

E. Recovery-Oriented Care is Safe and Trustworthy

Like all medical care, recovery-oriented care for mental health and substance use conditions is grounded in the Hippocratic Oath of “First, do no harm.” As an extension of this principle—and in recognition of the unfortunate prevalence of trauma in the lives of individuals with these conditions—concerted efforts are made to ensure that mental health and substance use services and supports are safe for those who are intended to benefit from them. People should not be worse off as a result of accessing health care, and any adverse effects or side effects of receiving treatments or participating in services are to be avoided as much as possible.

Unfortunately, and for the foreseeable future, the very act of seeking care for mental health and/or substance use conditions may be viewed by some people as harmful and damaging. There are at least two major sources of this situation—and of considerable suffering—that make accessing and benefiting from care itself a labor intensive and difficult process. Foremost among these is the discrimination that continues to affect people with mental health and/or substance use conditions in society at large and, even more importantly, within the health care system itself. This discrimination results in people with mental health and/or substance use conditions being viewed and treated as second-class citizens in a variety of life domains. One byproduct of repeated discrimination is that people come to view and treat themselves as second-class citizens as well.

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What advocates within the mental health community have come to call “internalized stigma” presents a second significant obstacle to accessing care and to recovery, undermining the self-confidence and self-esteem required for the person to take steps toward improving his or her life. The demoralization and despair that are associated with internalized stigma and feelings of inferiority also tap the person’s sense of hope and initiative, adding further weight to the illness and its effects.

Given this legacy, it becomes incumbent upon practitioners to identify and address those elements and characteristics of the current service system and the broader community that unwittingly contribute to the exacerbation of symptoms and

the creation and perpetuation of disability and dependency in individuals with mental health and substance use conditions. It also becomes incumbent upon the practitioner to pay careful and close attention to earning the trust of a person who is considering taking part in, unsure of, or new to care. As we noted above, the engagement process

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requires the cultivation of a trusting relationship. Here we note that this is true of just about every person seeking or receiving care, even if he or she does not require assertive outreach. Research has consistently demonstrated that a trusting relationship with a practitioner is one of the most important predictors of a positive outcome resulting from care for a mental health and/or substance use condition; more so than any particular theoretical approach or evidence-based technique. In recognition of this fundamental role of interpersonal

relationships in recovery, practitioners go beyond doing no harm and ensuring safety to cultivating trusting relationships which the persons being served view as helpful.

To this point in the Guidelines, our guiding assumption has been that mental health and substance use conditions are illnesses like any others and that, with few exceptions, seeking and receiving care for these disorders should resemble care provided for other medical conditions. Although we have made a point of stressing the need for outreach and engagement to ensure access to care, we otherwise may have given the reader the impression that people with mental health and/or substance use conditions are educated consumers of health care and that they will naturally act on their own behalf in making appropriate choices in this and other domains.

Experienced practitioners will no doubt consider such a perspective simplistic and naïve, and will suggest that up to 80% of the work entailed in treating these conditions is devoted to helping people to arrive at such a position of being willing to accept care. Once a person recognizes that he or she has a mental health and/or substance use condition and agrees to participate in treatment and/or rehabilitation, the bulk of the more difficult work may appear to be done. We appreciate this sentiment, and agree that it may take a generation or more (of eliminating stigma and discrimination) before many more people experiencing these conditions will be able to access and benefit from care in a more straightforward and uncomplicated manner.

Regardless of where any particular individual is in the process of understanding his or her condition and participating actively in his or her own recovery, practitioners are obliged to treat people with dignity and respect and to offer them safe and supportive environments. In addition to doing no harm themselves,

practitioners may need to identify sources of harm which have been done to individuals in the past so as not to recreate those situations in the present. For example, while trauma may not be intrinsic to mental health or substance use per se, there is considerable evidence that suggests that people experiencing these conditions at the present time have a greatly increased chance of having experienced a history of trauma earlier in their lives, as well as being at increased risk for exposure to victimization and trauma currently. One component of providing safe and trustworthy care thus becomes recognizing and being sensitive to the histories of trauma people may bring with them into treatment and also preparing them to take care of themselves, and to avoid further victimization, into the future.

Finally, determining what has been helpful to people in managing distress in the past and noting their preferences for how they would like to be treated in the future should they become distressed is an essential step toward ensuring that the care provided will be experienced as safe and trustworthy.

You will know that you are providing safe and trustworthy care when:

At the System/Agency Level

- E.1.** Agencies make concerted efforts to avoid all involuntary aspects of treatment such as involuntary hospitalization or medication.
- E.2.** Recommendations from individuals with trauma histories are aggregated and reviewed so services can be structured in a way that helps people feel safe. Special focus is placed on making inpatient, day treatment, intensive outpatient, and outpatient programs feel safe.
- E.3.** Training and resources on trauma-informed treatment are readily available to and utilized by practitioners, including training related to professional boundaries, confidentiality, dual relationships, and sexual harassment, as well as clinician self-care and vicarious trauma.
- E.4.** Efforts are made to ensure that individuals have their health care needs addressed and have ready access to primary health care services, including preventative health and dental care and health promotion, both to enhance and promote health and to reduce reliance on crisis or emergency care. Inquiries on health status and health care access are made during initial admission and periodically, e.g. every 6 months, thereafter. Exercise, nutrition, and other aspects of healthy living are promoted by the agency and interested individuals are linked to community resources that can enhance their active participation in maintaining a healthy lifestyle.

- E.5.** Policies and practices support healthy connections with children, family, significant others, and community.
- E.6.** In the process of developing advance directives or upon admission, individuals are asked to describe the strategies or intervention that have worked well for them in the past to assist them in managing their distress. They also are asked to specify for the staff the ways in which they would, and would not, prefer to be treated should they become distressed during their stay within the care setting. These preferences are documented in the person's health record and staff are made aware of the person's preferences in advance of the use of more restrictive interventions (e.g., restraints or seclusion).

At the Practitioner/Person in Recovery Level

- E.7. Internal barriers to recovery are identified and addressed.**
 - E.7.1.** It is important to acknowledge that some people with mental health and/or substance use conditions may be reluctant to assume some of the rights and responsibilities promoted in recovery-oriented systems. They may initially express reluctance, fears, mistrust, and even disinterest when afforded the right to take control of their treatment and life decisions. On these occasions, practitioners explore and address the multiple factors influencing mistrustful, reluctant or disinterested responses, as they often result from a complex interaction of the person's conditions and his or her past experiences in the health care system. Significant training and skill building within the recovery community is necessary to support people in embracing expanded roles and responsibilities. Education and ongoing support and mentoring for this purpose are perhaps best offered through mental health advocacy organizations and peer-run programs.
 - E.7.2.** Individuals with mental health and/or substance use conditions often have histories of trauma which impact on treatment and recovery. For example, there is considerable evidence that suggests that people living with these conditions at the present time have a greatly increased chance of having experienced a history of trauma earlier in their lives as well as being at increased risk for future victimization.⁵⁵ Evidence also suggests that the failure to attend to a person's history of sexual and/or physical abuse seriously undermines the treatment and rehabilitation enterprise, leading to a poor prognosis, while approaches that

⁵⁵Sells, D., Rowe, M., Fisk, D. & Davidson, L. (2003). Violent victimization of persons with co-occurring psychiatric and substance use disorders. *Psychiatric Services*, 54(9), 1253-1257.

are responsive to trauma significantly improve treatment effectiveness and outcomes.⁵⁶ Similar processes resulting from patterns of relating in a person's family context or immediate social environment may pose additional barriers to the person's recovery.

E.7.3. The above barriers represent more of an interaction between a person's condition and his or her experiences in the health care system and the community at large. In addition, the symptoms of certain illnesses themselves may also pose direct impediments to the recovery process. Hallucinations and delusions, for example, may compete with the information a person is receiving from health care practitioners, thereby discouraging the person from taking prescribed medications or participating in other treatment or rehabilitation. Similarly, impairments in such areas as working memory, executive processes, language, attention and concentration, and problem solving⁵⁷ can undermine a person's abilities to articulate and assert his or her personal wants, needs, and preferences in the context of a relationship with a clinical practitioner. Such cognitive impairments may be further aggravated by negative symptoms, currently considered to be among the most unremitting and malignant of the impairments associated with psychosis.⁵⁸ These include a lack of goal-directed activity, withdrawal, apathy, and affective flattening, all of which can create the impression that individuals are not interested in taking an active role in their care, thereby placing them at increased risk of being underestimated and undervalued as partners in the recovery planning process.

In certain conditions, the elimination or reduction of substance use or symptoms may also come with great ambivalence, e.g., while episodes of mania can be destructive, they may include a heightened sense of creativity, self-importance, and productivity that are difficult to give

⁵⁶For more details in this regard the reader is referred to the guidelines developed by R. Fallot and M. Harris as part of the DMHAS Trauma Initiative entitled *Trauma-Informed Services: A Self-Assessment and Planning Protocol*.

⁵⁷Saykin, A., Gur, R.C., Gur, R.E., Mozley, D., Mozley, R.H., Resnick, S., Kester, B. & Stafinick, P. (1991). Neuropsychological function in schizophrenia: Selective impairment in memory and learning. *Archives of General Psychiatry*, 48, 618-624.; Bell, M. & Lysaker, P. (1995). Psychiatric symptoms and work performance among people with severe mental illness, *Psychiatric Services*, 46(5), 508-510; Westermeyer, J. & Harrow, M. (1987). Factors associated with work impairments in schizophrenic and nonschizophrenic patients. In R. Grinker & M. Harrow (Eds.), *Clinical research in schizophrenia: A multidimensional approach*. p. 280-299. Springfield: Charles Thomas Books; Cornblatt, B. & Erlenmeyer-Kimling, L. (1984). Early attentional predictors of adolescent behavioral disturbances in children at risk for schizophrenia. In Watt, N.F., James, A.E. (eds.). (1984). *Children at risk for schizophrenia: A longitudinal perspective*. (pp. 198-211). New York, NY, US: Cambridge University Press; Seltzer, J., Cassens, G., Ciocca, C. & O'Sullivan, L. (1997). Neuropsychological rehabilitation in the treatment of schizophrenia. *Connecticut Medicine*, 61(9), 597-608.

⁵⁸Torrey, E.F. (1988). *Surviving schizophrenia: A family manual (Rev. ed.)*. New York: Harper & Row.

up. Being able to identify and address these and other aspects of illness requires knowledge and skill on the part of the practitioner. There thus is ongoing professional development regarding emerging evidence-based and recovery-oriented practices which allow people to manage, or bypass, their symptoms to build a gratifying life in the community.

- E.8.** Individuals request and receive supports and accommodations that help them to feel safe. They also describe for practitioners strategies that have worked for them in the past in managing their distress and suggest the ways in which they would like, and would not like, to be treated in the future should they become distressed.
- E.9.** Staff invite individuals to share their childhood and/or adult history of experiencing violence and abuse at a pace which is comfortable for them and also ask them what they will need in order to feel safer. Individuals notify staff of any concerns they have about personal safety and join with practitioners in developing safety plans.
- E.10.** Staff appreciate that understanding an individual's trauma history is an important part of assessing that person's relationships within his or her natural support network, at the same time recognizing that the process utilized in trauma screening may be more important than any of the specific content of the questions and answers.

Example of how this might look in practice:

One of the concerns about recovery-oriented practice that practitioners frequently raise has to do with the person's safety, particularly safety in relation to his or her own choices and decisions. A fundamental principle of recovery-oriented care is that practitioners elicit and honor the person's autonomy, agency, and self-determination. How is it possible to uphold that principle, they ask, and at the same ensure the person's safety? Are these not contradictory impulses? As in the following vignette, these principles may seem at times to be at odds with each other in practice. This fact represents one more reason to emphasize that recovery-oriented practice—rather than being merely “common sense”—actually requires clinical sophistication, advanced skills, and supervision. Here, as in life, there are few simple answers.

Yolanda, a 30-year old woman living in a supportive housing program, came to a consultant's attention because she had a troublesome habit of leaving the building in the middle of the night and wandering around the downtown area of a small city. The staff had tried in vain to convince Yolanda to stop her late night walks, at first trying to persuade her that it was too dangerous for her to be out alone at night in the city. When persuasion had not worked, the staff established program

parameters and rules which stipulated that Yolanda would not be allowed out of the building after 10:00 p.m., as she could not be trusted to cease this activity on her own and did not appear to appreciate the danger to which she was exposing herself. These efforts were in vain also, however, as Yolanda continued to “slip out” at night and disregard the new program rules no matter what consequences were put into place. The program was voluntary and the building was unlocked, and the staff had no way of preventing her from leaving short of physically blocking her way. They brought this situation to the attention of the program consultant, who had been stressing the need for client choice and self-determination in helping the program adopt a more recovery-oriented approach.

Initially the consultant asked the staff if they knew why Yolanda left the building in the middle of the night; did they know what she was after? She wondered with the staff what Yolanda was trying to accomplish during her late night walks, and whether or not this same agenda could be pursued in other, less dangerous, ways. Yolanda, for her part, however, was not interested in such discussions. At this point in time, she was not willing or able to disclose to the staff where she went or why, and was not willing or able to consider other alternatives, when she saw no reason to curtail her walks. The staff were torn between their wish to respect Yolanda’s right to make her own decisions and choices and their strong desire and need to keep her safe. Arguments and disagreements broke out between staff who took up either side of this ambivalence, with some blaming others for being paternalistic and others responding by faulting their colleagues for being careless, irresponsible, and even unethical. What were they to do?

After many lengthy and heated discussions about the issue, and after many conversations with Yolanda exploring her reasons for leaving the building and assessing her understanding of the degree to which she was exposing herself to risk, the staff finally agreed to a middle road. They reasoned that they could respect Yolanda’s choices without necessarily abandoning her to the ravages of illness or the dangers of the street. After having determined that Yolanda appreciated the risk she was taking each night that she left the building after dark, the staff brainstormed with her what steps could be taken to minimize the risks she took in doing so. What did other women do who needed to be out by themselves after dark? First, the staff took Yolanda to a store so that she could buy a rape whistle and a can of pepper spray. Once she realized that the staff were taking her wish to continue to take late night walks seriously, Yolanda shared with them that she was in fact frightened at times and that she would like to know how to take better care of herself in such situations. As a next step, Yolanda then asked the staff if they would transport her to a self-defense course for women at the local YWCA, for which she promptly registered.

While her late night walks did not stop, the staff felt better about having done everything that they could think of and that was within their power to ensure Yolanda’s safety while honoring her autonomy. As a result of these efforts,

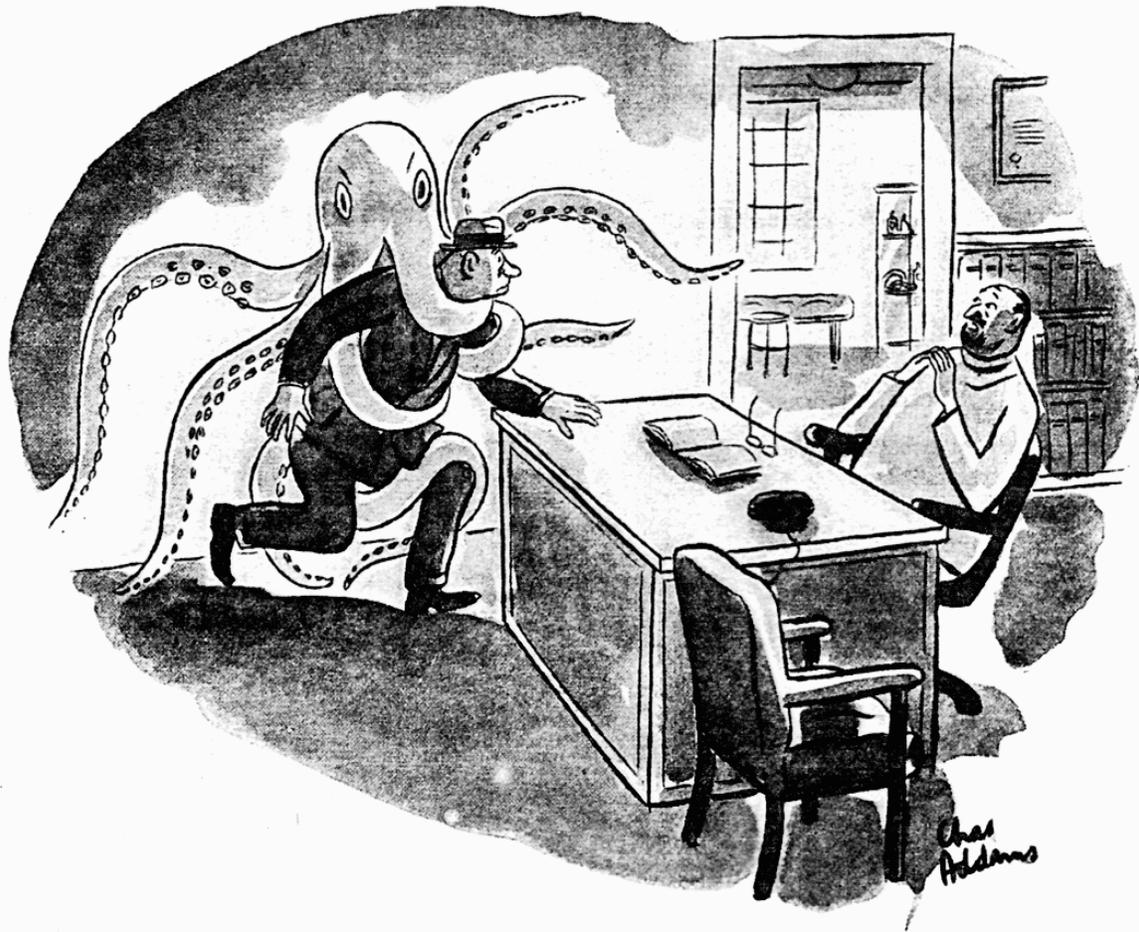
Yolanda's levels of trust in the staff and engagement in the program increased, she acquired new skills in self-defense, and she met potential new friends outside of the mental health system. For their part, the staff channeled their continued fears for Yolanda's safety and their anxieties about the liability they bore by making sure that they documented their conversations with Yolanda, her decisions, and the steps they had taken in all the appropriate places and, with Yolanda's permission, by discussing her situation with the local police and asking them to keep an eye out for her in their late night rounds. While she still will not tell the staff where she goes at night or why, she does report that she has become somewhat friendly with the cops who are on the night shift.

What you will hear from people in recovery when you are offering safe and trustworthy care:

- *I had always been under somebody's thumb. I learned to "behave" to get what I wanted and needed. I did what the money manager said, what the doctor said, and what the house manager said. I did it for everyone else but ME. So, I never learned how to do it on my own. But now I'm in a program where my case manager pushes me to try new things and to take responsibility for my life and my recovery. I get to make decisions, and they may not always be good ones. But my case manager is there for me to pick me up and help me try again. Two steps forward, one step back, but I'm getting there.*
- *I vowed after the last time that I'd never go back to the hospital. I remember "going off" in the ER because I was trying to tell them my little girl was gonna get off the bus and there won't be nobody there to get her. But they didn't understand me 'cause I wasn't right at the time. I told my therapist about this and me and her sat down together and made a list of everything I gotta do and take care of as a mother if I can't be there for my girl. And then she put that in my chart. If there ever is a next time, at least I know my baby will be OK.*
- *After my father passed away, I started to have terrible flashbacks of the abuse I suffered at his hand as a child. I had always thought that when he was gone, I'd finally be at peace. But, everything in my world just fell apart after he died. The abuse was all I thought about. I had been clean for two years, but I turned back to booze and drugs - totally lost control. I ended up in the hospital after an overdose. But when I woke up, there was my therapist, sitting right by my bedside. I heard later that she tore into the ER staff when they strapped me down to a gurney because I guess I lost it. I had shared with her the darkest secrets of my abuse, and she made damn sure I didn't have to re-live that in the hospital.*

- *I ran out of money last month and I couldn't come up with the rent. I admit, I was using and I blew a ton of my check on dope. But I was about to get kicked out of my apartment and I had no place to go. I told my case manager. I thought for sure he'd rat me out to my PO, but I didn't have no choice. I needed help. My case manager didn't rat me out... didn't even lay into me. He just laid out the options – what I had to do to get out of the jam. He helped me get back into rehab and worked out a plan with my landlord. Now I feel like I got a fresh start...*

The Importance of Not Overlooking the (not so) Obvious



“Now just sit down and tell me what seems to be the trouble.”

