# THEMES & CONCEPTS

## I. BUILD HOPE AND BELIEF IN RECOVERY

A. Help clients and staff understand that recovery is a possibility for all people diagnosed with serious mental health issues

B. Assist each person to discover and express their evolving definition of recovery

C. Demonstrate organizational belief in recovery

## II. IDENTIFY MEANINGFUL GOALS AND STRENGTHS TO ACHIEVE THEM

A. Identify clients' usable strengths

B. Set and achieve meaningful and important goals using highly individualized and specific strengths

C. Align with client to build a collaborative working relationship

## III. PLAN TO ACHIEVE GOALS

A. Plan to achieve goals by breaking them into smaller, measurable steps (short-term Identify clients' usable strengths

B. Use stages of treatment scale to guide intervention and evaluate progress

C. Use Shared Decision-Making Around the Use of Medications

## IV. ACHIEVE GOALS AND INDEPENDENCE

A. Evaluate progress and update the plan at each visit

B. Assist client with obstacle removal and create opportunities for goal achievement at every visit

C. Make use of naturally occurring resources to help clients connect to their community

D. Support clients to prepare to and then exit the system

E. Use self-management strategies to help people progress in their recovery

## V. DESIGN SYSTEM INFRASTRUCTURE TO SUPPORT INDIVIDUALIZED PATHWAYS TO RECOVERY

A. Provide leadership for recovery

B. Integrate recovery orientation into routine operations and daily management

C. Provide clinical mentoring/coaching and skill development that support clients' recovery progress

D. Develop and support effective use of peer supports (employed and volunteer) for clients at different stages of recovery

E. Involve peers in system design and improvement

F. Make access and transitions easier and responsive to clients' goals

### I. BUILD HOPE AND BELIEF IN RECOVERY

**A. Help clients/participants and staff understand that recovery is a possibility for all people diagnosed with serious mental health issues**

1) Use oral and written personal stories of recovery to help each other increase staff's belief that recovery is possible and an expected outcome of the program (examples:  videos, audio recordings, written accounts, journal articles, books, newsletters, etc.).

2) During the enrollment process, introduce new clients/participants to a peer who can share their personal recovery story, connect from lived experiences, and welcome them into the program/community.

3) Hold an orientation for all new clients that introduces them to the organization's belief in recovery and how the organization can specifically contribute to recovery process.

**B. Assist Each Person to Discover and Express Their Evolving Definition of Recovery**

1) Identify clients' strengths to help build hope for recovery

2) Ask persons receiving services what recovery means to them, what would they like more of in their lives, what would they like to expand, and if they were doing well, what would that look like?

3) Help clients develop a holistic view of their recovery, including values and big picture goals, using solution-focused techniques (examples:  Values Card Sort, Miracle Statement, Collage of images, Strengths Assessment).

4) Show clients a common definition of recovery (examples from SAMHSA, Pat Deegan, Recovery Innovations, etc.), get their reactions to it, and ask them how this applies to their life.

5) Use supervision time to develop a vision of recovery and practice engaging individuals in envisioning their own recovery

6) Explore the specific meaning of why a client's goal is meaningful and important in order to discover the "active ingredients" behind it.

7) Make recovery personal by supporting staff to share their own personal health and wellness goals, challenges and successes, including those associated with mental illness

**C. Demonstrate organizational belief in recovery**

1) Serve clients who are not taking medications, not clean and sober, and who don't acknowledge that they have a mental illness"

2)   Hire and involve people with lived experience at every level of the organization, in accordance with their strengths and skills.

3)   Engage peers in the development of program policies and procedures, staff hiring and development processes, and strategic organizational committees and initiatives

4)   Support staff to freely discuss their beliefs in recovery and reframe or challenge each other when expressing pessimism or diminishing belief in the potential for clients to recover and be resilient (examples: "recovery tune-up" sessions, huddles, formal monthly meetings, discussion scenarios)

5)   Set expectations for staff behaviors related to recovery by specially defining these in staff job descriptions and aligning performance evaluations with job descriptions.

6)   Set organizational goals for recovery that reflect personal growth rather than stability or symptom control

7)   Give staff regular feedback on how they doing related to recovery oriented goals, both collectively and individually

8)   Use techniques such as observation with feedback, modeling and role plays to help staff apply recovery concepts, skills, and tools

9)   Enhance the physical presence of the organization's facilities to demonstrate support and belief in recovery (examples include: availability of recovery oriented reading materials, reception staff who make people feel welcome)

II.    **IDENTIFY MEANINGFUL GOALS AND STRENGTHS TO ACHIEVE THEM**

A.  **Identify clients' usable strengths**
1) Create awareness of the importance of clients' particular strengths and how they may be used to drive their wellness or to achieve a self-determined goal (example: KU Strengths Assessment)
2) Identify and record specific and detailed client strengths (talents, skills, personal and environmental resources and supports) in seven life domains that can be used to achieve specific goals identified by the client
3) For a client who does not have a specific goal he/she wants to achieve, identify and record specific and detailed strengths (talents, skills, personal and environmental resources, desires and supports) in seven life domains that might indicate what is meaningful and important to the client and from which a meaningful goal could be identified.
4) Create opportunities for clients to discover their 'core gifts', strengths and goals and to find the meaning in their suffering

B.  **Set and achieve meaningful and important goals using highly individualized and specific strengths**
1) Use Strengths Assessment to identify clients' community-based goals as well as strengths linked to achieving those goals
2) Use objective tools from mental health, substance use and other fields (e.g. WRAP, Strength-Based Assessments, Importance/Confidence Ruler, What Color is My Parachute) to assist clients to frame their goals in ways that are concrete and specific and in a variety of life domains
3) Describe each strength in its most usable form so that the client can see how specifically that strength can be used to help them achieve their goal and to increase their confidence in their ability to achieve the goal.
4) Use an agenda map to list goals and identify order of goals to be addressed for clients who have multiple goals and might be stuck.
5) Help clients without goals to identify meaningful goals by:
- Using the value card sort exercise to help clients identify values most meaningful to them that will be translated into goals
- Asking clients about interests prior to developing illness that had meaning and were enjoyable

- Asking clients to describe what life would look like if they woke up tomorrow and everything was just how they wanted (miracle question) to begin exploring what has meaning in their life

6) Identify a goal and then use the Importance Ruler to evaluate confidence and evocate statements to support clients confidence for clients with repeated failures

7) Work with clients to discover their 'active ingredients' behind their goal(s) and to become clear on what they are searching for to identify options to achieve the goal(s) (active ingredients may be related to spirituality, sexual intimacy, etc.)

**C. Align With Client to Build a Collaborative Working Relationship**

1) Make explicit in policy and procedure that clients who are using may receive services regardless of active substance use (e.g. residential/housing services, employment services, etc.)

2) Use engagement strategies to build the working relationship and create an environment where substance use can be discussed:
   - Focus on engagement strategies without discussing substance use during initial sessions, unless clients wants to (elicit non-substance use related goals that are meaningful and important to the client, engage clients around goals that they chose, build a trusting relationship, listening to the person's perspective regarding their life or current situation)
   - Ask permission to discuss substance use
   - Discuss substance use in the context of something that is meaningful and important (e.g. a person's desire to work, raise their child, buy a car, etc.)

3) Use Longitudinal Assessment to understand what is going on with an individual over of time, their history of mental illness/treatment, their history of substance use (abuse)/treatment and the interaction between mental illness and substance abuse.

4) Use Motivational Interventions to enhance intrinsic motivation to change by exploring and resolving ambivalence (Miller and Rollnick, 1991)
   - Roll with Resistance/Dancing with Discord (avoid confrontation)
   - Express Empathy
   - Develop Discrepancy between what the person wants and current behavior
   - Support Self-Efficacy (help individuals believe they can make changes in their lives, eliciting change talk)
     - Use open ended questions versus closed to better understand a person's point of view and to elicit change talk (e.g. how current lifestyle relates to goal of keeping housing).

- Use open ended questions to better understand a person's point of view and elicit change talk
- Use empathic and strategic reflections to resolve ambivalence; eliciting change talk that moves toward "health"
- Use summaries to keep the person focused and evoke reasons to change negative behavior

5) Use the Motivational Interviewing Importance/Confidence Ruler to determine if the worker needs to develop discrepancy between a person's goals and current behavior or support self-efficacy to build a person's internal confidence to change by looking at past accomplishments and applying those to the current situation (e.g. looking at past success and asking the person how they did it)

6) Use the Pay-Off Matrix to understand pros and cons of behavior change

### III.  PLAN TO ACHIEVE GOALS

**A.  Plan to achieve goals by breaking them into smaller, measurable steps (short-term goals)**

1)  Identify with clients ways to utilize strengths, natural supports, self-help support, peer support, and community-based resources prior to intervening with program resources and services (for example: Framework for Support Model)

2)  Identify one or two specific and measurable steps that can be accomplish within the week to progress toward achievement of a specific goal

3)  Explore all possible outcomes, even those that are disappointing when prepping clients to pursue short term objectives,

4)  Identify and reduce barriers that decrease involvement and access to community-based resources and activities

5)  Use Payoff Matrix and other MI techniques to understand where a person is with making changes to achieve their goals, increase internal motivations

**B.  Use Stages of Treatment Scale to Guide Intervention and Evaluate Progress**

1)  Use stages of treatment worksheet on a monthly basis to assess where a client is in treatment

2)  Match intervention to stage of treatment (e.g. use motivation interventions with an individual who is still using to "elicit change talk" about using)

3)  Present stage at the beginning of each case presentation in strengths-based group supervision and then brainstorm stage specific interventions

4)  Discuss and practice stage appropriate interventions in group supervision monthly

5)  With people who remain in one stage for a long period of time, evaluate the effectiveness of current interventions and consider adding new interventions, revising the approach to an intervention, or intensifying services (e.g. systematically track Stages of Treatment scores for all clients with co-occurring disorders and staff clients who have not progressed in 2 consecutive quarters in group supervision evaluating current treatment services to see what else might be done)

6)  Develop strategies to remove barriers if team is having difficulty being effective in one particular stage (e.g. practice Motivational Interviewing skills; adjust productive standards to allow time for outreaching clients who are actively using)

C. **Use Shared Decision-Making Around the Use of Medications**

1) Support clients to use their "Personal Medicine" to achieve their goals and advance their recovery

2) Share the strengths assessment and personal recovery plan with prescribers and include them in group supervision processes

3) Work with clients to prepare for medication visits
   - Help people become more aware of side effects by using a side effect calendar
   - Talk with clients about their medication decisions in the context of their goals that are meaningful and important to them (e.g. "How do you think your current medications are helping or hindering your goal?")
   - Help people clarify their expectations about how medication may help them
   - Provide information on medication they are taking or considering (e.g. side effects)
   - Use role plays to prepare for medical visits
   - Assist client to create a cheat sheet for a doctor's visits: including what goal(s) are, how they feel the medications are working in relation to this goal(s), any question or concerns they have, etc.

4) Prescribe to support client goal achievement

## IV.    ACHIEVE GOALS AND INDEPENDENCE

**A.  Evaluate progress and update the plan at each visit**
   1)  At each visit, check in with clients' about where they are in their recovery and achievement of long-term goals and how they feel about their life overall
   2)  Review goals status with client at each encounter
   3)  Use an electronic system to keep track of short term goals, strengths to support achievement of goals, and the current status of the goals
   4)  Use the knowledge gained from the progress toward achievement (successful or not) of short term objectives to revise the Strengths Assessment and Personal Recovery Plan, including next steps

**B.  Assist client with obstacle removal and create opportunities for goal achievement at every visit**
   1)  Focus on strengths to help client tackle obstacles that are not based on functional impairments
   2)  Address barriers in the Personal Recovery Plan (some tied to impairments, some not)
   3)  Help the client recognize obstacles and plan to remove or work around them
   4)  Apply best practices and/or evidence based practices to deal with functional impairments

**C.  Make use of naturally occurring resources to help clients connect to their community**
   1)  Use Personal Recovery Plan to help clients achieve goals that are anchored in community
   2)  Provide emotional support and coaching to clients to access and utilize community supports instead of "mental health" and governmental resources  (example: integrate family members into the recovery process)
   3)  Link clients to community resources through advance research and information gathering about participation requirements or expectations, coaching and teaching skills; initially accompany them to gain comfort with environment, etc. (example: help clients throw house warming parties including neighbors and friends unconnected to the mental health system)

D. **Support clients to prepare to and then exit the system**
   1) Collaborate with clients to support their self-care strategies, for example exercise and diet, as well as activities that give their life personal meeting, for example writing, gardening, meditation, and pursing spiritual beliefs
   2) Implement non-traditional program that embraces training realm of expressive art as a practice (i.e. workshops such as dancing, painting, storytelling, poetry, etc.)
   3) Help clients take ownership of and responsibility for their own wellness using tools and procedures like WRAP, advance directives

E. **Use Self-Management Strategies for Clients in the Active Stage Of Treatment**
   4) Use timeline fall back calendar to track use
   5) Use contextual assessment with each episode of use to examine triggers and consequence of substance use when the person is in the active stage (e.g. the person has been clean for 2 months and then goes out on drinking for a week)
   6) Teach people specific coping skills (e.g. relaxation techniques, ways to deal with boredom, anger management, conversation skills, etc...)
   7) Use cognitive-behavior counseling and techniques to teach clients more effective skills for living without substances as well as minimizing and coping with negative thoughts and feelings (e.g. I relapsed and therefore I am a failure)
   8) Practice drink/drug refusal skills
   9) Develop relapse prevention plans (e.g. WRAP for addictions)
   10) Use relapses as a way to learn and grow from experience (e.g. You were sober for 2 months, that is not as long as you want but you were sober. How did you do it?)

## V. DESIGN SYSTEM INFRASTRUCTURE TO SUPPORT INDIVIDUALIZED PATHWAYS TO RECOVERY

### A. Provide leadership for recovery

1) Create and prominently post a vision and mission statement that clearly states what recovery means to the organization and the people receiving services
2) Set clear and specific outcome measures related to recovery that provide indicators of whether you are moving in the right direction
3) Share data with staff on a regular basis to guide improvement efforts related to recovery outcomes
4) Recognize teams' and clients' progress toward individual and organizational recovery goals
5) Identify paperwork and other activities that are no longer necessary or can be reduced

### B. Integrate recovery orientation into routine operations and daily management

1) Create care coordination teams that reflect the individuals served, including both make-up of the team and caseload sizes
2) Use Team Based Care to support client progress (versus using an individual, private practice model)
3) Incorporate the strengths model practices into the assessment, treatment plan, and progress note documentation standards
4) Revise audit review for medical necessity to align with strengths model (e.g. functional impairment as a barrier to goal achievement)
5) Hire staff who can work under recovery-oriented philosophy by using an interview process that helps identify key attitudes and perceptions of people with a serious mental illness and their approach for working with people.
6) Conduct new staff orientations that clearly outline the organization's belief in recovery and what will be expected of each staff person in relation to the organization's goals
7) Create job descriptions for all staff that clearly state the expectations for their position in relation to recovery and tie all job performance evaluations to them

### C. Provide clinical mentoring/coaching and skill development that support clients' recovery progress

1) Provide mentors/coaches with the time and opportunity to learn the same skills, tools, and methods they are supporting their staff to use

2) Use strengths-based group supervision process (allow 1 ½-2 hours per week for group coaching/mentoring, present 2-3 case presentations per session – KU model) or other strengths-based group processes

3) Review individual and population measures in clinical mentoring/coaching to promote client progress, manage workloads, and guide improvement efforts

4) Provide staff with field based mentoring to increase their skills with helping participants achieve recovery-oriented goals

5) Support staff to manage their case loads using Strengths Model Engagement Worksheet or other similar tracking methods

6) Support staff to prepare for visits with each client to reduce focus on crisis and 'problem of the day' (e.g. setting the agenda)

**D. Develop and support effective use of peer supports (employed and volunteer) for clients at different stages of recovery**

1) Include peer employees in team meetings or group supervision to help match peer supporters to individual participants and to provide a peer perspective for team problem-solving and planning

2) Employ peers to provide outreach and engagement services

3) Employ peers to welcome and engage new participants into services

4) Employ peers to provide peer coaching and mentoring for clients

5) Employ peers to provide navigation supports

6) Provide peer run groups for WRAP, health navigation, housing, employment, 12 step programs, and other recovery services

**E. Involve peers in system design and improvement**

1) Engage peers to participate in the development of program policies and procedures, Quality Improvement Committees and other strategic initiatives

2) Include peer support staff in the development of and as a participant in all clinical trainings, both internal and external to the agency

3) Engage and organize peers via a speakers bureau to share recovery stories that facilitate hopeful thinking

4) Use focus groups with people receiving services to evaluate various elements of the program.

5) Include peers in the staff interviewing and hiring decision process

F.  **Make access and transitions easier and responsive to clients' goals**

    1)  Use criteria to determine which clients are ready to transition to a lower (or higher) level of care, including discharge from the system

    2)  Use a structured procedure for transitioning clients between levels of care, including checklists, mentoring by peers who have recently transitioned, warm handoffs, clarifying logistics

    3)  Identify and prepare clients nearing readiness for transition to lower level of care

    4)  Support differentiation of services and create programmatic "pathways" for progress, accomplishment and movement

    5)  Create a mechanism for easy and quick entry back into services

    6)  Provide an array of services (menu) particularly in the areas of housing, employment and education that promotes individual choice and is responsive to their needs (and develop brochures that outline the "array of services")

    7)  Allocate time and resources for daily "Drop-In" services for both treatment and support

    8)  Create options for clients to talk with providers by the phone or email, including after discharge from program

    9)  Offer flexible hours to be available for services and activities after normal hours or on weekends and holidays