Practice Protocols for Recovery and Resiliency Oriented Behavioral Health Services

Purpose:

King County Ordinance #17553, passed in 2013, required implementation of the King County Recovery- and Resiliency-Oriented Behavioral Health Services Plan. Building upon progress made over the past decade, BHRD continues to implement the Recovery- and Resiliency-Oriented Behavioral Health Services Plan to shift to a fully integrated service model grounded in recovery. The practice protocols for recovery- and resiliency-oriented behavioral health services is one of a set of strategies used to accomplish this shift. People who live with mental health challenges identified the fundamental components of recovery to include:

- Self-Direction
- Individualized and Person-Centered
- Empowerment
- Holistic
- Non-Linear
- Strengths-based
- Peer Support
- Respect
- Hope
- Resiliency
- Responsibility

Existing policies and procedures specify what needs to happen for people participating in behavioral health services. The practice protocols address the way services are provided to better express the fundamental components of recovery. The protocols reflect the dictum articulated by the community of people living with disabilities, “nothing about us without us” as they have been developed in partnership with providers and people living with behavioral health issues.

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Expected System Outcomes:
The expected outcome is a system that continues to evolve to meet the promise of recovery. The recovery initiatives to date have created a strong foundation from which to build these protocols. The protocols address recovery and resiliency as supportive of overall health and wellness. The ultimate goal is better outcomes for the people receiving services.

While the protocols may become a guideline for practice liable to be reviewed for compliance, they are intended to be a blueprint for system change, and are understood as ideals representing a developmental process that will take a number of years to fully implement.

Definitions:
Service participant: a youth, adult, or older adult; OR the family and/or caregiver of a child who participates in behavioral health services in the publicly funded behavioral health system in King County. People who live with behavioral health challenges have the right to self-define in terms of how they are addressed, understanding that they are people first.

Trauma-informed care (TIC): the protocols begin with an attitude of respect; emphasize the sharing of information; support connection to self, family, and community; and perhaps most importantly, offer hope for recovery and resiliency. Choices are offered whenever possible and appropriate. This is important for recovery and resiliency as people living with mental health and substance use disorders have a high incidence of trauma.

Protocols: practices that demonstrate the fundamental components of recovery-oriented services. These practices can be adapted to fit the unique needs of each agency or program.

Examples are offered as suggestions and should be adapted to fit the unique needs of each agency or program. The examples can be a demonstration that the protocol has been achieved, as in "You'll know you've achieved this Protocol when…" If an agency meets the protocols in ways other than those suggested by the examples, the methods must be articulated in agency policy and procedures.

Other definitions and principles of recovery- and resiliency-oriented behavioral health services are described elsewhere in the King County Behavioral Health and Recovery Division (BHRD) Policies and Procedures (P&P).

Protocols:

1.0 Governance

1.1 The governing board of each behavioral health provider agency shall be briefed at least quarterly by agency management regarding agency progress relative to the King County recovery and resiliency initiatives.

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1.2 The governing board shall include a role for at least one person who self-identifies as a person with lived experience of behavioral health recovery.

1.2.1 If the behavioral health services are part of a much larger organization where the governing board is elected and/or has responsibility over many unrelated programs, the behavioral health program may substitute a local advisory committee that includes at least one person who self-identifies as a person with lived experience of behavioral health recovery.

1.2.2 Service participants who become members of boards shall receive appropriate orientation to board function and how to be an active member.

2.0 Culture

2.1 Agencies shall provide waiting rooms, reception areas, and other areas service participants gather that are welcoming and communicate a sense of safety, respect, and hope. Those serving children, youth, and families shall likewise provide an appropriate environment for their needs.

Examples include:

- Reception staff that are accessible, friendly, and welcoming;
- Colorful and interesting art;
- Magazines and other reading material that is in good repair, relatively current, and reflect the cultures and ages of the persons served;
- Plants, aquariums, toys, crayons, etc.;
- Facility, furniture and carpets in good repair;
- Lighting that is sufficient to read;
- Posters and literature about recovery and resiliency; and
- Staff help create a space that is physically and emotionally safe for those using the space.

2.2 Common areas are to be inclusive for those that use them. In as much as possible, agencies avoid giving the impression of “us versus them.”

Examples include:

- Reception staff easily accessible (rather than behind bullet proof glass with small windows); and
- Bathrooms inclusive of everyone (rather than staff bathrooms separate from service participants).

2.3 All staff engages with the person rather than with the diagnosis or disability, building trust over time.

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2.4 Throughout care, efforts are made to record the person's responses in their own words and in context rather than translating the information into professional language.

2.5 Agencies offer evidence-based practices as much as possible and when practical to do so.

2.6 To integrate employment within the larger system, the task of encouraging people to consider and engage in employment and/or education is the responsibility of the entire network, including those not specifically charged with supported employment or education tasks.

2.7 Recovery and resiliency principles and practices are considered for each special population served by the agency (e.g. youth, gender, older adults, diverse cultures, etc.)

2.8 Recovery and resiliency principles and practices are incorporated throughout all agency-written materials, including policies and procedures, clinical forms, records, brochures, client handbooks, websites, or other media.

2.9 Respect is demonstrated by simple courtesy (as age appropriate.)

Examples include:

- Phone calls returned in a timely manner;
- Personal boundaries and personal space are respected;
- Everyone is treated in an age-appropriate manner;
- Privacy is protected; and
- Appointments begin and end on time, as much as possible.

2.10 Relapses in substance use and exacerbations of psychiatric symptoms are to be viewed as evidence of the challenges of the person's condition and the non-linear nature of recovery; rather than indicative of a poor prognosis, non-compliance, or the person is not trying hard enough to recover.

2.11 Agency policies shall support hiring persons who live with behavioral health challenges for a variety of positions, not only peer support specialists.

2.12 All staff work as partners with service participants, collaborating to assist the person/family to reach their goals.

2.13 Services are grounded in an appreciation of the probability of improvement in the person's life, offering people faith and hope that recovery is "possible for me."

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2.14 The focus of services is on recognizing, enhancing, and using existing strengths and resiliency, sometimes called “building recovery capital.”

3.0 Service Participants

3.1 Service participants including families, shall be offered information about recovery and resiliency at intervals appropriate to the individual or family’s needs and interests. King County shall provide technical assistance and resources when available.

Examples include:

- Literature provided at the time of intake;
- Posters and literature available in the waiting rooms/reception area and other places clients congregate, including virtual space, e.g., on an intranet available to service participants;
- Psycho-educational groups;
- One-on-one by a behavioral health worker, who may be a peer support specialist;
- Celebratory and educational events provided for service participants to provide information and resources about behavioral health recovery and resiliency; and
- Other methods as identified by the agency.

3.2 Each person served is provided with an orientation to agency practices, how best to utilize services and what to expect as well as what will be expected. This can be provided in a variety of ways.

Examples include:

- Via the intake process;
- A behavioral health worker who may be a peer support specialist;
- Written and electronic materials; and
- Other methods as identified by the agency.

3.3 The agency shall establish and support an ongoing consumer advisory group(s):

3.3.1 The group(s) may be called a committee, a panel, a bureau, etc.

3.3.2 The agency shall provide a group charter or group description.

A. The charter or description shall outline the expectations and responsibilities of the group, including:

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1. Review of the agency's planning, implementation, and evaluation of recovery- and resiliency-oriented initiatives, both those required by King County and those generated by the agency itself.

2. Methods whereby the group provides input, assists in identifying barriers, recommends strategies to address those barriers, and receives feedback regarding those recommendations.

3. A process for resolution of conflicts among members when indicated, with the participation of agency staff.

B. Once the committee is formed, the committee shall review the description/charter and provide feedback and recommendations for changes.

C. The agency shall have final authority and responsibility for the content of the charter or description.

3.3.3 The agency shall provide a staff liaison that may or may not be a co-facilitator of the group.

3.3.4 This group must have a formal relationship with the agency's quality management process. This shall include:

A. A way for the group to provide recommendations for improvement;

B. A way for the group to be updated about the agency's plan and progress to a recovery and resiliency orientation; and

C. A way for the group to receive feedback about recommendations to the agency.

Examples include:

- A staff liaison who also sits on the agency's quality management team;
- A member of the group who also sits on the agency's quality management team; and/or
- Written reports from one group to another.

D. The majority of the members of the group shall be service participants of the agency who are not also employed by the agency.

E. The group must be of a size and composition commensurate with the size and complexity of the behavioral health services of the agency.

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F. The agency's executive leadership shall participate in meetings of the group periodically.

G. The group members shall be provided with an orientation, including:

1. How the group functions (Robert's Rules of Order, steps involved in conflict resolution, etc.);

2. Roles in the group (chair, vice chair, etc.);

3. The publicly funded behavioral health system in King County;

4. The Practice Protocols for Recovery- and Resiliency-Oriented Behavioral Health Services;

5. The agency's structure, funding, and organizational hierarchy; and

6. The agency's plan and progress on recovery and resiliency initiatives.

3.3.5 Stipends

A. Stipends are encouraged where possible.

B. If stipends are provided, clients shall be informed that stipends must be reported as income.

C. Clients shall be offered appropriate benefits counseling if receiving stipends.

3.3.6 The committee shall be informed that they are invited to send a member to attend any consumer workgroup or committee sponsored by King County.

3.4 The agency's executive director, chief executive officer, or their designee shall meet at least quarterly with clients to listen and respond to their concerns and perspectives. (Meeting quarterly with the agency's client advisory group would meet this standard.)

3.5 Information and agency updates are available routinely to people in recovery and their loved ones.

Examples include:

- A newsletter;
- Website;
- Postings in the reception area;

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- Information shared in ongoing consumer groups, etc.

4.0 Staff Reference: Foundational Mental Health Recovery Competencies and Curricula – Attachment L, Appendix 1.

4.1 Job announcements and recruitment and hiring processes (job interviews) shall include a review of an applicant's recovery competencies according to the Foundational Mental Health Recovery Competencies and Curricula.

4.2 Performance evaluations shall include the following considerations where possible:

4.2.1 Assessment of Foundational Mental Health Recovery Competencies.

4.2.2 Assignment of Foundational Mental Health Recovery Curricula for any competencies not already met.

4.2.3 Review of recovery outcomes of the clients on a staff person's caseload, e.g. housing, employment, etc.

4.3 Clinical staff recognition, promotion, and financial incentives (when available) shall take into account recovery- and resiliency-oriented skills and outcomes.

4.4 Clinical staff shall participate in training to build skills and practices in accord with the King County Mental Health Recovery- and Resiliency-Oriented Clinical Skills Inventory (Attachment L, Appendix 2). Clinical staff includes:

4.4.1 Psychiatric practitioners; and

4.4.2 All other clinical staff that has direct contact with clients, including peer support specialists.

4.5 Organizations are encouraged to provide recovery and resiliency training for non-clinical staff that have direct contact with clients. King County Behavioral Health and Recovery Division (BHRD) will provide training as resources permit.

4.6 Persons with lived experience of recovery shall participate in training staff about recovery and resiliency. This may include service participants and/or peer support specialists. Stipends to recognize this contribution and the expenses people may incur for this participation are encouraged.

4.7 Staff are given multiple opportunities to hear recovery stories from the people they have worked with, and known in times of severe illness.

4.8 Staff members from all levels of the organization are informed about the agency's planning, implementation, and evaluation of efforts to provide services from a

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recovery and resiliency orientation, including initiatives required by BHRD (e.g. performance toward incentive targets).

4.9 In as much as possible, program designs prioritize therapeutic relationships. Research has repeatedly shown that a therapeutic relationship perceived by the client as safe and positive is critical to good outcomes.

4.10 Staff encourage people to claim their rights and to make meaningful contributions to their own care and to the system as a whole.

4.11 Language

4.11.1 Staff are mindful of the power of language and carefully avoid the subtle messages that professional language has historically conveyed to persons living with behavioral health issues, and their loved ones.

Examples include:

- Referring to someone who lives with depression as "suffering from depression," as "suffering" is a self-description concept to be used only by the person who is experiencing the "suffering";
- "Case management" as people are not cases to be managed; and
- "Compliance" which suggests mindless conformity and the need to be taken care of as like a child. Terms like involvement, adherence, partnership, and cooperation are less passive, and more suggestive of someone taking responsibility for his or her own recovery.

4.11.2 Staff educate people about their diagnosis while avoiding the use of diagnosis as a short cut to refer to a person or as a label because labels yield minimal information regarding the person's experience or manifestation of illness or addiction. Two people who both have the diagnosis of schizophrenia are more different than they are alike.

4.11.3 Language used by staff is neither stigmatizing nor objectifying. "Person first" language is used to acknowledge that the person's individuality and humanity is more important than their illness.

4.11.4 Exceptions to person-first and empowering language that are preferred by some persons in recovery are respected.

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5.0 Access to Care

5.1 The agency shall promote access to care by facilitating swift and uncomplicated entry; and by removing barriers to receiving care, as much as possible, given access to care rules.

5.2 People can access a wide range of services from many different points.

6.0 Assessment

6.1 Assessment begins at intake and is revisited during recovery planning, and periodically throughout services.

6.2 Assessment includes listening and clarifying with the person their life story, not simply a recording of reported symptoms and problems. Simple, yet powerful, questions can be helpful, such as "What happened? What do you think would be helpful? What are your goals in life?"

6.3 The message that recovery is not only possible but probable is communicated explicitly via statements and questions.

Examples include:

- "This is your recovery; how can we be helpful?"
- "I believe your life can get better;"
- "Working together, we will get your life back on track;"
- "What would your best life look like?"

6.4 Staff realize and communicate that all parties bring a certain expertise to the table, understanding that individuals (and parents and caregivers of children,) have learned much in the process of living with and working through their struggles.

6.5 Staff include the subjective experience of the person. This includes what motivates them, their hopes and dreams, what they are concerned about. Staff endeavor to see their situation from their perspective.

6.6 Agencies balance the requirement to establish medical necessity with an approach that is solution-focused and supportive of recovery. Medical necessity requires identifying what isn't working in a person's life. Much of the information required for medical necessity will emerge from the person's life story and the reasons they have come in for services.

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For example:

- The person's stated goals are frequently the positive outcome of changes to what isn't working. If the service participant's goal is to get a job, when discussed, the person reveals difficulty in social situations, disorganized thought processes, etc.; and
- When the person describes symptoms that interfere with life goals, a hopeful and strengths-based response can acknowledge that symptoms are often disguised strengths. The ability to dissociate can be powerfully protective when a person is in a traumatic situation. Thus, recording symptoms to establish medical necessity can include reframing the symptoms in ways that acknowledge strengths.

6.7 A discussion of strengths is a central focus of every assessment. Challenges, problems, and issues should be addressed within a strengths and resilience-based framework. Exploring areas not traditionally considered "strengths," can be helpful.

Examples include:

- The individual's most significant or most valued accomplishments;
- Preferred ways of relaxing and having fun;
- Adaptive techniques the person has developed;
- Personal heroes; and
- Educational and social achievements, etc.

6.8 While strengths of the individual are a focus of the assessment, thoughtful consideration also is given to potential strengths and resources within the individual's family, natural support network, service system, and community at large.

6.9 Assessments explore the whole of people's lives while ensuring emphasis is given to the individual's expressed and pressing priorities. This includes life roles such as parent, spouse, partner, worker, etc.

6.10 Cause-and-effect explanations are offered with caution; as such thinking can lead to simplistic resolutions that fail to address the person's situation. In addition, simplistic solutions may be perceived as assigning blame for the problem to the individual.

6.11 Assessment shall be trauma-informed in that the focus is on what happened to the person, rather than a sole focus on what is wrong in the person's life. Many individuals with behavioral health disorders also have histories of trauma. Attending to such histories may support the person's recovery and resiliency.

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7.0 Recovery Planning for the Individual Service Plan (ISP)

7.1 Development of individualized, person-centered plans shall occur in a process of shared decision making – see this link (as of 2014) http://store.samhsa.gov/shin/content/SMA09-4371/SMA09-4371.pdf

7.2 Opportunities for employment, education, recreation, social and civic involvement, and religious participation are identified by the person in recovery via any useful or effective means such as community resource guides like *2-1-1.

7.3 The focus of care shifts from preventing relapse to promoting recovery and resiliency.

7.4 Goals and objectives are defined by the person with support from staff, with a focus on pursuing a life in the community; rather than defined by staff-based on clinically-valued outcomes (e.g., reducing symptoms, increasing adherence).The focus of planning is about building a meaningful and successful life in the community, including employment and/or other meaningful life activities, not merely maintaining clinical stability or abstinence.

7.5 People are asked what has worked for them in the past and when useful, these strategies may be incorporated in the ISP.

7.6 Plans respect the fact that services and practitioners may not remain central to a person's life over time. As appropriate, strategies to transition to independence from the behavioral health system are clearly defined.

7.7 The ISP shall reflect the range of formal and informal supports a person might utilize for their recovery, not only those provided by the agency.

Examples include:

- Peers in paid or volunteer positions;
- Mutual aid groups;
- Indigenous healers;
- Faith community leaders;
- Schools;
- Community and social groups and clubs;
- Primary care providers; and
- Other natural supports.

7.8 Individuals are seen as capable of illness self-management. Interventions support this as a valued goal of recovery-oriented services. Illness self-management strategies and daily wellness approaches, such as Wellness Recovery Action Plan

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(WRAP), are respected as highly effective, person-directed recovery tools, and are fully explored and utilized.

7.9 Within the planning process, a diverse, flexible range of options are available so that people can access and choose those supports that will best assist them in their recovery.

7.10 Plans consider not only how the individual can access and receive needed supports from the behavioral health system and the community, but how the individual can connect with others for mutual support.

7.11 Movement through a pre-set sequence of care is not required, as recovery is neither a linear process nor a static end product or result.

8.0 Ongoing Services

8.1 An individual's stage of change is considered at all points in time. Providers endeavor to meet each person where he or she is in the change process. Motivational assessment is continual and interventions are designed to enhance wellness and recovery.

8.2 Individuals are allowed the right to make mistakes, and this is valued as an opportunity for them to learn.

8.2.1 Unless determined by a court to require guardianship, individuals are presumed competent and entitled to make their own decisions.

8.2.2 Staff offer their expertise and suggestions respectfully while working with the person to identify the range of options and their possible consequences, both positive and negative.

8.2.3 Staff continue to try different ways of engaging and persuading individuals that respect the person's ability to make choices on their own behalf.

Examples include:

- Phone calls;
- Letters;
- Visits to locales the person is known to visit;
- Contacting other professionals involved with the person; or
- Contacting informal supports for whom staff has a release of information.

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8.2.4 Even in the earliest stages of recovery, staff assume the person's mental health and/or substance use disorder is less a defining characteristic and more simply one part of a multi-dimensional sense of identity.

8.3 Interventions are aimed at helping people to gain autonomy, power, and connections with others.

8.4 Opportunities and supports are provided for the person to enhance his or her own sense of personal and social efficacy.

8.5 People are allowed to express their feelings, including anger and dissatisfaction, without having these reactions automatically attributed to an illness.

8.6 Care is attentive to cultural differences across ethnicity, and other distinctions of difference (e.g., age, sexual orientation, gender, gender history, socio-economic status, religious affiliation/belief, language, national origin, immigration status/history, developmental and intellectual ability, mobility, and/or sensory impairments).

8.7 Staff focus on preparing people for the next steps of the recovery process by anticipating what lies immediately ahead, by focusing on the challenges of the present situation, and by identifying and helping the person address anticipated potential obstacles versus; dwelling on the past or worrying about the future.

8.8 When people express reluctance, fear, mistrust, and even disinterest in assuming the right and support to take control of their treatment and life decisions, staff assist them to explore and address the many factors influencing such responses. This is an important component of assessment and ongoing care and is basic to the recovery process.

8.9 When a service participant appears to disengage, the central concern shifts from: "How do we get the person into treatment?" to: "How do we support the process of recovery within the person's natural environment?"

8.10 Staff look for signs of systemic, social, and/or organizational barriers or other obstacles to care before concluding that a service participant is non-compliant or unmotivated.

8.11 Agencies do not exclude people from ongoing care based on symptomatology, substance use, or unwillingness to participate in prerequisite clinical or program activities.

9.0 Crisis Services

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9.1 Staff encourage individuals to devise and consult their own crisis plan, advance directives, Wellness Recovery Action Plan (WRAP), and/or other documents designed to reduce, modify, or eliminate distressing feelings and behaviors. Staff also assist the person with updating these documents when indicated, including identification of natural supports, respite locations in the community, complementary interventions, and a timetable for resuming responsibilities.

9.2 Staff take a holistic approach to assessing a crisis, considering that adults, children, families, and older adults with behavioral health issues often lead lives characterized by recurrent, significant stressors. Crises often represent the combined impact of multiple factors including lack of access to essential services and supports, poverty, unstable housing or homelessness, coexisting substance use, other health problems, discrimination, institutionalization, and victimization.

9.3 Staff understand that a crisis often severely impacts a person's normal abilities and responses, particularly a person with a history of trauma. Choices are offered in as much as possible.

9.4 Staff anticipate that a crisis event may become a cascading crisis that may be traumatic in and of itself. Crisis management may include forcible removal from one's home; being taken into police custody, handcuffed and transported in the back of a police car, and incarceration; evaluation in the emergency department of a general hospital; admission to withdrawal management services; transfer to a psychiatric hospital; a civil commitment hearing; and so on. At multiple points in this series of interventions, there is the possibility that physical restraints, seclusion, involuntary medication or other coercion may be used.

Intense feelings of disempowerment are definitional of behavioral health crises, yet as the individual becomes the subject of an intervention, the person may experience diminishing sense of control. In addition, when a person is detained in jail or the hospital or is voluntarily hospitalized, additional crisis can result such as rent having not been paid, the person's pet not having been attended to, etc. Natural supports may be a resource in attending to ancillary concerns such as a pet being fed, rent covered, etc.

9.5 Staff endeavor to respond to crises according to the following values and principles of crisis services identified and defined by SAMHSA in the document, "Practice Guidelines: Core Elements in Responding to Mental Health Crises" (see: http://store.samhsa.gov/shin/content/SMA09-4427/SMA09-4427.pdf for more information).

9.6 Coercive measures are used only as a last resort, after all less restrictive measures are employed.

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9.7 Staff endeavor to consider the following ten essential values when responding to crises:

- Reducing or minimizing risks of additional harm and ensuring a sense of emotional and physical safety.
- Intervening in person-centered ways.
- Sharing responsibility, including responsibility for managing risk in accordance with the capacity of the client.
- Providing trauma-informed care.
- Establishing feelings of personal safety.
- Basing interventions on strengths.
- Addressing the whole person.
- Addressing the person as a credible source.
- Preserving dignity, supporting ongoing recovery, resiliency, and natural supports.
- Prevention of future crises.

9.8 The following principles are to be employed when enacting the ten essential values for crisis services (in as much as possible):

- Access to supports and services is timely.
- Services are provided in the least restrictive manner.
- Peer support is available.
- Adequate time is spent with the individual in crisis.
- Plans are strengths-based.
- Emergency interventions are considered in the context of the individual's overall plan of services, advance directives (if available,) and any other plan for crisis management.
- Crisis services are provided by individuals with appropriate training and demonstrable competence to evaluate and effectively intervene.
- Individuals with a self-defined crisis are not turned away.
- Interveners have a comprehensive understanding of crisis.
- Helping individuals regain a sense of personal control is a priority.
- Services are congruent with the culture, gender, race, age, sexual orientation, and communication needs of the individual being served.
- Rights are respected.
- Services are trauma-informed.
- Recurring crises signal a possible mismatch between care and needs. A review of the assessment and the individual services plan may be useful.
- Meaningful measures are taken to reduce the likelihood of future emergencies.

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