LPS CLINICAL ASSESSMENT GUIDELINES (CAG)

for Improved Assessment and Delivery of Clinical Service to Involuntarily Detained Individuals

Module 1:
PHILOSOPHIES AND PRACTICE
Contents

Introduction and Overview ........................................................................................................ 3
The Recovery Model .................................................................................................................. 6
Ethical Standards of Behavioral Health Professions Related to Recovery ....................... 45
Recovery-Relevant .................................................................................................................. 74
Legal and Regulatory Requirements ..................................................................................... 74
Conclusion ............................................................................................................................... 90
References ............................................................................................................................... 91
Overview

Module I, *Philosophies and Practice*, can be useful in motivating adherence to recovery model based practice principles, understanding the relationship to the clinical assessment guidelines (CAG) and supporting motivation for the implementation of the guidelines in an involuntary detainment setting.

Key Topics

- The Consensus Assessment Guidelines (CAG)
- The Recovery Model
- Ethical standards of the various behavioral health professions that support these guidelines
- Core practice principles of the various behavioral health professions that support these guidelines
- Legal and regulatory requirements related to these guidelines
- Other fundamental values, concepts, practice principles, and legal requirements upon which the guidelines are based

Learning Objectives

Upon completion of module 1, providers should be able to:

- Identify core concepts and practice principles of the Recovery Model as it has been articulated and promoted by major behavioral health organizations
- Identify specific ethical standards, legal mandates, regulatory requirements, clinical rationale and institutional support for Recovery Model practices during involuntary detainment
- Articulate the specific ethical standards, legal mandates, regulatory requirements and clinical rationale for the various clinical assessment guidelines
  - For use in their own professional development
  - Supervision of others
  - Provision of administrative and community leadership for the dissemination of these innovations
  - Evaluate the extent to which Recovery Model principles are being implemented in their own practice (within involuntary detainment settings) and /or general practices within behavioral health service programs
  - Note additional technical support for performance evaluation can also be found in Module 6 Performance Measurement
Target Audience

- Behavioral health practitioners who will be implementing the CAG Guidelines
- Supervisors and administrators of behavioral health service programs which provide services to involuntarily detained individuals
- Community Stakeholders promoting the implementation of the Recovery Model and these CAG Guidelines
- Students of the Behavioral Health professions preparing for a career guided by recovery oriented practice
The Recovery Model
In this section, it is our intention to demonstrate how to implement components of the Recovery Model into the process of clinical assessment, intervention, and aftercare during involuntary detainment.

The recovery concept, originated in relation to treatment of substance-related disorders. The concept has been adapted or reinvented for application in community behavioral healthcare systems that serve individuals with serious, persistent primary mental disorders.

Many interpretations of the Recovery Model have been developed by proponents such as Dr. Ragins (2002, 2006, 2016), Mary Ellen Copeland (2006), William Anthony (2002) of the Center for Psychiatric Rehabilitation, and, in Great Britain, Julie Ripper and Rachel Perkins (2006). Despite the many documents promoting the recovery concept, there are very few structured recovery models available to guide behavioral health service delivery staff.

**Recovery can be understood as an inherent quality of the individual client, not just the service provider's philosophy of service delivery.**

**Personal recovery orientation:**

- is deeply felt, going well beyond what one consciously thinks of himself or herself
- is a profound sense of being equal to the essential challenges in life
- is not limited to confidence in some aspect of our lives but relates to all that we are at each next emerging moment
- is well grounded in an inherent adaptive sense that has survived the demanding course of evolution
- does not require constant management; it does not need to be produced or acquired; it only needs to be recognized, accepted, and appreciated.
Defining the Recovery Model

SAMHSA RECOVERY DEFINITION

Recovery from Mental Disorders and/or Substance Use Disorders

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

SAMHSA (Substance Abuse and Mental Health Services Administration) has developed a series of strategic initiatives in its effort to facilitate the development of more effective behavioral healthcare needs nationwide. These initiatives provide critical data from national surveys and surveillance, build public awareness of behavioral health issues, and evaluate and disseminate evidence-based and promising behavioral health practices. One of these is the Recovery Support Strategic Initiative, first established in 1997 when SAMHSA hosted the first of a series of dialogue meetings for mental health consumers and representatives from other groups to promote recovery and improve services. Integrated attention to co-occurring conditions has since become an important aspect of this project.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has established a Recovery Support Strategic Initiative (SAMHSA, 2017) as a means of partnering with people in recovery from behavioral health disorders, as well as with their family members. Its purpose is to guide behavioral health systems and promote individual-, program-, and system-level approaches that foster health and resilience and to increase access to resources that support recovery. Through this project SAMHSA has developed a working definition and principles of recovery that emphasize the role of abstinence in recovery from substance use disorders and indicates that an individual may be in recovery from a mental disorder, a substance use disorder, or both.
SAMHSA’s Working Definition of Recovery from Mental Disorders and/or Substance Use Disorders

(Note: SAMHSA’s full definition can be reviewed at: https://www.samhsa.gov/newsroom/press-announcements/201112220800)

SAMHSA recognizes there are many different pathways to recovery and everyone determines his or her own way. SAMHSA engaged in a dialogue with consumers, persons in recovery, family members, advocates, policy makers, administrators, providers, and others to develop the following definition and guiding principles for recovery. The urgency of health reform compels SAMHSA to define recovery and to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. In addition, the integration mandate in Title II of the Americans with Disabilities Act and the Supreme Court’s decision in Olmstead v. L.C., 527 U.S. 581 (1999) provide legal requirements that are consistent with SAMHSA’s mission to promote a high-quality and satisfying life in the community for all Americans. (SAMHSA, 2006)

The Recovery Support Strategic Initiative, SAMHSA (2016) delineated four major dimensions that support a life in recovery:

- **Health**: overcoming or managing one’s disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and nonprescribed medications if one has an addiction problem—and making informed, healthy choices that support physical and emotional well-being
- **Home**: a stable and safe place to live
- **Purpose**: meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors; and the independence, income, and resources to participate in society
- **Community**: relationships and social networks that provide support, friendship, love, and hope

**SAMHSA’s Guiding Principles of Recovery**

*Recovery emerges from hope.*

The belief that recovery is real provides the essential and motivating message of a better future—that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them. Hope is internalized and can be fostered by peers, families, providers, allies, and others. Hope is the catalyst of the recovery process.

**PROMOTING A SENSE OF HOPE**

- Takes a person-driven, strengths-based, holistic, culturally relevant, and respectful approach to the individual (see below).
- Engages in clinically meaningful, recovery-oriented treatment planning.
- Defines treatment goals in relation to the individual's own self-acknowledged strengths.
• Identifies treatment goals and objectives in terms of positive change rather than the removal of negative qualities (e.g., “exercise regularly” not “stop being so lazy”; “attend recreational activities at least four times weekly” not “avoid social isolation”).
• Identifies goals that are attainable in the future (i.e., a time frame that is foreseeable to the individual). Express realistic time frames for achieving resolutions to problems.
• Helps individual prioritize their goals to promote a focus on a manageable number of goals, rather than allowing the individual to become overwhelmed by a daunting array of goals.
• Identify the individual's recent achievements.
• Presents realistic images of how things could be if they were to improve.
• Respects and acknowledge the importance of religious or spiritual faith with those individuals who have a faith orientation.
• Being optimistic in a genuine way.
• Understands the Core Competencies and becomes familiar with the knowledge, skills, and methods of Wellness Recovery Action Planning and Motivational Interviewing.

Recovery is person-driven.

Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) toward those goals. Individuals optimize their autonomy and independence to the greatest extent possible by leading, controlling, and exercising choice over the services and supports that assist their recovery and resilience. These behaviors empower the individual and provide the resources to make informed decisions, initiate recovery, build on their strengths, and gain or regain control over their lives.

HOW TO PROMOTE PERSON-DRIVEN RECOVERY

• Convey comprehension of the involuntarily detained individual as a person in a social context, with a cultural identity, who has a past and a future. Establish this knowledge by reviewing outpatient records (if available), speaking with collaterals (with the individual's permission), and directly asking the person about these issues.

• If the individual has been receiving outpatient services prior to admission, review the goals that he or she has strived to achieve, whether they were listed in a formal treatment plan. Explain how the inpatient stay can be used to progress toward those goals.

• Draw attention to whatever the individual has done in the past to prevent the need for involuntary detentions at other times of crisis.

• Clearly inform the individual about what he or she can do during the involuntary detention to minimize the length of stay.

• Clearly inform the individual about the many voluntary aspects of an involuntary detention, those aspects in which the individual's choices will be respected and accommodated.
**Recovery occurs via many pathways.**

Individuals have distinct needs, strengths, preferences, goals, culture, and backgrounds including trauma experiences that affect and determine their pathway(s) to recovery. Recovery is built on the multiple capacities, strengths, talents, coping abilities, resources, and inherent value of everyone. Recovery pathways are highly personalized. They may include professional clinical treatment, use of medications, support from families and school communities, faith-based approaches, peer support, and other approaches. Recovery is nonlinear, characterized by continual growth and improved functioning that may involve setbacks. Because setbacks are natural, it is essential to foster resilience for all individuals and families. In some cases, recovery pathways can be enabled by creating a supportive environment. This is especially true for children, who may not have the legal or developmental capacity to set their own course.

**HOW TO ADDRESS THE MULTIPLE PATHWAYS TO RECOVERY**

- Determine the individual's preferences for the clinical encounter during the involuntary detention. Which medications has the individual used in the past, and which of these are preferred? Which types of clinical interventions (techniques and methods) have been provided to the individual in the past, and which of these are preferred? What kinds of relationships has the individual had with service providers in the past, and which of these are preferred?

- Describe the role of the inpatient service as a component of an integrated system of care, not something that stands in contrast to or in conflict with other resources.

- Express interest in whatever personal capacities, strengths, talents, and coping abilities that are recognized and valued by the individual.

- Utilize the Core Competencies Module to become familiar with a variety of pathways (methods) known to facilitate recovery among persons with mental illness. Especially see Wellness Recovery Action Planning, which includes pathways involving peer support, family support, and professional interventions as well.

**Recovery is holistic.**

Recovery encompasses an individual's whole life, including mind, body, spirit, and community. This includes addressing self-care practices, family, housing, employment, education, clinical treatment for mental disorders and substance use disorders, services and supports, primary healthcare, dental care, complementary and alternative services, faith, spirituality, creativity, social networks, transportation, and community participation. The array of services and supports available should be integrated and coordinated.
HOW TO PROMOTE A HOLISTIC APPROACH TO RECOVERY

Draw out the individual's own experience of the situation through inquiry.

- Be familiar with a wide variety of local community resources, their relative strengths and limitations, especially gatekeepers. Establish relationships with community agency staff.
- Develop and maintain a variety of educational handouts containing information and referral guides to a wide variety of local community resources.
- See the Clinical Assessment Guidelines, Section 11, Supports for Wellness and Recovery, and Section 8, Discharge Planning to become familiar with information especially relevant to a holistic approach to recovery for those who have been held in involuntary detainment.

Recovery is supported by peers and allies.

Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery. Peers encourage and engage one another and share a vital sense of belonging, supportive relationships, valued roles, and community. Through helping others and giving back to the community, one helps one’s self. Peer-operated supports and services provide important resources to assist people along their journeys of recovery and wellness. Professionals can also play an important role in the recovery process by providing clinical treatment and other services that support individuals in their chosen recovery paths. Peers and allies can play an important role for adults in recovery. Peer supports, such as parent partners, provide modeling, assistance and hope for the entire family coping with children and youth experiencing emotional and behavioral challenges.

HOW TO PROMOTE SUPPORT BY PEERS AND ALLIES

- Engage peer support organizations to participate on the service delivery team.
- Inform individuals about how peer support, both during and after involuntary detainment, can help address the individual's needs and concerns.
- Make individuals aware of the option of including family members and significant others in the assessment and service delivery process, and the potential benefits of doing so.
- Provide services that support the families and significant others of detained individuals. A loved one's hospitalization is a crisis for significant others, as well as the person being hospitalized. They can be assisted through this crisis with a focus on their concerns, even without revealing confidential information about their loved one.
- Help significant others of detained individuals learn how they can be optimally supportive to their loved one, in cases where the individual has given permission for such individualized communication.
- Utilize the Core Competencies Module to become familiar with the knowledge, skills, and methods of Wellness Recovery Action Planning (WRAP), which emphasizes techniques for individuals to use in selecting or developing a social support network.
Recovery is supported through relationship and social networks.

An important factor in the recovery process is the presence and involvement of people who believe in the person's ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change. Family members, peers, providers, faith groups, community members, and other allies form vital support networks. Through these relationships, people leave unhealthy and/or unfulfilling life roles behind and engage in new roles (e.g., partner, caregiver, friend, student, employee) that lead to a greater sense of belonging, personhood, empowerment, autonomy, social inclusion, and community participation.

HOW TO PROMOTE SUPPORT THROUGH RELATIONSHIPS AND SOCIAL NETWORKS

- Promote support by peers and allies, as noted above.
- In addition to addressing the symptoms and risks that necessitated the involuntary detention, speak with the individual about role functioning:
  - Which social networks have been sources of support for the individual?
  - How well has the individual met the expectations of these social networks?
  - In which social networks has participation been problematic or stressful for the individual?
  - Are there any social roles that were meaningful to the individual in the past in which the individual would like to restore participation?
- Discuss these social relationships with the individual throughout the course of treatment and in preparation for discharge.
- Utilize the Core Competencies Module to become familiar with the knowledge, skills, and methods of WRAP, which emphasizes techniques for individuals to use in developing a social support network.

Recovery is culturally-based and influenced.

Culture, including values, traditions, and beliefs, is key in determining a person's journey and unique pathway to recovery. Services should be culturally grounded, attuned, sensitive, congruent, and competent, as well as personalized to meet everyone's unique needs.

HOW TO PROMOTE CULTURALLY RELEVANT RECOVERY

- Become familiar with the variety of cultural factors that influence clinical encounters in general, including ethnicity, national origin, religion, political orientation, generational, socioeconomic class, gender, and sexual orientation cultures.
• Avoid a narrow focus on one kind of cultural influence to the exclusion of others.

• Determine the individual’s cultural identity. Of the various cultural influences in a person's life, which are most important and meaningful to the individual? Also, keep in mind that all persons are influenced by culture whether the person is aware of the influence.

• Become familiar with the aspects of the clinical encounter most influenced by a person's various cultures. These include how individuals define problems and how they perceive the causes of, and solutions to the problems. These also include preferences for the type of relationship a person prefers with service providers and types of intervention methods that are most acceptable to the individual.

• Become familiar with the DSM-5 Cultural Formulation Interview.

• Become familiar with resources such as faith based organizations, boys and girl's clubs, civic organizations, fraternities, sororities, and community centers.

• When discussing social networks and resources with the individual, determine which the individual considers most relevant. Does the individual prefer participation in culture-specific or multicultural contexts.

• When individuals actively participate in a process of shared decision-making, decisions about their care will inherently reflect the individual’s various cultural orientations.

• Utilize the Core Competencies Module to become familiar with the knowledge, skills, and methods of Shared Decision Making and Motivational Interviewing.

**Recovery is supported by addressing trauma.**

The experience of trauma (such as physical or sexual abuse, domestic violence, war, disaster, and others) is often a precursor to or associated with alcohol and drug use, mental health problems, and related issues. Services and supports should be trauma-informed to foster safety (physical and emotional) and trust, as well as promote choice, empowerment, and collaboration.

**HOW TO SUPPORT RECOVERY BY ADDRESSING TRAUMA**

• Be familiar with the various traumatic aspects of an involuntary detainment such as transportation in a police vehicle with officers in uniform, being held behind locked doors, seclusion, restraint (actual or anticipated), forced use of medication in emergencies, or stressful encounters with other individuals on the unit.

• Even though the focus will be on the immediate crisis, assess for the individual's exposure to past traumas by reviewing outpatient records (if available), speaking with collaterals (with the individual's permission), and directly asking the person about these issues.

• Consider how past trauma might arouse the individual’s sense of danger (e.g., a homeless person might be exceptionally protective of belongings; a sexually abused person may feel...
apprehensive, vulnerable, and humiliated by being unclothed; a person assaulted by another person during a previous hospitalization might exhibit suspiciousness, hypervigilance, and increased arousal during the current hospitalization).

- Actively resist re-traumatization during the involuntary detention.
- Utilize the Core Competencies Module to become familiar with the knowledge, skills, and methods of Verbal De-escalation and Trauma Informed Care.

**Recovery involves individuals, family, and community strengths and responsibility.**

Individuals, families, and communities have strengths and resources that serve as a foundation for recovery. In addition, individuals have a personal responsibility for their own self-care and journeys of recovery. Individuals should be supported in speaking for themselves. Families and significant others have responsibilities to support their loved ones, especially children and youth in recovery. Communities have responsibilities to provide opportunities and resources to address discrimination and to foster social inclusion and recovery. Individuals in recovery also have a social responsibility and should be encouraged to join with peers to speak collectively about their strengths, needs, wants, desires, and aspirations.

**HOW TO SUPPORT RECOVERY BY PROMOTING PERSONAL RESPONSIBILITY**

- See “How to Address the Multiple Pathways to Recovery” above.
- Empower the individual to recognize and participate in a course of services that are goal driven.
- Use a structured, solution-focused planning process.
- Promote the individual's self-direction by engaging the individual in making choices.
- Direct the individual's attention to the course of his or her recovery to date, and how personal strengths and resources have been used to achieve desired changes in the past.
- Engage the individual in mutually developing an inpatient discharge plan that not only links the individual to follow-up services but also reflects continuity with the individual's pursuit of personally relevant goals in the recent past.
- Provide realistic reassurance that the individual's basic needs (e.g., housing, meals, adequate clothing, access to medications) can and will be met if the individual and the designated resources follow through on their commitments.
- See Module II Core Competencies to become familiar with the knowledge, skills, and methods of Shared Decision Making, Wellness Recovery Action Planning, and Motivational Interviewing.
Recovery is based on respect.

To achieve recovery, people affected by mental health and substance use problems need community, systems, and social acceptance and appreciation—including the protection of their rights and freedom from discrimination. The people in their community must acknowledge that taking steps toward recovery may require great courage. Self-acceptance, developing a positive and meaningful sense of identity, and regaining belief in one’s self represent particularly important aspects of this process.

HOW TO SUPPORT RECOVERY BY DEMONSTRATING RESPECT

- Ask individuals for examples of past experiences in which they have felt respected, and past experiences in which they have felt disrespected. Present the individual with experiences that reflect his or her own perceptions of what constitutes respect.
- Accept the individual’s self-determination, including decisions about whether to engage others.
- Respect the individual’s confidentiality.
- Inquire about the individual's comfort (e.g., body temperature, dry clothing; food; water) prior to making assessment inquiries.
- Address the individual’s concerns about personal effects (e.g., cars, bikes, pets, personal belongings, home).
- Identify options and seek the individual’s preferences whenever possible.
- Provide the individual with an opportunity to say good-bye to staff and peers to the extent possible.
- See the Core Competencies Module to become familiar with the knowledge, skills, and methods of Verbal De-Escalation, Crisis Intervention, Shared Decision Making, Wellness Recovery Action Planning, and Motivational Interviewing.
Unfortunately, the Recovery Model is often presented as a contrast to standards established by the various professions providing behavioral health services. This leaves many practitioners, even those who are attracted to the Recovery Model, wondering whether it is possible to take a recovery-oriented approach to actual practice, the following questions may arise:

- Will it hold up in court? Does it conflict with my legal obligations as a professional?
- Will it lead to audit disallowances? Is it inconsistent with Medi-Cal regulations?
- Does it violate established ethical standards of my profession?
- Is it contrary to established principles of professional clinical practice?
SAMHSA’S EIGHT DIMENSIONS OF WELLNESS

The principle that recovery is holistic is well expressed in SAMHSA’s Eight Dimensions of Wellness (SAMHSA, 2016a). In support of the notion that “wellness is not the absence of illness or stress,” this conceptual framework clearly demonstrates the reason for the ever-growing attention to the premise that behavioral health and substance abuse treatment services are components of integrated health care systems. Services provided during involuntary detainment must be provided in a way that promotes, and does not inhibit the Eight Dimensions of Wellness.

The Eight Dimensions of Wellness are as follows:

- **Emotional**—coping effectively with life and creating satisfying relationships
- **Environmental**—good health by occupying pleasant, stimulating environments that support well-being
- **Financial**—satisfaction with current and future financial situations
- **Intellectual**—recognizing creative abilities and finding ways to expand knowledge and skills
- **Occupational**—personal satisfaction and enrichment from one’s work
- **Physical**—recognizing the need for physical activity, healthy foods, and sleep
- **Social**—developing a sense of connection, belonging, and a well-developed support system
- **Spiritual**—expanding a sense of purpose and meaning in life

An individual is influenced by all eight aspects of this framework throughout their life, including an individual’s participation in both inpatient and outpatient services.
Mark Ragins, MD

The SAMSHA model is framed in a wellness context. Dr. Mark Ragins, a leading theorist and proponent of the Recovery Model, presents a framework grounded in psychosocial rehabilitation and meaningful roles. Dr. Ragins describes recovery as “helping people who were stuck in patient roles to succeed in a variety of other meaningful roles” (2016)

Every individual, regardless of his or her history of hospitalizations or symptom severity can recover to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential. Even during an inpatient hospitalization, individuals can be engaged in the process of defining, pursuing, and achieving personally defined goals that support recovery, result in improved health and well-being, and promote full participation in the community. A warm, homelike, healing, and safe environment with compassionate staff who support and nurture individual recovery are cornerstones of inpatient behavioral healthcare.

While recovery concepts and services have been incorporated into a range of outpatient and residential programs, they have been more challenging to practice in the inpatient setting which tends to focus on immediate safety concerns. Inpatient units often lack the resources, staffing, and staff training to provide comprehensive psychosocial rehabilitation and recovery services that are integrated with the ongoing course of a person’s life.

This module presents a philosophy of inpatient care that embraces personalized, culturally appropriate, proactive, person-centered care and behavioral health recovery in one of the most intensive settings in mental health. For many staff whose careers were founded in a traditional approach, this method expresses a shift in organizational culture to an approach based on collaboration—in other words, engaging in a joint effort with the individual in his or her pathway to recovery. This culture shift is inherent to all recovery-oriented care and is imperative to achieving transformation. To fully integrate a model based in recovery and psychosocial rehabilitation, this module presents the philosophy, knowledge, and skills for inpatient-based, recovery-oriented services.

*The primary focus of inpatient psychiatric services is to reduce symptoms, stabilize behavior and prepare for discharge and aftercare. Therefore, inpatient services may not appear to be the best place to introduce an individual to the recovery perspective. However, this module aims to demonstrate ways in which inpatient programming and staff behavior can be consistent with the Recovery Model.*

Recovery is an ongoing process experienced by the individual, thus it is highly encouraged the individual's recovery plan:

- links seamlessly with the individual’s preadmission,
- carries on through the brief inpatient stay,
- transitions to the outpatient treatment plan,
- links with the individual’s follow-up residential and outpatient care service providers.
For individuals, whose initial encounter with the system of care is an inpatient service, an inpatient recovery plan should be used to introduce the individual to the recovery model and link seamlessly with post-discharge residential and outpatient care settings.

RAGINS’ FOUR-STAGE MODEL OF RECOVERY

Dr. Ragins provides a four-stage model of recovery, Hope, Empowerment, Self-Responsibility and Meaningful Role in Life.

Dr. Mark Ragins has captured key features of the Recovery Model in a behavioral health context with this statement:

The goal throughout is to help the person attain recovery. We guide them through the process of building hope, empowerment, self-responsibility, and attaining meaningful roles in life. We don’t leave recovery to chance, hoping that it will result from our treatment and rehabilitation efforts. We intentionally use treatment and rehabilitation as tools to promote recovery. We select techniques that emphasize growth, building skills and natural supports, learning from successes and failures, and internalizing recovery gains to enhance resilience and wellness, rather than emphasizing stability, caretaking, risk reduction, and treatment compliance. Recovery is inside of them, not us. (2016)

Developmental models such as this recognize that recovery is a developmental process, not only an idealistic vision or destination to be achieved. It is not likely that an individual would progress through all four stages during a single inpatient stay; therefore, it is helpful for inpatient staff to recognize everyone’s stage of recovery and adjust interventions accordingly.

Dr. Ragins’ complete four steps, or phases, are presented through a set of case scenarios about “Joe”. The “Joe Scenarios” illustrate how individuals moves through the four steps or phases as outline by Mark Ragins.
**Opening Case Scenario: Joe in Despair**

Joe is a 22-year-old man with bipolar disorder who has concluded that life is not worth living. Now in a major depressive episode, he is hospitalized following a week of elaborated suicidal ideation and preparation for a suicide attempt. His recent preoccupation with suicidal thoughts began after he had been told that he will need to take medication for the rest of his life. This came as a shock to Joe, who had always prided himself on his physical appearance and sexual prowess. Based on information Joe had received from friends and in the media, he was convinced that medications meant reduced libido and erectile dysfunction.

Joe had previously been misdiagnosed as having a major depressive disorder at a crisis program where, during a brief 20-minute interview, he neglected to reveal, and his therapist neglected to inquire about, his experience of a manic episode. At that time, because his bipolar disorder was not recognized, he was given a prescription for an antidepressant without a mood stabilizer. He was also told to return “if any problems developed” in response to the medication. The antidepressants triggered a manic episode. Initially Joe did not consider this to be “a problem” but later lost his job after verbally assaulting and humiliating his supervisor.

Although Joe had discontinued his antidepressant medication, he resumed its use after a deep depression had set in during this time of unemployment. He was so embarrassed by having lost his job that he did not return to the original physician, and did not mention his medication-induced manic episode to the next service provider. Joe said that he was diagnosed with major depressive disorder. The physician relied on that information and issued another prescription for the same antidepressant. This time the medication was taken for a sufficient duration to cause significant weight gain and induce the sexual side effects that were so important to Joe. Joe feared that he would need to take medication for the rest of his life and subsequently slipped into the suicidal preoccupation and alcohol consumption that led to his current hospitalization.

**Hope**

In the blackest times of despair what’s needed first is hope as a light at the end of the tunnel, some idea that things can get better, that life will be more than the present destruction. Without hope there’s no real possibility of positive action. To be truly motivating, however, hope must be more than just an ideal. It must take form as an actual image of how things could be if they were to improve. It’s not so much that people will attain precisely the vision they create, since realistically most outcomes are products of chance and opportunity more than careful planning. But is does seem essential to have some clear image, if people are to make difficult changes and take positive steps. (Ragins, 2016)
Case Scenario: Joe in Hope

During his current hospitalization, staff correctly diagnosed Joe’s bipolar disorder after engaging Joe in a thorough assessment. Staff informed Joe that while weight gain and erectile dysfunction often do occur with antidepressants, the effect might be different now that he will be prescribed a mood stabilizer plus an antidepressant. Staff told Joe that he should not suddenly stop taking the antidepressant, but that his dosage would be gradually reduced to see if his condition could be managed with a mood stabilizer alone. Staff informed him that medications affect individuals differently and that, if it turned out that another antidepressant were needed in addition to the mood stabilizer, other antidepressant options could be made available with the possibility that a different prescription might not have these side effects.

Although pleased to hear this information, Joe became furious. “Why didn’t that last doctor tell me that?! He never even mentioned the “s” word (sex)! I’m not a kid anymore dammit!”

Hospital staff also asked Joe about his history and preferences about eating, sleeping, exercise, and social relationships. Joe takes pride in his athletic ability, saying that he used to pitch a fastball at 84 mph and could do 100 push-ups. Now that he’s “out of shape,” he said it’s difficult to do twenty. He also expressed pride in his ability to attract women, and he professed to be a “great dancer.” Staff drew attention to these qualities and other positive things that he mentioned, focusing on those strengths that Joe already acknowledged. Instead of engaging him in setting a goal of getting back to 100 push-ups someday, they asked him how long he thought it would take to get up to thirty push-ups, noting that he could “move on from there.”

Staff also explained how changing some of his other behaviors could have the effect of reducing the severity of his mood symptoms while enhancing the effectiveness of the medications he was prescribed.

Staff introduced Joe to Jason, a peer support counselor who described how he had similar experiences and talked about how his problems had become less severe or resolved because of efforts he had taken. Jason also shared similar stories of friends he had met through his peer support self-help meetings. Noting Joe’s nonverbal cues when asked about alcohol and drugs, Jason also shared stories about friends who had abused alcohol or other substances.

Through explanation, demonstration, and positive examples, Joe was regaining a sense of hope about a future of possibilities.

For more information about how to approach an individual at the hope phase of recovery, see:

- Core Competencies Module: Motivational Interviewing (Phases 1 and 2: Pre-contemplation and Contemplation)
- Core Competencies Module: Crisis Intervention
- Clinical Assessment Guidelines, especially Sections 2 (Engagement) and 3 (Initial Clinical Assessment)
Empowerment

To move forward, **people need to have a sense of their own capability**, their own power. Their hope needs to be **focused on things they can do rather than new cures or fixes someone else will discover** or give to them. People often need someone else to believe in them before they’re strong enough to believe in themselves and to start **focusing on their strengths** instead of their losses. It also **often takes some actual experience of success to believe one can be successful**. Waiting until someone is ready to move on can often be stagnating and disempowering, because ‘readiness’ often occurs only in retrospect after something has been done successfully. (Ragins, 2016)

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**Case Scenario: Joe Is Empowered**

With a sense of hope restored, Joe was now willing and able to pay attention to information and resources that he had heard about but previously considered to be hopeless pipe dreams. He began to ask questions about various medications and their potential benefits, side effects, and limitations.

He spent more time with his Uncle Bill, a very nurturing high school physical education teacher and baseball coach, who let him know about newly developed nutritional supplements used by his students. When Uncle Bill spoke of the exercise regimens taught to his students Joe paid special attention. Joe told him that he was working on getting back up to twenty push-ups in a row, but was having difficulty doing so. Joe listened intently as Bill let him know that instead of going on irregular exercise binges, a slower steady incremental approach would be more effective.

During subsequent casual meetings over coffee, Joe and Jason would talk about what happens at peer support group meetings, as well as twelve-step meetings. Jason showed Joe his Wellness Recovery Action Plan (WRAP), a structured approach to acting. “It helped me to feel in charge of my own life again,” Jason said. Joe was especially interested when Jason spoke of the qualities he wanted from those who would potentially be of support in a crisis. He described how he created a list of people, with phone numbers, who were potential supporters in a crisis. He specified what he would like from each potential supporter, and identified how possible disputes among supporters should be handled. He asked Joe if he would be available in times of crisis.

Joe was gratified that someone would consider him as a resource, but the prospect of becoming responsible for another person’s well-being terrified him. “But I can’t even take care of myself,” he said. Jason replied, “Nobody can take care of themselves. We all take care of one another.” Nonetheless, Joe declined Jason’s request but said, “Someday, when I feel ready, I’ll be there for you.”
Jason also shared that he was an active participant in Al-Anon as a way of dealing with his problematic relationship with an alcoholic father. He also mentioned that he met his girlfriend at an Al-Anon meeting. Jason told Joe that he and his father, who had been “flirting with recovery” and going to occasional AA meetings, were both on their local fellowship’s softball team. Joe’s ears perked up when Jason told him that the team needed a good pitcher.

Open to new information about positive pathways, Joe was building on his restored sense of hope by taking in new information about the “how to” of recovery.

For more information about how to approach an individual at the empowerment phase of recovery, see:

Self-Responsibility

At some point, most people who recover realize that no one else can do it for them and that they must take charge of their own recovery. People can, and often need, to be supported in their efforts to recover, but they can’t be caretaken or protected into recovery.

Taking one’s own risks, **setting one’s own goals and path**, and learning one’s own lessons are essential parts of recovery. The **appeals of dependency and being taken care of can derail recovery**. (Ragins, 2016)

Case Scenario: Joe Assumes Self-Responsibility

As Joe was feeling empowered with new knowledge of local resources and introductions to people who were benefitting from them, he became much more inclined to follow through on his doctor’s referral for outpatient psychotherapy. He wanted to “get out of [his] rut” and become more actively involved in his own life, but deep ruts can feel overwhelming at times. Joe would share visions of his desired future with his therapist and asked the therapist for help in developing a WRAP.
Joe worked with his therapist to define a “Wellness Tool Box” and developed a list of coping techniques previously effective in reducing his symptoms. He also developed a “Daily Maintenance Plan” in which he specified coping techniques that were previously effective in staying well. He identified triggers and early warning signs of developing problems. Perhaps more importantly he identified actions to take when these signs of trouble emerged.

Over the next several years Joe had many opportunities to act on his WRAP by acting in anticipation of possible crises. He had presented his WRAP to each potential support person and confirmed their availability. He had intended to review his Daily Maintenance Plan each day, but soon discovered that his life was a bit too chaotic to follow such a strict regimen. Although Joe was proud of his regularity with medications, he would slip from time to time when under stress.

Despite his progress, Joe returned to the hospital for a brief stay about two years following his previous admission. This occurred at a time when his medications became irregular and he lapsed into a drinking binge. Now armed with a familiar WRAP, Joe was in a relatively good position to use information from his plan during the involuntary hold. He could address these issues with inpatient staff, and suggest treatment approaches when discussing issues noted in the inpatient treatment plan and when developing his inpatient discharge plan. He also felt bolstered by visits from Uncle Bill, Jason, and Rosa, a dear friend he met on his softball team.

Unlike his first hospitalization, Joe felt far from hopeless at the point of discharge. Unlike his experience with the discharge plan of his initial hospitalization, which he saw as a pro forma exercise in paperwork, he now took his discharge plan seriously. He considered it to be a next step in his recovery.

For more information about how to approach an individual at the self-responsibility phase of recovery see:

- Core Competencies Module: Wellness Recovery Action Planning (Practice Acting on Strengths, Resources, and Methods)
- Core Competencies Module: Motivational Interviewing (Phase 4: Action)
- Clinical Assessment Guidelines, especially Sections 7 (Treatment/Decision Making and Intervention), 8 (Discharge Planning), 9 (Care Coordination), 10 (Discharge), and 11 (Supports for Wellness and Recovery)
Case Scenario: Joe Enjoys Meaningful Life Roles

Joe still has bipolar disorder but he now actively manages his own mental health treatment, something he had once expected service providers to do to him or for him. He anticipates and responds to his own problems, facilitated by information and encouragement from staff and partners in self-help. He knows that he might wind up in the hospital at some point, but he also knows that he might not. And even if he did “backslide,” it would not be the end of his story.

Although Joe was initially embarrassed to take a job “flipping hamburgers” at a fast food restaurant two years ago, he has since become fascinated by the culinary arts. Following the fast food restaurant, he got a job as an apprentice chef in a diner, later moving up to sous chef. He felt hopeful about eventually becoming an executive chef someday, but for the time being he was very satisfied to be able to earn a living and pay his bills by doing something that felt like fun.

Joe now considers himself to be a “grateful alcoholic," reveling in the sense of spiritual awakening and nurturing social support that he has learned to develop through his twelve-step fellowship, in both Al-Anon and Alcoholics Anonymous (AA). He has restored relationships with several family members “who would have [him] back.” Over the past several years he has gradually become more and more active in a church, and with a little help and guidance from Uncle Bill, was proud to coach a church-sponsored Little League team.

Joe no longer depended on to staff to recommend treatment goals and objectives, but proactively let them know what he was trying to accomplish. He asked to review his clinical record from time to time and complained about how his diagnosis at admission never changed. “They stick it on me like a label,” he said.

Meaningful Role in Life

Note that in this paragraph Ragins refers to “the destruction,” which refers to all that is lost with the onset of serious mental illness. In recovery, it is the from which a person is recovering. Although a person with mental illness loses a previous level of psychosocial functioning, the person never loses the potential and capacity for restorative growth and development.

Ultimately to recover one must achieve some meaningful role apart from the destruction. Becoming a destruction victim is not a recovered role, and frankly, neither is being a destruction survivor. After achieving increased hopefulness, inner strength, and self-responsibility, these traits are applied to meaningful roles apart from the destruction. The blackness of destruction that once seemed to swallow the person whole recedes in importance as the person’s other meanings emerge. Connectedness to other people, belonging, and feeling accepted, which for a while may have only been possible with others who had experienced related destructions, within families, or with compassionate helpers, becomes possible in a variety of contexts. The isolation and aloneness the destruction imposed is increasingly broken and life re-entered. (Ragins, 2016)
He asked staff to change his diagnosis from severe to moderate to mild as his status changed. He asked staff to note partial and full remissions when they occurred. And much to this therapist’s surprise, he asked that his alcohol use disorder be documented so that he could show that he is now in sustained remission.

He knows he has a mental illness. His family and closest friends know that he has a mental illness. And he knows that his mental illness may or may not be a lifelong condition. But he also knows that life is good either way.

For more information about how to approach an individual at the meaningful role in life phase of recovery see:

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<tr>
<th>Core Competencies Module: Wellness Recovery Action Planning</th>
<th>(Practice Acting on Strengths, Resources, and Methods)</th>
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</thead>
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THE MILESTONES OF RECOVERY SCALE (MORS)

The following section demonstrates how these stages of recovery are also presented in Ragins Milestones of Recovery Scale.

The Milestones of Recovery Scale (MORS) represents an approach to operationalize and measure recovery. The properties of the MORS include:

Three (3) Dimensions

1. Level of Risk
2. Levels of Engagement with the Mental Health System
3. Levels of Skills and Supports
Eight (8) Categories

1. Extreme Risk
2. High Risk/Not Engaged
3. High Risk/Engaged
4. Poorly Coping/Not Engaged
5. Poorly Coping/Engaged
6. Coping/Rehabilitation
7. Early Recovery
8. Advanced Recovery

Instruction for Utilization

When using the Milestones of Recovery Scale in practice, staff are asked to circle the number that best describes an individual's stage of recovery (typically for the last two weeks). If the individual has not had any contact (face-to-face or phone) with any program staff in the last two weeks, staff are asked to indicate the consumer's last known stage of recovery and the date of the last contact that any staff have had with the individual.

Note that the Milestones of Recovery Scale can be especially relevant to discharge planning from an involuntary detainment. Review the definitions for each of the eight levels of recovery. Then use the worksheet that follows to consider how discharge planning might be affected for individuals at various levels.

Individuals experiencing a mental health crisis may present at various levels of risk, which impacts the degree to which the individual can be engaged. The following scale describes the levels.

1. “Extreme risk”—Individuals are frequently and recurrently dangerous to themselves or others for prolonged periods. They are frequently taken to hospitals and/or jails or are institutionalized in the state hospital or an IMD (Institution for Mental Disease). They are unable to function well enough to meet their basic needs even with assistance. It is extremely unlikely that they can be served safely in the community.

2. “High risk/not engaged”—Individuals often are disruptive and are often taken to hospitals and/or jails. They usually have high symptom distress. They are often homeless and may be actively abusing drugs or alcohol and experiencing negative consequences from it. They may have a serious co-occurring medical condition (e.g., HIV, diabetes) or other disability that they are not actively managing. They often engage in high-risk behaviors (e.g., unsafe sex, sharing needles, wandering the streets at night, exchanging sex for drugs or money, fighting, selling drugs, stealing, etc.). They may not believe they have a mental illness and tend to refuse psychiatric
medications. They experience great difficulty making their way in the world and are not self-supportive in any way. They are not participating voluntarily in ongoing mental health treatment or are very uncooperative toward mental health providers.

3. “High risk/engaged”—Individuals in this group differ from group two only in that they are participating voluntarily and cooperating in ongoing mental health treatment. They are still experiencing high distress and disruption and are low-functioning and not self-supportive in any way.

4. “Poorly coping/not engaged”—Individuals in this group are not disruptive. They are generally not a danger to self or others and it is unusual for them to be taken to hospitals and/or jails. They may have moderate to high symptom distress. They may use drugs or alcohol, which may be causing moderate but intermittent disruption in their lives. They may not think they have a mental illness and are unlikely to be taking psychiatric medications. They may have deficits in several activities of daily living and need a great deal of support. They are not participating voluntarily in ongoing mental health treatment and/or are very uncooperative toward mental health providers.

5. “Poorly coping/engaged”—Individuals in this group differ from group four only in that they are voluntarily participating and cooperating in ongoing mental health treatment. They may use drugs or alcohol, which may be causing moderate but intermittent disruption in their lives. They are generally not a danger to self or others and it is unusual for them to be taken to hospitals and/or jails. They may have moderate to high symptom distress. They are not functioning well and require a great deal of support.

6. “Coping/rehabilitating”—Individuals are voluntarily participating in ongoing mental health treatment. They are abstinent or have minimal impairment from drugs or alcohol. They are rarely being taken to hospitals and almost never being taken to jail. They are managing their symptom distress. They are actively setting and pursuing some quality of life goals and have begun the process of establishing “nondisabled” roles, but they often need substantial support and guidance. They may be productive in some meaningful roles, but they are not necessarily working or going to school. They may be “testing the employment or education waters,” but this group also includes people who have “retired.” That is, they express little desire to take on (and may actively resist) the increased responsibilities of work or school, but they are content and satisfied with their lives.

7. “Early Recovery”—Individuals are actively managing their mental health treatment to the extent that mental health staff rarely need to anticipate or respond to problems with them. Like group six, they are rarely using hospitals and are not being taken to jails. Like group six, they are abstinent or have minimal impairment from drugs or alcohol and they are managing their symptom distress. With minimal support from staff, they are setting, pursuing, and achieving many quality-of-life goals (e.g., work and education) and have established roles in the greater (nondisabled) community. They are actively managing any physical health disabilities or disorders they may have (e.g., HIV, diabetes). They are functioning in many life areas and are very self-supporting or productive in meaningful roles. They usually have a well-defined social support network including friends and/or family.
8. **Advanced Recovery**—Individuals in this group differ from group seven in that they are completely self-supporting. If they are receiving any public benefits, they are generally restricted to Medicaid or some other form of health benefits or health insurance because their employer does not provide health insurance. While they may still identify themselves as having a mental illness, they are no longer psychiatrically disabled. They are basically indistinguishable from their nondisabled neighbors.

THE SELF-ACTUALIZING TENDENCY

The Recovery Model expresses a set of very practical ideals, but it is not idealistic. It is based on fundamental social science principles affirming that all human beings, and all living things, are programmed to survive and thrive in an average expectable environment. The Recovery Model is an orientation to psychology that recognizes every person's fundamental adequacy to survive and thrive as fully as possible in this world by engaging one's strengths regardless of one's limitations.

Dr. Mark Ragins clearly expresses this inherent tendency toward growth.

People do recover. People do recover even when there is no cure for their illness. For example, people recover from strokes even though their nerve cells are still dead, or they recover from heart attacks even though the heart muscle never regrows. In fact, it is perfectly possible to recover without having an illness at all. People recover from a divorce, a parent's death, being raped, and all kinds of terrible tragedies. Most of us have recovered from something at some time during our lives. As mental health professionals, we are so busy treating illnesses that we get tunnel vision and forget to focus on helping people with their recoveries. (Ragins, 2002)

Four decades earlier, long before a Recovery Model was conceptualized as such, very similar ideas were developed by prominent psychologist Carl Rogers. A pioneering theorist of humanistic psychology, Rogers asserted that the fundamental tendency toward self-actualization is present in all living organisms—all people, including those with mental disorders.

The mainspring of creativity appears to be the same tendency which we discover so deeply as the curative force in psychotherapy—man's tendency to actualize himself, to become his potentialities. By this I mean the directional trend which is evident in all organic and human life—the urge to expand, extend, develop, mature—the tendency to express and activate all the capacities of the organism, or the self. This tendency may become deeply buried under layer after layer of encrusted psychological defenses; it may be hidden beyond elaborate facades which deny its existence; it is my belief however, based on my experience, that it exists in every individual, and awaits only the proper conditions to be released and expressed. (Rogers 1961)
This newer approach differs from the older one in that it has a genuinely different goal. It aims directly toward the greater independence and integration of the individual rather than hoping that such results will accrue if the counselor assists in solving the problem. **The individual and not the problem is the focus.** If this seems a little vague, it may be made more specific by enumerating several of the ways in which this newer approach differs from the old. In the first place, it relies much more heavily on the individual drive toward growth, health, and adjustment. **Therapy is not a matter of doing something to the individual,** or of inducing him to do something about himself. It is instead a matter of freeing him for normal growth and development, of removing obstacles so that he can again move forward. (Rogers 1942)

**THE EPIDEMIOLOGY OF HOPE**

Recovery models refer to hope, but this is not hope based on faith. Both models cited here clearly state that hope must be based on reality. The SAMHSA guidelines state that “the belief that recovery is real provides the essential and motivating message of a better future—that **people can and do overcome the internal and external challenges, barriers, and obstacles** that confront them.” (SAMHSA, 2006)

Behavioral health clients can generally sense false reassurance. Service providers can provide realistic reassurance only to the extent that they know recovery has repeatedly been empirically demonstrated.

The evidence base for recovery from symptoms of schizophrenia, for example, has been well documented by Robert Lieberman, M.D. (2002a and 2002b), as well as by the New Freedom Commission on Mental Health. In his keynote address to present the New Freedom Commission report, Michael Hogan, Ph.D. reported on the evidence:

We understand recovery to mean three things:

1. Recognition that some people—more than we have historically appreciated—do achieve complete recovery and remission.
2. Regardless of the seriousness of illness, a recovery-oriented approach expects and facilitates a meaningful and good life for each person despite living with an illness or disability.
3. The core and engine of recovery is hope—expectations for better outcomes on behalf of the person, his or her family, and his or her professional life. (Carter Center, 2003)
This positive outlook is supported by information presented in the Diagnostic and Statistical Manual of Mental Disorders. Not only are all behavioral health clients able to improve the quality of their lives and the extent of their participation in meaningful life roles, but many can overcome the symptoms of their mental illness. This is evident from the following epidemiological research findings reported in the DSM-IV TR diagnostic manual. (American Psychiatric Association, 2005)

**Schizophrenia**

Most studies of course and outcomes in schizophrenia suggest that the course may be variable, with some individuals displaying exacerbations and remissions, whereas others remain chronically ill. (APA Psychiatry 2005)

**Schizophreniform Disorder**

The DSM-5 description of the “development and course” of schizophreniform disorder states the following: “The development of schizophreniform disorder is like that of schizophrenia. About one-third of individuals with an initial diagnosis of schizophreniform disorder (provisional) recover within the six-month period and schizophreniform disorder is their final diagnosis. Most the remaining two-thirds of individuals will eventually receive a diagnosis of schizophrenia or schizoaffective disorder.” (American Psychiatric Association, 2005) In other words, two-thirds of individuals with schizophreniform disorder do not eventually go on to meet criteria for schizophrenia or schizoaffective disorder. This means that they do not go on to experience the characteristic symptoms of schizophrenia for longer than six months at a time. Unfortunately, the diagnosis of schizophreniform disorder is rarely used in public behavioral health settings. An individual presenting with this syndrome is likely to be diagnosed as having schizophrenia or schizoaffective disorder and provided with treatment for these conditions. Then, when symptoms go into remission as is characteristic of schizophreniform disorder, the remission is presumed to be because of medications and other services, which continue to be provided at the same level of intensity.”

**Autistic Disorder (now known as Autism Spectrum Disorder)**

Autism is one of the few diagnoses simply described as lifelong. “Autistic Disorder follows a continuous course” (APA Psychiatry 2005) Even then the DSM discusses various degrees of functional independence achieved by various people with autism.

**Mental Retardation (now known as Intellectual Disability)**

“Mental Retardation is not necessarily a lifelong disorder. Individuals who had mild mental retardation earlier in their lives manifested by failure in academic learning tasks may, with appropriate training and opportunities, develop good adaptive skills in other domains and may no longer have the level of impairment required for a diagnosis of mental retardation” (APA Psychiatry 2005)
Attention Deficit Hyperactivity Disorder (ADHD)

“In most cases seen in clinical settings, the disorder is relatively stable through early adolescence. In most individuals, symptoms (particularly motor hyperactivity) attenuate during late adolescence and adulthood, although a minority experience the full complement of symptoms of ADHD into mid-adulthood.” (APA Psychiatry 2005)

Substance Dependence (now known as Substance Use Disorder)

“Follow-ups reveal that 20 percent (or more) of individuals with alcohol dependence become permanently abstinent [and] . . . many others become intermittently abstinent.” (APA Psychiatry 2005)

Major Depressive Episode

“An untreated episode typically lasts four months or longer, regardless of age at onset. In most cases, there is complete remission of symptoms, and functioning returns to the premorbid level.” (APA Psychiatry 2005)

Major Depressive Disorder

“At least 60 percent of individuals with major depressive disorder, single episode, can be expected to have a second episode. Individuals who have had two episodes have a 70 percent chance of having a third, and individuals who have had three episodes have a 90 percent chance of having a fourth.” (APA Psychiatry 2005) Do the math and this means that less than 40 percent of people who ever meet criteria for a major depressive disorder will have four or more episodes, and 60 will have fewer than four episodes over the course of a lifetime.

“Follow-up naturalistic studies suggested that one year after the diagnosis of a major depressive episode, 40 percent of individuals still have symptoms that are sufficiently severe to meet criteria for a full major depressive episode, roughly 20 percent continue to have some symptoms that no longer meet full criteria for a major depressive episode, and 40 percent have no mood disorder.” (APA Psychiatry 2005)

Bipolar I Disorder

“Although most individuals with bipolar I disorder experience significant symptom reduction between episodes, some (20–30 percent) continue to display mood lability and other residual mood symptoms. As many as 60 percent experience chronic interpersonal or occupational difficulties between acute episodes.” (APA Psychiatry 2005) This means that 40 percent do not experience chronic interpersonal or occupational difficulties between acute episodes.
**Bipolar II Disorder**

“Although most individuals with bipolar II disorder return to a fully functional level between episodes, approximately 15 percent continue to display mood lability and interpersonal or occupational difficulties.” (APA Psychiatry 2005) Of course, this means that 85 percent do return to a fully functional level between episodes.

**Anorexia Nervosa**

“The course and outcome of anorexia nervosa are highly variable. Some individuals with anorexia nervosa recover fully after a single episode, some exhibit a fluctuating pattern of weight gain followed by relapse, and others experience a chronically deteriorating course of the illness over many years.” (APA Psychiatry 2005)

**Personality Disorders**

Even when it comes to personality disorders, which are “an enduring pattern of thinking, feeling, and behaving,” the DSM says, “Some types of personality disorder (notably antisocial and borderline personality disorders) tend to become less evident or to remit with age.” (APA Psychiatry 2005)

**FOUNDATION CONCEPTS OF RECOVERY IN PSYCHOLOGY**

Humanistic existential psychology recognizes that many individuals desperately attempt to take conscious control over something that very naturally flows freely within us. Many people try to think the right thoughts, feel the right feelings. Some even try to desire the right goals, carefully selected by authority figures in their lives. Cold, analytical, materialistic thinking can deaden a person’s sensitivity to his or her own rich, colorful inner life.

Some, having given up on remaking themselves, strive only to portray a presumably correct image to others, one that masks their true sense of self. In their pursuit of such a manufactured acceptance, they are left vulnerable to the whims of social influence, with little or no sense of their own grounding.

Such artificial pursuits leave a person with a pervasive sense of insecurity, self-consciousness, and self-alienation. Some people may cultivate an inner world that offers fertile ground for self-alienation and self-doubt.

In contrast, those who are willing and able to be fully present have learned to tap the richest possible source of personal fulfillment. Presence serves as a kind of natural energy conservation program by making it possible for a person to focus one’s precious energy on doing as well as one can in life—no more, no less.
Presence has long been recognized by philosophers and spiritual leaders across cultures as the source of true inner peace. Now, with the benefit of psychology and psychotherapy we have come to understand how this very same presence serves as a solid foundation for a genuine, deeply felt sense of security in ourselves and in life.

The dictionary provides a variety of definitions for “presence.” A close look at these definitions reveals a fertile common ground of insight. Here, both secular and spiritual perspectives coincide in establishing presence as the basis for a life-affirming sense of deep confidence. Presence refers to:

- the fact of being present
- the state of being self-possessed, collected, and paying attention
- an influence or spiritual essence felt to be present.

Being present. First, presence refers to the fact of being present, that is, the fact of our existence. In other words, whatever is real about us is the way in which we are present. In Taoist tradition, which is frequently cited in the humanistic existential psychology literature, this concept is expressed as “the Tao,” a term sometimes equated to the Western concept of God.

The Tao is “the way of the universe.” The Tao informs all things. Whatever is the driving force in all nature, the ordering principle that holds the planets in motion, each in its proper relation to one another, this is referred to as Tao. The Tao is what shapes the cycle of human development, a person’s natural patterns of learning and loving, one’s way of solving problems, just as it shapes the movement of planets and stars through the cosmos. Whatever thoughts, emotions, desires, and experiences arise within us, these reflect the way things are, whether they are pleasant or distressing, whether they are desirable or undesirable.

Paying Attention. Second, presence means being self-possessed, collected, and paying attention. This is what is meant by “presence of mind.” A person is always fully present. A person can be only in one place and time. The question is whether one is able and willing to pay attention to the ways in which he or she is present. Everyone can, but many people have been taught or pressured to choose otherwise.

Contact with a Spiritual Essence. Third, presence refers to an influence or divine spirit felt to be present. The presence of an omniscient, compassionate presence is at the heart of all major spiritual teachings.

The Judeo-Christian Bible speaks of this presence in the book of Exodus. Just before his liberation from slavery in Egypt, Moses has a conscious encounter with the Holy One. God tells him what is about to happen. Moses wants to pass the news on to his people and he wants to be able to tell them who sent him. So, he asks God for his name. God answers “I Am That I Am . . . and this shall be My name forever.” What does God mean by that? (Exodus 3:14)
This statement seems to be saying, “Don’t know me by a name. Don’t know me by something you think or say about me. Know me as I Am. Know me thorough your experience of me.” This statement also seems to be saying something about the present moment. God does not say, “I am what I’ve always been,” or “I am whatever I will eventually become.” God says, “I Am what I Am” right now. I exist in the present. My presence is in this moment. At the heart of Judeo-Christian spirituality, as in most other religious traditions, is “right here, right now.”

Elsewhere, we are told that the kingdom of God is not only with us, but within us. When asked “When will the kingdom of God come?” Jesus answers, “The kingdom of God will not come if you watch for it. Nor will anyone be able to say, ‘It is here’ or ‘It is there.’ For the kingdom of God is within you” Mitchell 1991, 104).

This spiritual perspective is not unique to the West. The Judeo-Christian value placed on being at one with God is clear in Taoism. Wu wee is the free flowing, spontaneous quality of life in tune with the Tao. It refers to the mind in harmony with its cosmic source. All living things experience this natural state of harmony, which is clear in human infancy and childhood. This quality is well known to psychologists and child development specialists today, just as it was known to Chuang-Tzu over two thousand years ago:

The infant cries all day long without straining its throat. It clenches its fist all day long without cramping its hand. It stares all day long without weakening its eyes. Free from all worries, unaware of itself, it acts freely without thinking, doesn’t know why things happen, doesn’t need to know. (Mitchell 1991, 215)

Similarly, Hinduism recognizes three elements of personhood—body, mind and spirit—referred to as Atman and Brahman, or the way in which God exists as the infinite center of every life. Our greatest quest is to unite ourselves with Brahman: “How to come to Brahman and remain in touch with it; how to become identified with Brahman, living out of it; how to become divine while still on earth” (Zimmer 1951, 80–81).

Those who come to know the way in which a higher power is guiding them find wisdom, strength, and joy. Having come to know and accept the natural order, they are never shaken the things in the world around them or within them. Like Chuang-Tzu's infant, they are secure in the confidence that who and what they are is exactly who and what they should be—and all that they need to be.
SPIRITUALITY, PSYCHOLOGY, AND RECOVERY

The above perspectives are the stuff that religion is made of. But how well does it sit with the insights of modern psychology? Psychological theory and science have not deviated from these insights, but have only come to verify and better understand them. For this reason, spirituality, has become one of the founding principles of a recovery orientation.

As noted earlier in this module, spirituality has been recognized as a key component of behavioral health practice, and especially in the literature on recovery. Dr. Mark Ragins has specified that recovery is holistic, that “recovery encompasses an individual’s whole life, including mind, body, spirit, and community” (year). The American Psychiatric Nursing Association has identified in its standards that an understanding of spirituality is among its list of competencies for psychiatric nurses. And it is among SAMHSA’s eight dimensions of wellness as described earlier in this module. (SAMHSA, 2006)

Psychology has long been interested in what makes it possible for a person to know what they need. How does a person know when he or she needs food and water? How does a person come to know his or her more complex needs, the satisfaction of which provides feelings of balance, security, and fulfillment? How do we know the answers to questions such as:

- Is this relationship good for me or not?
- How much money do I need?
- Do I belong in this line of work?
- Do I need to be taking more risks?
- Maybe I need to take certain risks but not others. Which ones?

Religion teaches that we can find the answers to such questions by opening ourselves to God’s will, or to the Tao. Leading psychological theorists, especially those of the existential/humanistic schools, do not use such mystical language, but speak of the same force in technical terms. For example, in 1939 psychoanalyst Kurt Goldstein determined that deep within we each have an inherent capacity to know what we truly need and the inherent drive to meet those needs. That drive was referred to as self-actualization, a kind of sovereign purpose to human life. (Goldstein 1939)

Goldstein’s principle was later reflected in gestalt therapy in which psychiatrist Frederick “Fritz” Perl’s referred to it as “organismic self-regulation,” a kind of “nonconscious internal organization” (Perls et al. 1951, 274). Perls knew that “if these things are let be . . . even their current derangements will tend to right themselves and come to something valuable” (1951, 247), a stance he likened to the Tao principle “stand out of the way.”

Carl Rogers expressed the same insight in his concept of an “organismic valuing process,” the key to successful development of our inherent drive toward self-actualization (1959, 224) “The human infant is having an inherent motivational system (which he shares in common with all living things) and a regulatory
system (the valuing process) which by its ‘feedback’ keeps the organism ‘on the beam’ of satisfying his motivational needs". (Rogers 1959, 222)

Rogers’ use of the term “organismic” reflects the fact that this essential efficacy operates at the level of the whole person, not in relation to any one aspect of our identity such as “me the behavioral health client,” nor in relation to any isolated goal we may pursue, such as “my desire to get rich” or “my desire to . . .”

Psychologist Abraham Maslow refers to the same kind of quality as “our inner nature” and describes it as “an active will toward health.” He notes that it not only exists in every newborn baby, but that as we grow older we never lose it. He argues, “If (our inner nature) is permitted to guide our life, we grow healthy, fruitful, and happy . . . Even though weak, it rarely disappears in the normal person—perhaps not even in the sick person. Even though denied, it persists underground forever pressing for actualization”. (Maslow 1968)

More recently Nathaniel Branden recognized the importance of our fundamental “metaphysical efficacy” and explored its relationship to self-awareness and self-acceptance as “my refusal to be in an adversary relationship to myself” (1983). He recognized that such efficacy is “the birthright of every conscious organism”. (Branden 1983)

In the new age and transpersonal psychology literature some prefer to call this natural direction finder the “Inner Guide.” The Inner Guide is how the fundamental way of the world, the natural order, is manifest in our individual lives.

These insights—both spiritual and psychological—affirm that at our core we are innately endowed with a fundamental efficacy. We each have a kind of spontaneous or automatic way of knowing what is real and true and, based on that understanding, knowing what needs to be done. Those who have a sense of connection to that fundamental competence enjoy a secure sense of deep confidence.

Both the spiritual and psychological perspectives recognize that this quality

- is natural, a “birthright,” inherent in all living things
- is something more than our physical bodies or conscious minds
- exists in the present moment
- exists at the level of our whole being, not isolated aspects of ourselves.

A person with serious, persistent mental illness experiences symptoms of distress or functional impairments, but that individual retains these qualities of personal strength, an “active will toward health.” In recovery-oriented services, the service provider relates to these qualities of the individual’s experience. Providers understand symptoms to be an important aspect of the person, but not the essential feature of what it means to be that person. (Maslow 1968, 4)
Whether one thinks of it as the organismic valuing process, the Inner Guide, God’s will, or the Tao, neither the service provider nor the client can intentionally create this quality, nor do they need to. We only need to accept the unity between the body, the conscious mind, and this essential force within us. We only need to stand out of its way.

**BEING PRESENT FOR EVERYDAY LIFE**

Psychologist Abraham Maslow illustrates the principle of confidence in the valuing process. Maslow began by identifying a group of “self-actualizing” individuals. The notion of self-actualization encompasses both presence and deep confidence. Their presence was evident in the fact that they were making full use of their talents and capacities. They felt fulfilled. And their sense of deep confidence was clear from the way in which they each felt safe in the world as it is.

Maslow was curious to know what other qualities these exceptionally healthy people had in common. He knew that such findings might help explain what makes self-actualization possible, and how it affects our everyday lives.

Some of his findings were what most people would expect. Self-actualizing people were fully present in the moment. They found ways to enjoy a continued freshness of appreciation for life as it unfolds. They were creative and more spontaneous than most others. They were confident enough in their own internal guide that they were not dependent on the opinions others hold of them. Still, they could hear what others had to say about them, and then take what made sense and leave the rest.

Maslow found several other qualities that come very close to the notion of presence. Self-actualizing people were found to be more accurate in their perception of reality than the average person and were more comfortable about accepting that reality. They had an unusual ability to detect manipulations and deceptions by others. They could distinguish things as they are from things as they would like them to be.

These self-actualizing people were also characterized by a profound sense of self-acceptance. They were aware and accepting of their own internal contradictions. They could simultaneously feel strong and weak. They could simultaneously like and dislike another person. They did not need things to be one way or the other. They could accept things as they were, knowing that everything in life has something of an upside and something of a downside, and a lot in between—and that that is okay.

It probably comes as no surprise that these exceptionally well-functioning people had qualities like presence, spontaneity, and confidence. But they also revealed qualities that might not seem so obviously “mentally healthy” to the average person—qualities that, to some, might even seem a little strange.

These self-actualizing people commonly reported having had spiritual experiences, cosmic or mystical feelings, or a sense of something that transcends the material world. These experiences reflect psychoanalyst Carl Jung’s notion of integral wholeness, “an attitude that is beyond the reach of emotional entanglements and violent shocks—a consciousness detached from the world.” (Jung & Storrs, 1983) Regardless of their religious orientation—some were probably even atheists—their spiritual experiences
sounded very much like the Judeo-Christian desire to be at one with God, the Taoist’s Wu Wei, or the Hindu’s unity of mind, body, and Atman and Brahman.

Many people have had such experiences, although they do not always talk about them. Some can recall moments of mystical experience, not necessarily the kind a person tries hard to arouse through elaborate ritual and prayer, nor the kind that some people chemically induce through use of intoxicating substances, but the kind that naturally wells up inside.

The experience often comes to a person at likely times: when one is hiking through beautiful surroundings, especially through wilderness or near bodies of water; when listening to an engaging music performance; during a moving religious ceremony; perhaps just walking into a beautiful building such as a place of worship, art gallery, or architectural masterpiece. These are inspiring moments, but a person can never clearly anticipate when they will arise. We cannot decide that we are going to feel a sense of metaphysical bliss, nor can we try to feel that way. The best we can do is expose ourselves to opportunities for inspiration.

These mystical moments can also come at times when a person would least expect it, even at times of great tragedy, such as during a psychiatric emergency. At times, such as these a person can come face-to-face with the reality of a great crisis, yet feel an incredible sense of inner peace. The person may have exerted all manner of conscious effort to separate his or her image of his or her life from the way it was. The person may have invested tremendous energy in keeping reality at bay. Suddenly, the person senses that he or she can transcend the chaos, sometimes with a sense of taking great courage from contact with a presence much greater than oneself. Thus, many individuals in crisis find that they are willing to be fully present with all the pain and sadness, all the anger and fear that had been festering just beneath the surface for so long.

What a relief these moments of surrender can be. At times like these a person has no need to plan the next steps or attempt to control the outcome of these events. The person’s world is here and now, with no sense of separation between “the thinking self” and “the feeling self,” between one’s intellect and experience. At times like these a person can come to know that he or she could do whatever needed to be done and that, it spites of one’s personal limitations, that would be good enough for now. In situations like this many people come into a sense of order amidst what had previously felt like chaos. The person feels complete, regardless of how his or her life or a loved one’s life might eventually turn out.

A person in recovery does not need to become an otherworldly type. A person in recovery does not want or need to experience such feelings day in and day out. But people in recovery savor those moments of acceptance and surrender when they arise, and they appreciate the wondrous sense of harmony that comes with them. By simply recalling those moments a person feels that much more secure. The person is reminded that whatever there was within him or herself that made the moment possible remains.

Abraham Maslow found that his self-actualizing people enjoy their spiritual harvest relatively often because of their self-accepting presence. They are at peace with the naturally arising spirituality in life because they are at peace with life as it flows.
Recovery-Oriented Clinical Care

1. Ward Environment and Service Program

Inpatient psychiatric wards are designed and programmed with an emphasis on safety. In addition to that, a recovery-oriented ward environment promotes client engagement and empowerment and instills a sense of hope, healing, and therapeutic change.

Recovery-oriented programming might include:

- an orientation to recovery group to ensure clients’ understanding of recovery concepts and principles
- psychosocial rehabilitation and recovery programming using evidence-based models such as Social Skills Training, Illness Management and Recovery (IMR), Wellness Recovery Action Plans (WRAP), or other recovery-oriented models.

Inpatient programming must be consistent with the recovery-oriented programming in other settings throughout the service system to ensure consistency and continuity of care across programs and levels of care.

2. Self-Responsibility and Self-Determination

Individuals must be actively engaged in defining personal goals based on their self-chosen values, interests, roles, and aspirations. When they participate in developing their treatment plan, they must be helped to understand how inpatient clinical interventions are designed to facilitate the individual’s achievement of those goals.

Individuals should be provided with:

- a detailed explanation, in clear and understandable language, of the purpose of hospitalization
- resources and opportunities available during inpatient treatment
- information consistent with the individual’s capacity for understanding
- information about the nature and extent of services and about the extent of the individual’s right to refuse service
- information about the extent to which family and significant others can participate in developing and implementing the individual’s treatment plan, and the individual’s right to choose or reject such participation.

3. Meaningful Participation
Clients and family members involved in the individual's care must be provided with and receive orientation to the inpatient unit. They must be presented with a review of recovery principles, clinical service programming, unit rules, and safety features of the unit. Clients' and family members' understanding of this vital information must be confirmed. This information must be reviewed as relevant throughout the individual's inpatient stay.

4. Family and Significant Others

Family and visitors can be important sources of support for many individuals and must be involved in the individual's care to the extent appropriate and desired by the individual.

5. Linking to the Client's Life

All definitions of the Recovery Model refer to a holistic process or pathway that encompasses the many facets of an individual's life. Although the staff of an inpatient unit may spend most of their waking hours in the unit over the weeks and months of their lives, individuals tend to feel that a brief inpatient stay takes them away from the life with which they identify. Inpatient services can only be provided with a recovery orientation when connected with the individual's general recovery path.

Individuals experiencing their first encounter with a behavioral health service system will be introduced to a recovery orientation during the episode of service. However, individuals who have participated in recovery-oriented outpatient services may already be on a path, pursuing recovery-oriented goals and objectives with the support of outpatient staff, community resources, and a personal support network. For these individuals, inpatient service providers must orient themselves to the individual's existing course of recovery by:

- reviewing the individual's outpatient treatment plan
- determining the extent to which the individual views that plan as relevant
- referencing elements of that plan perceived as relevant by the individual in the inpatient service plan
- communicating with the individual's existing primary service provider in the system of care
- communicating with family members and significant others who have been supporting the individual in his or her recovery, whenever the individual authorizes such communication
- communicating with the individual's anticipated primary service provider in the system of care prior to discharge to communicate the discharge plan
- documenting these communications in the individual's record.

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COMMON GROUND COMPONENTS OF A RECOVERY MODEL
Summary

The SAMHSA and Ragins models of recovery have been presented here because these two models coincide with each other, are consistent with the values expressed by the CAG Expert Panels, and capture the key elements referred to by others who cite recovery principles but without the context of a structured model.

This section of Module I takes a closer look at the common elements of the SAMHSA and Ragins models commonly found among the various descriptions of a Recovery Model in the behavioral health literature.

The foundation principles of a Recovery Model, common to most major models, are:

- Hope
- Individual based
- Self-responsibility
- Self-determination
- Empowerment
- Strengths-focused
- Spirituality
- Developing skills
- Restoring or acquiring meaningful life roles
- Developing natural supports

This and other CAG modules examine these foundations of a Recovery Model.

AN INTEGRITY-BASED APPROACH

When some people think about mental health services they focus on how to suppress or distract attention from an individual's symptoms, limitations, and self-doubts. However, the Recovery Model involves an acceptance of the whole person as he or she is. A recovery orientation acknowledges the person's weaknesses and limitations because it also recognizes that even people with mental illness are more than their illness. Like anyone else, they have strengths available to compensate for and grow beyond those weaknesses.

A recovery orientation to service delivery focuses on and emphasizes strengths, but it does not deny or ignore a person's limitations. To do so would be a rejection of the individual, the whole person as he or she is. Although the recovery model is often referred to as a strength-based approach, it may be more accurate to think of it as an integrity-based approach—recognizing, accepting, and appreciating the whole person.

When individuals are met with genuine acceptance of their integrity they are empowered to accept and appreciate themselves in the same way. People on a path to recovery:

- can say, “I can find peace and gratification even if I can't do some things as well as I'd like”
- can accept their limitations and their strengths
• have a fundamental sense of confidence in their strengths that makes it possible to examine their self-doubts and limitations squarely, and learn from them
• have such a sense of self-acceptance that they can feel free and open with other people without worrying about how they will be judged
• have such a sense of self-acceptance that they can be fully present right here and now without worrying about what might happen next or in the future.

Many people have known moments of deeply felt self-acceptance. Most people can recall times when they feel fully present in the moment, fully engaged with something. It may be skiing, sitting down to a good meal, reading a good book, hiking through a natural setting—anything that captures a person’s attention. At times like these the analytical mind is not trying to change the individual into anything other than who or what he or she is.

There is something very natural about such self-acceptance. That is why the potential for growth and recovery is inherent in all living things. We grow and change from a starting point in the here-and-now moment, not from someone else’s philosophical concept of who we are. This tendency to begin growing and changing from “who and what I am right here and right now” is an adaptive, natural sense that has survived the demanding course of evolution. Clients do not need to learn it from service providers, and they do not need to create it. Clients, like everyone else, need to allow this tendency to just be.

Recovery does not assure fame and fortune, limitless power, or popularity. It does not assure that a person will live happily ever after. But every person has some degree of talent, ability, and the desire to achieve goals. Recovery-oriented services are provided in such a manner that unrealistic self-doubt, promoted by the self-fulfilling, negative expectations of others, does not undermine an individual’s efforts at success. And when an individual does not have the talent, ability, or the desire to achieve a goal, recovery-oriented services remind that person that he or she still has everything it takes to live a fulfilling life without having to get caught up in trying to do the impossible or become someone that they are not.
Ethical Standards of Behavioral Health Professions Related to Recovery

The Recovery Model might be very different than common practices in public behavioral health service systems, but it closely follows well established professional standards and regulatory requirements. The model maintains consistency with ethical standards of all behavioral health professions, Medi-Cal and other third-party payer regulations, and the theoretical foundations of psychotherapy and other forms of clinical practice.
SAMHSA has established a set of standards for the implementation of recovery-oriented behavioral health practices. It has also provided funding for several major implementation initiatives, such as the joint project between the American Psychiatric Association and American Association of Community Psychiatrists. At the federal level, the Recovery Model has also been endorsed by the National Institute of Mental Health and the President’s New Freedom Commission on Mental Health (2008).

The following section outlines how professional disciplines specifically psychiatry, psychology, social work and marriage and family therapy align with concepts and principles of recovery oriented services.

Psychology/Psychiatry

Among professional associations, the Recovery Model has been formally endorsed by the American Psychological Association (APA). Note: both the American Psychological Association and the American Psychiatric Association use the acronym APA. For clarity, this document will use APA (Psychology) and APA (Psychiatry).

In a 2009 declaration, the APA (Psychology) committed to the following resolutions:
THEREFORE, BE IT RESOLVED that the APA endorses the concept of recovery as it applies to serve mental illness (SMI) BE IT FURTHER RESOLVED that APA will issue a position statement noting this endorsement, and that this statement will be actively promulgated to the public and appear on the APA website.

BE IT FURTHER RESOLVED that APA will work toward increasing the attention to promoting data-driven views on the realities of long-term outcomes for people with serious mental illness and to the importance of consumer-defined and community reintegration-centered goals in conceptualizing treatment in graduate and post-graduate training.

BE IT FURTHER RESOLVED that psychologists be encouraged to continue to promote the development, implementation, and rigorous evaluation of recovery-oriented services.

BE IT FURTHER RESOLVED that, consistent with the principles of recovery, that these efforts involve consumer input and other forms of active collaboration with consumers.

BE IT FURTHER RESOLVED that psychologists be encouraged to support and promote staff training and public education efforts designed to increase awareness of recovery-oriented concepts and treatment.

BE IT FURTHER RESOLVED that psychologists be encouraged to support and promote efforts at stigma reduction, with the understanding that the extent of recovery is partly a function of the degree to which people with SMI are accepted as valued individuals in their communities.

BE IT FURTHER RESOLVED that psychologists be encouraged to conduct further research on the outcomes of recovery-oriented interventions.

Social Work (MSW, LCSW)

Similarly, a recovery orientation has received support from the National Association of Social Workers (NASW) and other representatives of the social work profession. The Council on Social Work Education (CSWE) conceptualizes many of its accreditation standards about elements of the Recovery Model. In its policy statement regarding the Recovery Model, the NASW recognizes the model's broader value in human services as well as in mental health services. The NASW statement proclaims the following:

The Recovery Model is the focus of the mental health field, though its tenets can and should be extrapolated to other service fields. The goals of empowerment and self-actualization for traditionally disenfranchised populations, which are inherent in the Recovery Model, are very like the NASW Code of Ethics (1999), and the NASW's policy statements in Social Work Speaks (2003). Encouraging these goals is inherent in what it means to be a social worker. (NASW, 2015)

All schools granting master of social work degrees nationwide are subject to accreditation by the CSWE. Council accreditation requires that a program include course work that includes the following:
Educational Policy 2.1.10(a)—Engagement

Social workers

- prepare, substantively and effectively, for action with individuals, families, groups, organizations, and communities
- use empathy and other interpersonal skills
- develop a **mutually agreed-on focus of work and desired outcomes**.

Educational Policy 2.1.10(b)—Assessment

Social workers

- collect, organize, and interpret client data
- assess **the individual’s strengths and limitations**
- develop mutually **agreed-on intervention goals and objectives**
- select appropriate intervention strategies.

Despite many theoretical similarities to recovery, there are areas in which social work practice has fallen prey to the same persistent focus on illness, labeling, and deficits, which dominates the mental health care system and sets the consumer apart to be acted on by the practitioner. **The theoretical base of the person-in-environment and strengths based perspectives** (which call on social workers to empower consumers) and the Code of Ethics (NASW, 2008; which highlights self-determination and respect) **are often found by the practitioner to be at odds with the day-to-day realities of social work practice in the mental health system.** Social work practitioners who affirm a recovery orientation are seeking concrete assistance in determining how to carry out recovery-oriented practice in such an environment.

Marriage and Family Therapist (MFT)

The **Marriage and Family Therapist Licensing Law**, California Business and Professions Code Section 4980.36 defines the required content of a doctoral or master’s degree program that qualifies for licensure or registration. These requirements, supported by the California Association of Marriage and Family Therapists, include Recovery Model knowledge and skills. Note that the following list only includes relevant excerpts from the Business and Professions Code and, therefore, are not necessarily in consecutive order.

Sec. 4980.36

(c) A doctoral or master’s degree program that qualifies for licensure or registration shall do the following:

(1) Integrate all the following throughout its curriculum:

(A) Marriage and family therapy principles

(B) The principles of **mental health recovery-oriented care and methods** of service delivery in recovery-oriented practice environments, among others
(C) An understanding of various cultures and the social and psychological implications of socioeconomic position, and an understanding of how poverty and social stress impact an individual's mental health and recovery

(5) Provide students with the opportunity to meet with various consumers and family members of consumers of mental health services to enhance understanding of their experience of mental illness, treatment, and recovery

These professional organizations are not able to endorse a model that conflicts with their own codes of ethics or regulatory requirements. In fact, they have adopted or endorsed the Recovery Model because of the way in which it represents and promotes their standards.
Ethical Standards of Behavioral Health Professions Related to Recovery

The Recovery Model principles represented in the CAG are clearly and directly related to the ethical standards of the various behavioral health professions. The CAG supports staff in their efforts to comply with the expectations of both professional associations and licensing boards.

This review is based on the ethical and professional standards of the...

- NASW Code of Ethics, 2008
- American Association for Marriage and Family Therapy (AAMFT), Code of Ethics 2012
- American Psychological Association (APA Psychology), Ethical Principles of Psychologists and Code of Conduct, 2015
- American Psychiatric Association (APA Psychiatry), Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry, 2013 edition (based on the American Medical Association’s Principles of Medical Ethics)
- American Psychiatric-Nurses Association, Scope and Standards of Practice (2014)

Various professions, including psychiatry, psychology, social work, marriage and family therapy and nursing, share broad values and ethical principles such as:

- integrity (trustworthiness, honesty)
- respect for the dignity of the person served
- competence.

Such values are consistent with the CAG and the Recovery Model; however, they are broadly stated and substantially subject to interpretation. This review will focus on the ethical standards that are based on these values, but are stated in more specific terms to enable corrective action by professional associations when violations occur.
PROFESSIONAL BOUNDARIES
The following section discusses how various licensing agencies reference boundaries with clients which are aligned with recovery principles.

All behavioral health professions emphasize the importance of professional boundaries. Although professional codes of ethics generally do not explicitly use this term, professional boundaries are based on a variety of explicit ethical standards. Behavioral health professionals strive to inspire confidence in their clients and clients’ families. This is done, in part, by respecting clients’ dignity and self-determination, refraining from exploitation of clients, and acting in the clients’ best interests.

Maintaining professional boundaries also calls for the service provider to respect the individual’s confidentiality and privacy, gathering no more personal information than is necessary to accomplish the purpose of services. That, in turn, means that the service provider must be very clear about the purpose of services as defined by law, program design, and the individual’s goals and objectives.

Note that throughout the following section only relevant excerpts from the various professional association documents are included.

RESPECTING THE DIGNITY OF THE CLIENT

National Association of Social Workers (NASW)

Value: Dignity and Worth of the Person
Ethical Principle: Social workers respect the inherent dignity and worth of the person.
Social workers treat each person in a caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity. Social workers promote clients’ socially responsible self-determination. Social workers seek to enhance clients’ capacity and opportunity to change and to address their own needs. Social workers are cognizant of their dual responsibility to clients and to the broader society. They seek to resolve conflicts between clients’ interests and the broader society’s interests in a socially responsible manner consistent with the values, ethical principles, and ethical standards of the profession.

1.12 Derogatory Language
Social workers should not use derogatory language in their written or verbal communications to or about clients. Social workers should use accurate and respectful language in all communications to and about clients.
American Association for Marriage and Family Therapy (AAMFT)

Principle I: Responsibility to Clients
Marriage and family therapists advance the welfare of families and individuals. They respect the rights of those persons seeking their assistance, and make reasonable efforts to ensure that their services are used appropriately.

American Psychological Association (APA Psychology)

Principle E: Respect for People’s Rights and Dignity
Psychologists respect the dignity and worth of all people as well as the individual’s rights to privacy, confidentiality, and self-determination. Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision-making. Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status, and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of personal biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices.

American Psychiatric Association (APA Psychiatry)

Section 1: A physician shall provide competent medical care, with compassion and respect for human dignity and rights.

RESPECTING THE IMPORTANCE OF RELATIONSHIPS

National Association of Social Workers

Value: Importance of Human Relationships
Ethical Principle: Social Workers Recognize the Central Importance of Human Relationships
Social workers understand that relationships between and among people are an important vehicle for change. Social workers engage people as partners in the helping process. Social workers seek to strengthen relationships among people in a purposeful effort to promote, restore, maintain, and enhance the well-being of individuals, families, social groups, organizations, and communities.

COMMENT: Although other professions do not explicitly address the importance of human relationships as an ethical standard, the high value placed on human relationships is clear throughout the practice literature of all behavioral health professions.
INFORMED CONSENT

Ethical standards regarding informed consent provide the ethical basis in support of Recovery Model principles such as client self-determination, self-responsibility, and collaboration. These ethical standards support use of interventions such as shared decision-making and advance directives.

National Association of Social Workers

1.03 Informed Consent

(a) Social workers should provide services to clients only in the context of a professional relationship based, when appropriate, on valid informed consent.

Social workers should use clear and understandable language to inform clients of

- the purpose of the services
- risks related to the services
- limits to services because of the requirements of a third-party payer
- relevant costs
- reasonable alternatives
- clients’ rights to refuse or withdraw consent
- the timeframe covered by the consent.

Social workers should provide clients with an opportunity to ask questions.

COMMENT: Note that the re-traumatizing nature of many procedures used during an involuntary detention is a significant risk associated with this mode of intervention. Consumers should be so informed, consistent with the Trauma Informed Care principle that engagement can be facilitated when the practitioner demonstrates to the individual that he or she is aware of and can express an empathic understanding of the individual’s experience, even when the re-traumatizing intervention may be unavoidable.

COMMENT: Informing the client of the purpose of even an involuntary service is consistent with the 2015 amendment to the Lanterman–Petris–Short (LPS) law, which requires that such information be provided upon imposing an involuntary hold.
(b) In instances when clients are not literate or have difficulty understanding the primary language used in the practice setting, social workers should take steps to ensure clients’ comprehension. This may include providing clients with a detailed verbal explanation or arranging for a qualified interpreter or translator whenever possible.

(c) In instances when clients lack the capacity to provide informed consent, social workers should protect clients’ interests by seeking permission from an appropriate third party, informing clients consistent with the clients’ level of understanding. In such instances, social workers should seek to ensure that the third-party acts in a manner consistent with clients’ wishes and interests. Social workers should take reasonable steps to enhance such clients’ ability to give informed consent.

COMMENT: This standard supports social worker’s adherence to advance directives. Use of decision aids in a shared decision-making process is a way to fulfill the duty to enhance a client’s ability to give informed consent.

(d) In instances when clients are receiving services involuntarily, social workers should provide information about the nature and extent of services and about the extent of clients’ right to refuse service.

COMMENT: This standard recognizes that even involuntarily detained clients are entitled to refuse some aspects of service, and social workers are expected to provide this information to clients in language the client can understand.

American Association for Marriage and Family Therapy

1.2 Informed Consent. Marriage and family therapists obtain appropriate informed consent to therapy or related procedures and use language that is reasonably understandable to clients. The content of informed consent may vary depending upon the client and treatment plan; however, informed consent generally necessitates that the client:

(a) has the capacity to consent

(b) has been adequately informed of significant information concerning treatment processes and procedures

(c) has been adequately informed of potential risks and benefits of treatments for which generally recognized standards do not yet exist

(d) has freely and without undue influence expressed consent

(e) has provided consent that is appropriately documented.
When persons, due to age or mental status, are legally incapable of giving informed consent, marriage and family therapists obtain informed permission from a legally authorized person, if such substitute consent is legally permissible.

**COMMENT:** What constitutes “undue influence” varies from program to program and from one level of service to another. The exercise of professional authority that might be expected in a traditional behavioral health service program could very well constitute undue influence in a Recovery Model program that has led clients and the community to expect an emphasis on client self-determination and self-responsibility.

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**American Psychological Association**

**3.10 Informed Consent**

(a) When psychologists conduct research or provide assessment, therapy, counseling, or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons except when conducting such activities without consent is mandated by law or governmental regulation or as otherwise provided in this Ethics Code. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)

(b) For persons who are legally incapable of giving informed consent, psychologists nevertheless (1) provide an appropriate explanation, (2) seek the individual’s assent, (3) consider such persons’ preferences and best interests, and (4) obtain appropriate permission from a legally authorized person, if such substitute consent is permitted or required by law. When consent by a legally authorized person is not permitted, or required by law, psychologists take reasonable steps to protect the individual’s rights and welfare.

(c) When psychological services are court-ordered or otherwise mandated, psychologists inform the individual of the nature of the anticipated services, including whether the services are court-ordered or mandated and any limits of confidentiality, before proceeding.

**COMMENT:** Psychologists have an ethical obligation to inform even individuals who are incapable of giving informed consent with an explanation for the services being rendered. This is consistent with the 2015 amendment to the LPS law which requires that such information be provided upon imposing an involuntary hold. These ethical obligations are consistent with adherence to advance directives and use of decision aids in shared decision-making.

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**American Psychiatric Association**

**Section 8:** A physician shall, while caring for a patient, regard responsibility to the patient as paramount.
Annotation 4. In informing a patient of treatment options, the psychiatrist should assist the patient in identifying relevant options that promote an informed treatment decision, including those that are not available from the psychiatrist or from the organization with which the psychiatrist is affiliated.

COMMENT: In a Recovery Model, inpatient service program, the psychiatrist has an ethical responsibility to inform the individual of relevant options that promote an informed treatment decision. This is consistent with the use of decision aids and participation in shared decision-making about any significant issue that is subject to client consent. The psychiatrist should inform the individual of these resources because they promote an informed treatment decision, even if the psychiatrist is not the person engaged with the individual in various aspects of the inpatient treatment plan and discharge plan.

Section 2
A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception to appropriate entities.

Annotation 5. Psychiatric services, like all medical services, are dispensed in the context of a contractual arrangement between the patient and the physician. The provisions of the contractual arrangement, which are binding on the physician as well as on the patient, should be explicitly established.

COMMENT: After the patient has been informed of treatment options, including those that are not available from the psychiatrist, and the patient has made an informed treatment decision, the decision should be expressed in an explicit contractual arrangement, binding on both the physician and the self-responsible patient. These standards are consistent with Media-Cal treatment planning requirements and promote the principles underlying shared decision-making.

SELF-DETERMINATION

In addition to the following explicit references to client self-determination, this principle is implied by the informed consent provisions of ethical standards.

National Association of Social Workers

1.02 Self-Determination
Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals. Social workers may limit clients’ right to self-determination when, in the social workers’ professional judgment, clients’ actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others.
COMMENT: Social workers are required to not only accept client self-determination but to promote it as well. The requirement regarding assisting individuals in their efforts to identify and clarify their goals is not only consistent with Medi-Cal treatment plan requirements, but with shared decision-making as well. The exception to self-determination is narrowly defined as involving a risk that is serious, foreseeable, and imminent. Clearly there are many aspects of an involuntary hold that do not involve such a risk.

American Association for Marriage and Family Therapy

1.8 Client Autonomy in Decision-Making. Marriage and family therapists respect the rights of clients to make decisions and help them to understand the consequences of these decisions. Therapists clearly advise clients that clients have the responsibility to make decisions regarding relationships such as cohabitation, marriage, divorce, separation, reconciliation, custody, and visitation.

American Psychological Association

Principle E: Respect for People’s Rights and Dignity
Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination. Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision-making. Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices.

American Psychiatric Association

The APA’s ethical standards do not explicitly refer to self-determination or patient autonomy beyond the issue of informed consent. However, the APA’s standards do not conflict with these vital Recovery Model principles.

ACCESS TO RECORDS

A client’s access to his or her clinical record is an important aspect of client self-determination and self-responsibility. It is in the clinical record that a client can be reminded of treatment plan goals and objectives that may have been agreed to in the past but are no longer acceptable to the individual. In progress notes the individual can see what the staff member considered to be the significant issues addressed in a session and determine the extent to which there is or is not consensus on this issue.

A client’s right to access records is well established in The Health Insurance Portability and Accountability Act (HIPAA) 1996, and in the California Patient Access to Records Act (CA Health and Safety Code
Sections 123100-123149.5) and in professional codes of ethics. The California law, which predated HIPAA by many years, permitted clinicians to deny access to an individual who requested access to records if the clinician believed it would be “detrimental” in any way for the client to see the record. Professional codes of ethics also allow for such professional discretion. Mental health records were rarely made available to clients under these conditions. HIPAA then superseded California law and professional ethics on this issue and allowed for records to be withheld only if seeing the record would cause serious physical injury or death. If the client’s clinician is of that impression, then the client is entitled to a second opinion and the clinician is required to inform the client of that right.

National Association of Social Workers

1.08 Access to Records

(a) Social workers should provide clients with reasonable access to records concerning the clients. Social workers who are concerned that clients’ access to their records could cause serious misunderstanding or harm to the client should help in interpreting the records and consulting with the client regarding the records. Social workers should limit clients’ access to their records, or portions of their records, only in exceptional circumstances when there is compelling evidence that such access would cause serious harm to the client. Both clients’ requests and the rationale for withholding some or all the record should be documented in clients’ files.

(b) When providing clients with access to their records, social workers should take steps to protect the confidentiality of other individuals identified or discussed in such records.

COMPETENCE

Ethical standards regarding competence are essential to the credibility and effectiveness of the various behavioral health professions. The ethics of competence is closely related to several other ethical standards.

Behavioral health professionals do not have an ethical responsibility to be competent at everything that is within the profession’s legal scope of practice. But they do have an ethical responsibility to

- accurately represent their personal scope of competence to clients and employers
- refrain from engaging in practices for which they have not yet been adequately trained unless they are currently receiving proper training and/or supervision from a person who is qualified in the practice being learned
- keep current with emerging knowledge as it relates to the kind of practice in which they are engaged.

Standards regarding competence are closely related to standards involving honesty, integrity, and prohibitions against misrepresentation of one’s qualifications, training, and experience. Behavioral health professionals may not misrepresent their training, experience, knowledge, and skill as may pertain to the Recovery Model, evidence-based practices, differential diagnosis, or any other aspect of practice requiring
trained abilities. For example, it would be unethical for a behavioral health professional to claim to be using an evidence-based practice **without having objectively determined the degree of fidelity of his or her practice as compared to the practice method in question.** For another example, it would be unethical for a behavioral health professional to claim to be basing treatment on a documented treatment plan if the professional was **not conscious of the goals and objectives of that treatment plan.**

These issues also relate to a professional's responsibility to adhere to the conditions of his or her employment contract, which, in most cases, involves an assurance to the employer of competence necessary to implement a job description within a program design in exchange for the employer's assurance of a salary, benefits, and working conditions. The professional can only be expected to adhere to an employer's expectations that were made clear at the time the professional gave the assurance of relevant competence.

**National Association of Social Workers**

**4.01 Competence**

(a) Social workers should **accept responsibility or employment only based on existing competence or the intention to acquire the necessary competence.**

(b) Social workers should strive to become and remain proficient in professional practice and the performance of professional functions. Social workers should critically examine and keep current with emerging knowledge relevant to social work. Social workers should routinely review the professional literature and participate in continuing education relevant to social work practice and social work ethics.

(c) Social workers should base practice on recognized knowledge, including empirically based knowledge, relevant to social work and social work ethics.

**COMMENT:** Part (a) means that a social worker who does not have and does not intend to acquire the necessary competence to implement a Recovery Model program should not accept employment in such a program, if the nature of the program and its requisite knowledge and skills were made known to the job applicant by the employer. It also means that a social worker who accepted employment in a program that was not oriented to Recovery Model practices should not accept new job responsibilities involving the introduction of Recovery Model knowledge and skills unless the social worker has the requisite existing competence or intends to acquire the necessary competence.

**4.04 Dishonesty, Fraud, and Deception**

Social workers should not participate in, condone, or be associated with dishonesty, fraud, or deception.

**4.06 Misrepresentation**

(c) Social workers should ensure that their representations to clients, agencies, and the public regarding professional qualifications, credentials, education, competence, affiliations, services provided, and results to be achieved are accurate. Social workers should claim only
those relevant professional credentials they possess and take steps to correct any inaccuracies or misrepresentations of their credentials by others.

2.05 Consultation

(a) Social workers should seek the advice and counsel of colleagues whenever such consultation is in the best interests of clients.

(b) Social workers should keep themselves informed about colleagues’ areas of expertise and competencies. Social workers should seek consultation only from colleagues who have demonstrated knowledge, expertise, and competence related to the subject of the consultation.

American Association for Marriage and Family Therapy

Principle III
Professional Competence and Integrity
Marriage and family therapists maintain high standards of professional competence and integrity.

3.1 Maintenance of Competency. Marriage and family therapists pursue knowledge of new developments and maintain their competence in marriage and family therapy through education, training, or supervised experience.

3.7 Development of New Skills. While developing new skills in specialty areas, marriage and family therapists take steps to ensure the competence of their work and to protect clients from possible harm. Marriage and family therapists practice in specialty areas new to them only after appropriate education, training, or supervised experience.

3.11 Scope of Competence. Marriage and family therapists do not diagnose, treat, or advise on problems outside the recognized boundaries of their competencies.

7.4 Truthful Representation of Services. Marriage and family therapists represent facts truthfully to clients, third-party payers, and supervisees regarding services rendered.

8.8 Specialization. Marriage and family therapists do not represent themselves as providing specialized services unless they have the appropriate education, training, or supervised experience.

American Psychological Association

2.01 Boundaries of Competence
(a) Psychologists provide services, teach and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study or professional experience.
(c) Psychologists planning to provide services, teach or conduct research involving populations, areas, techniques or technologies new to them undertake relevant education, training, supervised experience, consultation, or study.
(d) When psychologists are asked to provide services to individuals for whom appropriate mental health services are not available and for which psychologists have not obtained the competence necessary, psychologists with closely related prior training or experience may provide such services to ensure that services are not denied if they make a reasonable effort to obtain the competence required by using relevant research, training, consultation, or study.

2.03 Maintaining Competence
Psychologists undertake ongoing efforts to develop and maintain their competence.

5.01 Avoidance of False or Deceptive Statements
(a) Public statements include but are not limited to paid or unpaid advertising, product endorsements, grant applications, licensing applications, other credentialing applications, brochures, printed matter, directory listings, personal résumés or curricula vitae, or comments for use in media such as print or electronic transmission, statements in legal proceedings, lectures, and public oral presentations and published materials. Psychologists do not knowingly make public statements that are false, deceptive, or fraudulent concerning their research, practice, or other work activities or those of persons or organizations with which they are affiliated.
(b) Psychologists do not make false, deceptive, or fraudulent statements concerning (1) their training, experience, or competence; (2) their academic degrees; (3) their credentials; (4) their institutional or association affiliations; (5) their services; (6) the scientific or clinical basis for or results or degree of success of their services; (7) their fees; or (8) their publications or research findings.

American Psychiatric Association

Section 1
A physician shall provide competent medical care with compassion and respect for human dignity and rights.

Section 2
A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception to appropriate entities.

1. The requirement that the physician conduct himself/herself with propriety in his or her profession and in all the actions of his or her life is especially important in the case of the psychiatrist because the patient tends to model his or her behavior after that of his or her psychiatrist by identification. Further, the necessary intensity of the treatment relationship may tend to activate sexual and other needs and fantasies on the part of both patient and psychiatrist, while weakening the objectivity necessary for control. Additionally, the inherent inequality in the doctor-patient relationship may lead to exploitation of the patient. Sexual activity with a current or former patient is unethical.

2. A psychiatrist who regularly practices outside his or her area of professional competence should be considered unethical. Determination of professional competence should be made by peer review boards or other appropriate bodies.
3. Psychiatric services, like all medical services, are dispensed in the context of a contractual arrangement between the patient and the physician. The provisions of the contractual arrangement, which are binding on the physician as well as on the patient, should be explicitly established.

Section 5
A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

1. Psychiatrists are responsible for their own continuing education and should be mindful of the fact that theirs must be a lifetime of learning.

2. In the practice of his or her specialty, the psychiatrist consults, associates, collaborates, or integrates his or her work with that of many professionals, including psychologists, psychometrists, social workers, alcoholism counselors, marriage counselors, public health nurses, and the like. Furthermore, the nature of modern psychiatric practice extends his or her contacts to such people as teachers, juvenile and adult probation officers, attorneys, welfare workers, agency volunteers, and neighborhood aides. In referring patients for treatment, counseling, or rehabilitation to any of these practitioners, the psychiatrist should ensure that the allied professional or paraprofessional with whom he or she is dealing is a recognized member of his or her own discipline and is competent to carry out the therapeutic task required. The psychiatrist should have the same attitude toward members of the medical profession to whom he or she refers patients. Whenever he or she has reason to doubt the training, skill, or ethical qualifications of the allied professional, the psychiatrist should not refer cases to him/her.

American Nurses Association (ANA)
In its “Psychiatric Mental Health Nursing Association: Scope and Standards of Practice (Draft 11/20/12)” the ANA expresses its support of the Recovery Model for members of the nursing profession serving mentally ill individuals. Consider the following excerpts:

“Here recovery is endorsed as the essential platform for treatment . . .”

“Since the Substance Abuse and Mental Health Services Administration (SAMHSA) has declared that recovery is the single most important goal in the transformation of mental health care in America (SAMHSA, 2006), psychiatric-mental health nursing is moving to integrate person-centered recovery-oriented practice across the continuum of care. This continuum includes settings where psychiatric-mental health nurses have historically worked, such as hospitals, as well as emergency rooms, jails and prisons, and homeless outreach services.”

“Safety issues for persons with psychiatric disorders and the nurses involved in assisting persons with mental illness in their own recovery process are major priorities for this nursing specialty in an environment of fiscal constraints and disparities in reimbursement for mental health services.”
In support of its endorsement of recovery the ANA has developed a curriculum for addressing psychiatric, mental health issues entitled “Essential Psychiatric, Mental Health, and Substance Use Competencies for the Registered Nurse” (American Academy of Nursing, 2012). The curriculum was developed in collaboration with the International Society of Psychiatric Nursing and the American Psychiatric Nurses Association. The following examples have been identified as “Essential Psychiatric-Mental Health Substance Use Competencies.” Note how closely these competencies follow the CAG for Involuntary Detention.

Essential I: Integration of liberal arts into educational programs for registered nursing practice
- Sample Content: Broaden the traditional clinical paradigm to include prevention, early intervention, rehabilitation, and recovery and resilience-oriented approaches to care

Essential VI: Inter-professional communication and collaboration for improving patient mental health outcomes in registered nursing practice.
- Sample Content: Engage in simulations of practice incorporating the Recovery Model

Essential IX: Registered nursing practice
- Competency 5.0: Incorporate patient self-determination and adherence strategies into patient centered care.
  - Sample Content
    - Patient Self Determination Act 1991
    - Self-determination as related to patient centered psychiatric care
    - Patient as active consumer and partner in care
    - Recovery model of mental health and substance use disorders rehabilitation
    - Common examples of self-determination: right to decision making, right to information, right of consent, right to refuse, right to be heard, right to know and have opinions considered
    - Illness and authority as potential barriers to self determination
    - Ethical, legal, economic, and practical concerns that influence self determination
    - Psychiatric Advanced Directives
    - Common strategies that support self-determination and adherence into patient centered care in illness
    - Explanations of benefit vs. potential harm without intervention
    - Explanations of benefit vs. potential harm in relation to drug misuse or abuse by patient
    - Motivational interviewing regarding self-determination and adherence
- Competency 15.0: Coordinate and manage care for a group of individuals with psychiatric disorders to maximize health, independence, and quality of life.
- Competency 15.4: Describes the principles, functions and care provider roles of the Assertive Community Treatment, Case Management, Recovery and Rehabilitation models.
  - Sample Content
    - Therapeutic communication
    - Collaboration
- Support Groups
- Assertive Community Treatment Model
- Recovery Model
- Relapse Counseling

- Competency 18.0: Develop an appreciation of patients as well as health care professionals' spiritual beliefs and values and how those beliefs and values impact health care.
- Competency 18.6: Lists common clinical areas for spiritual care intervention such as acute care; palliative care, long term care, addiction and recovery and mental health sites

This review is based on the ethical and professional standards of the...

- NASW Code of Ethics, 2008
- American Association for Marriage and Family Therapy (AAMFT), Code of Ethics 2012
- American Psychological Association (APA Psychology), Ethical Principles of Psychologists and Code of Conduct, 2015
- American Psychiatric Association (APA Psychiatry), Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry, 2013 edition (based on the American Medical Association’s Principles of Medical Ethics)
- American Psychiatric-Nurses Association, Scope and Standards of Practice (2014)
Any of the above cited ethical standards apply to behavioral health professionals in supervisory or administrative positions, as well as to those in direct service positions. The following additional standards apply specifically to those in supervisory and administrative positions.

**National Association of Social Workers**

**3.01 Supervision and Consultation**

(a) Social workers who provide supervision or consultation should have the necessary knowledge and skill to supervise or consult appropriately and should do so only within their areas of knowledge and competence.

**COMMENT:** A supervisor who expects a supervisee to engage in a practice that is new to the supervisee (e.g., WRAP planning, shared decision-making, motivational interviewing, Recovery Model) should do so only if the supervisor has the relevant knowledge and skill or provides the supervisee with consultation from a consultant who has the relevant knowledge and skill.

(d) Social workers who provide supervision should evaluate supervisees' performance in a manner that is fair and respectful.

**COMMENT:** The code of ethics does not fully specify what constitutes fairness in performance evaluation, but it is generally recognized that it is unfair to hold a supervisee accountable for expectations that have not been clearly defined and communicated to the supervisee. Standard 3.03 addresses this issue below.

**3.02 Education and Training**

(a) Social workers who function as educators, field instructors for students, or trainers should provide instruction only within their areas of knowledge and competence and should provide instruction based on the most current information and knowledge available in the profession.

**3.03 Performance Evaluation**

Social workers who have responsibility for evaluating the performance of others should fulfill such responsibility in a fair and considerate manner and based on clearly stated criteria.

**COMMENT:** Clearly stated criteria for implementing the competencies needed to meet CAG are provided throughout the Philosophies and Practices Module as well as the Competencies Module.
3.07 Administration
(a) Social work administrators should advocate within and outside their agencies for adequate resources to meet clients' needs.
(c) Social workers who are administrators should take reasonable steps to ensure that adequate agency or organizational resources are available to provide appropriate staff supervision.

3.08 Continuing Education and Staff Development
Social work administrators and supervisors should take reasonable steps to provide or arrange for continuing education and staff development for all staff for whom they are responsible. Continuing education and staff development should address current knowledge and emerging developments related to social work practice and ethics.

5.02 Evaluation and Research
(a) Social workers should monitor and evaluate policies, the implementation of programs, and practice interventions.
(c) Social workers should critically examine and keep current with emerging knowledge relevant to social work and fully use evaluation and research evidence in their professional practice.

American Association for Marriage and Family Therapy

3.5 Veracity of Scholarship. Marriage and family therapists, as presenters, teachers, supervisors, consultants, and researchers, are dedicated to high standards of scholarship, present accurate information, and disclose potential conflicts of interest.

Principle IV
Responsibility to Students and Supervisees
Marriage and family therapists do not exploit the trust and dependency of students and supervisees.

4.4 Oversight of Supervisee Competence. Marriage and family therapists do not permit students or supervisees to perform or to hold themselves out as competent to perform professional services beyond their training, level of experience, and competence.

4.6 Existing Relationship with Students or Supervisees. Marriage and family therapists avoid accepting as supervisees or students those individuals with whom a prior or existing relationship could compromise the therapist's objectivity. When such situations cannot be avoided, therapists take appropriate precautions to maintain objectivity. Examples of such relationships include, but are not limited to, those individuals with whom the therapist has a current or prior sexual, close personal, immediate familial, or therapeutic relationship.

COMMENT: In public behavioral health services, supervisors are customarily former direct service providers who, at times, assume responsibility for the supervision of former clinical practice peers. Often these collegial relationships have led to personal friendships that continue beyond the
promotion. This may be doneethically if the supervisor takes “appropriate precautions to maintain objectivity.”

8.7 Employee or Supervisee Qualifications. Marriage and family therapists make certain that the qualifications of their employees or supervisees are represented in a manner that is not false, misleading, or deceptive.

American Psychological Association

2.05 Delegation of Work to Others
Psychologists who delegate work to employees, supervisees, or research or teaching assistants or who use the services of others, such as interpreters, take reasonable steps to (1) avoid delegating such work to persons who have a multiple relationship with those being served that would likely lead to exploitation or loss of objectivity; (2) authorize only those responsibilities that such persons can be expected to perform competently on the basis of their education, training, or experience, either independently or with the level of supervision being provided; and (3) see that such persons perform these services competently.

7.06 Assessing Student and Supervisee Performance
(a) In academic and supervisory relationships, psychologists establish a timely and specific process for providing feedback to students and supervisees. Information regarding the process is provided to the student at the beginning of supervision.
(b) Psychologists evaluate students and supervisees based on their actual performance on relevant and established program requirements.

American Psychiatric Association

Principle III
When the psychiatrist assumes a collaborative or supervisory role with another mental health worker, he or she must expend sufficient time to assure that proper care is given. It is contrary to the interests of the patient and to patient care if the psychiatrist allows himself/herself to be used as a figurehead.
How to Address Spirituality Within the Bounds of Secular Recovery-Oriented Practice

While service providers are prohibited from proselytizing or pressuring an individual to accept religious beliefs or engage in religious practices, the fundamental tenets of a person’s spiritual nature must be understood and appreciated in recovery-oriented practice. Anything that can enhance an individual’s sense of self-acceptance versus self-alienation, their sense of integrity versus self-fragmentation and mindfulness of the here and now can also enhance an individual’s sense of spirituality. Such practices are supported by the tenets of good clinical practice.

An understanding of a person’s spiritual nature needs to be applied within the ethical bounds and scope of practice of a secular profession.

The California Department of Health Care Services (2014) handbook on patient’s rights states the following.

Your right to practice your religion cannot be denied by anyone. You may not be pressured in any way to participate in religious practices, and you do not have to accept a visit from representatives of any religion. After you are admitted to a facility, let the staff know as soon as possible whether you have any special religious preferences.
Practical Steps when Inquiring about Spirituality

1. **Be open to addressing spirituality.** Ask about it. How does the individual want to address such issues, if at all?

2. Support/reinforce **coping techniques** that have worked in the past. Be open to exploring the individual's past use of prayer, meditation, reading sacred writings, forgiveness, confession, religious ritual, fellowship within a faith community, or consultation with religious leaders and teachers.

3. If the individual freely expresses informed consent to do so, a sense of deeper spirituality might be enhanced through
   - quoting or paraphrasing relevant scripture familiar to the client and clinician
   - gently confronting the individual on discrepancies between his or her own religious beliefs and behaviors
   - gently confronting the individual on discrepancies between his or her own spiritual strivings and behaviors
   - exploring the meaning of these issues and images to the individual in an empathic manner.

4. Help the individual recognize and accept his or her own **ambivalences** and life's inherent **paradoxes**.

5. **Promote self-acceptance**—in other words, the willingness to receive and acknowledge oneself in the present moment without censure or judgment.

6. Become very familiar with one’s own spiritual hunger and spirituality as a **basis for empathy** with the client's expressions of spirituality.

7. Take a spiritual stance in one’s work with clients—that is, **be genuine, authentic, and fully present**.
For further information about approaching spirituality within a secular practice, see the following:


- A review of empirical studies demonstrating associations between religion, religious participation, and spirituality, on the one hand, and health/mental health on the other
- A review of technical issues related to use of religious and spiritual issues in a secular clinical practice
- A review of empirical studies demonstrating associations between religion, religious participation, and spirituality, on the one hand, and health/mental health on the other
SUMMARY OF ETHICAL STANDARDS

Behavioral health professionals have an ethical responsibility to:

- obtain informed consent from clients, except in emergencies
- respect and promote client self-determination
- engage only in practices in which the professional is competent or is in the process of gaining competence
- represent accurately his or her own competence to clients, employers, and the public.

Behavioral health professionals in the role of supervisor or administrator, have the additional ethical responsibility to;
- supervise only within the scope of one’s own competence
- monitor and evaluate policies, program implementation, and practice interventions
- evaluate supervisee performance fairly, based on expectations (criteria) that have been set in advance
- advocate for provision of appropriate and adequate supervision of staff

- prohibit students or supervisees from performing services beyond their competencies
- prohibit students or supervisees from holding themselves out as competent to perform services beyond their competencies
- authorize only responsibilities that supervisees can be expected to perform competently
- expend sufficient time to assure that proper care is given to supervisees' clients.
Legal Issues
BEGINNING WITH THE CLIENTS CURRENT STATE OF BEING

Recovery-oriented practice can be rewarding for the service provider, but it is not an end. It is designed to accomplish positive outcomes with the individual. As such the inpatient unit’s recovery approach, must be well suited to the individual. Clearly inpatient staff will be able relate differently to everyone per the individual’s:

- decision-making capacity
- previous experience with recovery-oriented services
- stage of recovery

An individual who is momentarily disabled by associational disturbances and other acute psychotic symptoms, is new to the service system, and has not contemplated the possibility of personal recovery will need to be approached very differently than an individual who is deeply depressed, coherent, free of psychotic symptoms, can articulate key principles of recovery, and has made strides toward his or her own personal vision of recovery for several years.

Informed Consent

Self-responsibility, self-determination, empowerment, collaboration (between therapist and client), and informed choice are among the founding principles of a recovery-oriented approach. At least two factors must be considered when implementing these principles:

- the individual’s mental capacity to consent
- the quality of information provided to the individual

Decision-making capacity is a clinical determination in which a practitioner assesses whether an individual has the requisite cognitive capacities to make behavioral healthcare decisions. Although an individual’s informed consent is obviously not required to meet conditions of a 5150-involuntary hold, even an involuntarily held individual has the right to give or withhold consent for issues such as medications (under most circumstances) and selection of goals and objectives in an inpatient discharge plan.

There are four major components to decision-making capacity:

- understanding
- appreciating
- formulating
- communicating
The first two components represent the individual’s ability to comprehend and appreciate the nature and expected consequences of each decision, including the potential benefits and risks of each option. The latter two components represent the ability to develop a judgment and convey a clear decision. Decision-making capacity is distinct from competency, which is a judicial determination made by a court of law.

The following guidelines are commonly used to determine a person’s capacity to give consent. A valid consent means that the person has the capacity to:

- understand the nature of the act to which the person is consenting (for example, a person may have the capacity to consent to a discharge goal of establishing stable housing at a board and care home but not to the use of a medication)
- understand that the consent can be withdrawn at any time
- retain that information long enough to be able to evaluate it and decide
- can consider both advantages and disadvantages of giving consent
- communicate the decision (not necessarily by spoken language—a valid communication could involve simple muscle movements such as an eye blink or squeezing a hand).

The following additional principles should be considered. Even if a person has the capacity to consent, a valid consent:

- is one that is given at the time it is relevant; a person’s consent to accept a medication in an outpatient clinic two weeks ago does not necessarily mean that the person should be presumed to have given consent to that same medication two weeks later during an inpatient hospitalization
- is given without coercion or intimidation
- can be withdrawn at any time
- must be given by the individual who is about to experience the effect of the decision; it may not be given by another person, even though the other person has the power of attorney for certain purposes.

A person’s capacity to consent is not always clear. When in doubt it is best to seek consultation from a knowledgeable colleague. In the case of persons whose decision-making capacity is marginal due to an acute episode of a mental disorder, intellectual disability, or neurocognitive disorder, it may be helpful to check with others such as healthcare professionals or family members who have known the person over time and who are familiar with the person’s usual ability to make decisions.

A valid consent must be based on an informed decision by a person who has the mental capacity to consent. If a physician were to prescribe a medically unnecessary pharmaceutical to an individual out of personal curiosity or convenience, and the individual was led to believe that the medication was medically necessary, the individual’s consent would not be valid because it was not informed consent.

If a staff member were to document a discharge goal with a person who has a serious mental illness and who said “OK” but did not have the mental capacity to formulate a meaningful consent, then simply saying

LPS Clinical Assessment Guidelines: Philosophies and Practices
“OK” would not constitute a valid consent. But most people with mental illnesses do have the capacity to consent.

The quality of information must also be considered when evaluating the extent to which an individual’s consent is truly informed. *Black’s Law Dictionary*, 6th edition presents the following definition of informed consent to treatment:

A person’s agreement to allow something to happen (such as surgery) that is based on a full disclosure of facts needed to make the decision intelligently; i.e., knowledge of risks involved, alternatives, etc. Informed consent is the name for a general principle of law that a physician has a duty to disclose what a reasonably prudent physician in the medical community in the exercise of reasonable care would disclose to his patient as to whatever grave risks of injury might be incurred from a proposed course of treatment, so that a patient, exercising ordinary care for his own welfare, and faced with a choice of undergoing the proposed treatment, or alternative treatment, or none at all, may intelligently exercise his judgment by reasonably balancing the probable risks against the probably benefits. *(Zed Barth v. Swedish Hospital Medical Center, 812 Wash.2d, 49 P.2d 1, 8.) (Black, 1990)*

Further clarification is available in California Civil Jury Instruction 532 which defines “informed consent” as follows:

A patient’s consent to a medical procedure must be “informed.” A patient gives an “informed consent” only after the [insert type of medical practitioner] has fully explained the proposed treatment or procedure.

[An/An] [insert type of medical practitioner] must explain the likelihood of success and the risks of agreeing to a medical procedure in language that the patient can understand. [An/An] [insert type of medical practitioner] must give the patient as much information as [he/she] needs to make an informed decision, including any risk that a reasonable person would consider important in deciding to have the proposed treatment or procedure, and any other information skilled practitioners would disclose to the patient under the same or similar circumstances. The patient must be told about any risk of death or serious injury or significant potential complications that may occur if the procedure is performed. [An/An] [insert type of medical practitioner] is not required to explain minor risks that are not likely to occur.

Additional relevant principles have been established in judicial precedents:

- A physician is required to disclose “all information relevant to a meaningful decisional process.” *(Cobbs v. Grant (1972) 8 Cal.3d 229, 242 [104 Cal.Rptr. 505, 502 P.2d 1].)*
- “When a doctor recommends a procedure then he or she must disclose to the patient all material information necessary to the decision to undergo the procedure, including a reasonable
explanation of the procedure, its likelihood of success, the risks involved in accepting or rejecting the proposed procedure, and any other information a skilled practitioner in good standing would disclose to the patient under the same or similar circumstances." (Mathis v. Morrissey (1992) 11 Cal.App.4th 332, 343 [13 Cal.Rptr.2d 819].)


- Courts have observed that a case known as "Cobbs" created a two-part test for disclosure. "First, a physician must disclose to the patient the potential of death, serious harm, and other complications associated with a proposed procedure." (Daum v. SpineCare Medical Group, Inc. (1997) 52 Cal.App.4th 1285, 1301 [61 Cal.Rptr.2d 260].) "Second, '[b]eyond the foregoing minimal disclosure, a doctor must also reveal to his patient such additional information as a skilled practitioner of good standing would provide under similar circumstances." (Id. at p. 1302, citation omitted.) The doctor has no duty to discuss minor risks inherent in common procedures when it is common knowledge that such risks are of very low incidence. (Cobbs, supra, 8 Cal.3d at p. 244.)

- The courts have defined "material information" as follows: "Material information is that which the physician knows or should know would be regarded as significant by a reasonable person in the patient's position when deciding to accept or reject the recommended medical procedure. To be material, a fact must also be one which is not commonly appreciated. If the physician knows or should know of a patient's unique concerns or lack of familiarity with medical procedures, this may expand the scope of required disclosure." (Truman v. Thomas (1980) 27 Cal.3d 285, 291 [165 Cal.Rptr. 308, 611 P.2d 902], internal citations omitted.)

- "Obviously involved in the equation of materiality are countervailing factors of the seriousness and remoteness of the dangers involved in the medical procedure as well as the risks of a decision not to undergo the procedure." (McKinney, supra, 120 Cal.App.3d at p. 441.)

- Expert testimony is not required to establish the duty to disclose the potential of death, serious harm, and other complications. (Cobbs, supra, 8 Cal.3d at p. 244.) Expert testimony is admissible to show what other information a skilled practitioner would have given under the circumstances. (Arato v. Avedon (1993) 5 Cal.4th 1172, 1191–1192 [23 Cal.Rptr.2d 131, 858 P.2d 598].)

- A physician must also disclose personal interests unrelated to the patient's health, whether research or economic, that may affect his or her medical judgment. (Moore v. Regents of Univ. of Cal. (1990) 51 Cal.3d 120, 129–132 [271 Cal.Rptr. 146, 793 P.2d 479], cert. denied, 499 U.S. 936 (1991).)

- Appellate courts have rejected a general duty of disclosure concerning a treatment or procedure a physician does not recommend. However, in some cases, "there may be evidence that would support the conclusion that a doctor should have disclosed information concerning a non-recommended procedure." (Vandi v. Permanente Medical Group, Inc. (1992) 7 Cal.App.4th 1064, 1071 [9 Cal.Rptr.2d 463].)
• “Our high court has made it clear that battery and lack of informed consent are separate causes of action. A claim based on lack of informed consent—which sounds in negligence—arises when the doctor performs a procedure without first adequately disclosing the risks and alternatives. In contrast, a battery is an intentional tort that occurs when a doctor performs a procedure without obtaining any consent.” (Saxena, supra, 159 Cal.App.4th at p. 324.)

Consent to Release Information

Staff should be sure that a consent-to-release-information form constitutes duly authorized and informed consent. The consent form should contain sufficient information to:

- accurately determine the individual's identity (e.g., address, phone number)
- identify the specific purpose of the request
- identify to whom the information should be sent
- show the date when the consent was signed
- indicate the duration of time for which the consent remains valid.

Case documentation should show sufficient information to indicate that the individual who signed the release understood its purpose.

After one has determined the appropriateness of a signed release, the services that have been provided to the individual should be summarized and sent, rather than communicated through verbatim clinical documentation, to the third party. This approach will make it possible to avoid releasing information that:

- is irrelevant to the purpose of the individual's consent
- unnecessarily reveals sensitive private information
- unnecessarily reveals the identities of the individual's significant others.

No more information should be released than is necessary to accomplish the individual's purpose. If too little information is revealed, and the third-party requests additional information, and the individual consents to releasing more information, staff can follow up with the additional information.
Legal Duties, Responsibilities and Regulatory Requirements Review

The CIBHS “Statewide Clinical Assessment Guidelines for Involuntary Detainment of Individuals: Analysis and Methodology from the Regional Meetings” (2014) identified various key drivers of policy change. Drivers are key conditions, barriers, influencing factors, structural impediments, and other factors that create difficulties to the provision of consistent, skillful clinical assessments of detained people that may result in improved outcomes for these people post-release. Participants were instructed to consider what the major impediments might be to an improved (consensus) clinical assessment process.

The following were among the impediments identified by the expert panels:

- Stigma/clinicians/communities fear of suicide . . . fear of reprisal for disastrous results such as suicide, etc. can cause the treating entity to be more conservative, less collaborative, and not marshal natural resources and assets as much as they might.
- Fear of liability (see above).

The CAG calls on service providers to yield control in support of client self-direction and client self-responsibility. In contrast, it is likely that the practitioners’ risk management attorneys might be advising them and their administrators to exercise whatever authority and legally permitted control is needed commensurate with their legal duties and responsibilities to the individual and to the community.

In view of the concern that practitioners and providers might be more conservative than necessary in managing their risk, at least two approaches can ease this tendency:

- Practitioners can become more precisely familiar with what their duties and responsibilities are under the law to avoid inaccurate assumptions about liabilities that they do not actually have.
- The law can establish immunities from liabilities when practitioners act in good faith to implement principles of a Recovery Model.

MORE PRECISE FAMILIARITY WITH LEGAL DUTIES AND RESPONSIBILITIES

Behavioral health practitioners are subject to a myriad of legal obligations that have been designed to protect the rights and interests of individuals and the public. They are subject to three types of legal obligations.

Codified law—what most people think of as “the law”—are explicit requirements, permissions, and prohibitions written by legislatures and entered well-structured and numbered legal codes. Examples of legal codes related to behavioral health care practice are the Welfare and Institutions Code, Health and Safety Code, Business and Professions Code, Family Code, Probate Code, and Penal Code.

Administrative agencies such as the Department of Health Services or the Board of Behavioral Sciences write delegated laws, also known as regulations. These regulations have the effect of law because the
legislature delegated the authority to write the regulations and their consequences to an administrative agency. Regulations can be found in the California Code of Regulations where, like codified law, they are organized into numbered items.

Common law is the most perplexing aspect of a behavioral health practitioner's legal obligations. Common law is a massive array of legal principles established in court cases over the centuries, some even going back to cases in England before the American Revolution.

A behavioral health practitioner can easily look up obligations established in a codified law or regulation. They are listed in law books but are also readily accessible at state Web sites such as leginfo.legislature.ca.gov. Here a practitioner can learn, for example, the definition of reportable child abuse, and the exact way the report must be submitted and to whom. Here a practitioner can discover the exact information that must be provided to an individual at the start of an involuntary hold.

In contrast, there is no place where a practitioner can look up common law. Even if there were a place that listed all judicial precedents, it would be very difficult for a practitioner to know which precedents are relevant to a situation. These situations call for consultation with an attorney.

The legal standard of care presents the most challenging aspect of common law for behavioral health practitioners. The “standard of care” refers to a professional’s legal duty to act “in a prudent and reasonable manner.” This means that behavioral health professionals must adhere to a “community standard of practice” and follow the same professional standards as their peers with comparable qualifications.

At one time the standard of care was based on what reasonable practitioners within a local community would do under similar circumstances. Current definitions call for a broader frame of reference. By considering what reasonable and prudent practitioners in various communities would do, people who are vulnerable, oppressed, and living in poverty can expect the same quality of care as can people who live in wealthier communities.

Malpractice suits often reference the standard of care when a client feels that he or she has suffered harm due to a behavioral health practitioner’s negligent failure to adhere to the standard of care. See the following two examples:

- a client suffers injuries in an automobile accident that occurred when driving while intoxicated and sues the therapist for failing to conduct an adequate substance abuse assessment, or the client sues the therapist for knowing that the client had a substance abuse issue but failed to treat it properly
- a client suffers a severe back injury as the result of jumping from a high place in a failed suicide attempt, and sues the therapist for failing to conduct an adequate suicide risk assessment; or, the client sues the therapist for knowing that the individual was suicidal but failed to manage the suicide risk properly.
The standard of care is not just a curious concept of interest to academics within the legal profession. That became crystal clear to the psychologist treating Prasenjit Plodder, the University of California student who murdered Tatiana Tarasoff. In that case the therapist presumed that when Mr. Poddar revealed a danger to engage in a violent act against his girlfriend he should notify the police, regardless of the individual’s confidentiality protections. The therapist did notify the police, who investigated Mr. Poddar and concluded that he was not a danger. The police told him to stay away from Ms. Tarasoff.

At the end of summer when Ms. Tarasoff returned from a trip to Brazil, Mr. Poddar stalked her and stabbed her to death. Not surprisingly the Tarasoff family felt that insufficient care was taken to protect Ms. Tarasoff. In two court cases that ensued it was established that the police had no duty to notify Ms. Tarasoff but that the psychotherapist should have done so. These judicial decisions established “the Tarasoff duty.” Most people think of this as a matter of codified law, but it is based on the standard of care, which is an aspect of common law.

The standard of care is a vague concept, and vague liabilities tend to lead to conservative practice. In a court of law, the attorney for the plaintiff will generally bring in expert witnesses of the same profession and from the same locality as the defendant, establish that he or she is a “prudent and reasonable” person, and examine him or her to establish what he or she would have done if acting as the therapist in the case at issue. The defendant therapist will likely testify as to what actions were taken, and the clinical record will weigh heavily in supporting or discounting the therapist’s claims. In some cases, only the clinical record, and not the therapist’s testimony, will be the basis for determining the quality of care that has been provided.

The standard of care is explained as follows in the standard California Civil Jury Instructions, which is what a jury will be told that a patient or client is entitled to expect from a healthcare practitioner, including behavioral health care practitioners:

**California Standard Civil Jury Instruction 502: Standard of Care for Medical Specialists**

[A/An] [insert type of medical specialist] is negligent if [he/she] fails to use the level of skill, knowledge, and care in diagnosis and treatment that other reasonably careful [insert type of medical practitioners] would use in the same or similar circumstances. This level of skill, knowledge, and care is sometimes referred to as “the standard of care.” (CACI No. 502.)

The practitioner must determine the level of skill, knowledge, and care that other reasonably careful [insert type of medical specialists] would use in the same or similar circumstances, based only on the testimony of the expert witnesses [including [name of defendant]] who have testified in this case.] (CACI No. 502.)
Of course, a jury cannot be expected to have prior knowledge of what a “reasonably careful” practitioner would do in the case under consideration. Jury members will rely on expert witnesses brought before them by the plaintiff and defendant. Per the California Civil Jury Instructions, they will be told the following:


Precedence has been established in a court case that has a bearing on other malpractice cases. The following is an example of such a precedent.

As a rule, the testimony of an expert witness is required in every professional negligence case to establish the applicable standard of care, whether that standard was met or breached by the defendant, and whether any negligence by the defendant caused the plaintiff's damages. A narrow exception to this rule exists where “the conduct required by the particular circumstances is within the common knowledge of the layman." [Scott, supra, 185 Cal.App.4th at pp. 1542–1543]]

This exception is, however, a limited one. It arises when a foreign object, such as a sponge or surgical instrument, is left in a patient following surgery and applies only when the plaintiff can invoke the doctrine of res ipsa loquitur. The “common knowledge” exception is generally limited to situations in which . . . a layperson "[c]an say as a matter of common knowledge . . . that the consequences of professional treatment were not such as ordinarily would have followed if due care had been exercised." [Scott, supra, 185 Cal.App.4th at pp. 1542–1543]]

This principle illustrates the importance of public education. Assume that a behavioral health practitioner chose an intervention during an individual's involuntary detention based on the individual's advance directive or participation in a shared decision-making process. Assume that the intervention deviates from standard practice that would have been followed by most practitioners who do not use advance directives or shared decision-making processes, but would be considered by practitioners who support a Recovery Model.

If the lay members of the jury believe it is common knowledge that a person in an acute psychotic episode who is being involuntarily detained due to danger to others should not be directly involved in decisions about how to manage the danger he or she presents to others on the ward, this could complicate the defense of the recovery-oriented practitioner. This is not to say that there would be no viable defense, only that the defense could be weakened by such “common knowledge." In contrast, consider how such a case might be different if it had become common knowledge that even individuals on involuntary holds are entitled to self-determination and self-responsibility whenever possible.

What if a therapist determines that a client presents a danger of violence to another person, but is uncertain as to whether the danger is serious enough to warrant a violation of the client's right to confidentiality? Recognizing that there is often likely to be such gray areas during behavioral health practice, the legislature
has resolved the dilemma by providing therapists with immunity from liability law to resolve the confusion in favor of public safety over confidentiality.

LEGAL LIABILITIES AND IMMUNITIES

The law provides a variety of immunities from liability for behavioral health professionals who engage in good-faith, prosocial, legally permitted actions that might be perceived as conflicting with other laws. For example, a practitioner seeking to fulfill a duty to warn and protect (“Tarasoff duty”) may be perceived as violating a client’s confidentiality rights under the law. However, the legislature has provided immunity from liability law to encourage practitioners to err on the side of protecting a potential victim when in doubt about the conflict between the duty to warn and the duty to protect confidentiality.

Other Examples:

Advance Directives

Failure to follow an Advance Health Directive may result in liability for damages specified in California law or actual damages, whichever is greater, plus attorney’s fees (Cal. Probate Code Section 4742). Violators may also be liable for negligence, malpractice, and battery claims.

Healthcare providers are not subject to civil or criminal liability or to discipline for unprofessional conduct for compliance with advance healthcare directives (Cal. Probate Code Section 4740), which states the following:

Probate Code Section 4740

A healthcare provider or healthcare institution acting in good faith and in accordance with generally accepted healthcare standards applicable to the healthcare provider or institution is not subject to civil or criminal liability or to discipline for unprofessional conduct for any actions in compliance with this division, including, but not limited to, any of the following conduct:

(a) Complying with a healthcare decision of a person that the healthcare provider or healthcare institution believes in good faith has the authority to make a healthcare decision for a patient, including a decision to withhold or withdraw healthcare

(b) Declining to comply with a healthcare decision of a person based on a belief that the person then lacked authority

(c) Complying with an Advance Healthcare Directive and if the directive was valid when made and has not been revoked or terminated.

(d) Declining to comply with an individual healthcare instruction or healthcare decision, in accordance with Sections 4734 to 4736, inclusive. (Added by Stats. 1999, Ch. 658, Sec. 39. Effective January 1, 2000. Operative July 1, 2000, by Sec. 43 of Ch. 658.)
Probate Code Section 4734

(a) A healthcare provider may decline to comply with an individual healthcare instruction or healthcare decision for reasons of conscience.

(b) A healthcare institution may decline to comply with an individual healthcare instruction or healthcare decision if the instruction or decision is contrary to a policy of the institution that is expressly based on reasons of conscience and if the policy was timely communicated to the patient or to a person then authorized to make healthcare decisions for the patient. (Added by Stats. 1999, Ch. 658, Sec. 39. Effective January 1, 2000. Operative July 1, 2000, by Sec. 43 of Ch. 658.)

Probate Code Section 4735

A healthcare provider or healthcare institution may decline to comply with an individual healthcare instruction or healthcare decision that requires medically ineffective healthcare or healthcare contrary to generally accepted healthcare standards applicable to the healthcare provider or institution. (Added by Stats. 1999, Ch. 658, Sec. 39. Effective January 1, 2000. Operative July 1, 2000, by Sec. 43 of Ch. 658.)

Probate Code Section 4736

A healthcare provider or healthcare institution that declines to comply with an individual healthcare instruction or healthcare decision shall do all the following:

(a) Promptly so inform the patient, if possible, and any person then authorized to make healthcare decisions for the patient.

(b) Unless the patient or person then authorized to make healthcare decisions for the patient refuses assistance, immediately make all reasonable efforts to assist in the transfer of the patient to another healthcare provider or institution that is willing to comply with the instruction or decision.

(c) Provide continuing care to the patient until a transfer can be accomplished or until it appears that a transfer cannot be accomplished. In all cases, appropriate pain relief and other palliative care shall be continued. (Added by Stats. 1999, Ch. 658, Sec. 39. Effective January 1, 2000. Operative July 1, 2000, by Sec. 43 of Ch. 658.)

Parent Access to a Minor’s Records

When treatment of a minor is based on parental consent to treatment, the parents have a presumptive entitlement to review the record. However, there are circumstances in which parental access to the record could be detrimental to the child’s welfare, as in cases of children who have been abused by a parent. The following law provides immunity to service providers to encourage them to err on the side of protecting the child’s safety when in doubt about the conflict between the duty to permit parental access to records and the duty to protect the minor client:
CA Health and Safety Code Section 123115
(a) The representative of a minor shall not be entitled to inspect or obtain copies of the minor’s patient records in either of the following circumstances:

(1) With respect to which the minor has a right of inspection under Section 123110.

(2) Where the healthcare provider determines that access to the patient records requested by the representative would have a detrimental effect on the provider’s professional relationship with the minor patient or the minor’s physical safety or psychological well-being. The decision of the healthcare provider as to whether a minor’s records are available for inspection under this section shall not attach any liability to the provider, unless the decision is found to be in bad faith.

Child Abuse Reporting

The following section of the Child Abuse and Neglect Reporting Act establishes immunity from liability for those making good-faith reports pursuant to that law. Similar protections are provided in the California Welfare and Institutions Code Section 15634 regarding reports of elder and dependent adult abuse.

California Penal Code Section 11172
CHILD ABUSE AND NEGLECT REPORTING ACT

(a) No mandated reporter shall be civilly or criminally liable for any report required or authorized by this article, and this immunity shall apply even if the mandated reporter acquired the knowledge or reasonable suspicion of child abuse or neglect outside of his or her professional capacity or outside the scope of his or her employment. Any other person reporting a known or suspected instance of child abuse or neglect shall not incur civil or criminal liability as a result of any report authorized by this article unless it can be proven that a false report was made and the person knew that the report was false or was made with reckless disregard of the truth or falsity of the report, and any person who makes a report of child abuse or neglect known to be false or with reckless disregard of the truth or falsity of the report is liable for any damages caused. No person required to make a report pursuant to this article, nor any person taking photographs at his or her direction, shall incur any civil or criminal liability for taking photographs of a suspected victim of child abuse or neglect, or causing photographs to be taken of a suspected victim of child abuse or neglect, without parental consent, or for disseminating the photographs, images, or material with the reports required by this article. However, this section shall not be construed to grant immunity from this liability with respect to any other use of the photographs.

(b) Any person, who, pursuant to a request from a government agency investigating a report of suspected child abuse or neglect, provides the requesting agency with access to the victim of a known or suspected instance of child abuse or neglect shall not incur civil or criminal liability because of if access.
The “Tarasoff Duty” To Warn

When exercising this duty to warn, a psychotherapist may become vulnerable to suits based on breach of confidentiality or privileged communication. Thus, the law gives psychotherapists immunity from monetary liability.

California Civil Code Section 43.92

PSYCHOTHERAPISTS DUTY TO WARN OF THREATENED VIOLENT BEHAVIOR OF PATIENT; IMMUNITY FROM MONETARY LIABILITY

(a) There shall be no monetary liability on the part of, and no cause of action shall arise against, any person who is a psychotherapist as defined in Section 1010 of the Evidence Code in failing to warn of and protect from a patient threatened violent behavior except where the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims.

(b) If there is a duty to warn and protect under the limited circumstances specified above, the duty shall be discharged by the psychotherapist making reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency.

(c) It is the intent of the legislature that the amendments made by the act adding this subdivision only change the name of the duty referenced in this section from a duty to warn and protect to a duty to protect. Nothing in this section shall be construed to be a substantive change, and any duty of a psychotherapist shall not be modified because of changing the wording in this section.

(d) It is the intent of the legislature that a court interprets this section, as amended by the act adding this subdivision, in a manner consistent with the interpretation of this section as it read prior to January 1, 2013. (Amended by Stats. 2012, Ch. 149, Sec. 1. Effective January 1, 2013.)

Premature Release of Involuntarily Detained Individuals

Welfare and Institutions Code Sec. 5154

(a) Notwithstanding Section 5113, if the provisions of Section 5152 have been met, the professional person in charge of the facility providing seventy two (72-)hour treatment and evaluation, his or her designee, the medical director of the facility or his or her designee described in Section 5152, the psychiatrist directly responsible for the person's treatment, or the psychologist shall not be held civilly or criminally liable for any action by a person released before the end of 72 hours pursuant to this article.

(b) The professional person in charge of the facility providing 72-hour treatment and evaluation, his or her designee, the medical director of the facility or his or her designee described in Section 5152, the psychiatrist directly responsible for the person's treatment, or the psychologist shall not be held civilly
or criminally liable for any action by a person released at the end of the 72 hours pursuant to this article.

Although there are laws that promote a general recovery orientation for public behavioral health services, these laws primarily apply to administrative entities and not to individual practitioners. No immunity from liability laws exists to protect either administrative entities or individual practitioners who chose to deviate from traditional practice to engage clients in shared decision-making or other aspects of recovery-oriented practice.

Despite Recovery Model values in support of self-responsibility, there are also no laws that clearly establish shared legal liability when intervention decisions based on shared decision making results in negative consequences for the client. Clearly the development of such laws should be considered as a means of overcoming the “fear of reprisal for disastrous results such as suicide, etc. [that] can cause the treating entity to be more conservative, less collaborative, and not marshal natural resources and assets as much as they might.”
Patient's Rights

The California Department of Health Care Services provides an excellent review of codified patient rights in its handbook, *Rights for Individuals in Mental Health Facilities Admitted Under the Lanterman-Petris-Short Act*. A copy of the handbook is available at


Written for an audience of consumers and their significant others, the handbook explains the complexities of the patients' rights issues.

**Patients' Rights Law** is composed of a complex and evolving system of statutes, regulations, and court decisions. This handbook should be considered a guide, but it may not accurately reflect all the rights available to persons always.
The person in charge of the facility in which the client receiving treatment is responsible for ensuring that all the client’s rights in this handbook are protected. The client should be informed of his or her rights in a language and a manner that he or she can understand:

- On admission to a facility
- When there is a change in his or her legal status
- When the client is transferred to another unit or facility
- At least once a year.

The client should contact his or her patients' rights advocate if the client believes that his or her rights may have been denied or violated, or if the client has questions that may not be specifically addressed in this handbook.

The handbook then goes on to explain the many facets of patients' rights by addressing the following issues:

- Access to the patients' rights advocate
- What to do if the client has a complaint
- Rights while the client is involuntarily detained
- Confidentiality
- Medical treatment
- Right to refuse treatment
- Medications and the informed consent process
- Capacity hearing for medications
- Rights that cannot be denied:
  - The right to humane care
  - The right to be free from abuse or neglect
  - The right to social activities and recreation
  - The right to education
  - The right to religious freedom and practice
  - The right to be free from discrimination
- Rights that may be denied with good cause:
  - Clothing
  - Money
  - Visitors
  - Storage Space

For additional information about legal issues relevant to recovery, see Module 5 LPS and Legal Support for Recovery Oriented Practice.
The Philosophies and Practices module presents the clinical, ethical, and legal concepts underlying the CAG for persons involuntarily detained. Drawing on fundamental tenets of the clinical literature, professional codes of ethics, and codified laws and regulations, this information serves as the knowledge base for the skills and attitudes needed for a robust implementation of the guidelines at twenty-four-hour services and the other service system components that precede or follow an individual’s stay at a twenty-four-hour service.

The information provided in this module has been designed to present the substantial knowledge base for learning the skills, techniques, and methods presented in modules addressing core competencies, administrative implementation, and performance evaluation.
References


Child Abuse and Neglect Reporting Act, Cal. Penal Code § 11164 et seq.


Psychotherapists; Duty to Warn of Threatened Violent Behavior of Patient; Immunity from Monetary Liability, Cal. Civil Code § 43.92.


