prevention plans, including advance directives which specify personal and treatment preferences in the event of future crises.

- C.17.8.** People are allowed to express their feelings, including anger and dissatisfaction, without having these reactions immediately or routinely attributed to symptoms or relapse.
- C.17.9.** Care is not only attentive to cultural differences across race, ethnicity, and other distinctions of difference (e.g., sexual orientation), but incorporates this sensitivity at the level of the individual. Only an individual-level process can ensure that practitioners avoid stereotyping people based on broad or inaccurate generalizations (e.g., what all lesbians want or need), and enable them instead to tailor services to the specific needs, values, and preferences of each person, taking into account each individual's ethnic, racial, and cultural affiliations.
- C.17.10.** Rather than dwelling on the person's distant past or worrying about the person's long-term future, practitioners focus on preparing people for the next one or two steps of the recovery process by anticipating what lies immediately ahead, by focusing on the challenges of the present situation, and by identifying and helping the person avoid or move around potential obstacles in the road ahead. Although the practitioner deemphasizes the person's early personal history (because it may not be relevant) and long-term outcome (because it cannot be predicted), either of these perspectives may be invoked should they prove useful in the current situation. Especially as these issues pose barriers to recovery, practitioners utilize appropriate clinical skills within the context of a trusting relationship in order to enhance the person's capacity to overcome, compensate for, or bypass these barriers.
- C.17.11.** Interventions are oriented toward increasing the person's recovery capital as well as decreasing his or her distress and dysfunction. Grounded in a person's "life-context," interventions take into account each person's unique history, experiences, situations, developmental trajectory, and aspirations. In addition to culture, race, and ethnicity, this includes less visible but equally important influences on each person's development, including both the traditional concerns of practitioners (e.g., family composition and background, history of substance use and relapse triggers) as well as less common factors such as personal interests, hobbies, and role models that help to define who each person is as an individual and as a member of his or her network.

- C.17.12.** Practitioners are willing to offer practical assistance in the community contexts in which people live, work, and play. In order to effectively address “individuals’ basic human needs for decent housing, food, work, and ‘connection’ with the community,” practitioners are willing to go where the action is, i.e., they get out of their offices and out into the community.⁴³ They are prepared to go out to meet people on their own turf and on their own terms, and to “offer assistance which they might consider immediately relevant to their lives.”⁴⁴
- C.17.13.** Care is not only provided in the community but is also oriented toward increasing the quality of a person’s involvement in community life. Thus, the focus of care is considered more important than locus of where it is provided. The focus of care includes the process of overcoming the social and personal consequences of living with psychiatric and/or substance use disorders. These include gaining an enhanced sense of identity and meaning and purpose in life and developing valued social roles and community connections despite a person’s continued symptoms or disability. Supporting these goals requires that practitioners have an intimate knowledge of the communities in which people live, the community’s available resources, and the people who are important to them, whether it is a friend, parent, employer, landlord, or grocer. Practitioners also are knowledgeable about informal support systems that are in communities such as support groups, singles clubs, and other special interest groups, and actively pursue learning more about other possibilities that exist to help people connect.
- C.17.14.** Efforts are made to identify sources of incongruence between the person and his or her environment and to increase person-environment fit. This is done both by helping the person assimilate into his or her environment (through symptom management, skill acquisition, etc.) and by helping the community to better accommodate people with disabilities (through education, stigma reduction, the creation of niches, etc.), with the common goal being to develop multiple pathways into and between members of communities.
- C.17.15.** In order to counteract the often hidden effects of stigma, practitioners explicitly draw upon their own personal experiences when considering the critical nature of various social roles in the lives of all individuals (e.g., being a parent, a worker, a friend, etc), continuing to view people

⁴³Curtis, L.& Hodge, M. (1994). Old standards, new dilemmas: Ethics and boundaries in community support services. *Psychosocial Rehabilitation Journal*, 18(2), 13-33.

⁴⁴ Rosen, A. (1994). Case management: The cornerstone of comprehensive local mental health services. *Australian Hospital Association, Management Issues Paper No. 4*. April, 47-63.

in recovery squarely within the context of their daily lives (i.e., as opposed to within institutional settings).

Example of how this might look in practice

At times, following a training on functioning as a recovery guide, practitioners have asked how to get people who appear to be disinterested or who lack motivation or personal goals to get on the tour bus. One response is that we are to get on their ‘bus’, join them on their recovery journey, rather than try to persuade them to join us on ours. How to do so, however, is the challenge. The following story provides one example of what this process might look like; in this case involving a real bus.

Tyrese was a man in his 40’s who spent the majority of his days sitting in a chair or on a couch at the drop-in center, smoking cigarettes and watching television. While he conversed with others on occasion, he seemed just as happy to sit by himself, lost in his thoughts, cigarette smoke, or the television show that happened to be on at the moment. His appearance was disheveled and he would occasionally blurt out something which appeared to be in response to hallucinated voices. In this respect, Tyrese was perhaps not as alone as he appeared. Although this drop-in center had a fairly lenient policy regarding “hanging out,” the staff eventually became concerned about Tyrese and what, if anything, he was getting from his visits to the drop-in center. He repeatedly turned down invitations to participate in activities and responded to the suggestions of his peers and staff about what else he might do by conveying disinterest. He appeared to be stuck, and the staff began to feel stuck with him as well.

When it came time for his service review, the only goal which Tyrese could identify that interested him was a job. He had no work history, had not graduated high school, had no identifiable skills, and could not—or would not—state any more clearly what kind of job he might be interested in. All of the efforts the members and staff of the drop-in center made to involve Tyrese in activities were fruitless. Everyone appeared to have run out of ideas and figured that it was least better for Tyrese to come to the drop-in center everyday even if he did nothing than to remain at home alone.

Shortly after the staff became resigned to viewing the drop-in center as a better alternative for Tyrese than his staying home alone it occurred to a staff member to wonder about what Tyrese’s home life was like. Where, in fact, did he live? And with whom? It had not occurred to them to ask, or when they did ask, Tyrese had not been forthcoming with answers. No one seemed to know much about his life outside of the drop-in center. With this recognition, one staff member—the one who first wondered about what Tyrese did outside of the drop-in center, and with whom—decided that this was a mystery that could be solved. He decided to spend

more time with Tyrese and try to learn more about his life. Tyrese, however, would not answer the usual questions of who he lived with, where, etc. Finally, more out of desperation than anything else, the staff member asked Tyrese “Well, how do you get here every day?” To this question, and to the staff member’s surprise, a small light shone in Tyrese’s eyes and he responded “I take the bus.” “Which bus?” the staff member persisted. After further discussion it emerged that Tyrese in fact took two buses to the drop-in center each day, that he lived on the other side of town, and that Tyrese did not mind the 45 minute bus ride but, in fact, enjoyed the rides back and forth as much as his time at the drop-in center.

Tyrese, it turned out, enjoyed buses, enjoyed riding buses, and knew more about the bus system in this city than just about anyone else outside of the bus company. When the staff member asked to accompany Tyrese home from the center one day, Tyrese talked non-stop throughout the 45 minute ride and change of buses about the different routes, the different schedules, and how he had learned over the years to be able to get from any point in the city to any other point by taking no more than three buses. The staff member also noticed that while he was on the bus, Tyrese appeared to be animated, attentive, and interested. He didn’t have time to entertain or respond to voices, as he was busy greeting the bus driver, explaining the routes to his fellow rider, and savoring each moment of the ride. At the end of their first ride together, it came as no surprise to the staff member that Tyrese confided to him that what he liked most about the drop-in center was the fact that it provided bus tokens at a reduced rate (and had a wide screen television).

The staff member shared his experiences with Tyrese and his new insights into his life outside the drop-in center with the staff, but no one had any immediate ideas about what to do with this information. Then, when budget cuts came down from the state and the program had to give up its van and transportation service, the staff had to brainstorm and problem solve about how some clients would be able to get to the center. During this discussion, one staff member initially quipped that perhaps Tyrese could teach other members how to use the bus service. What started out as a joke quickly was turned into a proposal, however, and Tyrese was approached with the idea. Would he be interested in teaching other members about the city’s bus system, and would he be willing at first to ride with them and show them the routes until they became comfortable themselves?

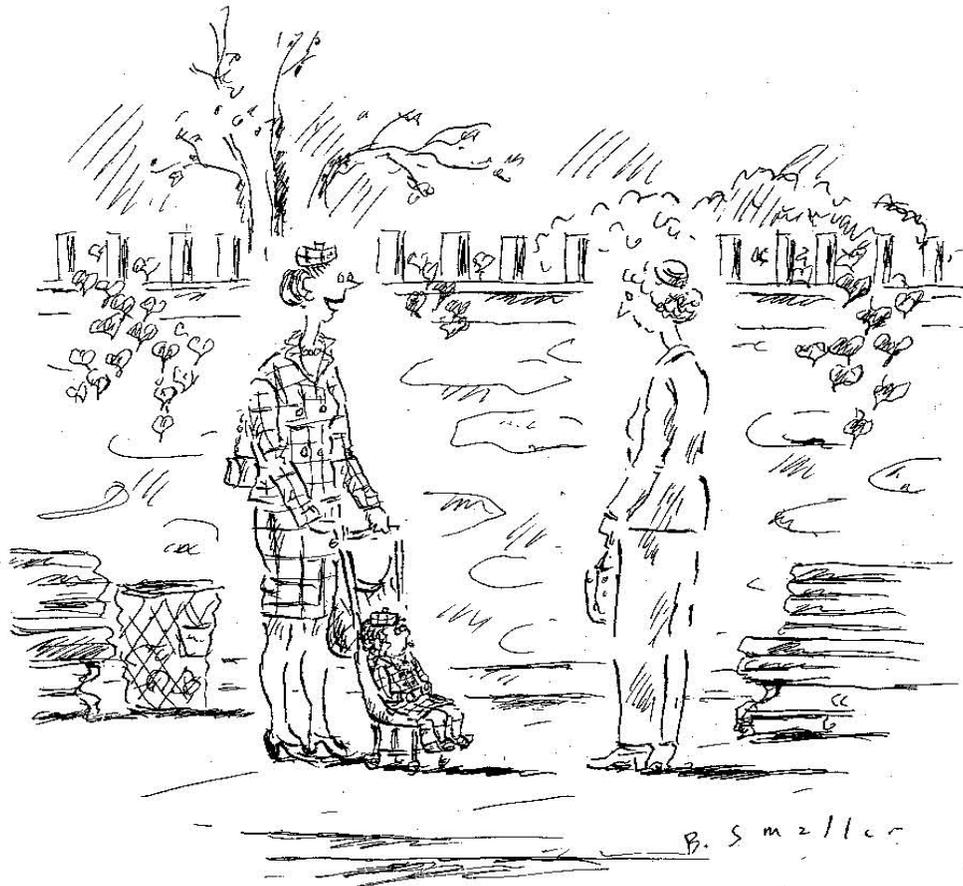
To the staff’s surprise, Tyrese’s eyes again lit up and he responded with excitement. The fact that the staff were even willing to pay him for this service did not seem to be as important to him as the fact that he was being seen, and valued, for what he had to offer. While becoming the bus trainer did not stop his voices or initially improve his hygiene, it did engage Tyrese in the life of the center, enabled him to make friends among his peers, and got him up off the couch. Over time, however, he did wash and cut his hair so that he could wear a new baseball cap he had bought with the word “conductor” on the front.

What you will hear from people in recovery when you are offering person-centered care:

- *It's amazing what you can do when you set your mind to it ... especially when you're no longer supposed to have one!*
- *She believed in me, even when I didn't believe in myself. Hope was the biggest gift she could have given me... and it saved my life.*
- *It made such a huge difference to have my pastor there with me at my planning meeting. He may not be my father, but he is the closest thing I've got. He knows me better than anyone else and he had some great ideas for me.*
- *I used to think my life was over, but my illness isn't a death sentence. Its just one small part of who I am. Sometimes I forget about those other parts – the healthy parts of me. But my counselor always reminds me. You really need someone like that in your life.*
- *Not everybody thought it was a good idea for me to try to get my daughter back. But they realized that without her, I didn't have a reason to be well. So, we figured out a plan for what to do if I couldn't handle the stress, and my team has stood beside me every step of the way. Was it "too stressful" at times? You bet! But every day is a blessing now that I wake up and see her smiling face!*
- *I thought I was so alone in my problems. I may not feel as though I have much strength right now, but I realize I can draw strength from all the people around me... my friends, my neighbors, my pastor, and my counselors here.*
- *When they asked me about what I was good at and what sorts of things in my life made me happy, at first I didn't know who they were talking to. Nobody ever asked me those kinds of questions before. Just sitting through that interview, I felt better than before I had walked through the door!*
- *No one here treats me like a label. Just because I have schizophrenia, that doesn't tell you a whole lot. My roommate does too, but we couldn't be more different. Folks here take the time to get to know lots of things about me, not just the things that go along with my diagnosis.*
- *When he asked me, "So how can I best be of help!" I thought, "Oh great, I've really got a green one. You are supposed to be the professional—you tell me!" But I get it now. I need to decide what I need to move ahead in my recovery. And I needed to know it was OK to ask people for that. That was the key.*

- *When she ever showed up on my doorstep with a bag of clothes so my baby could start kindergarten, I knew this one was different. I couldn't care about myself or my recovery until I knew my kids were OK. She didn't pity me, or look for a pat on the back. She just knew, this was what I needed and it made all the difference in my recovery.*
- *I was terrified of going back to that hospital. My case manager couldn't guarantee me that it wouldn't happen again. But we sat down together and did a plan for how to make things different if there ever was a "next time." Knowing my dog would get fed, making sure somebody talked to my landlord so I wouldn't get evicted, and being able to write down how the staff could help me if I lost control... All those things made the idea of going back less scary.*

The Importance of Not Overlooking the (not so) Obvious



"Isn't it funny? We have the exact same taste!"

