

The Department of Mental Health and Addiction Services Promoting a Recovery-Oriented System of Care

Purpose: The purpose of this policy is to express formal endorsement of the Recovery Premises and Values formulated by the recovery community in Connecticut and to provide a framework for the promotion of a system of care that is based on, embodies, and furthers the vision of recovery encompassed in these premises and values. This policy acknowledges that the system of care that currently exists emerged, for the most part, out of an earlier vision of the goal of mental health and addiction services, and that substantial changes will need to be made in order to bring the system as a whole in accord with a vision of recovery that continues to evolve. In this sense, the policy that follows not only pertains to current practice but also provides guidelines for the future development of the system of care, offering an ideal the system can strive to attain.

Definitions:

Recovery has several different meanings within the mental health and addiction communities. Given these different meanings, there is no one definition of the term that will prove acceptable to all parties involved. For the purposes of this policy, recovery will be defined to include the following meanings: 1. A return to a normal state (e.g., following an episode of depression); 2. A process or period of recovering (e.g., following trauma); 3. A process of gaining or restoring something (such as, e.g., one's sobriety); and 4. An act of obtaining usable resources from unusable sources (such as, e.g., in prolonged psychosis). Taken together, these four meanings suggest a broad vision of recovery that involves a process of shifting in one's orientation and behavior from a focus on a troubling event or condition to the restoration or rebuilding of one's life in the aftermath of this event or condition in a way that makes sense of and integrates, if not actively builds on, elements taken from the event or condition involved.

A recovery-oriented system of care is an integrated network of culturally-responsive mental health and addiction services and supports that first and foremost promotes the recovery of individuals with psychiatric and/or substance use disorders and the community of caring and involved others to which these individuals belong. These services and supports include the full range of hospital and community-based services, acute and non-acute levels of care, active clinical treatment and rehabilitative interventions, and self-help and user-run supports that the Department of Mental Health and Addiction Services funds, facilitates, or fosters.

Policy Statement:

Background: Although a long-standing cornerstone of approaches to addiction and its sequelae, the concept of "recovery" represents a relatively recent advance in mental health services. Based on successful experiences with self-help, twelve-step groups in the addiction community and on psychiatric research documenting a full spectrum of outcomes for serious mental illnesses, recovery within the mental health community has come to represent both the possibility of improvement in a person's condition and the importance of the person assuming an active and responsible role in minimizing the

disruptive and destructive impact of the events or illness on his or her life. In both recovery *from* trauma and recovery *in* prolonged psychiatric disorder, the person becomes engaged in a process of gaining some degree of mastery over the unwanted intrusions of the events or illness, similar to the mastery a person in recovery from substance use gains over his or her addiction. Managing one's sobriety, one's response to trauma, or the unwanted intrusions of a psychotic or affective disorder then both allows and requires an inter-active process of restoring or rebuilding one's life as a worthwhile and contributing member of a community. Even though a person may continue to have a troubling condition, one can be said to be recovered, recovering, or in recovery to the degree that one has been able to shift in one's orientation and behavior to this task of rebuilding a life despite or within the limitations imposed by the condition. In addition to being hopeful and assuming an active role, recovery in this way finally involves restoring or developing a positive and meaningful sense of identity apart from one's condition and beyond the role of addict, victim of trauma, or mental patient.

Philosophy and Values: The Department of Mental Health and Addiction Services hereby formally endorses the premises and values of recovery formulated by persons in recovery and their loved ones through the combined efforts of the Connecticut Council for Addiction Recovery and Advocacy Unlimited, Inc., and included as an Appendix to this policy statement.

Statement of Policy: Based upon these premises and values, and the definition of recovery above, the Department of Mental Health and Addiction Services accepts as its first and foremost priority promoting the recovery of individuals with psychiatric and/or substance use disorders and the community of caring, involved others to which these individuals belong. A recovery-oriented system of care is envisioned as one that identifies and builds upon each individual's strengths and areas of health in addressing his or her behavioral health needs and concerns across levels of disability and over time so that each person has the opportunities, effective, culturally-responsive treatments, and *in vivo* supports he or she needs in order to achieve a sense of mastery over his or her condition and regain a meaningful, constructive sense of membership in the community. In keeping with this vision, the Department will ensure that existing policies, procedures, programs, and services are revised, and that all new policies, procedures, programs, and services are developed, to be in accordance with the principles of a recovery-oriented system of care. Finally, the Department will ensure that all future strategic planning and resource development efforts build on existing strengths and move the system of care further in the direction of promoting recovery. The core principles for a recovery-oriented system of care are as follows:

- *Focus on people rather than services.* A fundamental component of a recovery-oriented system is the shift in focus from services and programs to the people they are meant to serve. While treatment planning is intended to be individualized, the system continues to be managed programmatically. People do not fit neatly into program boxes, however, no matter how much we try to shove them in. Services need to be redesigned so that people and their recovery, rather than the efforts of providers, are the foci of our attention.
- *Monitor outcomes rather than performance.* As a direct corollary of the first principle, it is no longer enough to demonstrate that services are offered or

interventions are delivered if it cannot be shown that they have an effect for the people they serve. Performance indicators only indicate how a program performs, they do not indicate whether or not people get better as a result of receiving such services. As a recovery-oriented system assumes that improvement is possible, services need to be evaluated in terms of the outcomes they produce for individuals, the extent to which they actualize recovery.

- *Emphasize strengths rather than deficits or dysfunction.* To the degree that recipients of service continue to be viewed as ‘mental patients,’ ‘addicts,’ or victims (i.e., in terms of their diagnoses or disabilities) the system has yet to shed its institutional mindset of the past. Living in the community rather than a hospital or residential treatment setting involves being a contributing member of society, and thereby having the same rights and responsibilities as other members of society. The shift to a recovery-oriented system raises the question: How can a person take advantage of these rights and fulfill these responsibilities while she or he has a disability? Within this context, the primary focus remains on exercising one’s rights and fulfilling one’s responsibilities (i.e., on what the person wants from and has to offer the community in return) rather than on the disability *per se*, and a primary challenge becomes one of making the accommodations needed for the person to function despite the disability.
- *Educate the public to combat stigma.* The primary barrier to recovery is the same as the primary barrier to access: stigma. With rare exceptions, as people improve they gradually leave the public system and are more and more reticent to acknowledge their history of substance use or psychiatric disorder. Although understandable, the fact that people who improve typically conceal their history of disability allows stereotypes of mental illness and addiction to continue, fueled by media accounts of rare but tragic acts of violence perpetrated by people with untreated behavioral health disorders. One challenge for a recovery-oriented system of care is thus to provide a realistic and balanced account of behavioral health disorders that allows for both extremes and for the considerable middle ground in between. To the extent that people avoid accessing care due to stigma they prolong their period of untreated illness, which then worsens the course and outcome of their disorder, further perpetuating the cycle of stigma. Education is the only vehicle for slowing down, and eventually stopping, this destructive cycle.
- *Foster collaboration as an alternative to coercion.* If behavioral health disorders are illnesses like other medical conditions, then people with behavioral health disorders should be treated like people with other medical conditions. Very few people with behavioral health disorders become incapacitated to the degree that they can no longer make their own decisions or act on their own behalf. Current statutes are clear about the criteria for such circumstances. In all other circumstances, people with behavioral health disorders should be accorded the same rights and responsibilities for self-determination as people with diabetes, asthma, or hypertension. This shifts the focus from forcing people into treatment to offering to be of assistance to them as partners in *their* recovery.

- *Promote autonomy and decrease reliance on professionals.* A cornerstone of recovery is hope; offering people a sense of the possibility that they can improve their condition and need not be resigned to continuing to be solely the recipient of the care of others. In this sense, progress within a recovery-oriented system of care involves becoming less reliant on the services of providers and becoming inter-dependent with and among one's "natural supports" (i.e., family, friends, neighbors, landlords, employers, grocers, etc.). Essential to this shift are both creating opportunities for self-help/mutual support among peers and also, and equally important, increasing access to opportunities for community integration based on each individual's interests and choice.

Operational Strategy: A key strategy in moving toward a recovery-oriented system of care is to incorporate empirical outcome data and evidence-based practices emerging in the behavioral health field. Outcome studies consistently have documented a full spectrum of outcomes for people with psychiatric and/or substance use disorders ranging from full recovery to extensive and prolonged disability resulting in premature death. Little is known, however, about the factors that would predict full or partial recovery. Given this uncertainty regarding individual outcomes and the increasing availability of new and effective treatments, it is crucial that all individuals be offered hope and a sense of the possibility that their condition can improve over time. Recovery-oriented systems of care are based on the premises that many people will improve over time, that for some improvement will take a matter of years rather than weeks or months, and that it cannot be predicted ahead of time who will and who will not improve when and at what pace.

As a result, it is incumbent upon a recovery-oriented system of care to *address people's needs across levels of disability and over time, matching services to needs at each level, in each phase, and in each area, of disability.* A useful analogy for behavioral health disorders in this sense is cancer, in which earlier detection and intervention also typically lead to better outcomes. With cancer, some people have one episode and recover fully, others need more intensive treatment in order to regain and maintain functioning, and others die and will continue to die until more effective treatments are discovered. While perhaps a harsh reality, this is a current reality nonetheless, and one which will need to be taken into account in the evolution of a system of care. A recovery orientation does not, and cannot, require denial in the face of suffering and significant disability. On the contrary, a recovery-oriented system of care holds out hope and the possibility for improvement in the lives of all those experiencing behavioral health disorders, no matter how severe, prolonged, or disabling any particular condition or combination of conditions may be. In addition, a recovery-oriented system of care acknowledges the barriers to recovery that may undermine or block an individual's efforts to improve including stigma, lack of access to care, and the relative scarcity of culturally-responsive services. In addressing these barriers, the Department will develop services and interventions that are accessible, acceptable, and responsive to the concerns, needs, and aspirations of people with behavioral health disorders across the range of severity, duration, and disability.

