

Handouts and Reference Materials from Mark Ragins, MD

I have enclosed in this packet several short documents that highlight various aspects of recovery based transformation...

- 1) Recovery Oriented Service Delivery
- 2) Staffing FSPs

If you would like more detail, I have written several longer documents that contain almost all of the details and stories in my presentations. You can find these on the MHA Village website at www.mhavillage.org at dr. "mark's writings."

- 1) A Road to Recovery
- 2) A Guide to Mental Health Transformation on a Personal Level
- 3) Proposition 63 Begins: The Mental Health Services Act Implementation Toolbox
- 4) Building MHSA Programs

As you will see, the website contains my writings over a number of years. I try to add new articles as I write them. For more information on the MHA Village, peruse the website! You can also check out www.mhala.org.

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Recovery-Based Service Coordination

By Mark Ragins, MD

Recovery based programs pride themselves on treatment planning and service delivery that is “consumer driven.” We don’t assume we know what’s best for people. We don’t tell them what they have to do or limit our help to what we think is right. We try to support them as they find their own path to recovery.

But the day to day reality isn’t that straightforward. We don’t actually support every goal people might create – for example killing your family or using lots of drugs while we pay their rent and help them get off when the police catch them. We do try to persuade people do what we think would be helpful. Sometimes, like with payees or medication management or hospitalization we even coerce people. We do have some overall vision for what we’re trying to accomplish we’re trying to sell to people.

Reality is closer to “value driven and consumer centered.”

We have some values that are socially driven, like cost containment, not bothering the neighbors, helping out the police, and increasing the safety of our community. We need to promote these values to stay in business. We have some values that are Quality of Life driven like housing, staying out of jail and hospitals, finances, employment, education, physical health, etc. These values are incorporated into our Outcomes and we’re held accountable for them. We also have some values that are recovery based. We want people to recover. We’re trying to be accountable for recovery progress with the Milestones of Recovery tool.

Service coordination at its best is an effort to promote those values along a path that is centered on each person’s choices.

In the same way that traditional mental health programs prescribe certain treatments based upon people’s diagnosis and case management / rehabilitation needs, recovery-based programs base their services upon people’s recovery stage, quality of life goals, and society’s needs. When we get into disagreements with the people we serve about what service they want, we can regroup ourselves by asking which of the three value sets is generating the conflict. Do we disagree about what would promote their recovery at this point? Do we disagree about how to pursue which Quality of Life goals at this point? Or do we disagree about what is socially acceptable?

Often we’re least sure about where someone is in recovery and how to help them progress.

The Milestones of Recovery tool was designed to help staff reliably describe where someone is along their recovery path. It was built around three dimensions: 1) Risk – Presumably you’re in an early stage of recovery if you’re at high risk for more damage. 2) Engagement – This doesn’t mean “compliance with staff treatment and meds.” This means connected with other people around the process of rebuilding. Presumably you’re

not very far along in recovery if you're seriously suffering but not connected with anyone trying to work to improve. On the other end, presumably if you're far along in recovery you don't need much professional help and can successfully live with natural supports.

3) Skills and supports – Presumably the more skills you have the better, while the supports you need keep progressing.

As people move through each milestone of recovery their service needs change in all three dimensions: Risk, Engagement, and Skills and Supports. Being aware of where people are in their recovery process can clarify how to handle common conflicts. For example, if someone wants you to drive them somewhere and you want a life coach to teach them how to take a bus to get there, it helps to know what their skills and supports are. This also applies for if they want to be their own payee and you don't think they're ready. On the other hand, if you want to hospitalize someone or give them a life coach for overnight crisis support and they think they can manage on their own, the issue isn't just skills and supports, but also risk. This may also apply for getting off medication management. When they complain that you used to buy them lunch and now you won't, it may be that their level of engagement has changed.

Note that these recovery based considerations do not give you authority to override the person's choices any more than clinical considerations did. They are a way of clarifying the collaboration for both of you.

Pursuing quality of life goals may require different services depending on someone's progress in recovery. It's not that they can't pursue certain goals, for example employment, until they've achieved more recovery. It's that the way to pursue their goal changes. For these purposes let's simplify the 8 Milestones into three groups, irrespective of their diagnosis: 1) "unengaged," 2) "engaged, but poorly self-directed," and 3) "self-responsible."

People who are "unengaged" generally do not collaborate in their recovery. They might refuse all treatment, come in irregularly during crises, only want charity and entitlements but not treatment, or be brought into treatment repeatedly or involuntarily for being dangerous or disruptive. People who are "engaged, but poorly self-directed" might want to collaborate in their recovery, but have trouble coordinating the services they need. They may miss appointments, take medications poorly, abuse substances, or have poor skills or support. They need someone to help coordinate their services. People who are "self-responsible" not only collaborate in their recovery, they can coordinate it.

The three groups are not dependent entirely on consumer traits. System traits, primarily "engageability" and "directability," also affect who is in which group. For example, there were many people who went to the Mental Health Association's Homeless Assistance Program who wouldn't go to a local mental health clinic to make appointments and get medications. However, when I started handing out pills at HAP's drop-in center, most of them wanted to take pills. They weren't really "medication resistant." They were "clinic resistant." When I changed the "engageability" of psychiatric services, many of them changed from "unengaged" to "engaged, but poorly

self-directed.” Similarly, it is far easier for consumers to coordinate their own services if they are available at one site in an integrated services program, instead of scattered in several separate systems.

Keep in mind that every service is designed to help the person grow into the next stage. For example, you can meet the housing needs of an “engaged, but poorly self-directed” person with a Board and Care by adding structure, making decisions for people, and taking care of their needs, but this is unlikely to lead to them growing into the “self-responsible” stage. On the other hand, supported housing where you provide for their needs in an apartment setting while training them to do it for themselves both meets their housing needs and is likely to lead to growing into the “self-responsible” stage. All services should be seen as “transitional” but rarely strictly “time limited.” Transitions are likely to lead to the most conflicts as services change. It can sometimes help transitions if staff have been talking about them from the outset, so they’re not surprised. Although transitions can be gradual, staff have to change to keep working with people moving forwards alongside them as they progress.

For each stage there is a key service delivery question: For “unengaged,” it’s “What’s the engagement value of this activity?” For “engaged, but poorly self-directed,” it’s “What’s the rehabilitation value of this activity?” And for “self-responsible,” it’s “What’s the community integration value of this activity?”

Here’s some concrete examples of how services can be differentiated so people can successfully pursue their goals at any stage.

Program Differentiation:

Employment:

Stage 1: day labor, “work for a day – house for a day”

Stage 2: agency businesses, supported employment including job development and coaching, group placements, supported mental health employment

Stage 3: non-disclosure competitive employment job development, competitive mental health employment

Housing:

Stage 1: hospitals, IMDs, vouchers, SROs, crisis residential, family

Stage 2: Board and Care, drug treatment programs, sober living, supported housing, master leases, IHSS, family

Stage 3: independent living, ownership

Finances:

Stage 1: small grants and loans

Stage 2: interim funding, rental subsidies, payee, grants and loans, agency savings accounts

Stage 3: grants and loans, community bank accounts

Substance Abuse:

Stage 1: harm reduction, motivational interviewing, DDA meetings, referrals

Stage 2: harm reduction, motivational interviewing, DDA meetings, drug treatment and detox programs, sober living, 12 step work

Stage 3: relapse prevention, ongoing 12 step work, giving back

Therapy:

Stage 1: engagement, empathy, crisis, drop-in groups

Stage 2: supportive, strengthening, cognitive, relationship, “corrective emotional experiences”, drop-in groups

Stage 3: appointment based individual or group, dynamic, uncovering, self-help (including creating WRAP, advanced directives)

Medication:

Stage 1: med exploration, med trials, high flexibility and accessibility

Stage 2: med management, long acting injections, high flexibility and accessibility

Stage 3: self- management, regular appointments

Social:

Stage 1: “accepting” environment in the program, peer outreach, staff organized activities

Stage 2: peer networking, supported socialization

Stage 3: community development and integration

Education:

Stage 1: exposure

Stage 2: supported education, agency classes

Stage 3: career development

Crisis response:

Stage 1: outreach, crisis walk-in, meet practical needs while engaging, collaborate with coercive services diverting when possible

Stage 2: home visits, crisis walk-in, 24 hour emergency hotline, peer run warm line, coordinate support services in the community, “life coaches”

Stage 3: peer support, peer run warm line, coordinate natural supports in the community, utilize self-directed crisis plans (WRAP, advanced directives)

Services should be chosen by recovery stage, not by what's easiest to access at the time. Mismatching recovery stage and service, or lacking some of these services, make it harder to promote successful outcomes.

It is possible to collaborate with other agencies to provide more services, but usually not in Stage 1, only when facilitated by a case manager in Stage 2, and independently coordinated by the consumer using referrals only in Stage 3.

People are usually in the same stage for every service they're receiving, because their stage reflects how far they've come in recovery, not how far they've pursued any particular goal area. These stages are not intended to be used as prerequisites for each other. People should use whatever stage's services they're in at the time. Some people may resist moving on even when they are able.

Notice also that these aren't the only services possible to offer. This is just a list of what we've tried at the Village. I had an interesting conversation with a woman in a planning workshop trying to apply my recovery planning stages to assist the battered Hispanic women she works with (Unengaged – collocate a mental health worker and a recovered peer at the church where these women come to talk to the priest and at the ER where they come for medical treatment for their beatings; Engaged but not self-coordinating – have a mental health worker stick with these women in a motivational interviewing approach when they return to their men and when they're ready, walk alongside them through the steps necessary to escape the abuse and recover; Self-Responsible – have a work sheet of the steps to take and the resources available and a recovered peer to offer support along the way.)

When delivering services, it's important to focus not just on what's done, but also how it's done. The values behind the practices are crucial. Some values, like consumer inclusion, hope, empowerment, choice, self-determination, pursuing quality of life goals, experiencing non-patient roles, and individualization of services are important throughout treatment and some are more important in certain stages of recovery.

Value differentiation:

Stage 1: Unengaged

- There's "No Wrong Door": People shouldn't be expected to understand our system design well enough to go to the right place for what they need themselves. Every entry into the system ought to lead to every service and it's the responsibility of whoever greets them as they come in the door to get them successfully to the right place.
- Everyone is welcoming: Too often we focus on our tasks of gate keeping and rationing, before we make new people feel welcome. If new people are seen as

unwelcome additional burdens by staff they are unlikely to greet them with open arms.

- Create a “counterculture of acceptance”: Most people with serious mental illnesses (and substance abuse experience a lot of rejection from our community. To be helpful, our programs need to accept people that outsiders may not. This is not to say we should tolerate being abused or injured, but many people need a sanctuary of sorts, a place to let down their walls and work on recovering.
- A good treatment is built on a good relationship: Use everything possible to build relationships including charity (e.g. listening, respecting, doing things for people, self-disclosure, sharing non-treatment time and activities).

Stage 2: Engaged, but not self-coordinating

- Support, don’t care-take: Staff are often needed intensively to facilitate people getting services and needs met. This is done with the person not for them, while teaching them the skills to be able to think it through themselves and do it themselves. People will often prefer things being done for them, but that doesn’t promote self-responsibility and recovery.
- Services are mobile: Their lives, their problems, and their goals are in the community not in our offices, so we need to be out there too. Build skills by doing things together where they need to be done, not by talking about how they’re done in the office.
- Services are accessible: These people have serious problems coordinating things, including our appointments. The needed flexibility usually requires a team working together so there’s a better chance someone is available
- Integrate services into a “one-stop shop”: Having personal relationships with multiple service staff makes it more likely they’ll actually access the services they need.
- Be a “no fail” program: Instead of rejecting people or taking over their lives when they do things wrong, focus on how they can learn from their missteps and what changes they need to make. Instead of closing their case when they don’t show up, do assertive re-engagement. Go out and find them.

Stage 3: Self-Responsible

- Create natural, community supports and roles: It’s important to work ourselves out of a job. We want to help people find friends to support them, to find places to belong besides with us, to have more meaningful roles in their lives than being good patients.
- Promote self-help: We should teach people skills to manage a variety of symptoms and to get their needs met and connect them to other people in recovery who can support each other.
- Encourage people to “give back”: No longer should they be just “consumers” of services. They can give back to our programs and to others in need. They can be role models bringing hope to others. Some even pursue mental health employment.

- Encourage mental health advocacy: Not everyone will want to promote the recovery movement or even disclose their illnesses outside our programs, but those who chose to can have a profound impact on stigma and the community's perception of mental illnesses.
- Create "graduation" rituals and services: It's important to have a positive exit from the system (even for people who continue to take medications), but there are serious personal issues for both the people taking the risk of moving on and for the caring staff they leave behind that need to be addressed. We need to remember that full recovery is far more common, and far more realistic, than we imagine.

A recovery program can create flow if it pervasively emphasizes growth and movement forwards. This helps both by moving people to higher levels where they do more for themselves and by "graduating" people. Flow and service rationing are inversely related. The more flow we create the less rationing we need. The less flow we create the more rationing we need.

While it may be easier to give a man a fish than teach him to fish, only the teaching creates self sufficiency and flow.

Staffing Full Service Partnership Teams (2006)

A substantial portion of the new adult Community Support Services money from the Mental Health Services Act will be going to create new Full Service Partnership Teams. Full Service Partnership (FSP) is a new name designed to build on the concepts of ACT teams and Integrated Service Agencies without constraining ourselves within those models' definitions. FSPs are considered a powerful part of system transformation because they target resources to those people in highest need, they facilitate outreach if needed to help engage people, they accommodate people who do poorly with appointment based services, and they are able to incorporate quality of life support services and funding. Those are all features that are weak in our present system that the transformation is trying to improve.

To actually run a FSP will require programs to create teams that include both present staff in altered roles and new staff. Many of our present clinics run more or less as a group of individual practices with each professional staff responsible for their own caseloads and the services they provide, with only limited sharing of clients and teamwork. Therefore, creating teams will be a change for many current staff.

Creating teams offers a number of potential advantages:

- 1) No one staff is capable of assisting people with the entire range of quality of life services - from employment to housing to money management to health care to legal assistance to family support to education to benefits assistance to substance abuse assistance to community integration - they may need. Without a team people are likely to be offered only whatever services the staff they are assigned to feels comfortable with providing leaving their other needs largely unmet. It is possible for a team of staff to assist people with the entire range of services if the team is carefully assembled.
- 2) If more than one staff member is familiar with each client, it is possible for their primary staff to be serving someone else in the community and still have another staff available to assist them. This makes it possible for staff to combine community, appointment based, and walk-in services.
- 3) If staff are assembled that are not just a multidisciplinary team, but also a multi-experiential team they will be able to engage and work with a wider variety of people than any one staff member could. For example the team can include someone that works well with paranoid people, psychotic people refusing medications, actively substance abusing people, drug dealers, depressed, hopeless, unmotivated people, dirty, smelly people, women who won't leave battering men, men who batter women, prostitutes, pimps, thieves, and

people with severe personality disorders. It would take a saintly staff member to engage and work with all those people successfully, as we are now expected to do. It is more realistic to expect a team consisting of a variety of caring staff to work together to create a counterculture of acceptance able to engage and work with all those people successfully.

4) Recovery work often depends on staff taking on a variety of roles besides clinician so that the people being served can take on a variety of roles besides chronic mental patient. Recovery work also often depends on staff creating more adult-to-adult relationships with the people being served while including emotional connectedness, guiding, and healing into these "friend-like" relationships. Both of these tasks require altering the traditional roles and boundaries rules that were constructed to protect both staff and clients in private practice, office-based, professional and psychodynamic treatment settings. In order to alter these rules while maintaining strong ethics, and personal, emotional and physical safety staff must work in teams. Teammates are needed to dilute transference relationships, give each other emotional strength in times of need, watch each other's backs to avoid ethical lapses, and protect each other emotionally and physically. If a team creates a strong emotional and ethical matrix, boundaries and roles can be safely lowered and healing relationships dramatically increased.

However, creating teams also has its challenges:

1) Many staff and clients prefer individual work. They like the additional privacy and sense of intimate safety that comes with a good individual therapy relationship. It feels easier to open up emotionally. Trust is built that isn't easily transferred to other staff. It can be difficult for staff to convince new clients of the advantages of a team milieu especially if they don't believe its better themselves.

2) Many staff are working in programs where they don't really like or trust many of their teammates. Hiring doesn't generally have much input from the people who have to be teammates with the new staff. Firing or reassignment are often more dependent on civil service rules, unions, or administrative needs than on compatibility of teammates. While on paper teams have a variety of important strengths, in practice they can easily deteriorate with personal conflicts, antagonism, and form factions.

3) With high work loads, that sometimes feel like being stuck on a conveyer belt, staff may prefer to try to get their own work done as best as possible rather than create a system of shared responsibility that they have less comfort with and control over. Many staff feel that some of their coworkers are slackers likely to give them extra work without reciprocation in a shared system. Staff are also afraid of being cast in the slacker role so they're unlikely to ask for help from their busy coworkers even if they need it, and more to the point, even if their clients would benefit from it.

4) Our programs are generally set up with professional differentiation. Each profession values their particular skills and identity. They tend to have their own treatment schemas, languages, processes, and goals. For someone to be qualified to supervise their work properly the supervisor needs to be of the same profession as the supervisee. Therefore, teammates usually are not accountable to their team leader as much as to their professional supervisor which can badly weaken the team itself. There is a large resistance to altering this structure because it feels like a direct attack on the professions themselves and the inherent value professional roles bring to staff.

5) It may be difficult for staff with substantially different educations, salaries, and experience to act as "classless" teammates. Often internal hierarchies will be formed with some staff expecting other, "lower" staff to work for them. There's a classic definition of teamwork as "a group of people doing what I tell them to" that captures this issue.

A FSP is likely to incorporate four groups of people into its teams who have not often been teamed together before: Psychiatrists, paraprofessionals, consumer and family member staff, and licensed clinicians. Each of these groups brings their own gifts that would be missed without them and each brings their own challenges.

Psychiatrists:

The time when psychiatrists were fully included on teams in CMHCs, including many in leadership positions, is long past. While decreasing the number of and roles for psychiatrists may have been initially driven by cost cutting concerns, we are now at the point where there often aren't enough psychiatrists available even if funding were to be allocated. Psychiatrists have been so consistently relegated to isolated, highly reductionistic, exclusively medication oriented roles that there is very little desire to increase their roles or belief they would contribute substantially if they were more included.

The most obvious advantage of including psychiatrists would be to increase the probability of engaging people with medications. People are more likely to take medications if they have a good relationship with the psychiatrist or if another staff they have a strong relationship with accompanies them to their medication appointments. Since FSPs are designed to target poorly engaged people and they're designed to continue to work with people when they miss appointments and stop medications, instead of just discharging them, this is an important concern.

The most obvious challenge to including psychiatrists is professional differentiation. It is difficult for psychiatrists to be comfortably supervised by non-psychiatrists and there is a tendency for psychiatrists to expect to automatically be at the top of the hierarchy like

other physicians rather than be true colleagues. The relationship between the team leader and the psychiatrist is crucial.

Beyond those issues, however, are other challenges unique to psychiatrists. First is the high caseload expectation. It is difficult for any person to keep track of more than 150 people's stories and relationships in their head. Every other staff routinely has a caseload less than 150 whereas almost every community psychiatrist has a caseload larger than 150. The two most common ways of dealing with this are for psychiatrists to focus their attention very narrowly on the illness part of the person and to use the chart as a memory crutch. Both of these widespread practices are likely to be harmful to the people being served. In addition, trust is usually based not on an actual relationship between the two people, but based on the doctor role itself: "Trust me. I'm a doctor." A well functioning team can serve as a memory and relationship extender for the psychiatrist and promote real trust.

Second, is the difficulty differentiating between symptoms and feelings. If a psychiatrist only gets to know, and only writes down to remember, features of the illness, they are more likely to diagnose feelings as symptoms and treat them with medications instead of addressing emotional or life circumstance issues. Many people find it easier to take a pill than to make emotional or life changes and willingly collude in a "medication only" treatment plan. Unfortunately, it's only rarely really successful. For people not willing to collude in labeling feelings as symptoms, we often accuse them of lacking insight and being noncompliant and the psychiatrist simply doesn't know the person well enough to offer what they want. A well functioning team can assist with the information needed to make differentiations between symptoms and feelings and assist in helping people work on their lives.

Third, psychiatrists routinely have ultimate legal and medical responsibility for people even if they don't know them very well. This is likely to lead to caution, self protection and risk avoidance. Decisions ranging from involuntary hospitalization to employment to child custody to becoming your own payee are likely to be affected. Usually this protective bias hinders recovery. The team can make more group decisions and share responsibility. In crisis situations every team has an "emotional core" person they can turn to. If this person is not the psychiatrist, there may be a conflict between emotional cohesion and following the psychiatrist's medical orders. Who the team really trusts and whose decisions get implemented may be different people.

Paraprofessionals:

There is a substantial resistance to hiring more paraprofessionals instead of more licensed clinicians. Hiring people with "just" Bachelor's degrees or "life experience" feels to many professionals like we're "dumbing down" our staff. They argue that since we're focusing on

people with very serious, persistent mental illnesses we need the most clinical training and expertise we can get in our staff.

Within the medical model paraprofessionals have serious liabilities. They don't know how to do diagnostic assessments. They have limited understandings of psychopathology and psychodynamics. They can only bill for certain services and often need the licensed staff to cosign their notes. At best, they are likely to be viewed as helpful underlings or "go-fers."

Within a recovery model paraprofessionals serve two crucial roles: Generalist "case workers" and specialist support service providers.

Whether they're called case workers or community workers or personal service coordinators, their two main functions are engagement and coordination/skill building. Being able to engage someone is sometimes a clinical skill, but more often it's a personal skill. Staff must be able to accept people who would normally be rejected, open their heart to people, and have a willingness to connect with people instead of distance themselves from them. It's easier to create a true counterculture of acceptance when paraprofessionals are included to increase hiring choices and staff diversity. Less experienced staff may need help from more experienced staff to preserve their emotional strength and maintain strong ethics without distancing and dehumanizing. Coordination/skill building often requires going into the community doing things alongside people while teaching them how to do it themselves. People may need help coordinating an enormous range of things from grocery shopping to Social Security benefits to employment interviews to their love life. Many licensed staff are reluctant to perform these services because it's not what they were trained to do or because it's unprofessional or even because they're just not very good at it. Engagement and coordination/skill building are not "lesser" services. They are core recovery services.

A FSP should include a variety of specialist support service staff like housing, employment, education, substance abuse, community integration, money management, and family support. These jobs require a high level of specialized skills which are not often taught in the usual professional training programs. Staff will usually have learned these skills through life experience or on the job training. It is usually not very effective to have staff without these specialized skills try to do these jobs even if they have other professional training.

There is a choice of whether to have these staff included as full team members or as attached specialists. There is also a choice of whether to have these staff relate primarily to clients or to the community.

Consumers and Family Members:

When consumers and family members are included in the team there is a choice whether to have them work in designated consumer and family positions or as paraprofessionals. A program may have consumers and family members hired as peer advocates or as consumer and family representatives to insure inclusion of consumer and family perspectives or to provide peer support services, but those are unlikely to be full FSP team members. FSP team members will likely have the same generalist and specialist roles as other paraprofessional team members.

There are substantial risks involved in creating designated consumer and family positions. They may be treated as second class employees rather than as equal teammates. There is a risk of low expectations and other staff caretaking them. If instead, they are treated the same as any paraprofessional staff (or even professional staff if they have professional training) they will break down the "us vs. them" boundaries and we will all become less stigmatizing. They should be hired, not out of pity for their disabilities or struggles, but out of respect for the added strengths and skill sets their "life experiences" have given them. The relevant qualification is not a documented diagnosis or open case in treatment, but rather the ability to use past experiences and self disclosure to help people. As with any person with a disability, they may need accommodations to perform their job, but they shouldn't have lower job expectations or demands. Consider how differently we treat a blind colleague than a mentally ill colleague. Consumer or family status is not an excuse for substandard work.

It may be helpful to have a consumer or family member mental health worker training program to increase the qualifications of new consumer or family staff. Some of this can be combined with other paraprofessional training programs or on the job orientation and training, and some can be separated out, especially for unique "consumer" or "family" issues (e.g. self disclosure, changing self identity and roles, Social Security benefit changes, and not expecting everyone to need the same things that helped you.) Special attention should be paid to helping consumer and family staff not reenact their own harmful treatment experiences as either victim or perpetrator. Programs may want to have volunteer, transitional employment, or training positions for consumers or families to prepare them to be staff (permanent staff who are identified consumers or family members can contribute unique supervision and support), but overlap between people's treatment providers and their mental health employment may create substantial problems. Therefore, the more separation between the two sites the better. Treatment providers are encouraged to advocate for, coach, and support the people they are serving who are working in mental health, just as they would any employment, but hiring of consumers or their families by the same team that is serving them should be limited to temporary engagement, exposure, or training positions. Permanent employment should be separated. Once they are hired as permanent staff, it's preferable to treat them as responsible equals.

Staff who have mental illnesses themselves or who have family members with mental illnesses may freely choose whether to disclose that information universally, selectively, or not at all. Although there are clear benefits for the people being served from staff disclosure including increasing hope and decreasing stigma and the walls between us, disclosure is entirely a personal decision. Staff should not be pressured to disclose. In addition, supervisors and co-staff should not discriminate against or hinder someone because they have disclosed and acknowledged their role as mentally ill consumer or family member. They must be treated with respect as a colleague. Demeaning them or creating a hostile work place for them should not be tolerated.

Licensed Clinicians:

Although many licensed clinicians admire and are touched by the goals and values of the recovery movement, most will also perceive it as a clear threat to their way of life. The role of therapy seems to be being transformed from one of our most essential, mission defining services (perhaps second only to medications) to a vague activity to be incorporated into other services. Many therapists may resent being asked to be therapeutic outside of the usual parameters of office based individual and group therapy and being asked to work in ways that are often contrary to what they were taught. A range of fears, including physical and emotional danger, ethical concerns, malpractice claims, inability to bill productively, and loss of effectiveness are likely to emerge. Although standard therapy formats may have limited effectiveness and be unusable by many of the people we serve, they are comfortable to therapists and feel safe. They are also what they have been trained to do, have mastered, enjoy doing, and value. Therapy has been internalized into their identities: "We are therapists. What will happen to us if therapy isn't what we do?" A true personal transformation is being forced upon them.

Transformation requires three steps: breaking down, adding new features, and reforming.

Step 1: Breaking down involves looking within the practice to find the values and functions. Staff came to the various licensed professions for a variety of reasons, trying to accomplish a variety of things, and hopefully found ways to be fulfilled and of service within therapy structures. Therapy structures may not be essential for fulfillment and service, but they are how they're commonly achieved in our present system.

What services actually require regular, individual or group, appointment based structures? Many "targeted," "manualized" therapies claim they do (for example, EMDR, CBT, DBT, behavioral desensitization, trauma groups, skill building, and psychoeducation). To be fair though, most experienced therapists don't practice "manualized" therapies. They've made adaptations to the techniques, pick and chose what fits their personal styles, and incorporate them into a more "eclectic" long term, supportive therapy structure. Transference based psychodynamic therapy, for example, has evolved to depend more on

training people to be conscious of their psychodynamic patterns and making interpretations than on creating and resolving true transference regressions. Recovery isn't asking for the abandonment of these techniques, but it is asking for new adaptations, picking and choosing, and incorporation into an "adult-to-adult," "friend-like," case management relationship.

Most therapists are able to safely and comfortably have a variety of fulfilling, helpful friendships outside the therapy structure. Therefore, at least theoretically, what recovery is asking for is possible. Friendships, like recovery relationships, aren't relationships without boundaries. They have different boundaries than therapy structured relationships that are often individually developed depending on the person.

Step 2: We're adding two new features: 1) Instead of using long term, supportive therapy as the underlying, relationship maintaining matrix to incorporate our therapeutic techniques, we're using the same engagement and coordination/training the paraprofessionals are doing. This helps us achieve a variety of quality of life goals and help people build community based skills and supports while achieving therapeutic goals and healing. 2) We're being flexible enough to maintain relationships with people who would normally drop out of appointment based individual or group therapy and be lost to us or require coercion to re-engage.

Step 3: We're reforming a new "therapy - case management" role. We can address all those fears (including physical and emotional danger, ethical concerns, malpractice claims, inability to bill productivity, and loss of effectiveness) within our transformed roles and create new protections and comforts while preserving the old fulfillments and services.

Licensed clinicians also have to perform a variety of tasks to keep the entire team functioning. They are usually responsible for doing intake assessments and triage. They have to oversee treatment planning authorization and documentation. Often, though not necessarily, they are the administrative and emotional leaders of the team. They may have supervision, treatment modeling, and teaching responsibilities as well.

They also have a responsibility to create a "therapeutic milieu." In the not terribly distant past, there used to be something called "milieu therapy" that was included in almost everyone's treatment plan. The idea was that the staff, in addition to performing individual services, together created a healing environment for the people being served. Under pressure from budget accountability, medical reductionism, high case loads, risk avoidance, poor building maintenance, and even professionalization "therapeutic milieus" have almost disappeared from our community clinics. Most simply do not have a very welcoming or healing feel to them.

FSPs, because of their flexibility to accommodate drop-ins and because of the intensity of services and relationships can create internal healing cultures - like a group therapy without any set hours - that aren't generally possible in standard outpatient settings. Licensed clinicians can bring special skills to help create a healing environment. Some of this work is done directly by being part of the environment (for example, by helping to maintain relationships with difficult people, providing "corrective emotional experiences," and training people to be conscious of their psychodynamic patterns and making interpretations) and some of this work is done indirectly by supporting teammates (for example, by consulting and educating, sharing countertransference reactions, building team cohesiveness and emotional strength).

Like the paraprofessionals, many of the licensed staff will bring specialist skills and services (for example, medication management, health care, crisis management, specialized assessments, community advocacy and development, and rehabilitation) that can be accessed by all the people on the team.

FSP Staffing Patterns:

When we've put together all these ideas, we've found that the overall "staff items" making up the teams have changed. Compare these two sample 100 member FSP staffing patterns.

"Traditional-Clinical" FSP team	"Recovery-Based" FSP team
1 Psychiatrist	1 Psychiatrist
1 Supervising Social Worker	1 Team Leader (Supervising SW, psychologist or MH RN)
3 Psychiatric Social Workers	1 Psychiatric Social Worker or 1 RN (depending on leader)
1 Mental Health Counselor RN	1 Psych Tech or nurse aid
1 Psychologist	5 Case Managers (may be consumers, case workers, or community workers)
2 Medical Case Workers (one housing, one employment)	1 Housing specialist
2 Peer Advocates	1 Employment Specialist
	1 Benefits Worker/ Financial Planner
	2 Outreach workers (one licensed, one consumer, case worker, or Community worker)

(Both teams cost about the same \$900,000.)

Notice the following differences:

1) We've define our recovery-based staffing pattern by roles rather than by allocated quotas for each profession. This is especially relevant for jobs that aren't really taught in any professional school (e.g. team leader, housing specialist, employment specialist, and outreach worker). Hiring by profession could easily get you stuck without the needed skills. Incidentally, the State MHSA Workforce Development Committee has already taken the approach of looking at function instead of profession too.

2) Consumers are integrated into the team, hired because of their skills, rather than as segregated, potentially second class employees.

3) Because of cost savings by decreasing licensed personnel three addition staff could be hired. That dramatically decreases the case loads. For example, if you decide that the team leader, psychiatrist, housing specialist, and employment specialist don't have case loads, but the nursing staff, financial planners, and outreach workers do, and that this team has 100 members, the "traditional-clinical" caseloads would be 14 and "recovery-based" caseloads would be 10. Another way to look at that is that the "recovery-based" team could have a specialized financial planner and half sized case loads for the nurses and the two outreach workers and still have the same caseload as the "traditional-clinical" team.

Implementing FSP teams with staffing patterns like those on the "recovery-based" side of the table will present substantial challenges to Human Resource Departments creating job descriptions and to Unions advocating for their professional guilds.

As I reread this paper, part of me feels somewhat overwhelmed by all the changes we are asking people to make, but part of me also feels excited by the prospect of being able to help a lot of people who have fallen between the cracks. For me, that's what this transformation is all about.