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

III.   PLAN TO ACHIEVE GOALS

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

B. Prescribe medications using shared decision making techniques

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 manage their own health and wellness

V.   DESIGN SYSTEM INFRASTRUCTURE TO SUPPORT INDIVIDUALIZED PATHWAYS TO RECOVERY

A. Provide leadership for recovery

B. Provide supervisory supports and skill development that support clients' recovery progress

C. Create and supervise effective use of peer supports (employed and volunteer) for clients at different stages of recovery

D. Involve people with the lived experience of recovery in system design and improvement

E. 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"

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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)

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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

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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.)

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 shared decision making techniques when prescribing medications

1) Pending

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

V. DESIGN SYSTEM INFRASTRUCTURE TO SUPPORT INDIVIDUALIZED PATHWAYS TO RECOVERY

A. Provide leadership for recovery
1) Define 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 outcomes.
4) Initiate verbal, written and symbolic rewards that recognize staff for achieving the outcomes related to recovery set by the organization.
5) Promote a culture of experimentation and process improvement by routinely asking the people you supervise three questions: 1) what have you tested this week; 2) what have you learned; 3) are there any barriers I can help remove so you can continue your testing, learning and improvement
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) Hire staff who can work under the recovery-oriented philosophy by using an interview process that gets at key attitudes related to the people being served.
8) 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.
9) Align all supervisory job duties with supporting staff to improve skills and achieve client outcomes.
10) Align audit and compliance processes with recovery practices

B. Provide supervisory supports and skill development that support clients' recovery progress
1) Use strengths-based group supervision process (e.g. University of Kansas Supervision Model)
2) Provide staff with field based mentoring to increase their skills with helping participants achieve recovery-oriented goals
3) Allow supervisors time and opportunity to learn the same skills, tools, and methods they are supporting their staff to use.
4) Set core competencies for all skills, tools, and methods being used by staff to evaluate their level of proficiency.

5) Review individual and population measures in clinical supervision to promote client progress, manage caseloads, and guide improvement efforts

C. **Create and supervise effective use of peer supports (employed and volunteer) for clients at different stages of recovery**
1) Employ peers to welcome and engage new participants into services
2) Employ peers to provide outreach and engagement services
3) Employ peers to provide peer coaching and mentoring
4) Employ peers to provide navigation supports
5) Provide peer run groups for WRAP, health navigation, housing, employment, 12 step programs, and other recovery services
6) Include peer employees in team meetings to help match peer supporters to individual participants and to provide a peer perspective for team problem-solving and planning

D. **Involve people with the lived experience of recovery in system design and improvement**
1) Include peer support staff in staff development trainings both internal and external to the agency
2) Engage and organize peers via a speakers bureau to share recovery stories that facilitate hopeful thinking
3) Engage peers to participate in the development of program policies and procedures, Quality Improvement Committees and other strategic initiatives

E. **Make access and transitions easier and responsive to clients' goals**
1) Provide an array of services (menu) particularly in the areas of housing, employment and education
2) Segment clients across an array of levels of care to support differentiation of services and create programmatic "pathways" for progress, accomplishment and movement
3) Create and use criteria to define when and under what circumstances clients are ready to transition to a lower (or higher) level of care, including discharge from the system
4) Identify and prepare clients nearing readiness for transition to lower level of care
5) Develop procedure for transition between levels of care that reflect stage of recovery , including checklists, mentors by peers who have recently transition, warm handoffs, clarifying logistics

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

7) Create options for clients to talk with providers by the phone or email

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