

Emerging Challenges and Innovations in Recovery

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3 Essential Recovery Transformations

- 1. *Person-Centered:*** Moving from centering our efforts on the treatment of illnesses and the reduction of symptoms to a holistic service of people and the rebuilding of lives
- 2. *Collaboration:*** Moving from professional directed relationships emphasizing informed compliance with prescribed treatments to individualized relationships emphasizing empowerment and building people's self responsibility
- 3. *Resilience:*** Building hope for recovery upon each person's strengths, motivations, and learning from suffering rather than upon the competence of professionals and medications to reduce or eliminate the burden of their illnesses

The Role of Recovery is Expanding

From its roots in the consumer movement, dual diagnosis, and rehabilitation, recovery has expanded productively into many other areas.

- “high utilizers”
- Jail and homeless diversion
- Transitional age youth
- Older adults
- Health and wellness
- Collaborative medication services
- Trauma informed inpatient services
- Culturally sensitive outreach and engagement

Elements of a Mature Recovery Based Program

1. **Leadership** – consistently focused on recovery and based on bottom-up input
2. **Amplify consumer voices** – basing decisions on consumers' direct experiences
3. **Focus on positive psychology** – hope, resilience, strengths, creativity, community building, supportive spirituality
4. **Working in partnership** – staff in life coaching roles, motivational interviewing, shared decision making, self-directed care
5. **Person centered planning** – goal driven, rebuilding life focus
6. **Symptom self management** – WRAP, DBT, family education, advanced directives, CBT, DBT, hearing voices training
7. **Community inclusion and social roles** – supported housing, employment, education, parenting, citizenship, anti-stigma
8. **Holistic wellness** – risk reduction, wellness activities, integrating primary care, integrated dual diagnosis, trauma, complementary health
9. **Peer role / peer support** – support groups, recovery education for consumers, peer counseling, warm lines, consumer operated programs
10. **Continuous self assessment / quality improvement** – staff learning culture

What's next for Recovery?

- 1) Applying recovery to **administration** – recovery oriented leadership, mentoring, supervision, and accountability
- 2) **Creating flow and graduation** to avoid overwhelming caseloads,
- 3) Expanding “strengths based” services to **building resilience and community**, and
- 4) Applying recovery to the **integration of mental health and primary health care**.

What do you think?

Recovery Oriented Administration

Staff should be treated by administration the way we want them to treat their clients.

Staff routinely complain that administrators don't "practice what they preach". Some of this is feeling administrators are too distant from daily work with clients and some is feeling that administration isn't done with the same values as expected from line staff.

Recovery Based HIPAA

- Write chart notes in a way that they can be actively shared with people without shaming them or damaging our treatment relationships. When people know what's in their charts they can also make better disclosure decisions and profit from those decisions.
- Actively work with people to take control of their illness and recovery narrative so its disclosure is not shaming or feared.
- Encourage and prepare people to take responsibility for consequences of their actions instead of relying on hiding from them and avoiding them. Help people make better decisions so there's less to hide.
- Work on decreasing stigma and prejudice both in our community and within the person themselves. Build acceptance of their illnesses, lives, decisions, and selves.
- Help people learn to trust us and others based on other factors besides the ability to keep secrets.
- Help people build healthy, interdependent relationships so they're less dependent on us and less fearful and avoidant of others who care about them.
- Help build a culture of mutual respect in our programs and our communities so people are less likely to victimize each other even when they have an opportunity to do so.

CREATING RECOVERY-BASED CULTURES:

RECOVERY-ORIENTED LEADERSHIP

1. Hope
2. Authority
3. Healing
4. Community Integration

What is recovery-oriented supervision?

Mentoring vs. Supervision

Relationships are the foundation for promoting growth and learning

Mentoring is a possible emotional relationship between the supervisor and supervisee.

To be effective the mentor has to see something of themselves in the mentee and the mentee has to see something they admire in the mentor.

Mentoring Tasks

- 1) Seeing a possible future for someone that they don't, because the mentor has a different perspective of the mentored person than they do of themselves, perhaps broader or more "mature" (or because the mentor sees their own "past self" in them).
- 2) Persuading the person of the possibility of that future.
- 3) Being able to open an opportunity to that future that they wouldn't have on their own.
- 4) Helping them recognize the changes that are going on as they pursue the opportunity as progress towards the vision.
- 5) Sustaining the effort of the person when they want to give up and not pursue the envisioned better future until they can sustain it on their own (at which point they can sustain it even if the mentor gives up on them, although that would end the mentoring relationship).
- 6) Maintaining the history of where they've come from and how much the change means.

Stages of Recovery Based Careers

- Student / Intern: Dialogue and relationship skills, Understanding impact of illnesses, Usefulness in goals, Poverty services
- Early Career: Collaborative medication, Trauma effects, Strengths based, Team work, Shared responsibility with clients, family impact
- Mid Career: Collect stories from “practice”, Develop “art” of treatment, Emotional engagement with stability and without burnout, community engagement, leadership
- Late Career: Numerous long term relationships / stories, Experience / patience, Mentoring

MHA-LA's Principles for Managing and Leading our Staff

- Trust and security: Managing fear without creating a culture of defensiveness
- Relationship based: Sharing our lives with each other and being more like a family than a business
- Hope and growth expectation: We expect our staff to grow and develop, no matter what level we're at
- Learning by doing and risk taking: Staff can try something new when we're "motivated and excited" not when we're "prepared and likely to succeed"
- Building a strong, purpose-driven culture of respect: Our purpose is to serve our members to help them have better lives the way we would want to be served
- Staff self-responsibility: Every activity has self selected, motivated line staff champions - initiators, developers, building buy in, and self evaluators

Learning Cultures: Expectations of Line Staff

- Understand the “big picture” top-down vision and purpose and incorporate “administrative concerns”
- Generate bottom-up concrete plans
- Support bottom-up leaders
- Generate time and motivation to implement plans
- Spend time in groups evaluating impact and making changes in plans
- Sustain process beyond leaders’ initial enthusiasm

Funding models

All funding models must include some “rationing”. We will never have enough money to give everyone what they need.

- Regulated care – governmental regulations determine eligibility and payment
- Managed care – business oriented case managers make rationing decisions
- Designed care - clinicians make service and rationing decisions

Managed Care

Designed Care

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|---|---|
| 1. Contracted managed care company is responsible for budget and services | 1. Treatment team/ Integrated Services Agency is responsible for budget and services |
| 2. Target population determined by diagnosis | 2. Target population determined by disability and social responsibility – may include “involuntary outreach and engagement” |
| 3. Medical model focus on symptom relief and treating illness | 3. Recovery model focus on helping people recover and integrate into community |
| 4. Menu of services predetermined- mostly traditional MH services | 4. Menu of services extremely flexible based on an individual's needs – may include “quality of life services” / “poverty services” |
| 5. Services usually time-limited in theory, but indefinite in practice | 5. Services growth oriented, usually of indefinite duration with some graduation |
| 6. Providers are a combination of government staff and contracted services- may be badly fragmented | 6. Providers almost exclusively program staff working as a team – strongly integrated |
| 7. Case managers have relationships to providers, act to restrict and regulate service delivery and increase "red tape" | 7. Case managers have highly personal relationships with consumers, act to access and regulate service delivery and decrease "red tape" |
| 8. Clinical and financial needs negotiated between case manager and provider | 8. Clinical and financial needs negotiated between case manager/provider and consumer |
| 9. Attempt to provide array or spectrum of services delivered according to predetermined set of regulations centered around "medical necessity“ | 9. Attempt to provide integrated, comprehensive services delivered based on ongoing assessment of client needs/wants |
| 10. Accountability for providing services authorized | 10. Accountability for consumer quality of life outcomes |
| 11. Clinical staff must obtain approval and authorization for service decisions | 11. Clinical staff empowered to make service decisions and accept responsibility for consequences |
| 12. Consumers and families use grievance process and appeal to impact program decisions | 12. Consumers and families directly involved in program development |

A culture that promotes flow and graduation needs to...

- Believe that growth and recovery is the expected, usual outcome.
- View “stability” as stagnation, an inadequate outcome.
- Have staff who are hopeful about themselves and instill hope in the people they serve.
- Emphasize possibilities instead of disabilities.
- Feel confident in their ability to promote growth and recovery.
- Focus emotions more on celebrating successes than on avoiding blame for failures.
- View setbacks as inevitable and opportunities for learning and further growth rather than as failures and reasons to give up.
- Promote growth oriented risk taking instead of risk avoidance.
- Believe that people will be able to manage after we’re gone.
- Focus on leaving people with a useful legacy since our role in their lives is likely temporary.

Promoting client flow “paradoxes”

- Promoting flow usually has negative impacts for staff and programs
- Relationship based services need to have relationship transitions to promote growth
- Focus on engagement reduces drop-outs but increases flow – “spillage” is not flow
- Client-driven services require using motivational interviewing skills to promote change and growth
- People often need to feel secure to have the courage to take risks to grow
- Stabilizing people and protecting against risk sometimes protects against the opportunity to grow
- People can grow and even graduate from services even with incurable conditions if they become resilient and self reliant enough.
- Effectively creating a “counterculture of acceptance” within a program instead of creating more accepting resources in the community decreases the odds of people leaving us.

Taking strengths seriously

- “I can already see in you the strengths you’ll use to overcome this tragedy”
- “There will likely be another [relapse, manic episode, breakup, etc.]. The question is if you’ll handle it without falling apart.”
- “Do you have the resilience to handle the unexpected?”
- “What “protective factors” do you have in your life?”

Levels of “Strength Based”

- Intellectual – “engagement,” collect life story, look for interests and skills, find non-patient roles in the hospital community, prepare for community roles
- Emotional – empathy, authentic caring and affection, “counterculture of acceptance,” safe sanctuary, healing from illness and destruction, reopening their hearts
- Spiritual – meaning in suffering, gift from wound, reconnect with soul and spirit

Socially Responsible Mental Health

- Outreach
- “No Wrong Door”
- Linkages and Triage
- Community Support Services
- “Refugee” Services
- Community Development –
creating “niches”

Community Integration

Our job is not to help people with mental illnesses avoid responsibilities – who would want an irresponsible neighbor, employee, spouse, or parent – but to help them to meet their responsibilities.

Many of their major problems – poverty, limited employment opportunities, drugs, family struggles, and loneliness – are the same as everyone else's problems

Sometimes our job is to help people be able to live better in our community and sometimes our job is to help our community be a better place for people with mental illnesses to get along in.

- Find “welcoming hearts”
- Develop and support “niches”
- Move from individual advocacy to “the community is our client”
- Ally with other community advocacy and development groups

Battling Stigma

Stigma is usually seen as a community problem rather than a problem with staff, families, and consumers themselves.

Fear and trauma lead to avoidance and protectionism.

Education is usually our “solution” and rarely what’s actually needed.

How can the community help?

1) Engage with people

- Start a conversation, Ask “How are you?” and “really want to know”,. Connect to the person, not the illness – be yourself, not a junior mental health professional
- Give something practical - food, clothes, blanket, take to lunch, let them make a phone call
- Scared? Think about why. Get a little experience and comfort – come to morning meeting, shadow an outreach worker, go to clubhouse or an AA meeting
- If you’ve recovered from mental illness, childhood trauma, war, substance abuse, etc. share your story and give them hope

2) Connect people to services

- Help them find resources – multiservice center, Village, food banks, shelter, “quality of life” police.
- Advocate for them – help them problem solve and get through “red tape”, help fill out a form, make a call, go with them
- Follow-up – it shows you weren’t just trying to get rid of them

How can the community help?

3) Contribute to services

- Bring in donations – food, clothes, toiletries, household goods, “presents”, books, “tickets”,
- Volunteer,
- Promote services politically and locally,
- Give money

4) Involve people in your life

- Create opportunities in the community for involvement where you’re involved – church, jobs, “internships”, volunteering, clubs, bowling, community events – share something in your life, create some “welcoming” for them
- Sustain a friendship – mentor, share sorrows and celebrations, have fun together – this isn’t about “feeling sorry for someone”

“Person Centered” NAMI

If our focus is truly on helping people have better lives instead of just treating symptoms, then you don't have to have training in mental illness to help, you just have to know how to live better.

NAMI can act like a PTA does for a school, helping it's local clinic with fund raising, volunteers, classes, community opportunities, mentors, and community development.

Integrated Health and Mental Health – Who will be served?

- Stigma averse populations – people who will access MH services within a primary care setting, but reject MH settings and labeling
- Traumatized populations
- Cultural populations with access and disparity issues
- SPMI populations likely to be stigmatized and rejected in primary care settings, not have their physical conditions taken seriously, and struggle to effectively use “standard services”
- Including both family focused care and separate child and adolescent care, including challenging Transitional Aged Youth
- Focusing services on “high utilizers” – “hot spots”, J-curves, ACT teams,
- Focusing on people with complex- co-occurring conditions– e.g. chronic pain, substance abuse, end of life, post-partum, SPMI with multiple early death risk factors, cardiac conditions with depression

Integrated Health and Mental Health – What models will we use?

- Most people have chronic conditions that benefit from a chronic illness model, rather than a series of fragmented, presenting complaint, “acute care” visits
- Incorporate the contributions of the recovery model to increase engagement, motivation, partnership, and self-responsibility for care
 - Person centered care vs. illness centered care – quality of life goal driven services
 - Patient driven care vs. professional driven care – shared decision making, empowerment
 - Strengths based vs. deficit based – rehabilitation focus, building skills and supports, protective factors, resilience
- Incorporate major focus on prevention, wellness, and early intervention
- Incorporate community building, self help, and “natural supports” focus

Integrated Health and Mental Health – How will services be organized?

- Need to move from the reliance on centering on infrequent, very rapid primary care and psychiatry medication visits with very busy doctors who don't have time to communicate with anyone else
- Need to use integrated multidisciplinary teams including mental health staff
- Need to include peer staff
- Need to include case managers / navigators
- Need to include poverty services

THANK YOU!

To get a copy of my book *A Road to Recovery*
download at www.mhavillage.org and click on “dr. mark’s writings”
...where you will find more of Dr. Mark’s articles on recovery,
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for more recovery oriented training, consultation and workforce development opportunities
from Mental Health America of Los Angeles:

thinking outside the box is so 1969. to be truly innovative and make new ideas work you need to build your own box.

what we do. we enhance your existing programs, help you build new ones, and develop your staff into a strong, recovery-oriented workforce.

we help you build your own box.



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