THRIVING IN AN ERA OF CHANGE

Ijeoma Achara, PsyD
Poll Question

Please select one of the titles that most closely fits your role in your organization.

a. Executive Director/Senior Leadership
b. Peer Support Provider
c. Clinician
d. Supervisor
e. Case Manager
My Hope

affirm challenge inspire equip
TOGETHER WE’VE MADE AMAZING PROGRESS
My Why
Recovery is the process of self-discovery and change as one grows beyond the catastrophe of mental illness. It is a way of leading a satisfying life despite the possible limitations imposed by the mental illness.

(Anthony, Cohen, Farkas, & Gagne, 2001)
Increased Focus On:
• Cost-Efficiency
• Accountability
Changing Healthcare Landscape

2

Payment Reform Is Increasing the Focus on Outcomes and Quality of Care
Changing Healthcare Landscape

Current Paradigm

*Produce More (VOLUME)*

Emerging Healthcare Environment

*Produce Better (VALUE)*
Changing Healthcare Landscape

Increasing Understanding of the Impact of the Social Determinants of Health
Factors that Influence Health Status

**HEALTH CARE**
- Smoking: 51%
- Obesity: 19%
- Stress/Coping: 20%
- Nutrition: 10%

**ENVIRONMENT**
- Living Environment
- Safety
- Housing
- SES/Employment

**LIFESTYLE**
- Social Support

**HUMAN BIOLOGY**

Arthur C. Evans Jr.
These account for 70% of healthcare outcomes.
Two Potential Pitfalls When Confronted with Changing Environments and New Innovations

**Psychological Trap:** We’ve always done it this way, OR, we already do that

**Strategic Trap:** It's working now, why change it?

Vijay Govindarajan, Author and Professor at Dartmouth's Tuck School of Business
What Happened to Them?

• Blockbuster
• Kodak
• Borders
• Blackberry
• Sony
Takeaways

1. “Change almost never fails because it’s too early. It almost always fails because it’s too late.” – Seth Godin

2. Changing dynamics equal the playing field for smaller organizations.

3. Don’t just adapt, make the right adaptations, at the right time.

4. Have a vision for the future and take calculated risks based on your understanding of the needs of people and the trends in the marketplace, If there was a lot of “evidence,” it probably wouldn’t be innovative anymore.

5. Know and leverage your strengths.

6. Most important, stay connected to your Why.
But What Does This All Mean for Us?

Are You Positioned to Successfully Support People?
Continued Challenges in BH Systems

<table>
<thead>
<tr>
<th>Challenge</th>
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<tbody>
<tr>
<td>Unmet Need:</td>
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<td>Delays in Help Seeking:</td>
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<td>Low Pre-treatment Initiation Rates:</td>
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<tr>
<td>Low Retention:</td>
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<tr>
<td>Inadequate Service Dose in SUD:</td>
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<td>Lack Of Continuing Care in SUD:</td>
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<td>Recovery Outcomes:</td>
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<td>Revolving Door of Treatment:</td>
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Paradigm for High Performing Organizations Is Shifting

<table>
<thead>
<tr>
<th>FROM:</th>
<th>Who can get populations healthy?</th>
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<tr>
<td>TO:</td>
<td>Who can keep them healthy?</td>
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How do we make this shift?
Common Myths About Recovery Orientation

The primary focus is adding peer staff to a service setting.

Small tweaks are all that is necessary to make services more recovery-oriented.

It’s all about “feel good fluff.”
### 3 Approaches

<table>
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<tr>
<th>ADDITIVE</th>
<th>SELECTIVE</th>
<th>TRANSFORMATIONAL</th>
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<tbody>
<tr>
<td>Adding peer and community based recovery supports to the existing treatment.</td>
<td>Practice and Administrative alignment in selected parts of the organization – e.g. pilot “recovery projects”</td>
<td>Cultural, values based change drives relationships, practice, policy and fiscal changes in all parts and levels of the organization. Everything is viewed through the lens of and aligned with recovery oriented care.</td>
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A Closer Look

Let's take a closer look

What exactly do we mean by recovery-oriented treatment services?
Health is a state of COMPLETE physical, mental and social well-being and not merely the absence of disease or infirmity.

World Health Organization
Assertive Outreach, Engagement and Early Intervention

“... My clients don’t hit bottom; they live on the bottom. If we wait for them to hit bottom, they will die.

The obstacle to their engagement in treatment is not an absence of pain; it is an absence of hope.”

Outreach Worker (quoted in White, Woll, and Webber 2003)
Benefits of Assertive Outreach and Engagement

The Financial Impact of Small Changes

- **CO-MHAR** – Reduced wait times, reduce no shows, increase admissions = savings of 172,320.00

- **JEVS** – Increase Retention = Additional income of $249,000.00

- **Minsec** – Increased admissions = 266,000.00 additional income

- **Sobriety Through Outpatient** = Re-engaged 15% of assessment no shows = Additional income of 209,000.00
What Does it Look Like?

- Reminder calls prior to appointments
- Pre-treatment peer support groups
- Offer per mentors as soon as contact is initiated
- Use the most charismatic staff in reception
- Enhance expectations of positive outcomes
- Ensure that people have options that match interests
- Conduct frequent walkthroughs
- Ensure that intake staff are skilled in connecting service offerings to people’s interests
- Obtain locator information
- Incorporate concurrent/collaborative documentation
- Alternatives to Admin Discharge for continued use
- Connecting with community based and natural supports for earlier intervention
Assessment: 4 Primary Differences

1. Assessment is broader in scope. Focuses on multiple life domains.
2. Assessment expands beyond the challenges of the past and the here and now, and focuses also on the desired future state.
3. Assessment is truly an ongoing process.
4. Focus on strengths and recovery capital is viewed as equally important to focusing on challenges.
Assessing Recovery Capital

WHAT’S THE RELEVANCE?
Changing Our Questions: Examples

- Can you tell me a bit about your hopes or dreams for the future?
- What kind of dreams did you have before you started having problems with alcohol or drug use, depression, etc.?
- What are some things in your life that you hope you can do and change in the future?
- If you went to bed and a miracle happened while you were sleeping, what would be different when you woke up? How would you know things were different?
Person-centered Planning: What are the main differences?

Focus of Traditional Plans

- What needs to happen in treatment
- Reflect mainly what the provider thinks needs to happen
- Not individualized
- Strengths listed but not used
- Not connected to life goals and what is important to the person
What Might This Look Like?

Peers working with people prior to initial assessment/and or planning meeting

Providing people/families with info describing the goals of the process and their participation

Having peer led workgroups to assist people with identifying interests/goals

Supporting people in identifying their Circle of Support
Getting in the Driver’s Seat of Your Treatment: Preparing for Your Plan

Importance of education and skill-building among individuals to prepare for recovery planning...

http://www.yale.edu/PRCH/documents/toolkit.draft.4.16.10.pdf
Example: Person-Centered Recovery Plan

Program for Recovery Community Health (PRCH), 2015.

**GOAL** as defined by person

**STRENGTHS/ASSETS** to Draw Upon

**BARRIERS /ASSESSED NEEDS** That Interfere

**SHORT-TERM OBJECTIVE**
- Behavioral
- Achievable
- Measurable

**INTERVENTIONS/METHODS/ACTION STEPS**
- Professional/“billable” services
- Clinical and rehabilitation
- Action steps by person in recovery
- Roles/actions by natural supporters
Is This Consistent with a PCP Approach?

**GOAL:**

“I would like to become consistent in taking my medications and staying clean.”

**OBJECTIVES:**

- Attend all group and counseling sessions
- Attend and participate in at least two AA/NA meetings weekly
- Obtain a sponsor
- Identify triggers
Plan Component: Goals

• Big picture changes or accomplishments in the person’s life

• Identified by the person and stated in their own words

• Not necessarily very specific, or time framed

• Longer term goals

• Stated in positive terms (strength-based)
Examples of Goals: I Want to...

- Live independently
- Have satisfying relationships and social support
- Improve my education or employment so I can have a better quality of life
- Have better housing
- Become better parents, spouses, etc.
- Get my children back
- Open my own bank account
- Be reunited with my family
What About Service Goals??????

- Stop using – become abstinent
- Maintain psychiatric stability
- Take my medications everyday
- Attend group and individual each week
- Get discharged from this program

Key Question Is: WHY????
Benefits of a Person Centered Approach?

Example: Western New York Care Coordination Program

Janice Tondora, Yale Program on Recovery and Community Health

OUTCOMES ACHIEVED

• 68% Increase in competitive employment
• 43% decrease in ER visits
• 44% decrease in inpatient days
• 56% decrease in self-harm
• 51% decrease in harm to others
• 11% decrease in arrests
Individualized Services

A Menu of Options Promotes Relevance, Choice and Ownership
Culture is central not peripheral, to recovery as culture is the context that shapes and defines all human activity (USPRA, 2008).
Partnership-Consultant Approach

Relationships

- Professionals support people in making their own choices
- Risk taking is supported even when failure is an option
- Doing with, rather than for or to
WHAT DOES IT MEAN FOR SERVICES TO BE COMMUNITY-BASED?

Community Integration
“The central concern shifts from How do we get the client into treatment? to How do we nest the process of recovery within the person’s natural environment.”

William White
Do the lives of the individuals you serve revolve mostly around their homes, and behavioral health agencies, or do they get to live, work, learn, and play like others in their community?
What Does it Look Like?

• Actively assisting people in improving the quality of their life beyond symptoms

• Assertively connecting people to existing community resources

• Leverage community and business partnerships to create opportunities

• Walking alongside people to support them in building or rebuilding a meaningful life
Continuing Support

- It takes 4 to 5 years for the risk of relapse to drop below 15%.
- The most critical period of vulnerability is the first 90 days following a tx episode.
- Continuing support should be nested in the person’s natural environment.
Continuing Support vs. Discharge Planning
Approaches to Continuing Support

MULTI-MEDIA
(FACE TO FACE, TECHNOLOGY-BASED, MAIL)

- Recovery check-ups
- Linkages to Recovery Community Organizations
- Home visits
- Peer Support groups
- Assertive linkage to mutual aid societies
- Participation in peer leadership councils
- Recovery centers
- Sober houses

- Clinic based individual and group sessions
- Mail
- Internet and phone-based RSS
- Assertive Linkages to natural supports
- Embedded within natural settings (e.g. faith communities, barber shops, shelters)
What Does It Look Like?

- Educating people regarding the role of continuing support
- Assessing recovery capital
- Providing people with a menu of options for continuing support
- Creating a continuing support plan
- Being assertive about our responsibility to provide ongoing support
- Providing support in people’s natural community settings
- For people with SUD provide higher intensity support in first 90 days
Integrating Peer Support Services
Benefits of Peer and Other Recovery Supports

Examples from Connecticut

- 24% decrease in expenses
- 46% increase in number of people served statewide
- 40% increase in outpatient care
- 25% decrease in annual cost per client
- 14% lower costs with recovery supports
Potential Roles of Peer Staff

Some Examples Include:

• Conducting assertive outreach
• Facilitating life skills and other peer support groups
• Participating in all phases of person-centered planning processes including assessment and treatment/recovery planning
• Focusing on recovery capital assessment at the individual, family and community level
• Assisting people in identifying recovery goals and strategies to attain their goals
• Orienting people to the variety of resources available in the community and assertively connecting them to those resources
Potential Roles of Peer Staff

- Peers in local Emergency Rooms, Shelters
- Peers in Primary Care Settings
- Peer staffing engagement or recovery centers within agency or community
- Pre-treatment engagement groups
- Story-telling sessions
- Participation in court diversion programs
- Assertively connecting people to relevant resources in their community
- Peers participating in the development of continuing care plans
Potential Roles of Peer Staff

- Attending community based support groups with people until they are comfortable enough to attend on their own
- Connecting people to others who have made progress addressing similar challenges
- Helping people identify and address any existing or potential obstacles to continued participation in services or obstacles to community integration
- Helping people bridge multiple levels of care and easing their transition from each level to the next
- Maintaining contact with people after they have left services
- Conducting periodic checkups with people who have left services
The typical bridger relationship evolves from primarily social support and companionship to skill building, community integration and active linking to community resources:

1. Personal relationship building emphasizing the development of trust, mutual respect, encouragement and emotional support.

2. Encouragement of deeper involvement in peer support groups, exposure to community resources, attention to skills inventory (and working on mastering identified desired skills)
3. Following discharge, intensified peer supports are paramount. Deeper skills teaching, learning wellness self-management skills, increased connections to community supports and resources, and regular, honest communication is emphasized.

4. Setting the stage and laying the ground work for independence. Revisiting skill inventory and addressing skills not yet quite developed. Meetings in the community are emphasized. Support for the establishment of a wider circle of friendships, and enhanced social activities in the community. Positive risk-taking and greater independence are supported.
Peer Bridger Program - Seattle

Benefits?
Seattle Times Article:

“In the first year, re-hospitalizations plunged, saving $550,000.00”
What are the opportunities for collaboration with clinical or other staff?

Possibilities in a Clinical Setting

Expanding Beyond Welcoming, Supporting, and Checking-In

1. Peer staff orient people to the assessment and service planning process

2. Do all or part of the service assessment process together (e.g. the life domains questionnaire, and recovery capital scales have really important content for clinicians)
What are the opportunities for collaboration with clinical or other staff?

1. Share peer staff global assessment with clinical team to inform individualized service planning
2. Peer Staff conduct recovery plans with individuals
   • Difference between treatment focused IRP and person-directed recovery plan
3. Peer staff involved with the development of continuing support plans
4. Peer staff participate in team meetings and staffings
Common National Challenges
Strategies for Successful Implementation

Don’t underestimate what the implementation process entails
Beyond Treatment: Promoting Community Health: Example: Recovery Walk
Mural Paint Day

Promoting Community Health: Example Philadelphia’s Mural Arts Initiative
Department Of Behavioral Health And Intellectual DisAbility Services
“When the community starts getting together around this process, other good things start happening too.”

Betsy
Porch Light participant
Neighborhood Decay and Disorder
Types of Nbrhd Decay & Disorder

PHYSICAL DECAY
- condition of residential and commercial buildings, boarded-up windows, vacant lots and buildings

PHYSICAL DISORDER
- graffiti, trash, litter, drug needles & paraphernalia

SOCIAL DISORDER
- public drinking, fighting/arguing, loitering, selling drugs, violence
## Does Adding A Second Mural Nearby in the Same Neighborhood Make A Difference?

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Effect Size (Cohen’s $d^*$)</th>
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<tbody>
<tr>
<td></td>
<td>Time$_1$ – Time$_2$</td>
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<tr>
<td>Neighborhood Collective Efficacy</td>
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<tr>
<td>Social Cohesion &amp; Trust</td>
<td>.37</td>
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<tr>
<td>Informal Social Control</td>
<td>.32</td>
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<tr>
<td>Neighborhood Aesthetic Quality</td>
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<tr>
<td>Overall Neighborhood Aesthetic Quality</td>
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<tr>
<td>Quality of the Walking Environment</td>
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<tr>
<td>Aesthetic Ratings of Specific Buildings</td>
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<tr>
<td>Perceived Neighborhood Safety</td>
<td>.49</td>
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<tr>
<td>Behavioral Health Stigma</td>
<td>-.22</td>
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**Judging Effect Sizes:** 0.2 = “small effect”  0.5 = “medium effect”  0.8 = “large effect”

**Bottom Line:** Effects remain after two years. Although most effects decrease after two years, all are sustained at some level, and a few grow.

Philadelphia Department of Behavioral Health and Intellectual Disability Serv.

*Achara Consulting*
Creating a Plan for Next Steps

• Prioritize practice changes: What’s the low hanging fruit? What might serve as a catalyst for additional change?

• Create short-term wins

• Identify needed supports
If there is no transformation inside of us, all the structural change in the world will have no impact on our institutions.

Peter Block