Recovery and Resiliency - Oriented Behavioral Health Services Plan

2012–2017

King County

Department of Community and Human Services
Mental Health, Chemical Abuse and Dependency Services Division
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Executive Summary

The Department of Community and Human Services (DCHS), Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) has prepared this Recovery and Resiliency-Oriented Behavioral Health Services Plan to guide the development of a mental health and substance use disorders treatment services system in King County. According to the plan, services will evolve to better support the recovery and resiliency of King County residents living with these challenges. The plan is presented to the King County Council in concert with a request for a new recovery and resiliency Ordinance.

The federal governmental agency, the Substance Abuse Mental Health Services Administration (SAMHSA), and the Washington State Department of Social and Health Services' Division of Behavioral Health and Recovery have recognized that the process of recovery and identifying and building resiliency are common to the experience of living with mental illness and/or substance use disorders.

The SAMHSA Recovery Support Strategic Initiative from 2011 defines behavioral health recovery as follows:

> *Recovery in behavioral health is a process of change through which individuals work to improve their own health and well-being, live a self-directed life, and strive to achieve their full potential.*

King County began a system change process to reorient publicly funded mental health services to a recovery focus in 2005, having begun researching and reporting on recovery indicators several years earlier. The substance use disorders treatment system has been developing a Recovery-Oriented System of Care for the last two years.

The community of providers and parent partners that serve children, youth, and families have long maintained that the principles and values of resiliency are a better fit than those of recovery for that population. The youth provider network in King County has endorsed the definition of resiliency developed by the Ohio Resiliency Project, as follows:

> *Resiliency is an inner capacity that when nurtured, facilitated, and supported by others empowers people, including children, youth, and families, to successfully meet life's challenges with a sense of self-determination, mastery and hope.*

This plan is intended to align the goals and initiatives for recovery and resiliency for both the mental health system and the substance use disorders system in King County.

The critical importance of a holistic approach to recovery and resiliency is becoming clear in the research — there is no health without mental health. Research has demonstrated that people living with mental illness die 25 years younger than the general population. People with both mental illness and substance abuse die 35 years younger.

The Centers for Disease Control and Kaiser Permanente, among other researchers, have identified a history of trauma as a significant risk factor for mental illness and substance abuse. The percentages of people receiving mental health and/or substance use disorders treatment who have histories of significant trauma is very high, some estimate as high as 90 percent. Behavioral health services must be trauma-informed in order to be effective and avoid inadvertently re-traumatizing people.

This Recovery and Resiliency-Oriented Behavioral Health Services Plan addresses both holistic healthcare and trauma-informed-care. The values, principles, and practices included address services for people across the age span, for outpatient and residential services.

The goals and initiatives of this plan align well with the vision, mission, and guiding principles of the King County Strategic Plan, and clearly reflect the goal of Health and Human Potential. Through promoting and supporting people in their recovery, we provide opportunities for the community of people who receive public mental health and substance abuse treatment to realize their full potential.

Four over-reaching strategies have been identified to achieve change for the behavioral health care system in King County:

1. Policy and contract changes
2. Measurement of outcomes
3. Workforce training
4. Support for grassroots pressure for change.

Strategies are developed and will be addressed in one or more of three phases identified for this change process to occur over five years. Because recovery is not linear, tasks and challenges will be revisited as needed.

Phase I.	Create a Shared Vision of Progress
Phase II.	Initiate and Implement: 2014-2015
Phase III.	Consolidate, Increasing Depth and Complexity

A strong foundation for recovery and resiliency-oriented services has been laid in the King County behavioral health system over the last ten years. This plan will build a strong structure for continued system change resulting in behavioral health services that will empower people to find their hope and rebuild their lives. People who have walked a recovery road grow in ways that enrich the community as whole.

Introduction

The King County Department of Community and Human Services (DCHS), Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) seeks to align and integrate recovery and resiliency initiatives for behavioral health services. Behavioral health services will attend to whole health and be trauma-informed.

This new King County recovery and resiliency plan for behavioral health addresses the differences in needs and priorities that may exist across the life span. Prevention, for both mental health and substance use disorders, will be explicitly included in the service array and in system planning. Recovery and resiliency principles will be infused into residential services as well as outpatient services.

Background

In 2004, the World Health Organization reported that the United States (U.S.) has the highest annual prevalence rate (26 percent) for mental illnesses among a comparison of 14 developing and developed countries. At the same time, the study indicates that money used to treat mental health problems in the U.S. and abroad is not being spent in the most effective way possible.

According to the 65th World Health Assembly, as of 2012 adolescents are generally perceived as a healthy age group, and yet an estimated 10-20 percent of them experience a mental health problem. Depression is the main cause of worldwide disability among adolescents, and suicide is the second most common cause of death among young people. Poor mental health is strongly related to other health conditions and development outcomes in young people, including lower educational achievements, substance abuse, violence, and poor reproductive and sexual health.

The 2009 Substance Abuse and Mental Health Services Administration (SAMHSA) National Survey on Drug Use and Health found that 23.5 million persons aged 12 or older needed treatment for an illicit drug or alcohol abuse problem (9.3 percent of persons aged 12 or older). Of these, only 2.6 million (11.2 percent of those who needed treatment) received it at a specialty facility.

The SAMHSA Administrator, Pamela Hyde, J.D., noted in 2011, “Behavioral health services are critical to health systems and community strategies that improve health status and they lower costs for individuals, families, businesses, and governments. The value of behavioral health services is well documented. Studies have shown that every dollar invested in evidence-based treatments yields $2.00 to $10.00 in savings in health costs, criminal and juvenile justice costs, educational costs, and lost productivity. Yet, too many people do not get needed help for substance abuse or mental health problems and health care costs continue to skyrocket."

The federal government and a growing number of states are recognizing the fundamental commonality of recovery for persons with mental illness and for those with substance use disorders, especially for people living with both challenges.

States adopting recovery concepts as the guiding policy for their behavioral health systems include Texas, Vermont, Nebraska, Massachusetts, Delaware, California, New York, Ohio, Pennsylvania, and Wisconsin. The recovery approach guides services in New Zealand, Australia, Israel, the United Kingdom and Ireland, among other countries.

Recognizing the vital importance of mental health recovery, the Metropolitan King County Council and the MHCADSD have been working toward a recovery orientation in both the mental health and substance use disorders treatment systems for a number of years.

The goals and strategies of the 2005-2010 King County Recovery Plan for the mental health system have largely been met. There is much to celebrate. A strong foundation has been laid for system transformation to one that consistently supports people in their recovery and resiliency. That said, this process is, in many ways, just beginning. This is a profound culture change that requires long-range planning and implementation in a step-wise process. Please see Appendix A – A History of Recovery in Mental Health in King County.

Recovery for persons served in the substance use disorders treatment system has taken on dimensions of whole health and living a satisfying life in the community of choice. These goals take the system beyond the long standing marker of sobriety as recovery. Concepts and practices further developed in the mental health recovery movement are increasingly adopted by the substance use disorders treatment system, such as involving people who participate in services in the evaluation of the implementation of recovery-oriented services and adding peer services beyond "sponsors". The substance use disorders treatment system in King County has been investing in the development of a Recovery Oriented System of Care (ROSC) through its vision of prevention, screening and early intervention, treatment, and recovery, that is integrated with primary health care. Recovery means spreading the positive message that behavioral health is essential to overall health, that prevention works, treatment is effective, and people can and do recover.

Since adoption of recovery as a guiding principle for the King County mental health system in 2005, families and those who provide services to children, youth, families, and older adults consistently report that resiliency is a more relevant principle to the experience of children, youth, families, and older adults gaining or regaining wellness. The core recovery principles of client centered care and incorporation of client voice require that a behavioral health system be responsive to the perspective of these families. For this reason, MHCADSD has begun to include the principles and values of resiliency on par with those of behavioral health recovery in the current planning for a recovery and resiliency oriented behavioral health system.

A recovery and resiliency-oriented behavioral health system must include a focus on physical health and integrated healthcare. The National Association of State Mental Health Program Directors (NASMHPD) published a study in 2006 called Morbidity and Mortality in People with Serious Mental Illness. The report analyzed data from 16 states and found that, on average, people with severe mental illness die 25 years earlier than the general population while people with co-occurring mental illness and substance abuse disorders have life expectancies 35 years shorter than individuals without these illnesses. The benefits of providing effective care well exceed the costs. For every dollar spent on substance abuse treatment, seven dollars in future healthcare spending is saved.

Addressing the epidemic of chronic medical illness and premature death for persons with mental illness and/or substance use disorders is essential to realizing the promise of recovery. Poor physical health puts additional barriers on the path to recovery, stealing time, energy, and personal resources that could go toward recovery.

Even more tragically, premature death robs the recovering individual of the fruits of a long, hard effort; a meaningful life in the community. Most persons with serious mental illness (SMI) do not reach recovery until their mid-40's. Now that people with SMI are dying 25 years sooner than the general population, they are left with many fewer years of life to enjoy their recovery.

The evolution and final design of the mental health and substance use disorders treatment systems as a result of health care reform is not yet known. What is clear is that physical health and behavioral health are complementary and related. Both must be assessed, addressed, and coordinated in a holistic approach. As integration with primary health care progresses, education for all medical staff regarding behavioral health recovery and resiliency will be necessary.

A recovery and resiliency-oriented behavioral health system must be trauma-informed. Multiple studies have demonstrated strong links between trauma and later substance abuse and the symptoms of mental illness. Not surprisingly, people with histories of repeated trauma are more likely to face homelessness, poor physical health, and addiction and mental illness diagnoses placing them at further risk for victimization and trauma. As a result, homelessness, substance abuse and mental illness are both outcomes of and risk factors for future abuse.

Definitions

Behavioral health is defined as mental health and a life free of substance use disorders. The behavioral health system includes those agencies that provide mental health services for persons living with serious mental illness and/or substance use disorders treatment. The goal of the behavioral health system is to promote resiliency and recovery of normal functioning and participation in family and community life for persons with serious mental illness and/or substance use disorders.

A new definition of recovery for people with behavioral health challenges was announced by the federal SAMHSA on December 12, 2011:

> "A process of change through which individuals work to improve their own health and well-being, live a self-directed life, and strive to achieve their full potential."

As delineated by SAMHSA, there are four major dimensions that are essential to a life in recovery:

- Health: Overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way
- 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

The principles of recovery that inform services and service delivery are described as:

- Holistic
- Person-driven
- Based on respect
- Emerges from hope
- Occurs via many pathways
- Supported by peers and allies
- Culturally based and influenced
- Supported by addressing trauma
- Supported through relationships and social networks
- Involving individual, family, and community strengths and responsibility

This definition of resiliency was developed by the Ohio Center for Innovative Practices:

> "An innate capacity that when facilitated and nurtured empowers people to successfully meet life's challenges with a sense of self-determination, mastery, and hope."

Services for children, families, youth, and older adults that focus on the principles of resiliency are more appropriate than recovery alone.

The children's mental health service providers in King County have adopted the following principles as being in accord with the system of care described in the Children's Mental Health Plan. These principles of resiliency apply to everyone on a recovery journey.

- Resiliency is a belief and faith that all people have strengths and are capable of overcoming challenges
- Everyone has the right to hope and success starting at birth and lasting a lifetime.
- Communities and systems have responsibility and commitment to nurture resiliency.
- People are recognized and acknowledged as experts in their experiences.
- People have a voice and choice in services and supports.
- A resiliency-oriented mental health system is sensitive to culture, community, and values of the individual.
- Services and supports are individualized, flexibly delivered, and tailored to meet the unique needs of the person.
- A resiliency-oriented behavioral health system is affirming of people with unconditional acceptance.
- In a resiliency-oriented system, supports and services focus on promoting resiliency, while reducing risks and stabilizing symptoms.
- A resiliency-oriented system provides access to a continuum of care that addresses health promotion, education, and intervention across developmental ages and stages.

Whole Health recognizes that physical, emotional, nutritional, environmental, and spiritual aspects of one's life all contribute to one's health and disease. Providing integrated care ensures the whole person is assisted to live their best life and is the best insurance for a life of recovery and resilience.

Trauma-Informed Care is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma that emphasizes physical, psychological, and emotional safety for both providers and survivors; and that creates opportunities for survivors to rebuild a sense of control and empowerment.

Trauma-Informed Care services recognize the prevalence and pervasive impact of traumatic experiences on people who are receiving services, people who provide services, and people who manage direct service staff. Policies and procedures are reviewed by the agency and adjusted to reflect respectful practices that consciously avoid re-traumatizing, patronizing, or stigmatizing.

Each person's judgments, beliefs, and frame of reference are regarded as a reflection of her or his unique life experience. Agencies offer respect, seek information about life experience, create connection, and offer hope. A welcoming and inclusive environment is offered both for people receiving services and for people offering services. Clients and families are recognized as the experts about what has happened to them and what they want to happen next. The person providing services is the expert in treatment within the context of what the client wants.

What is a Recovery and Resiliency-Oriented Behavioral Health System?

Fundamentally, recovery is not a practice; it is a culture. It is not as much what you do, but how you do it. Recovery focuses on values and meaning more than on behaviors. The following seven values of a recovery and resiliency-oriented system were developed by the Mental Health America Village in Los Angeles.

1. Welcoming and Accessible

Recovery and resiliency programs are fundamentally relationship based. We try to "meet people and families where they are". Symptoms, stigma, trauma, low motivation, and negative treatment experiences can all be obstacles to getting help. Meeting people where they are facilitates the identification and building of resilience.

2. Growth Orientation

Holding the belief that people and families can recover acknowledges the fact that all people can grow and change. They may not be able to eliminate all their symptoms or behaviors, but they can regain control of their lives, rebuild their lives, grow, heal, and achieve meaningful lives. A growth orientation means holding an overarching expectation that people will learn and grow from their experiences, eventually even moving beyond mental health services.

3. Consumer Inclusion

Recovery is a collaborative process that requires ongoing effort and commitment from the person and/or family who is participating in services. Recovery is built upon the strengths and resiliencies of a person or family that enable them to overcome, not upon the strengths of the staff's caretaking or their treatment.

4. Emotional Healing Relationships and Environments

Recovery and building resiliency includes a process of healing from the symptoms of the illness itself, and also from trauma, destruction, and rejection. Programs often need to be a place of listening and empathy, acceptance and safety; a sanctuary to grow beyond.

5. Quality of Life Focus

Recovery and resiliency is achieved when a life is rebuilt, even if the illness persists. People and families may need a great deal of direct support, guidance, opportunity creation, and learning skills to rebuild their lives beyond the mental health agency and staff.

6. Community Integration

Recovery and resiliency means moving beyond getting needs met from mental health professionals. Hospitalizations and jail stints often reflect failures in community integrations. Life occurs out in the community, not inside a program, even a pleasant one. Recovery is a return to a web of personal relationships, familial, intimate, neighborly, even spiritual. Many other parts of our community need to contribute to recovery. It is not a private journey isolated in a professional's office; it is an embracing of life.

7. Staff Recovery

Staff must live the values of recovery and be actively growing themselves if they are expected to be effective recovery workers. In recovery, the same rules and values apply to everyone. This entails moving from caretaking to empowerment, believing in and understanding recovery, and moving from treating illnesses to improving lives. Staff must move from being the detached expert to an emotionally engaged guide. This requires a blurring of traditional hard boundaries and role definitions to promote healing.

The Mental Health America Village in Los Angeles also articulated the following characteristics of a progressive, recovery and resiliency-oriented organization:

Leadership
Consistently focused on recovery and resiliency and based on bottom-up input, providing opportunities and avenues for contribution and participation

Amplifying Consumer and Family Voices
Basing decisions on their direct experiences and wisdom

Focusing on Positive Psychology
Hope, resilience, competence, strengths, creativity, community building, supportive spiritualty, sense of meaning, joy

Working in Partnership
Staff in life coaching roles, motivational interviewing, shared decision-making, self-directed care

Person and Family-centered Planning
Goal-driven, rebuilding life focus

Symptom Self-management
People using tools such as Wellness Recovery Action Plan, Dialectical Behavioral Therapy, family education, advance directives, Cognitive Behavioral Therapy, hearing voices training

Community Inclusion, Justice, and Social Roles
Supported housing, employment, education, parenting, citizenship, anti-discrimination, support for appropriate accommodations for social inclusion, supportive connections (building natural supports)

Holistic Wellness and Rejuvenation
Risk reduction, wellness activities, integrating primary care, integrated dual diagnosis, trauma-informed care, complementary health, sanctuary

Peer Role/Peer Support
Support groups, recovery education for consumers, peer counseling, warm lines, consumer-operated programs

Continuous Self Assessment/Quality Improvement
Staff learning culture; living recovery values throughout the relationships of people involved in the mental health system: executive staff, non-clinical staff, clinical staff, peers, etc.

Recovery & Resiliency and the King County Strategic Plan

The values, principles, and goals of a recovery, resiliency, and trauma-informed system mesh well with the vision, mission, principles and goals of the overarching King County Strategic Plan: Working Together for One King County. The vision statement of the Strategic Plan states:

> "A diverse and dynamic community with a healthy economy and environment where all people and businesses have an opportunity to thrive."

Further, the mission statement goes on to state:

> "King County government provides fiscally responsible, quality- driven local and regional services for healthy, safe, and vibrant communities."

The explicit intention of a recovery and resiliency-oriented system is to assist people to thrive by providing quality services with a focus on health, safety, and connection to community.

As in any system, the Guiding Principles of King County are the ideals or code of conduct that defines the system's core values and priorities. The Guiding Principles of the King County Strategic Plan include:

1. Collaborative
2. Service-oriented
3. Results focused
4. Accountable
5. Fair and just
6. Innovative
7. Professional

All seven of these principles are echoed in those of recovery and resiliency. The fundamental components of both include that services be collaborative, both on an individual level, and on a system level. The orientation is that services be of high quality, professional, and innovative. A recovery and resiliency-oriented system measures individual and system outcomes and holds providers accountable for the quality of services they provide via contracting and policies and procedures. Such a system ensures services are trauma-informed and do not inadvertently re-traumatize individuals. The recovery movement is a civil rights movement and requires that people are seen as citizens first and persons living with a mental illness second.

Six of the eight goals of the King County Strategic Plan that align with those of a recovery and resiliency oriented services system include:

1. Justice and Safety
2. Financial Stewardship
3. Service Excellence
4. Public Engagement
5. Quality Workforce
6. Health and Human Potential

Recommendations

This new plan for recovery and resiliency-oriented services in King County builds upon the strong foundation for recovery and resiliency achieved over the last five years in the mental health system and the goals and strategies identified in the Recovery Oriented System of Care (ROSC) developed for the substance use disorders service system. In addition, the plan will:

- Align goals and strategies for the mental health (MH) treatment system and the substance use disorders services system (SUD), coordinating and collaborating where ever possible.
- Continue to engage stakeholders in a process to identify barriers and develop strategies to enhance the progress made to shift the system to a recovery and resiliency orientation.
- Pursue a new ordinance requiring implementation of a new Recovery and Resiliency-Oriented Behavioral Health Services Plan in King County, giving the weight of law to the need for continued system change.
- Address the following four strategies to achieve change for the behavioral health care system in King County as follows:

    1. Policies and contracts to support recovery and resiliency-oriented services and focused monitoring of practices
    2. Measurement of outcomes
    3. Workforce training
    4. Support for grassroots pressure for change

- Assign the strategies that are developed to one or more of three phases identified for this change process to occur over five years. Because recovery is not linear, tasks and challenges will be revisited as needed.

    Phase I. Create a Shared Vision of Progress
    Phase II. Initiate and Implement: 2014-2015
    Phase III. Consolidate, Increasing Depth and Complexity

"Through the support and dedication of the counselors in mental health and substance abuse programs I was able to overcome barriers that prevented me from having a quality of life. Though their support today I am a Certified Peer Counselor, I volunteer for The Warm Line. I own my own home and I am in college going for the AAS degree in Human and Social Services along with Chemical Dependency counseling. "

- Diana Cooper, a King County consumer sharing her recovery story.

Phase I. Create a Shared Vision of Progress: 2012-2013

The key task of the first phase of change includes developing a shared vision for the MH system and the SUD treatment system. This includes strategies to develop and expand the evolution of the King County behavioral health system as a progressive, recovery and resiliency-oriented system. All stakeholders must be involved.

A. Activities already employed and planned include the following.

1. Joint board and provider meeting held January 2012. The draft of the recovery and resiliency plan and appendices for behavioral health services was announced and made available to attendees. Input was invited.

2. Leadership Summit sponsored by MHCADSD on June 11, 2012, gathered 120 stakeholders of the behavioral health system in King County for inspiration and sharing of strength, experience, and hope. Dr. David Pilon from the Mental Health America Village in Los Angeles presented the keynote and led a community visioning exercise with attendees to inform planning for recovery and resiliency. Afternoon break-out sessions focused on specific initiatives of Phase I, including Standards for Recovery and Resiliency-Oriented Services, the revised Standards for Peer Support and the expansion of the use of medications to assist recovery, among others.

3. Board meetings for both MH and SUD system took place in summer 2012.

4. Stakeholder forums for line staff, consumer/clients, families, advocates, and community will be scheduled for 2013.

5. Revisit stakeholder group structure, charters, etc. and revise and add groups as indicated. Ensure significant consumer/family voice for all planning, implementation, evaluation, and modification of strategies and initiatives.

B. Strategy I - Policies and Contracts to Support Recovery and Resiliency-Oriented Services and Focused Monitoring of Practices

1. Mental Health Services

   a. Recovery plans are required of new agency contracts in 2011 for the first year of the contract.

   b. Development of Standards for Recovery and Resiliency-Oriented Practices. The Policy and Procedure stakeholder workgroup began reviewing the Agency Recovery Plan template and making recommendations in July 2011. The cost benefit of each proposed standard is considered. Review and input is sought from stakeholders, including families/caregivers and the child and family and older adult serving systems. Standards include:

      i. Recovery-oriented practices described on the Agency Recovery Plan become contractual requirements as Standards, e.g., consumer voice in planning, implementation, and evaluation of recovery and resiliency plans.

      ii. Descriptions and indicators of a recovery and resiliency-oriented intake and assessment process, and a similar description of the recovery planning process that meets the requirements of the Washington Administrative

Code. Process and practices are described that allow establishment of medical necessity, while communicating hope and partnership.

c. Peer Support Services

i. Revision of Peer Support Standards. The previous standards were written in 2007. National guidelines have since been published as a result of the Pillars of Peer Services conference. Ensure review and input from stakeholders, including families/caregivers and the child and family and older adult serving system. Consider the cost-benefit of each proposed standard.

ii. Continue to embed requirements for peer support services and appropriate training and support in all specialty contracts and services, e.g. mental health court, housing, supported employment, etc.

d. Develop an action plan in partnership with providers and residents to better infuse recovery principles and practices in the mental health residential facilities in King County.

2. Policy and Contract – SUD

a. Review all policies and procedures for person-first language in 2012, with staff making recommendations for changes for 2013.

b. Identify policy changes to support the Recovery-Oriented System of Care.

c. Continue the development of peer services and the development of standards.

i. Work with state partners to develop standards for peer support.

ii. Continue to include peer support in specialty contracts when possible.

iii. Conduct literature search to better delineate the role of peer providers.

iv. Identify funding to support peer providers.

C. Strategy II - Measurement of Outcomes

1. System Outcomes - The incentives process for the MH system currently measures the structures, processes, and system outcomes that clients and families have identified as aligned with recovery and resiliency.

a. MH – Continue the financial incentive implementation process. Continue to include stakeholders in identifying appropriate system and individual targets for agencies, retiring measures as outcomes are achieved and adding others.

b. SUD – Identify financial or other mechanisms to support incentives for providers to shift to a recovery-oriented system with appropriate measures and

targets. Explore piloting different payment structures with the state that might better support incentives for recovery and resiliency-oriented services.

2. Individual outcomes – For both MH and SUD, engage in a stakeholder process to select a method of measuring individual outcomes.

D. Strategy III - Workforce Training.

Training the workforce to become one that can work successfully in a recovery and resiliency oriented system requires a proactive curriculum.

1. The following 12 Aspects of Staff Transformation by Mark Ragins, M.D. will be considered in the development of training. Please see Appendix B.

   - Looking inward and rebuilding the passion
   - Building inspiration and belief in recovery
   - Changing from treating illnesses to helping people lead better lives
   - Moving from caretaking to empowering, and sharing power and control
   - Gaining comfort with co-staff who have mental illness and multiple roles
   - Valuing the subjective experience
   - Creating therapeutic relationships
   - Lowering emotional walls and becoming a guiding partner
   - Understanding the process of recovery
   - Becoming involved with the community
   - Reaching out to the rejected
   - Living recovery values

2. Training will support the resilience and excellence of the workforce.
3. Mental Health Workforce Training:

   a. Members of the workforce hired after 2011 are required to complete (or test out of) the Foundational Recovery Curriculum to meet the identified competencies via continued provision and availability of the *Essential Learning* on-line learning management system. Please see Appendix C.

   b. Assessment of recovery and resiliency skills training needs via the Recovery and Resiliency Oriented Skills Inventory. The Inventory will be completed by members of the workforce as a survey via Essential Learning in lieu of a course requirement in 2012. This skills survey was built upon the foundation of the United States Psychiatric Rehabilitation Association's certification curriculum for certification as a psychiatric rehabilitation specialist. The survey was reviewed and edited in a stakeholder process, and focuses upon the following:

      i. Positive psychology - hope, resilience, strengths, creativity, community building, supportive spirituality

ii. Working in partnership - staff in life coaching roles, motivational interviewing, shared decision making, self-directed care

iii. Person centered planning - goal driven, rebuilding life focus

iv. Symptom self management – Wellness Recovery Action Plans©, Dialectical Behavioral Therapy, family education, advance directives, Cognitive Behavioral Therapy, hearing voices training, etc.

v. Community inclusion and social roles - supported housing, employment, education, parenting, citizenship, anti-discrimination

vi. Holistic wellness - risk reduction, wellness activities, integrating primary care, integrated dual diagnosis, trauma-informed-care, complementary health

c. Plan in a stakeholder process for future skills training, incorporating the findings of the skills inventory

d. Coordinate with the state to identify topics for peer training and provide training within available resources.

4. SUD Workforce Training:

a. Continue the motivational interviewing learning collaborative with clinical supervisors (a training program that was developed with input from stakeholders.)

b. Identify additional recovery and resiliency oriented competencies in a stakeholder process.

c. Identify appropriate training to address needed competencies

d. Consider on-line training via Essential Learning, including both courses currently in the catalog and courses that might be created.

E. Strategy IV - Promoting Grassroots Pressure for Change.

Promote the education of consumers, families, and the community to support and promote grassroots pressure for change for both MH and SUD treatment.

1. MH and SUD. For both, continue and expand the following efforts:

a. Recovery Celebrations and other smaller events closer to the agencies

b. Recovery and Resiliency Poster Art and Poetry Contest in conjunction with a Recovery Month Calendar

c. Recovery and Resiliency Roundup quarterly newsletter

d. Recovery and Resiliency Articles of the Month

e. King County Recovery and Resiliency web site

f. Recovery and Resiliency Behavioral Health Conference

g. Outreach to community organizations

h. Encourage the development of consumer-run organizations by offering training in establishing 501C3 status, creating a board, responding to requests for proposal and grant opportunities.

i. Campaign for respect, dignity, and social Inclusion:

   i. YouTube recovery campaign

   ii. Facebook page for recovery and resiliency in behavioral health

   iii. Explore multi-faceted campaign inviting people to stand and deliver their recovery and resiliency stories with friends, neighbors, colleagues.

Phase II. Initiate and Implement: 2014 - 2015

The key tasks of Phase II are to initiate change and implement the strategies identified in Phase I. Barriers to change will be identified and strategies to overcome those barriers will continue to be identified and refined in Phase II.

A. Strategy I - Policies and Contracts to Support Recovery and Resiliency-Oriented Services and Focused Monitoring of Practices

1. MH

   a. Publish the Standards for Recovery and Resiliency-Oriented Practices in the King County Mental Health Plan Policy and Procedure manual.

   b. Publish the Standards for Peer Support Services in the Policy and Procedure manual.

2. SUD

   a. Review policies and procedures in a stakeholder process to ensure inclusion of person-first and other language supportive of recovery and resiliency.

   b. Request providers to sign a letter of intent to participate in recovery and resiliency initiatives.

   c. Design or select a provider self-audit tool that assesses progress in implementing recovery and resiliency practices.

   d. Identify and support a training program appropriate for peer providers.

   e. Review contracts and requests for proposals for the potential of incorporating peer support in program design.

B. Strategy II - Measurement of Outcomes

1. System Outcomes – Financial Incentives

   a. MH -- Continue incentive implementation process, identifying new incentive measures as targets are achieved and stabilized

   b. SUD - Realign fiscal and other resources for incentives
      i. Identify measures and targets in a stakeholder process
      ii. Begin providing incentives based upon provider intent to participate and completion of the self-audit.

2. Individual Outcomes – MH and SUD - Finalize decision about method, plan for implementation – cost, training, technical requirements.

C. Strategy III - Workforce Training – MH and SUD

1. Pursue identified training design
2. Implement workforce training
3. Peer training: MH — Continue peer trainings, support, and continuing education; SUD — develop and invest in appropriate peer training.

D. Strategy IV - Promote grassroots pressure for change for both MH and SUD treatment through education of consumers, families, and the community

1. Consider targeting recovery funds on increasing consumer participation in leadership trainings, with the purpose of training other consumers across King County.
2. Fund consumer pilot projects and ensure that selected projects are consumer-identified and run operations. Look for ways to support the development of consumer operated services that support recovery and resiliency.
3. Support, enhance, and expand on the current array of persons who can speak about their personal experience of recovery and resiliency. Arrange for presentations in agencies, at consumer groups, and at family support groups.
4. Develop positive media coverage about people in recovery in order to educate the public.
5. Work closely with consumers, advocacy groups, and providers to encourage the development and expansion of a consumer movement in King County.

Phase III. Consolidate, Increasing Depth and Complexity: 2016–2017

Phase III is identified as a period to consolidate the changes made in Phase II, based on the vision articulated in Phase I. Activities and goals of Phase III are intended to increase the depth of recovery and resiliency-orientation throughout the behavioral health system in King County.

A. Strategy I - Policies and contracts to support recovery and resiliency-oriented services and focused monitoring of practices

1. MH

   Include aspects of the Standards for Recovery and Resiliency-Oriented Mental Health Practices in the contract compliance site visit., and include aspects of the Standards for Peer Support in the contract compliance site visit.

2. SUD - Include participation in recovery initiatives in agency contracts.

3. Develop Standards for Behavioral Health Care.

4. Continue implementation of policy/resource changes.

5. Continue evolution of performance measures and practice guidelines.

B. Strategy II - Measurement of Outcomes

1. System Outcomes – financial incentives

   a. MH - Continue incentive implementation process, identifying new incentive measures as targets are achieved and stabilized.

   b. SUD - Review agency progress in implementing recovery practices and begin baseline measurement for targeted outcomes.

2. Individual outcomes – implement and evaluate the selected method of measurement.

C. Strategy III - Workforce Training for Both MH and SUD - Provide advanced training on recovery-oriented services and systems for the workforce and the community.

1. Evaluate workforce skills training selected, use stakeholder process to revise as indicated.

2. Continue SUD and MH peer trainings, support, and continuing education.

3. Continue providing technical assistance and knowledge transfer between agencies about recovery practices.

4. Begin to explore and articulate a certification process for peers and clinicians as recovery and resiliency specialists.

D. Strategy IV - Education of consumers, families, and community to support and promote grassroots pressure for change for both MH and SUD

Continue and expand activities; participate with providers and other organizations in promoting social inclusion and initiatives to reduce stigma through social marketing.

Conclusion

Developing a recovery and resiliency-oriented behavioral health system requires a paradigm shift. People must become actively involved in their treatment and clinicians must become facilitators who assist them to achieve their goals. In order for people and families challenged by mental illness, behavioral challenges, and/or substance use disorders to develop or return to normative life roles, there must be an emphasis on creating and utilizing natural supports, developing activities and relationships outside of the treatment system, and living in community-based housing. The development of community connections and the involvement of natural supports will help assist people to become integrated members of the community.

King County is aware that making this profound paradigm shift will take time. We are committed to encouraging a learning environment so that all system participants, including MHCADSD staff, providers, and those who participate in services, learn how to implement the recovery and resiliency model within system constraints. We will continue to assess our system, gather information, create reasonable benchmarks and work with providers and consumers to implement this model together. Through the work groups, MHCADSD will establish goals and measurements in collaboration with providers, consumers, and other stakeholders. Updates on progress will be reported regularly to the Metropolitan King County Council.

The MHCADSD is invested in ensuring that the progress made with regard to recovery and resiliency-oriented behavioral health services continues and expands in an era of healthcare reform. The MHCADSD will look for every opportunity to increase integration and quality of healthcare for the people who participate in services as healthcare reform is implemented over the next five years.

The ultimate goal of the transformation of the system is that consumers may achieve the promise of what the rest of the population takes for granted. That promise includes the support of family and friends, the sense of purpose and contribution to society through employment and meaningful activities, and the feeling of belonging and selfhood that comes from no longer defining oneself by an uncontrollable diagnosis, but by the proactive development and fulfillment of one's potential.

King County remains committed to the vision of recovery and resiliency. Some might look at this time of budgetary constraints as a time to pull back. Instead, MHCADSD will continue investing in the necessary strategies for system change to transform the behavioral health system in King County to one that truly supports the mental health and wellness of the people who participate in behavioral health services.

Appendix A - A History of Recovery in Mental Health in King County

Ordinance 13974

In 2000, King County recognized the desirability of moving beyond maintenance as a goal of mental health treatment and adopted Ordinance 13974 establishing the goal of recovery, defining recovery and requiring reporting of client progress for working age adults based on definitions of dependent, less dependent and recovered and outcomes related to housing stability and employment.

Ordinance 13974 was adopted early in the process of development of the recovery model with only a limited understanding of the concepts of recovery and without the full benefit of research on best practices and the experience of other systems that have made a successful transition. In addition, it was limited to only working age adults.

It became clear that changing to a recovery model entailed a fundamental change in how business is done, not just the addition of some new employment and housing services. It was also increasingly clear that business-as-usual cannot be maintained in the face of growing demand and more limited resources.

In the years immediately following the adoption of the first recovery ordinance, “recovery” became the rallying cry for people living with mental illness and those that work with them. The 2003 report of the President's New Freedom Commission on Mental Health recognized the recovery orientation as a best practice model appropriate for public mental health agencies.

The Washington State Legislature amended the Community Mental Health Services Act, Chapter 71.24 Revised Code of Washington, to include recovery concepts in the 2005 session.

Further research by the King County MHCADSD regarding the concepts of recovery and the literature on results in other parts of the country indicated that systems based on recovery are more cost-effective. The recovery model changes the goals of the system from community support or maintenance of persons with serious mental illness, to recovery of function and participation in the community to the maximum extent possible in spite of illness that persists in most cases. As people succeed in recovery, they require fewer high-end services, such as hospitalization and incarceration, and they begin to contribute financially to their own welfare.

Based on this information and with an understanding the process of system change, MHCADSD developed a five-year strategic Recovery Plan. The goal was to convert the King County mental health system to a system based on recovery concepts and the implementation of evidence-based and best practices that help children, youth, adults, and seniors with serious mental health conditions recover their lives.

Ordinance 15327

On November 15, 2005, the Metropolitan King County Council passed Ordinance 15327, a revised mental health recovery ordinance. The Council action also adopted the Recovery Plan for Mental Health Services, dated August 2005, to serve as a guide for implementation. This included a five-year work plan for transforming King County's mental health service system from one based on community support and maintenance to one based on recovery and resilience. The recovery plan described the work plan in three phases to occur over five years:

Phase I. Create a shared vision of recovery (2005-2006)

Phase II. Initiate change (2006-2008)

Phase III. Increase depth and complexity (2008-2010)

Phase I: Creating a Shared Vision of Recovery

In order to create a shared vision of recovery, a number of activities were initiated. Integrated stakeholder groups formed for planning and evaluation of system change. Executive retreats took place for provider agency management staff to ensure a common understanding and investment in moving the system forward. Presentations on recovery were provided for mental health workers and consumers. A thorough review of evidence-based practices was completed to gain knowledge and expertise in recovery principles.

The MHCADSD invested in hiring a recovery specialist to lead and focus the recovery initiatives. Mental health provider agencies declared their intent to participate in recovery initiatives.

Consumer voice was promoted in multiple levels of the system – in individual services, in agency and county-level policy decisions, in governance and oversight functions, and in the work force. Services identified as recovery-oriented or recovery-promoting are those that consumers themselves identify as the services that they most need, want, and will use. By listening to their voices and implementing the services that will assist them in their recovery journeys, King County has made and continues to make progress in changing the philosophy that guides the way the mental health system does business.

Phase II: Initiate Change

In order to initiate change within the publicly funded mental health system, a shift in approach needed to occur within King County and among the provider network. In the Phase II Implementation Plan, published in June 2007, three key strategies were articulated to facilitate the needed changes:

Strategy 1 – Rewarding Structures, Processes and Outcomes that Promote Mental Health Recovery

Strategy 2 – Provide Workforce Training in Recovery Practices

Strategy 3 – Use of Regulatory Practices to Promote Change, Including More Focused Monitoring on Policies, Procedures, and Contracts

Strategy 1: Rewarding Structures, Processes and Outcomes that Promote Mental Health Recovery

The MHCADSD worked with an expert consultant and developed a way to reward recovery practices, and create incentives for change. The Incentives Implementation Work Group was formed as a partnership of provider mental health agencies and MHCADSD staff. The work group began in 2007 to identify ways to define, measure, and prioritize the incentives. The incentives plan allows for incentives to be individualized to each agency, taking into account their size, the population they serve, and their unique challenges as they transform to a recovery orientation.

The domains for which outcomes are desired were identified in a stakeholder process early in Phase II, including employment, education, and meaningful life activities, community tenure (staying out of the hospital or jail), quality of life, and housing.

Development of incentives focused on the first three of these domains. While having a safe place to live is clearly the foundation of recovery, housing development is a long-term, complex, and high-cost venture. The amount of funding available for incentives was determined to be too small to be useful in that arena. However, MHCADSD continues to work with the Seattle Housing Authority, the King County Housing Authority, and housing developers to advocate for housing development for mental health consumers. In addition, ending homelessness is one of four key foci of DCHS, which hosts the Committee to End Homelessness in King County. The committee is a broad coalition of government, faith communities, non-profits, the business community, homeless, and formerly homeless people working together to implement the regional Ten-Year Plan to End Homelessness in King County. Jackie MacLean, DCHS Director, participates in the Interagency Council of the Committee to End Homelessness. Given other department efforts on housing and homelessness, the available recovery incentive dollars have been focused on the other three domains.

Multiple process and outcome measures have been identified for three of the four domains and all of these measures will be tracked. In order for the incentive payments to have sufficient weight to motivate change, only a subset of these measures have incentive payments attached.

The selected process measures are tailored to address the differences in the needs of children and youth, adults, and older adults. The original measures included:

Youth and Families (age 0-17)

1. Increased number of age appropriate developmental assessments
2. Increased number of collaborative contacts with other involved systems
3. Parent and peer support services are provided

Adults (age 18-59)

1. Supported employment services are provided
2. Face to face services are provided within seven days of release from incarceration or hospitalization
3. Peer support services are provided

Older Adults (age 60+)

1. Care plans reflect older adults are engaged in meaningful activities
2. Care plans reflect client voice and choice

Data is provided to the agencies to assist them in monitoring their performance to the incentive measures and for system improvement.

In 2007, mental health agencies first received the incentive funds by committing to participate in recovery initiatives via a letter of intent. This included an increase in case rate payments beginning in June 2007 through December 2007. Agencies were explicitly encouraged to utilize these funds to begin shifting to more recovery oriented services.

A template of a self-assessment and an Agency Recovery Plan were created to inform the agencies about the types of strategies the agency might need to employ to effect broad change. The Agency Recovery Plan template described elements, including services and systems, expected in a recovery oriented program.

All 16 mental health agencies completed a self-assessment and created an Agency Recovery Plan, with goals and objectives unique to the people they serve and the strengths and challenges of the agency. This was the basis of the 2008 incentive payments. All 16 agencies earned this incentive payment. Significant progress was evident in the 2009 review of Agency Recovery Plan implementation.

As has been found true in other parts of the country, as incentives are earned and the processes are fully integrated, they can be considered established. New measures are then selected to have incentives attached.

Strategy 2 – Provide Workforce Training in Recovery Practices

Experience has shown that the system demonstrates improved flexibility, strength, and integrity, inasmuch as recovery principles are expressed throughout the transformation process and across all levels of the system. For example, the initial work force training plan was largely developed by County staff. The planned training would have provided exactly the same training for everyone and the one-size-fits-all approach proved ineffective.

A more thoughtful planning process that better incorporated recovery principles resulted in a training plan that includes the ability to assess the strengths and needs of each person to be trained, in order to develop a training plan individualized to the participant and the agency's goals. In 2009, consumers and providers worked in partnership with County staff to identify the competencies needed in order for services to be more recovery-oriented and arrived at a revised work force training plan.

Peer support is included in the National Consensus Statement of the fundamental components of recovery and is a promising practice strongly endorsed by local and national mental health consumers and family advocates. As part of Strategy 2, in 2007 MHCADSD began sponsoring the state approved peer counselor training locally to ensure King County consumers had access. Two to three peer counselor trainings have been provided each year since 2007. In 2009, MHCADSD began providing a "test prep" session for graduates of the peer counselor training, resulting in higher rates of success in passing the peer counselor exam.

The stakeholder process to develop the workforce training plan brought the insight that training also needed to be provided to consumers. Half-day events for consumers titled, 'Recovery Celebrations', were provided across the county to bring the great news about recovery to the people living with mental health challenges.

The *King County Recovery Roundup* began publication in spring 2008 and has been updated and distributed widely every quarter since. In addition to providing periodic updates of current transformation efforts, the *Roundup* includes a recovery story submitted by a King County consumer. The publication affords an opportunity to provide education to the community-at-large about mental health recovery.

Strategy 3 – Use of Regulatory Practices to Promote Change, Including More Focused Monitoring on Policies, Procedures and Contracts

Standards for peer support services were developed in 2007 for the responsibilities, training, and supervision specific to peer support services. The standards form the basis for monitoring the quality of peer services in the future.

An annual review of policies and procedures and contracts began to define and refine the expectations related to practices that better support mental health recovery. Wording was amended, where necessary, to ensure person-first language. The rationale behind person-first language is recognition of the human being first, and that the disability is only a part of that person. It makes us think about the person as coping with a mental illness, rather than being thought of or defined by the mental illness.

Phase III. Increase Depth and Complexity - Achievements in 2010-2011

Phase III, which began in 2009, was completed in 2011. The strategies appropriate to earlier phases of implementation were modified to match the needs of an evolving system.

Strategy 1: Rewarding Structures, Processes and Outcomes that Promote Mental Health Recovery

Incentives, initially awarded for structures and processes, began in 2010 to shift to actual outcomes. Structures are the service delivery models that meet fidelity standards and/or are priority services or practices that promote recovery. Processes are the activities agencies engage in that ultimately result in desired outcomes for consumers.

While the early focus of the incentives for employment was the establishment of high fidelity supported employment programs (structures and processes), a shift to paying incentives for the outcome of actual employment requires accessing a broad base of supports and resources for consumers. An ad-hoc work group of consumers, providers, and County staff met in 2009 to identify barriers to employment and strategies to address those barriers. The process resulted in a focus on employment in 2010 and several high profile training events for the community.

The incentive measures have changed system infrastructure. Low performance in 2008 for the adult measure of contact within seven days of jail or hospital release led to an ad-hoc work group in 2009 to identify the system barriers to improve performance relative to incarcerated individuals.

This resulted in agencies identifying forensic staff to specialize in working with the criminal justice system. King County developed a comprehensive and intensive training for working with the courts, jails, defense attorneys, and the probation system. The training has helped the forensic staff be successful in engaging people before and after release from jail, and to provide technical assistance to all staff within the agency. As a result, system-wide performance improved by 26 percent.

COMPARISON OF BASELINE DATA FOR INCENTIVES TO 2011 PERFORMANCE

Measure	Baseline Period	2011 Performance	System Target
Children			
Developmental assessments	(2008) - Few found	89%	80%
Collaborative contacts	(2008) - 21.1%	62%	80%
Parent peer supports	(2009) - 1148 hours of service	2360 hours of service	not set
Adults			
Employment	(2009) - 12.5%	16.9%	40%
Face to face service within seven days of hospital or jail release	(2007) - 65.4%	82%	80%
Peer support	(2009) - 51418 hours of service	60773 hours of service	not set
Older Adults			
Increase meaningful activity	(2009) - 89%	97%	90%
Collaborative contacts	(2010) - 20%	34%	80%
Care plans that include client voice and choice	(2009) - 88%	98.5%	90%

The receipt of the recovery incentives in a given year is based on performance and progress establishing structures and processes in the previous year. Agencies are notified early in the year what their targets are for the year and are provided with data throughout the year to assist them in monitoring their progress.

A goal of incentive implementation is to use routinely submitted data as much as possible, minimizing the number of record reviews or other methods to determine target achievement. For the first time, in 2011, most of the targets were determined by submission of data.

For most measures, a system target has been set. To earn the incentive payment, agencies must show improvement that is a percentage of the difference from their baseline and the system target. In 2010, a long range system target was established for employment of adults. Agencies must meet an individualized target of 10 percent of the difference between their performance last year and the system target of 40 percent. Given the challenges of the current economy, agencies can earn one half of their incentive if they reach 50 percent of their target.

The employment measure was initially only available to those eight agencies that had supported employment programs. For 2010 payments, those agencies were required to report a 100 percent increase in the number of services provided. For 2011, all adult serving agencies are eligible for the employment incentive (except Evergreen Health Services, as they serve primarily older adults). Earning the incentive required an increase in the number of adults becoming employed in 2010, as compared to 2009.

In recognition of the current funding constraints for mental health services, the target for 2011 peer services for 2012 payments was maintained at the same level of services as provided in 2010 (if the agency was over the target for 2010) or achieving the target as set in 2010 (if the target was not met).

Consumer voice, choice, and meaningful activity, as reflected on the Individual Service Plan, have been the outcomes for older adults since 2009. The system target was 85 percent for the first two years.

Providers of older adult services agreed to increase the target to 90 percent and to add a new incentive in 2011: collaborative contacts. Collaborative contacts are those made with other systems or supports involved with an older person, for example, medical, family, or residential facility. All of the agencies achieved at least 90 percent on voice, choice and meaningful activities in 2011. For this reason, those two measures are considered to be met. New measures for 2012 performance for 2013 incentive payments for older adults include health care needs addressed on the Individual Service Plan and the addition of a plan to implement or increase peer support services.

For children and youth, developmental screening instruments have been identified, developed in collaboration with the youth provider network, and adopted system-wide. Agencies submitted a mid-year progress report toward implementing the assessments in 2010 for 2011 incentive payments.

Strategy 2 – Provide Training in Recovery Practices

Strategy 2 was revised from work force training in recovery to widen the provision of training and support to consumers, workers, and the community at large. The revision was made in response to recommendations from the Recovery Advisory Committee and the Voices of Recovery Advisory Committee. Recovery literature confirms the principle that recovery is best fostered and supported in the context of a relationship where both the consumer and the worker are recognized as experts in their experience and understanding of what works to support recovery. The expanded focus of Strategy 2 also addresses issues of social inclusion and reduction of stigma in the community.

Workforce Training: Recovery competencies were developed via a stakeholder process in 2009. MHCADSD chose to contract with Essential Learning, the preeminent provider of web-based online training in behavioral health. This allows for individualized training plans for agencies and staff and recognizes already existing strengths. Incorporating these recovery principles in our system planning and provision of training creates a strong system that has integrity. Members of the workforce that have direct contact with consumers were loaded into the Essential Learning Management System as learners. County clinical staff, including Crisis and Commitment Services staff and contract monitoring staff, are included, for a total of 3,000 learners. Courses for 2010 and 2011 were defined and assigned.

Recovery Training via Essential Learning—Required Courses

2010
Path to Recovery
Motivational Interviewing
Self-Direction, Person Centered Planning and Shared Decision Making To Facilitate Recovery, Part I and Part II

2011
Wellness Recovery Action Planning One-on-One
Supported Employment for Social Service Agencies (for adult providers)
Strengths-based Perspectives for Children's Services (for children providers)
A Culture-Centered Approach to Recovery
Peer Specialists 101: Research, Core Competencies, and Ethics

Educational Institutions:
The Recovery Advisory Committee recommended contacting the institutions that educate those who want to work in the mental health field to ensure recovery and resiliency are included in the curriculums of those entering the field. As a result, in 2011 the Recovery Specialist provided recovery and resiliency trainings to students at Seattle Central Community College. The coordinator of the Human Services Program at the college will be facilitating contact with the other community colleges in King County for similar training. The University of Washington School of Social Work has been in the process of revising their curriculum and senior management of King County offered to provide information regarding recovery and the training believed to be helpful to people in their recovery process.

Peer Support Services:
Support provided by people already in recovery and who have been trained to share their strength, experience, and hope with their peers is among the most powerful of recovery supportive practices. Since 2007, 11 local certified peer counselor trainings were funded by King County, with nearly 300 peers trained.

The number of employed peer support specialists and Full Time Equivalent (FTE) positions continue to grow. In 2007, there were 14.9 FTE positions in King County. By 2010, there were 54.65 FTE positions, or 83 peers working, including parent partners. In addition, a number of specialty service contracts have required the inclusion of peer staff.

In the King County Mental Health Plan network, 82 percent of the agencies provide peer services. Of the agencies serving adults, 80 percent provide peer services. Of the agencies serving children, 66 percent report providing parent partners/parent peers and/or youth peers. Of older adult serving agencies, 66 percent provide peer services.

Continuing education for peer support specialists was provided in 2010 and 2011 in Wellness Recovery Action Plans and in Tobacco Cessation and Wellness. Agencies received technical assistance to support the success of peer services.

Skill building in Illness Self-Management: Wellness Recovery Action Plan (WRAP) is a symptom self-management tool created by Mary Ellen Copeland. King County has provided WRAP Facilitator training twice since 2007. The training enables one peer from each agency to become a WRAP facilitator, to lead groups of people creating their own WRAP together. Everyone in the workforce has taken WRAP one-on-one training via an on-line training created by the Copeland Center.

Training for the Mental Health Community :
The first annual two-day conference in September 2011, "Recovery and Resiliency: Stepping Stones to Wellness", brought in nationally known keynote speakers on recovery and resiliency. The theme of wellness, leadership, and skill building guided the 36 workshops offered, most by a partnership of a peer and a professional. There were 12 workshops regarding children, youth, and families and six regarding employment. Altogether, there were 250 people in attendance; adult consumers and parents of children in the system, and mental health workers. Planning is already underway for the 2012 King County Recovery and Resiliency Conference for both mental health and substance use disorders.

"Bringing Hope to Every Interaction," was a training presented twice in 2010. Attendees included reception, clerical, and non-clinical administrative staff from provider agencies and DCHS.

Training and education happens in a number of ways for the community of people who live with mental health challenges. The theme of the second annual recovery celebrations in 2010 was "Love, Work, and Laughter—Keys to Recovery". Over 200 people attended these events that were offered in five different locations throughout the county. A similar attendance showed up for the first five recovery celebrations provided in 2009 based on the fundamental components of recovery. People were invited to share their email addresses if they were interested in receiving updates and announcements about recovery activities in King County.

The theme for the 2011 poster art contest was "Recovery and Resiliency as Stepping Stones to Wellness". Current and former clients of the King County Mental Health Plan were eligible to enter. The winner received a $150 gift certificate. The winning artwork was incorporated into a poster that received wide distribution across King County. The winning artwork was a colorful, playful, yet simple illustration of the theme. The artist was recognized at the 2011 Exemplary Services Award Ceremony in September 2011.

A recovery and resiliency article-of-the-month has been identified and provided to the mental health community in King County since April 2010.

The quarterly newsletter, the *King County Recovery Roundup*, was renamed the *Recovery and Resiliency Roundup* in 2011. Since 2008, the *Roundup* has provided education about recovery and resiliency, and updates to the community about system change efforts. A column was added for creative work by persons living with mental health challenges.

The King County Mental Health Recovery and Resiliency Webpage went up in 2008 and is updated at least quarterly with an inspirational recovery story and information about recovery, resiliency, and wellness.

Employment: Employment is a key indicator of recovery. In 2010, King County sponsored a retreat for agency senior management to assist in identifying barriers and strategies to achieving better employment outcomes.

Also in 2010, King County provided a half-day conference titled "Recovery, Making it Work" on employment for consumers and those who support them featuring Dr. Mark Ragins, a nationally known expert in recovery. The two-day conference in 2011 included a focus on employment.

A dinner event was also provided for psychiatric practitioners from contracted mental health agencies in October 2010. Dr. Ragins offered his perspective about how psychiatric services can be provided to enhance people's success at employment.

Employment outcomes have improved despite the bad economy.

Strategy 3 – Use of Regulatory Practices to Promote Change, Including More Focused Monitoring on Policies, Procedures and Contracts

The principles and values of resiliency were explicitly added to the recovery initiatives in 2011, having heard from child, youth, family, and older adult providers that "recovery" as a concept did not fit well for those populations. The MHCADSD is endeavoring to give resiliency an equal place at the table. The principles and values of resiliency add resonance to the recovery components that truly apply to everyone of any age.

The contract for outpatient provider agencies and the policies and procedures for the King County mental health system require participation in King County recovery and resiliency initiatives. The contract compliance site visits for 2011 reviewed the agencies practices and policies and procedures related to this participation and reviewed progress on the inclusion of client voice in care planning.

The Recovery Advisory Committee, the Voices of Recovery (VOR) Committee, ad hoc committees, and periodic recovery events have gathered stakeholder input.

Consumer voice has been strengthened in the last year by adding consumers to more committees and meetings, including the Incentive Implementation Work Group, Clinical Directors, Mental Health Advisory Board, Quality Council, and the monthly Partnership Meeting (a business meeting of provider agency executives and King County staff). Voices of Recovery holds meetings open to representatives from agency consumer groups. These stakeholder groups all provide review and comment on the findings from recovery-oriented reviews of agency performance and as new policies and procedures are developed.

In 2011, a new work group of consumers and providers began reviewing King County Mental Health Plan policies and procedures to ensure language encourages and is supportive of recovery, resiliency, and trauma-informed-care principles.

"Recovery has only recently become a word used in relation to the experience of psychiatric symptoms. Those of us who experience psychiatric symptoms are commonly told that these symptoms are incurable, that we will have to live with them for the rest of our lives, that the medications, if they (health care professionals) can find the right ones or the right combination, may help, and that we will always have to take the medications. Many of us have even been told that these symptoms will worsen as we get older. Nothing about recovery was ever mentioned. Nothing about hope. Nothing about anything we can do to help ourselves. Nothing about empowerment. Nothing about wellness..."

"Now the times have changed. Those of us who have experienced these symptoms are sharing information and learning from each other that these symptoms do not have to mean that we must give up our dreams and our goals, and that they don't have to go on forever...People who have experienced even the most severe psychiatric symptoms are doctors of all kinds, lawyers, teachers, accountants, advocates, social workers. We are successfully establishing and maintaining intimate relationships. We are good parents. We have warm relationships with our partners, parents, siblings, friends, and colleagues. We are climbing mountains, planting gardens, painting pictures, writing books, making quilts, and creating positive change in the world. <u>And</u> it is only with this vision and belief for <u>all</u> people that we can bring hope for everyone."

- Sherry Mead and Mary Ellen Copeland

Appendix B—12 ASPECTS OF STAFF TRANSFORMATION

By Mark Ragins, M.D.

There is a lot of talk about transforming our mental health system into a consumer-driven recovery-based system, but very little talk about transforming staff to work successfully in this new system. Recovery programs, to this point, tend to rely on creating small counter-cultures with dynamic leadership, staff that are different or want to change, and new non-professional and consumer staff. Transforming existing programs with existing staff will require a proactively guided process of staff transformation to succeed. This paper describes 12 aspects of staff transformation.

1. Looking Inward and Rebuilding the Passion: Recovery work requires staff to use all of themselves in passionate ways to help people. It cannot be done effectively in a detached, routinized way. Recovery staff tend to be happier, more full of life, and more actively engaged. To achieve this, staff has to look inwards to remember why our hearts brought them into this field in the first place. For many staff, our hearts have been buried under bureaucracy, paperwork, under-funding, frustrations, and burn out. Staff must be nurtured, encouraged to play and explore, to bring our lives into our work, and cherished for our individual gifts and hearts. Staff with hope, empowerment, responsibility, and meaning can help people with mental illnesses build hope, empowerment, responsibility, and meaning. Administrative leadership must effectively promote their staff before further transformation can occur.

2. Building Inspiration and Belief in Recovery: Staff spend the vast majority of our time and emotions on people who are doing poorly or in crisis. We neglect the stories of our own successes and our roles in supporting these successes. Staff need to be inspired by hearing people tell their stories of recovery, especially the stories of people we have worked with and also known in darker times. We also need to be familiarized with the extensive research documenting recovery and the concept of the “clinicians’ illusion” that gets in the way of us believing in this research. Ongoing experiences of people achieving things we “know are impossible” are crucial.

3. Changing from Treating Illnesses to Helping People with Illnesses Have Better Lives: Recovery staff treat “people like people” not like cases of different illnesses. The pervasive culture of medicalization is reinforced by the infrastructure. Goal setting needs to reflect quality of life, not just symptom reduction. Quality of life outcomes need to be collected. Treatment must be life-based, not diagnosis-based. Assessments must describe a whole life, not an illness with a psychosocial assessment on a back page. Progress notes need to reflect life goals, not just clinical goals. Team staff meetings need to discuss practical problems of life.

4. Moving from Caretaking to Empowering, Sharing Power and Control: Staff have generally adopted a caretaking role towards people with a mental illness. We act protectively, make decisions for them because of their impairments, even force them to do what we think is best for them at times. Recovery practice rejects those roles, although many staff and mentally ill people are comfortable with them. Analogously, as parents must stop being caretakers for our children to become successful adults, staff must stop being caretakers for people we work with to recover. There are enormous issues around fear of risk taking, feelings of responsibility for the people we work with, and liability concerns that become involved as staff try to become more empowering. There may also be personal issues around power and control. Most staff feel most efficient and effective when we are in control and people are doing what we want them to. Especially when facing repeated failures, or crisis, frustration is likely to grow. We are likely to reject collaboration and want to take more power and control.

5. Gaining Comfort with Co-Staff Who Live with Mental Illness: Recovery requires breaking down the "us vs. them" walls. People with mental illnesses must be included as collaborators, co-workers, and even trainers. Working alongside mentally ill people as peers (not as segregated, second-rate staff) is probably the single most powerful stigma-reducing and transforming experience for staff. For people with mental illness to recover and attain meaningful roles beyond their illness roles, staff need to take on roles beyond our illness treatment roles. Programs can promote this transformation by creating activities like talent shows, cook-outs, neighborhood clean-ups, art shows, etc., where staff and people who live with mental illness interact in different roles.

6. Valuing the Subjective Experience: Staff have been taught to observe, collect and record objective information about people to make reliable diagnoses and rational treatment plans. Recovery plans are collaborative. To achieve this collaborative partnership, staff must appreciate not just what's wrong with a person, but how that person understands and experiences what's happening. Knowing what it would be like to be that person, what they're frightened off, what motivates them, what their hopes and dreams are, are all part of a subjective assessment. Charted assessments, "case conferences" (shouldn't these be "people conferences?"), team meetings, and supervision all should value subjective understandings.

7. Creating Therapeutic Relationships: Recovery work emphasizes therapeutic work more than symptom relief. Our present system relies on illness diagnosis, treatment planning, treatment prescription, and treatment compliance. Staff can be interchangeable, professionally distant, even strangers, so long as the diagnosis, plan and compliance is preserved. Recovery work relies on the same foundation as psychotherapy: (1) an ongoing trusting, collaborative, working relationship, (2) a shared explanatory story of how the person got to this point, and (3) a shared plan of how to achieve the person's goals together. Staff need to gain, or regain, these skills. Program designs must prioritize relationships so staff can create relationships.

8. Lowering Emotional Walls and Becoming a Guiding Partner: People repeatedly tell us that we are the most helpful when we're personally involved, genuinely caring, and "real". Psychotherapeutic and medical practice traditions, ethical guidelines, risk management rules, and personal reluctance come together against lowering emotional walls. Staff needs lots of discussion and administrative support to change in spite of these strong contrary forces. To best support a person on their path of recovery, staff need to act not as detached experts giving them maps and directions, but to actually become involved, walking alongside them as guides, sharing the trip. Staff's emotional and physical fears of the people we work with need to be dealt with as well as to lower the walls.

9. Understanding the Process of Recovery: Staff are familiar with monitoring progress as a medical process. We follow how well illnesses are diagnosed, treated, symptoms relieved, and function regained. We alter our interventions and plans based on our assessment of this process. Recovery work monitors a very different process - the process of recovery. Analogously to the grief process hospice works with, the recovery process can be described by a series of 4 stages: (1) hope – believing something better is possible, (2) empowerment - believing in ourselves, (3) self-responsibility - taking actions to recover, and (4) attaining meaningful roles apart from the illness. Where hospice staff help people die with dignity, recovery staff help people live with dignity. Staff grow in their understanding of the recovery process and their skills in promoting recovery.

10. Becoming Involved in the Community: Recovery tries to help people attain meaningful roles in life. These roles will require them to be reintegrated into the community, to be welcomed and to be valued, to find their niches. Recovery cannot be achieved while people are segregated from their communities or protected in asylums. To support this, staff must work in the community. We can't be segregated from our communities or act solely as protectors in asylums. We need to be welcomed and valued and to find our niches. This is a substantial change for most staff and may trigger personal insecurities. Community development and anti-stigma work are important new programmatic and staff responsibilities.

11. Reaching Out to the Rejected: Recovery is being promoted, not just as a way of helping people who are doing well do even better, but also as a way of engaging with and helping people who do not fit well with the present system. Recovery programs have proven success with people with dual diagnoses, homeless people, jail diversion people, "non-compliant" people, people with severe socio-economic problems, and people lacking "insight". Each of these people has different serious obstacles to engagement and treatment, and staff often have serious prejudices against them. A "counter-culture of acceptance" needs to be created to work with them. This often requires both an attitudinal change in staff and training in specialized skill sets. The system transformation will not be considered a success if we continue to reject these people in need.

12. Living Recovery Values: “Do as I say, not as I do” is never a good practice. When the walls and barriers are reduced and emotional relationships enhanced in a good recovery program, it’s even harder to hide. Staff must live the values of recovery and be actively growing ourselves if we expect to be effective recovery workers. In recovery, the same rules and values apply to all of us. Leadership and administration that treats the staff the way we want them to treat the consumers: Emphasizing staff hope, empowerment, responsibility (giving them control over some funds, choices, “high risk-high support”), and meaningful roles. Encourage staff to take on multiple roles besides professional so consumers can take on multiple roles besides patient, lots of individual expressiveness. Valuing every staff as an expert in something. Encouraging staff to be emotionally expressive and open about themselves with consumers and each other.

Appendix C - Foundational King County Recovery Competencies and Curricula

All members of the mental health workforce who work with people whose services are publicly funded via the King County Mental Health Plan shall receive training in recovery and resiliency principles. The foundational competencies are described in Section I. The courses and curricula that will address the competencies are described in Section II. All newly hired staff must complete the full eight courses within two years of date of hire.

Section I. Competencies

Orientation to Mental Health Recovery

A belief in and understanding of Recovery that includes:

Understanding and *using* the ten core principles from the national consensus statement on recovery (hope, self direction, individualized and person-centered, empowerment, holistic, non-linear, strengths-based, peer support, respect, and responsibility) plus resiliency, added by the Washington State Transformation Project

The history and course of the consumer movement

The research about the probability of mental health recovery

An understanding of and a commitment to protect consumers' rights

Discovering how "recovery" serves the mission, enriches the provider's experience and ability to be present to the people we serve and the work.

The Clinical Relationship: Creating A Culture of Respect:

Building a clinical relationship based upon mutuality and partnership.

Understanding the continuum of the recovery process model from unaware disengaged/dependency to aware/interdependency /independence. Ability to engender hope, optimism, and recovery for people at every level of disability, various degrees of insight, and/or various levels of motivation, "dependent, unaware", etc.

The ability to inspire people to assume or resume employment, education, a social life or normalized housing, and to thrive in these roles.

Recovery Care Planning

Able to partner with adult consumers and families of children and youth as they direct and design their Individual Service Plan for recovery and resiliency, including:

- Assisting people to recognize their strengths and to utilize their strengths in implementing their recovery plan
- Assisting people to explore what recovery means to them and what they need to realize that vision
- Assisting people to prioritize and set goals with objectives that are specific, measurable, achievable, realistic, and timely.

Encourage and support adults/families/youth to consider each life domain, including housing, education, financial assets, vocation, leisure and recreation, health and wellness (including mental health), intimacy and sexuality, and spirituality.

Able to inspire and support people to use mainstream and personal resources that might meet their needs.

Understand the value of risk taking by adult consumers and staff in order to promote further growth.

Able to promote and responsibly support personal choice even when the clinician doesn't necessarily agree.

Documentation of the Service Process

Documenting the process of service provision in a recovery model that meets sometimes apparently conflicting requirements such as demonstrating medical necessity.

Promoting Respect, Dignity and Social Inclusion

Understanding external, institutional and self stigma and the effects on adults, youth, and families

Able to teach and support people to cope with stigma

Able to help them to challenge and overcome discrimination and social exclusion.

Cultural Considerations in Promoting Recovery

Understanding how recovery principles might be unique or different in different cultures.

Assisting Consumers to Develop WRAP and/or Advance Directives

Knowledgeable about WRAP and Advance Directives. Able to support and assist people to develop and implement a WRAP plan. Able to assist people in developing Advance Directives.

Understanding Peer Support Services

Understanding the mutually affirming roles of peer support and professional services, including how a peer support specialist differs from a case aide.

Employment

Knowledgeable about how to support people to find, get and keep jobs, either directly or as a referral, and if referred, how to support that continued relationship and the person's successes.

Working with Family (including families of choice)

Understanding the family experience of a family member with a psychiatric disability. Knowledgeable about the affect on roles in a family. Able to encourage and support family/professional/consumer collaboration.

Section II. Foundational Recovery Curricula via Essential Learning (EL)

Agencies may assign the King County (KC) version of the course, which includes a test -out exam (if the learner passes the test-out exam, they get credit for the course,) OR the Essential Learning (EL) version of the course, which gives them Continuing Education Units (CEU) for national accrediting bodies. Both the KC and EL versions can be used for state certification CEUs.

Please note that each of the following four courses (A. through D.) are embedded in a curriculum and it is the curriculum that must be assigned, rather than the course.

A. EL Curriculum: Path to Recovery (2 credit hours). Addresses: “Competency I: Orientation to Mental Health Recovery”.

B. EL Curriculum: Motivational Interviewing (4 credit hours). Addresses: “Competency III: Recovery Care Planning”. “Competency II: The Clinical Relationship: Creating a Culture of Respect”

C. EL Curriculum: Self-Direction, Person Centered Planning and Shared Decision Making to Facilitate Recovery – Part 1 (1.5 credit hours) Addresses: “Competency III: Recovery Care Planning”.

D. EL Curriculum: Self-Direction, Person Centered Planning and Shared Decision Making to Facilitate Recovery – Part 2 (1.5 credit hours) Addresses: “Competency III: Recovery Care Planning”.

Please note that each of the following courses are simply courses and can be assigned as a course.

E. EL Course: WRAP One-on-One (3 credit hours)) Addresses: “Competency VII: Assisting Consumers to develop WRAP and/or Advance Directives”

F. Those Serving Adults: EL Course: Supported Employment for Social Service Agencies (2 credit hours) Addresses: “Competency IX: Employment”

Those Serving Children: – EL Course: Strengths-based Perspectives for Children’s Services. (1.5 credit hours) Addresses: “Competency I. Orientation to Mental Health Recovery & Resiliency for Children and Families”

G. EL Course: “A Culture-Centered Approach to Recovery” (3 credit hours) Addresses: “Competency VI. Cultural Considerations in Promoting Recovery”.

H. EL Course: “Peer Specialists 101: Research, Core Competencies and Ethics” (1 credit hour) Addresses: “Competency VIII. Understanding Peer Support Services”