# Seven Key Strategies that Work Together to Create Recovery Based Transformation

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**Abstract** This article describes seven key strategies used by the Mental Health Center of Denver in its quest to become a recovery-focused center. The description includes circumstances that were converted into opportunities for multi-level changes within the organization. The changes described include: (a) Vision and persistent leadership, (b) Consumer inclusion and involvement, (c) Seize opportunities to add recovery oriented ideas into clinical practice, (d) Providing the right level of service at the right time, (e) On site staff recovery training, (f) Hiring the right people, and (g) Outcome driven learning and quality improvement. We share our quest to show other centers that although system transformation takes work, it is something that centers across the nation can accomplish, and it makes our work much more meaningful.

**Keywords** Recovery orientation · System transformation · Community mental health · Learning collaborative

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## Introduction

The concept of recovery is an innovative topic in community-based mental health and received increased attention within the last decade. Both the Surgeon General's Report on Mental Health (U.S. Department of Health and Human Services [DHHS] 1999) and the President's New Freedom Commission on Mental Health (DHHS 2003) focused on transforming mental health care from a system, which concentrates on symptom reduction, into a recovery-oriented system that strives for restoration of a meaningful life. Prior to these reports, many consumer leaders wrote accounts of their own recovery, most notably Deegan (1988) and Steele and Berman (2001). More recently, experts in the field of psychosocial rehabilitation discussed the importance of hope in recovery, the so-called *Recovery Effect* (Anthony 2004), and incorporating supported employment as an evidenced based practice (Bond et al. 2001). In 2005, Farkas, Gagne, Anthony and Chamberlin (Farkas et al. 2005) discussed Values Based Practice as a guide for the underlying beliefs which drive a Recovery Oriented Mental Health Program. In 2009, the Substance Abuse and Mental Health Service Administration (SAMSHA) invited a select group of researchers, practitioners, and consumers to the *Innovations in Recovery Seminar*, in Washington, DC., to explore specific areas where recovery occurs, including: (a) the importance of hope, (b) the use of technology to document and promote recovery among consumers, (c) the use of recovery principles for accreditation, and (d) the development of standards. To date, many mental health service providers have started the difficult process of becoming recovery-oriented institutions; however, few centers have fully embraced the recovery movement.

Although we have come a long way toward accepting the fact that recovery from mental illness happens, 12 years

after the initial U.S. Surgeon's (DHHS 1999) report, we are still far from full system transformation. Based on this, one must ponder, why is recovery-oriented system transformation so difficult? There are multiple reasons for this difficulty, from the delay between research and practice (Druss 2005) to more specific issues like: (a) staff training, (b) technology needed to facilitate tracking and quality improvement, (c) the development of instruments that can adequately measure recovery, and perhaps most importantly, (d) the center's commitment to recovery. Currently, recovery seems more like a paradigm shift, as described by Kuhn (1996); that is, for system transformation to happen, something fundamental must change. People must believe that recovery can happen, and practices must change accordingly at all levels of an organization (Anthony 2004). Moreover, transformations should take place in a nurturing environment that empowers not only consumers, but staff who believe in recovery. Although the original call for action came from the Federal government, it is our belief that the real catalysts are the mental health centers. We believe that very few centers in the nation have fully embraced recovery-oriented system transformation, and the Mental Health Center of Denver (MHCD) may be one of the leaders in this commitment to change, as evidenced by its receipt of the 2005 NCCBH Community Provider of Excellence Award. This award was granted, not only because of a philosophical stance toward recovery, but because MHCD has been able to demonstrate the effectiveness of its approach. For example, the Court-to-Community program, which provides MH services to repeat offenders, has shown a reduction in arrests of more than 70%, and the City of Denver has saved an estimated 1.7 million $ over 3 years (*Outcomes Quarterly* 2010, Summer). In the 2 Succeed in Employment program, which provides vocational assessment, job readiness, and job coaching to adults, reported a 38% improvement in consumers' employment status. Similarly, about 55% increased their interest in educational/learning activities, and over 25% of the consumers obtained employment within 8 months after enrollment in the program (*Outcomes Quarterly* 2010, Fall). The Growth and Recovery Opportunities for Women program**,** which provides services to homeless women, reported: (a) an 80% reduction in homelessness, (b) a 67% reduction in substance abuse, and (c) large gains in overall mental health recovery (*Outcomes Quarterly* 2010, Summer). What makes MHCD unique in regard to recovery-oriented system transformation? In MHCD's case, there have been a set of circumstances which worked to its advantage, along with concerted efforts from multiple people at MHCD, who have worked to take advantage of these circumstances. The purpose of this article is to share seven key strategies that, in our experience, have accelerated recovery-oriented

system transformation at the MHCD, including: (a) vision and persistent leadership, (b) consumer inclusion and involvement, (c) seize opportunities to add recovery oriented ideas into clinical practice, (d) provide the right level of service at the right time, (e) on site staff recovery training, (f) hire the right people, and (g) utilize outcome driven learning and quality improvement. It is our hope that sharing our experiences will assist other mental health centers to engage in the challenge of transforming their center to incorporate recovery-oriented philosophy, services, and outcomes.

MHCD's Vision and Persistent Leadership

The MHCD is a large mental health center, established in 1989 to provide a more community-based system of care to ensure equal access to behavioral healthcare for Denver's culturally diverse communities. Annually, MHCD provides an array of mental health services to approximately 7,000 individuals including adults, children, and families. We provide specialized services for: (a) homeless individuals and families, (b) people living with HIV/AIDS, (c) the deaf and hard of hearing communities, (d) the elderly, (e) co-occurring disorders, (f) Latinos(as) through a specialty clinic, and (g) supported employment through the Rehabilitation Department.

Our first strategy is related to our center's vision toward a recovery-oriented system, and the persistence of our leadership to accomplish this vision. The MHCD's CEO, executive management, and Board of Directors have played a key role in MHCD's commitment toward recovery. The CEO of MHCD is a psychiatrist who still provides services to consumers and has pushed MHCD to allow for a high level of consumer involvement. Under their leadership, MHCD has been able to implement long-term goals as well as quality improvement projects to drive system transformation. Passionate about recovery, resiliency, strengths-based approaches, and evidence-based practices, the executive management team has brought to the organization multiple strengths and a wellness culture which fostered the recovery-oriented system transformation.

Part of this commitment from our center's leadership is reflected in one of the initial changes in MHCD's process of system transformation: A change in the mission statement to reflect our focus on recovery. Similar to most mental health centers across the nation, MHCD's original mission statement was: *To provide effective and appropriate access to quality mental health services so that individual dignity and self-sufficiency is enhanced*. The statement reflected the importance of quality services, and our commitment to help consumers have a good life, but it did not focus on helping people to lead productive lives in spite of their illness. In 2004, MHCD changed its mission

statement to: *Enriching Lives and Minds by Focusing on Strengths and Recovery,* which exemplifies MHCD's partnership with consumers to promote strengths and recovery. This commitment toward recovery will be appreciated by the reader throughout this paper.

Consumer Inclusion and Involvement

The MHCD consumers have a major voice in driving organizational policy, agency decision-making, program development, and the specific types of services they receive; thus, creating consumer inclusion and involvement as our second critical strategy. At MHCD, two board members are consumers of mental health services and, currently, two board members have immediate family who are impacted by serious mental illness. In addition, MHCD has several positions that are staffed by consumers including: (a) the Office of Consumer and Family Affairs (OCFA), (b) vocational counselors, (c) case managers, (d) residential counselors, and (e) non-clinical staff. Selected examples of consumer inclusion and involvement are the Recovery Conference, Recovery Committee, and consumer employment initiatives.

*The Recovery Conference*

The conference celebrated its 12th anniversary on May 2011, continuing to provide an opportunity to bring new, fresh ideas about recovery into MHCD, as well as focusing *on the partnership between consumers, providers, and family members regarding the possibility of recovery from mental illness* (MHCD 1999). MHCD's Recovery Conference committee, which includes staff and consumers, has been able to bring multiple perspectives to share what they know about recovery. The conference represents a forum to update stakeholders about MHCD's most recent efforts to continue moving the recovery agenda.

*The Recovery Committee*

Following the second Recovery Conference, many individuals saw the need to do more than an annual conference to transform MHCD to a recovery focused system, and the Recovery Committee was created in 2000 to develop recommendations for change. In its inception, the Recovery Committee included psychiatrists, clinical staff, managers, and consumers. The consumers were highly valued by their participation and were paid for their services, resulting in a lasting relationship with a high degree of involvement and commitment. Using logic models to clarify the committee's goals, objectives, actions, and outcomes (Kellogg Foundation 2004), the committee quickly moved toward

defining: (a) recovery,[1] (b) recovery-oriented outcomes, and (c) what activities would drive those outcomes.

*Consumer Employment*

The staff of MHCD's Rehabilitation and Outcomes Departments partnered to find ways to incorporate consumers as experts in the field, as well as provide employment within MHCD. The inclusion of consumers had a large impact on how values and practices occurred at MHCD and led to the creation of several consumer-initiated projects. The one with the highest impact was the Consumer Report Card project (McGuirk et al. 1998). Through this project, MHCD created surveys to evaluate services and hired consumers to collect the survey data. The impact of the Consumer Report Card expanded beyond service improvement to: (a) assist in revising staff expectations about what consumers can accomplish, (b) created the seeds for the Office of Consumers Affairs led by a consumer, as well as (c) the creation of a survey team that to this date plays a key role in data collection led by consumers (McQuilken et al. 2003).

Seize Opportunities to Add Recovery Oriented Ideas into Clinical Practice, and Provide the Right Level of Service at the Right Time

Our next two strategies can be better understood by describing a critical element in MHCD's history: The Goebel lawsuit.

In 1981, Ruth Goebel, a mentally ill woman was released from Denver General Hospital without supporting services and froze to death on the streets of Denver. A class-action suit filed against the state (i.e., the Goebel suit) in 1994 resulted in increased funding to provide services for 1,600 consumers, along with strict court oversight and accountability in multiple domains. In order to ensure a high level of accountability and quality of services, MHCD was required to track key information on a regular basis.

Furthermore, the Goebel lawsuit required services delivery according to the Assertive Community Treatment (ACT) model, as well as steps down to intensive case management. Each consumer became connected with a team of providers rather than only one individual case manager. Part of the model implemented at MHCD dictated different types of teams with varying levels of service intensity, including: (a) High Intensity Treatment Teams (HITT) with a therapist to consumer ratio of 1:12,

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[1] Recovery from mental illness is a *non-linear process of growth* by which people gradually move from *lower to higher levels of fulfillment* in the areas *of safety, hope, level of symptom interference, social networks, and active growth.*

(b) Independent Living Team (ILT) and Supported Living Team (SLT) with a therapist to consumer ratio of 1:12, (c) Community Treatment Teams (CTT) with a therapist consumer to ratio of 1:25, and (d) Outpatient Treatment Teams (OTT) with a therapist to consumer ratio of 1:40. Also a result of the suit, the Rehabilitation Department was increased three-fold, and a clubhouse was co-located with supported employment.

Traditional ACT services contained a limited discharge criteria based on the idea that consumers will *always* require a high level of service; therefore, consumers could be discharged only under very specific circumstances (e.g., death). As a result, the ACT model created a closed system where consumers could not enter or exit the program, and many high need individuals (e.g., homeless and mentally ill) did not receive services.

On March 2001, the Court held the State of Colorado in contempt for failure to seek the funds needed to provide services. As part of the settlement, the court-appointed monitor, a person with a strong orientation toward recovery, persuaded the Court and plaintiff's counsel to support the concept of recovery and to understand that consumers may not require the same level of service for the remainder of their life.

To support the new approach toward recovery and move away from Utilization Management, the implementation committee and the Outcomes department created the Recovery Needs Level (Flynn et al. 2004), which assigns consumers to treatment levels based on two tenets: (a) consumers do recover from mental illness and may need access to different levels of services over their life span, and (b) better use of resources requires that we provide the right level of service at the right time.

The Recovery Needs Level (RNL) measures the primary clinician ratings in 15 domains with an expert-designed algorithm to assign consumers to four levels of services, as displayed in Table 1.

The RNL, like the majority of the instruments developed at MHCD, was further developed using Rasch Modeling

**Table 1** Recovery need levels

| RNL level | Treatment provided | Therapist to consumer ratio |
|---|---|---|
| 1 | High intensity case management with residential services | 1:10 |
| 2 | High intensity case management | 1:10 |
| 3 | Medium intensity case management | 1:20 |
| 4 | Traditional Outpatient | 1:80 |
| 5[a] | Psychiatry-only Services | |

[a] The RNL is under revision to include a fifth level of services which includes consumers who receive only psychiatric services

techniques (Bond and Fox 2001) with a Cronbach's alpha of 0.78 (Holland et al. 2007). Our data shows that 18 months is the average length of time needed by a consumer admitted to Level 1 to progress into lower levels of service. Although the rationale is to graduate consumers to lower level of services as they recover, if a consumer experiences a crisis and needs more intensive services, (s)he can go back to a higher level of service if the clinical team deems the move necessary. To educate consumers about the RNL, The implementation team created a consumer-lead Consumer Recovery Training Team (CRTT) to educate consumers and clinicians in recovery and what it meant for consumers. The CRTT defined what it meant to graduate to a less intensive level and provided training to approximately 1,200 adult MHCD consumers on the process of moving to less intensive treatment. Also, the implementation team developed a process for both staff and consumers to appeal the decisions regarding change to assure consumers and clinical staff that the consumers were safe, if they were not ready for a change.

In the end, the major outcome of the lawsuit was to provide more recovery oriented services to our consumers. In addition, it afforded the opportunity to provide consumers with the right level of service at the right time, thus fostering recovery and opening slots for consumers who needed a higher level of service.

On Site Staff Recovery Training

Our fifth strategy includes the development of recovery-oriented trainings for all our staff. In MHCD's experience, the recovery-oriented approach is not widely disseminated. Except for a very few colleges and universities across the nation, recent graduates do not understand the recovery philosophy and how to implement recovery in practice. Therefore, MHCD has developed in-house training. For example, every new employee, regardless of his/her position, goes through Recovery 101. In this training, clinical staff is introduced to the concept of recovery from mental illness, and they are inspired to work, knowing that they will help consumers with their recovery. Nonclinical staff learn about what their clinical counterparts do and, more importantly, how they can support MHCD's mission. Two of the most lasting lessons all staff learn are: (a) recovery is a process, not a destination, which addresses a systematic approach to recovery; and (b) recovery is individualized, not standardized, and as such, it must address where the individual is and how best to progress. One cannot simply force all consumers into a one-size-fits-all standardized treatment plan because each and every consumer has personalized needs, preferences, and priorities. Therefore, continuous on-site staff recovery-oriented training is a critical component to MHCD's recovery-oriented system transformation.
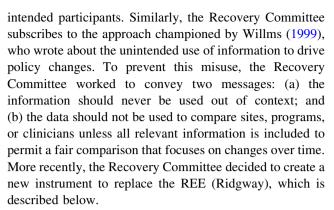
## Hiring the Right People

The MHCD management is accustomed to think outside the box, which encourages a culture of motivation and achievement geared toward success. However, perhaps innovation is most reflective of the fact that MHCD hires staff based more on the individuals and their attributes than their training and education. What makes MHCD unique in the provision of mental health services is the constellation of people who infuse a creative stew, with flavors or strengths that complement each other rather than compete. Therefore, strategy six involves hiring the right people to facilitate recovery-transformation within a mental health center.

## Outcome Driven Learning and Quality Improvement

The last piece of the puzzle, and what may be the greatest challenge to system transformation, was the creation and use of recovery-oriented outcomes. As a result of the Goebel lawsuit, MHCD was required to collect outcomes monthly and report them to a court monitor. Many of the original outcomes were deficit-oriented (e.g., number of days in jail, hospital, emergency room, detoxification facilities), and a few outcomes related to employment or engagement with services (Olmos-Gallo 2004). As a result, clinicians, administrators, and other stakeholders became accustomed to data collection and reporting, which played a critical role in MHCD's ability to become an outcomes oriented system.

Concurrent to the Recovery Committee's mandate, a SAMHSA-funded program was creating indicators to demonstrate its efficacy, one of which was termed, the *Recovery Markers*. The Markers became a way to create accountability for external stakeholders and funders and to check progress for clinical staff. At the same time, the Evaluation and Research department was transforming data collection and reporting to increase its meaningfulness for practitioners. The transformation concentrated specifically in connecting the recovery and strengths based philosophy to the outcomes collected, which were mostly deficit-based. The Recovery Committee became the catalyst by combining these two efforts.

Based on a literature search (Ralph et al. 2000), the committee identified several potential instruments that could be used to measure recovery (e.g., the RAS; the ROSI, both documented in Campbell-Orde et al. 2005); however, the committee decided to develop new instruments, and use the Recovery Enhancement Environment (REE; Ridgway 2003). One of the reasons the Recovery Committee decided to go with a new set of instruments was related to practice: Most of the existing instruments did not reflect critical elements of MHCD's recovery definition (e.g., exclusion of critical constructs like safety) or the

intended participants. Similarly, the Recovery Committee subscribes to the approach championed by Willms (1999), who wrote about the unintended use of information to drive policy changes. To prevent this misuse, the Recovery Committee worked to convey two messages: (a) the information should never be used out of context; and (b) the data should not be used to compare sites, programs, or clinicians unless all relevant information is included to permit a fair comparison that focuses on changes over time. More recently, the Recovery Committee decided to create a new instrument to replace the REE (Ridgway), which is described below.

The MHCD created three instruments to gather information from different vantage points: (a) the Consumer Recovery Measures (CRM) captures the consumer's perception of his/her own recovery; (b) The Recovery Markers Inventory (RMI) measures the clinician's point of view regarding factors associated with recovery; and (c) Promoting Recovery in mental health Organizations (PRO) where consumers evaluate how the mental health center staff helps/hinders their recovery efforts.

### The Recovery Markers Inventory

In all, the RMI (Olmos-Gallo et al. 2009) tracks people's progress in eight areas usually associated with recovery, including: (a) employment, (b) education, (c) active growth orientation, (d) symptom management, (e) participation in services, (f) housing, (g) substance abuse (level of use) and (h) substance abuse (stages of change). The instrument is completed once a quarter by case managers or clinicians and was created using partial credit Rasch Models (Bond and Fox 2001). It has a person reliability of 0.75, item reliability of 1.0, and construct and concurrent validity are appropriate (Olmos-Gallo et al.).

### The Consumer Recovery Measure

The CRM contains 17 items in a Likert scale which is completed by the consumer every quarter. The consumer rates his/her perception of: (a) hope, (b) safety, (c) symptom management, (d) social network, and (e) active growth. Active growth and symptom management are areas also rated in the RMI by the clinician, providing two different perspectives on the same concept. The instrument was created using a Rasch rating scale model and has a person reliability of 0.83, item reliability of 0.96, and construct and concurrent validity are appropriate (DeRoche et al. 2011).

### Promoting Recovery in Mental Health Organizations

The newest instrument is the PRO which is administered once a year by the Consumer Survey Team to a stratified

random sample of consumers (e.g., about 10% of the active consumers). In this instrument, the consumers rate the extent to which six different categories of professionals promote recovery (e.g., therapist, case manager, psychiatrist, nursing staff, rehabilitation staff, residential staff, and front desk staff). The rationale for the breakdown is based on the assumption that different types of staff will promote recovery in a different manner. Currently, the PRO contains 10 and 18 items per scale and, presently, we are conducting a second pilot study to reduce the scale to 10 items per scale.

### Creating a Comprehensive Vision of Recovery

With the guidance of the Recovery Committee, and the assistance of Consumer Advisory Board and the Consumer Survey Team, MHCD's Evaluation and Research department is creating statistical models including the CRM, RMI, and the PRO to increase our understanding of how recovery happens. Some results point toward a very complex picture of recovery, whereas others are very obvious. For example, consumers, who receive services within high intensity teams, start lower in their RMI, but show a highly accelerated raise in their RMI compared to consumers who receive services at lower intensity teams (Olmos-Gallo et al. 2009). Below we describe two studies that demonstrate our ability to learn about recovery through our instruments.

### The Hope Study

We recently completed a study that explores the effect of the clinician's hope on the consumer's hope and his/her recovery (Olmos et al. 2009). Clinicians brainstormed ways to increase hope in their consumers, and during the next 6 months, they used those *hopelessness-busters* on a regular basis. Before the intervention, the consumer's and clinician's perception of hope were out of sync. This relationship changed dramatically after 6 months. An unexpected finding was that, in general, the higher the consumer's sense of hope, the more symptom interference they experienced. However, the relationship between hope and symptom management seemed to improve over time, which suggested that hope may develop over time. Feedback from consumers provided several potential explanations, like "*when you are under heavy medication, you are so sedated that you don't even realize you have symptoms.*" Currently, we are exploring this relationship further.

### The Consumer Survey Team as a Model of Employment

This study started as a consequence of a negative outcome: A high turnover rate for members of the Consumer Survey Team (CST). We found that this was because of a very good reason: becoming a member of the CST meant an increase in confidence, hope, social support, and a change in perspective and identity, which are usually associated with recovery (Onken et al. 2007). The positive outcome was that turnovers were associated with a consumer finding a permanent job. Becoming part of the CST increased the support factors associated with employment, or as one of the members explained it: "*We have all found the strength to move forward in our own recovery thanks to the journey of being on the survey team*" (Anderson et al. 2008).

### Development of Feedback Systems: Allowing for Quality Improvement

Despite the fact that MHCD is very active in research, as a mental health center, our priority is the use of outcomes to move the recovery agenda. Therefore, an important priority is to let key stakeholders access recovery information in a user-friendly manner. Currently, MHCD Quality Systems is working on ways to improve data capture (e.g., creating reminders for clinicians to enter data), and the development of reports linked to our Management Information System. Access to recovery information at different levels of aggregation is critical so all stakeholders can benefit from this knowledge. The Quality System group consults with individuals across MHCD to make reports more useful and create opportunities to use outcome data to drive clinical practice. Similarly, the Recovery Committee has created trainings and opportunities to use the data in constructive ways. For example, during clinical team meetings and clinical supervision, providers explore what works with consumers, or why some consumers do not seem to benefit as much from similar strategies. As such, members of the Recovery Committee, Quality Systems, and Evaluation and Research are in constant communication to explore new ideas, design new studies, and share results to further increase our understanding of recovery.

## Discussion

Throughout this article, we have described seven key strategies that MHCD has utilized to be ahead of the curve, and in a unique position as far as a recovery-oriented system transformation is concerned. As described, MHCD has experienced a fair amount of circumstances which helped it move into a recovery oriented system, for example, the legal scrutiny provided by the Goebel lawsuit. However, chance has not been the only element in this creation; in fact, it is not even the most important element: Individuals committed to recovery deserve that distinction. For example, the Goebel suit provided administrators with

the opportunity to implement strategies aimed to accelerate recovery, such as the RNL to demonstrate that consumers recover, or the increase in recovery training to both staff and consumers to reinforce the importance of recovery. Organizational commitment is one of the key ingredients because system transformation takes time, no matter how much effort is put into it. For example, when the Recovery Committee first met and set the development of a logic model, the committee's feeling was that this goal would be accomplished in a few months; instead, it took 2 years. We encourage other centers to be realistic about time goals and not become discouraged when the goals seem to take longer than expected.

Some mental health centers may wonder whether they will have the ability to transform their mental health system to focus on recovery, given that their environment may not provide such fertile ground. As we have explained in this paper, the keys to become a recovery-oriented center are more about having a commitment toward recovery, a vision for change, an ability to seize every opportunity to implement changes that can help foster this recovery environment, and last but not least, patience. Centers can start with small steps such as: (a) make certain that consumers are included at all levels of the organization so they can have a permanent voice; (b) implement training that emphasizes recovery; (c) include as part of the outcomes tracked, instruments that show improvements in recovery indicators, like better housing, changes in employment and education; and (d) create accountability based on recovery change and not on services provided. However, in the end, consumer recovery is not a one-size-fits-all approach, and MHCD does not have all the answers. That is why MHCD is partnering with other like-minded centers to create a *Learning Collaborative* so we can share these strategies, as well as other information that we have learned: From providing a common language that everyone involved can understand (e.g., provided by the instruments and other definitions) to sharing their experiences in implementing programs and projects, training materials, hiring techniques, and strength-based supervision practices. In the end, what is important in this new paradigm is to advance the field and learn from each other what works for what group of consumers under what circumstances.

These are very exciting times at MHCD. Every time we are faced with new data, a new version of an instrument, the results of a new analysis, or feedback is received from stakeholders, there is a sense of excitement. The road ahead calls for review of Evidence Based Practices (EBP) under a new lens: Very few EBP were conceptualized under the assumption that people can recover, and "lived experiences of consumers were not part of the process of evaluation" (Campbell-Orde et al. 2005, p. 18). Therefore, there are some EBP that need to be reanalyzed in this journey toward

a system where all parties fully believe that people recover from mental illness to become productive members of our society.

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