

A Culture of Recovery Requires Program Redesign

BY BARBARA JONES, RN, M.S., C.N.S.

For many years, mental health care has followed a linear treatment medical model in an institutionalized and complicated legal system. To improve mental health care in America, the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services, in partnership with several other federal agencies, has defined and encouraged a new recovery model.

The new working definition of recovery is congruent with the ideals of Catholic health care organizations across the nation: “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.”

As ideal as this model sounds, changing a culture to embrace it takes a great deal of time and patience, and there are many barriers to overcome. At Wheaton Franciscan Healthcare -St. Francis in Milwaukee, the Mental Health and Addiction Care unit is well underway in the process.

The unit has undergone an evaluation of staffing, program, philosophy, safety and partnerships with the community, and every aspect of our operations has been influenced by an understanding of the new recovery model, from the type of person we hire to the complete program design. Because recovery happens in many different ways, we believe it is important to have a wide variety of treatment modalities available to best suit patients at their point in treatment. Evaluating the program structure led us to expand some activity and therapeutic groups into the evening hours, for example, and to add others, such as music therapy. We are developing plans to add pet therapy in the future.

We have redesigned the therapy team to include a behavioral health liaison to serve not only the intake coordination at the Mental Health and Addiction Care unit, but to offer greater mental health resources and promote recovery principles elsewhere in the Wheaton Franciscan system. We also have embarked on a very ambitious monthly plan of staff education that includes content in the recovery model principles, emo-

SAMHSA'S GUIDING PRINCIPLES OF RECOVERY

Recovery

- Emerges from hope
- Is person-driven
- Occurs via many pathways
- Is holistic
- Is supported by peers and allies
- Is supported through relationship and social networks
- Is culturally based and influenced
- Is supported by addressing trauma
- Involves individual, family and community strengths and responsibility
- Is based on respect

Source: SAMHSA; adapted from <http://blog.samhsa.gov/2012/03/23/defintion-of-recovery-updated/>



tional intelligence, cognitive behavioral therapy, therapeutic communication, cultural diversity, trauma-informed care, music therapy, legal and ethical issues, de-escalation training and community resources.

PATIENT-DRIVEN CARE

One of the recovery model's key principles is that recovery is person-driven. That means the patient

indication of progress is to evaluate their ability to cope with their symptoms and function in daily living, rather than to measure a pure decrease in symptoms.

Psychiatric units all across the country hold interdisciplinary care conferences to review plans of care, but how many include the patient in that care-plan review? Including the patient's purpose and abilities in daily life must be incor-



must be included in the process of directing his or her care and controlling his or her life. Mental health patients tend to have very high rates of recidivism, which can be improved only by including the patient in setting goals and getting their buy-in with the treatment plan.

That is a culture change for some providers, to focus treatment on what the patient's goals are, rather than what the professionals think the goals should be. A traditional medical model focuses on absence of symptoms as a measurable goal, but, as with any chronic illness, people with behavioral health illnesses may live their entire life with symptoms. For many patients, a better

porated into treatment in order to change the traditional culture of symptom management to a recovery model.

Here's an example: Say you were to offer a patient the choice either to be so sedated his hallucinations would cease but he would be unable to function independently, or to have less medication, some perpetual mild hallucinations and be able to hold down a simple job. What might some patients choose? The reality is few professionals have ever asked.

To be sure, striving for a recovery model brings many challenges. A patient can be so acutely ill that she isn't cognitively able to participate in a

structured meeting and may not even be accepting of her diagnosis. Nevertheless, the treatment team needs to advocate on behalf of the patient and include the patient in the discussion as much as possible.

The faith-based values of Catholic health organizations are important in accepting the setbacks that likely will come in the process of a patient's recovery, and they can help to build the spirit of the patient, family and community support system.

ONE SIZE WON'T FIT ALL

Another principle of the recovery model is that recovery occurs via many pathways. Mental health and substance abuse treatment is inherently unique for each individual. No two patients will respond in exactly the same way, and each individual has a unique set of life experiences that factor into the journey to recovery.

The great challenge in today's health care system is that offering an array of different treatment

modalities is very expensive, and it is not always very efficient. In very well-intentioned efforts to de-institutionalize behavioral health care and integrate care into the community, the natural effect has been the loss of many options for health care treatment simply because there isn't enough concentrated volume to support every program.

The severe shortage of psychiatrists and specially trained psychiatric nurses and therapists in the United States has led to great challenges in access to care and limits on the variety of programs a system can offer. Providing mental health care is not as simple as following a standard protocol; it takes a highly skilled workforce to find the right combinations of medications, occupational therapy, family support, peer support, cognitive therapy, counseling, creative arts, education and other treatments that will work for each patient. In a world of shrinking budgets, organizations often find it more difficult to provide continuing education to develop staff in all the new concepts necessary to bring on a change in culture.

COMMUNITY ROLE

In its definition of the recovery model, SAMHSA states "communities have responsibilities to provide opportunities and resources to address discrimination and to foster social inclusion and recovery."

One obvious example is that churches all across the country routinely open up their basements to Alcoholics Anonymous meetings — but how many of those AA members get invited to the church picnic? While it is clearly necessary for the community to help provide housing, health care and other resources for those in need, it is equally important to provide opportunities for acceptance and inclusion.

Our nation has made great strides in accommodating physically challenged people in the community and workplace, but it has made little progress in identifying and demanding successful accommodations for the mentally challenged. Our current culture continues to stigmatize and make judgments on patients with mental illness or substance abuse problems.

Similarly, the amount of time providers spend obtaining insurance authorization and completing legal paperwork for mental health treatment has helped create a culture of disrespect and avoidance of the most severe patients, as well as impacting the time available to providing direct patient care. Greater efficiencies in financial and legal processes can greatly improve the culture

RECOVERY DEFINED

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) created this working definition of recovery from mental and substance use disorders to help with the design, measurement and reimbursement of services and supports to meet patients' individualized needs.

RECOVERY: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. These major dimensions support a life in recovery:

Health: Overcoming or managing one's disease(s) or symptoms — for example, abstaining from use of alcohol, illicit drugs and non-prescribed medications if one has an addiction problem — and for everyone in recovery, making informed, healthy choices that support physical and emotional well-being

Home: A stable and safe place to live

Purpose: Meaningful daily activities, such as a job, school, volunteerism, family caretaking or creative endeavors, and the independence, income and resources to participate in society

Community: Relationships and social networks that provide support, friendship, love and hope

Source: SAMHSA



and feelings of respect patients experience and improve their success in recovery.

INTEGRATION THROUGHOUT THE SYSTEM

Medical providers need to think about incorporating greater behavioral health awareness

The amount of time providers spend obtaining insurance authorization and completing legal paperwork for mental health treatment has helped create a culture of disrespect and avoidance.

into every aspect of their care delivery. Chronic and acute behavioral health patients are admitted every day to medical floors, OB units, cancer centers, cardiac units and receive every aspect of medical treatment. In order to provide holistic health care, treatment must reflect “a process through which one gradually achieves greater balance of mind, body, and spirit in relation to other aspects of one’s life, including family, work, and community.”¹

That means health care organizations must ensure greater behavioral health specialty resources are available throughout the system to consult and support front line staff, much in the way the diabetic educators, wound nurses and similar positions are highly valued resources.

Yet behavioral health units are typically isolated from the rest of the health system, and while patients may transfer back and forth, strong collaboration rarely occurs across specialties. With the short lengths of stay today, we often miss the opportunity to identify and address the behavioral health issues that may have a catastrophic effect on the long-term outcomes of the patient.

A lifelong journey of recovery is not a continuous progression through treatment but involves chutes and ladders. It may include multiple stays in inpatient units, partial hospitalization day treatment, intensive outpatient groups, community support groups, spiritual counseling and outpatient psychiatry and individual therapy.

The journey may be further complicated by any combination of voluntary treatment, involuntary admission, court-ordered treatment, stipulations, and even commitments. Lack of coordination, confidentiality and liability concerns par-

ticularly with the high-risk patients, lead some providers to resist becoming involved with these cases and not have the resources available that they will need.

It is difficult to establish trust and mutual respect with a patient who has been tossed around like a hot potato nobody wants. Yet the principles of respect — not to mention culturally competent care — are essential in the recovery model. The model requires more than just listing religious affiliation, ethnic background and language on an assessment tool. It takes a culture shift of really working with the patient to explore beliefs and values and how they affect recovery. To truly build that relationship of respect and sensitivity to a patient, it is best in an ongoing relationship through a full continuum of care. However this often is not the case.

TRAUMA-INFORMED CARE

Trauma-informed care is an emerging concept that has been incorporated into the recovery model. A high percentage of mental health and substance abuse patients have experienced physical, emotional or environmental trauma. While ensuring the safety of patients is certainly not a new concept in behavioral health care, it is new to promote safety in a manner that cultivates trust and sensitivity to the individuals’ experiences.

Empowering patients, offering choices, allowing for failure and offering forgiveness are great culture changes from the days of ultimate staff control and very strict rules and structure, with no exceptions, to avoid possible disruption to the milieu. However many mental health units are becoming more flexible in rules and expectations, carefully balancing a therapeutic milieu with individualized, trauma-informed care.

HOPE

Hope is the greatest of SAMHSA’s ten guiding principles of recovery: “the belief that recovery is real provides the essential and motivating message of a better future.” The journey to recovery is not an easy road, and patients with mental health or substance abuse issues may endure great struggles and sacrifice to be successful.

The message to a patient diagnosed with a lifelong illness cannot be a naive ideal to find a cure, or a decimating sentence of doom, but a realistic message of hope and preservation that comes

Empowering patients, offering choices, allowing for failure and offering forgiveness are great culture changes from the days of ultimate staff control.

with dedication and persistence. Health care providers need to partner with their patients to focus on their strengths in this journey.

Past culture in mental health treatment often included negative judgment and low expectations of patient success. The disjointed health care system typically does not allow providers to follow the patient through their continuum and see success. Yet if the professionals have no hope, how will the patient and family experiencing the situation have any hope? And without hope, there is little strength to keep going on the recovery journey.

BEYOND THE WALLS

Changing to a culture of recovery involves hospitals taking the initiative to reach out and learn about their community, build networks and alliances and collaborate on aftercare plans that encompass all the patient needs. A discharged patient who goes back to an unstable home environment, unhealthy relationships, lack of structure or routine and no enjoyable purpose in life is highly unlikely to maintain the goal of symptom management and will instead continue in the spiral of recurrent treatment and setbacks.

Especially in a time of limited resources, we see a greater importance in the role of care management in discharge planning, family meetings

and coordination. Catholic health organizations are in an excellent position to explore new ways to integrate different mental health and substance abuse treatment programs into non-traditional settings. “Faith-based organizations can serve as a bridge when they focus on mental health issues, including discrimination and stigma in housing, insurance parity, seclusion and restraint, the criminal justice system, and addictions,” SAMHSA observed in its 2004 publication, *Building Bridges*.²

At Wheaton Franciscan Healthcare-St. Francis, the next step in our plans include a greater focus on building relationships and working together to meet the always changing needs of our community.

Clearly the culture change to achieve a recovery model in mental health care cannot happen without great intention, staff education and dedication of resources. But we believe the return on investment, in quality of care and impact on our community, is immeasurable.

BARBARA JONES is director, mental health and addictions, Wheaton Franciscan Healthcare, Milwaukee.

NOTES

1. Cori Kautz Sheedy and Melanie Whitter, *Guiding Principles and Elements of Recovery-Oriented Systems of Care: What Do We Know from the Research?* (Rockville, Md.: Center for Mental Health Services, 2009).
2. Substance Abuse and Mental Health Services Administration, *Building Bridges: Mental Health Consumers and Members of Faith-Based and Community Organizations in Dialogue* (Rockville, Md.: Center for Mental Health Services, 2004), 10.

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

www.chausa.org

HEALTH PROGRESS®

Reprinted from *Health Progress*, March - April 2013
Copyright © 2013 by The Catholic Health Association of the United States
