

Recovery Oriented Supervision in PSR Programs

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By:

Adrienne Sheff-Eisenberg, Psy.D.,MFT

Director of Adult Services

asheff@sfvcmhc.org

and

Greg Walston,MA, MFT

Assistant Director Community Support Services

gwalston@sfvcmhc.org

San Fernando Valley Community Mental Health Center,
Van Nuys, CA. 91405

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Within the last 15 years, there has been a shift in the paradigm guiding mental health rehabilitation services for persons with serious mental illness. Then in 2004, the California Mental Health Services Act was put into legislation, extending psychiatric rehabilitation to include the Recovery Model. The Recovery Model embraces and mandates the concepts of Hope, Wellness, Empowerment and Recovery as the core of mental health services.

The change in the emphasis of psychiatric rehabilitation or psychosocial rehabilitation program services primarily embodies a move to a more recovery focused, person-centered approach. This approach (deceptively) seems very simple on the surface, but in fact requires the development and use of a whole new skill set by the practitioner. It may also require un-learning, or far more restraint in the use, of other therapeutic modalities such as psychodynamic or strictly clinical medical model approaches.

Much has been written about the Recovery Oriented approach to working with persons with serious mental illness, but little has been documented regarding the skills needed to effectively supervise practitioners using this model. Recovery Oriented services place a high priority (and value) on de-emphasizing diagnosis and pathology, and instead emphasizing the strengths approach, instilling hope, empowerment, and personal responsibility on behalf of the client. Recovery Oriented services and interventions also place a very high value on exposing consumers to non-disabled roles and on the use of natural supports, natural environments, and natural consequences. The purpose of this paper is to look at the skills necessary to supervise mental health practitioners incorporating this model into their available treatment options.

A second step in the process (of moving towards a more Recovery Oriented treatment model) involves an equally unconventional or counterintuitive shift, with regard to the more traditional forms of psychiatric rehabilitation being practiced in varying degrees for almost 30 years since the days of de-institutionalization. Many psychiatric rehabilitation practices (day treatment services, residential treatment, pre-vocational skills programs) and even outpatient intensive case management (ACT) programs often remain stuck in assisting the consumer in maximizing their functioning "within" the mental health community". The result is that consumers often reach a plateau where their identity is defined (and thus limited) by their "role" as a disabled person. The individual develops and maintains their role in the community as being a person with a disability. Even when in the larger mainstream community, he/she adapts and maintains the identity of a person with a disability, such as a resident of a program, a member in a Clubhouse or work unit, a disabled worker or student.

The Recovery Oriented practice assists the person in going above and beyond their disability and assuming non-disabled roles in the mental health and/or

mainstream community, so the individual becomes truly integrated within the community with the least amount of isolation or stigma. Community integration becomes a focal point and an achievable goal.

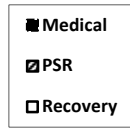
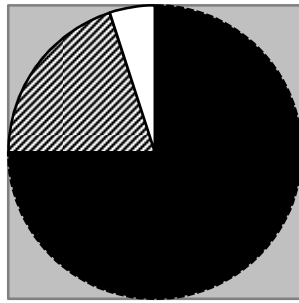
Supervision of practitioners, programs and services that promote this subtle but important change requires a vision and strong commitment by the supervisor, in order to facilitate this fundamental paradigm shift. This applies to improvements for existing programs as well as developing new ones that are more consumer friendly. The following are suggested guidelines for supervisors, to create and instill this model in existing rehabilitation programs, since skill-building is an essential component of any recovery oriented treatment model. Also, it is clear that effective supervision involves two distinct components; program supervision and clinical supervision.

Program supervision

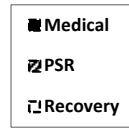
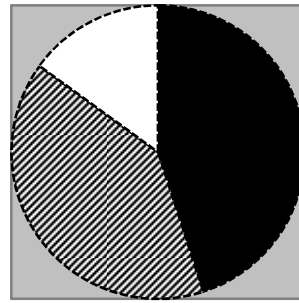
To effectively understand program supervision, one needs to first examine the models of rehabilitative services that currently exist for this population, and then evaluate the percent usage of medical model, rehabilitative and recovery services that comprise or are or potentially applicable in each setting. It is important to note that Recovery Oriented services can and should be incorporated into all levels of care, even in the most acute cases. Additionally, the basic values of human dignity, person-centered care, empowerment, self-responsibility and instilling hope must be part of all service delivery models.

Generally, programs use a mix of different percentages of Medical, PSR and Recovery-based models. The Recovery Model is a logical, natural extension of the rehabilitation approach. For example: In the medical model the goal is primarily to manage the illness. In PSR, however, the goal is to help the disabled person fit into the community, and in the Recovery model the goal is to go one step further by promoting the client's involvement in non-disabled roles, health and wellness, and self-management. It is important to note that nothing in the Recovery model (or its use) contradicts, interferes with, or weakens any other treatment modalities. To the contrary, it strengthens and builds on them.

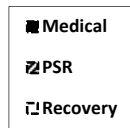
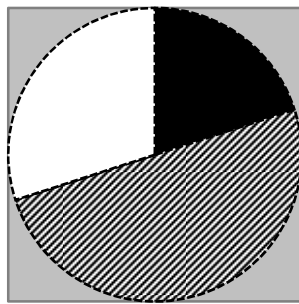
The following examples demonstrate how the three models fit together to promote different levels of care and how a supervisor can incorporate a more recovery focused approach in each level of care. These are illustrated in Figure 1. Note that at each level of service, the necessity of the Medical model decreases, and more recovery oriented interventions are utilized to encourage greater and greater autonomy on the part of the consumer.



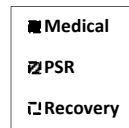
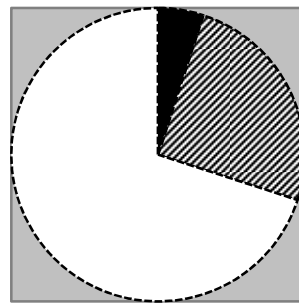
1.1 Hospital



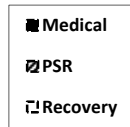
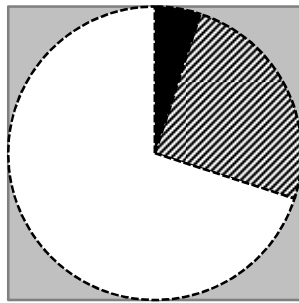
1.2 ACT Program



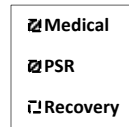
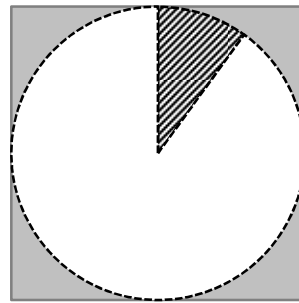
1.3 Clubhouse



1.4 Wellness Center



1.5 Vocational



1.6 Client Run Center

Figure 1. Percentages of Medical, PSR, and Recovery Models by program

For example, in a hospital setting the emphasis might be:
75% medical model, 20% rehabilitation services; and 5% recovery - focused.

Essentially the structure of the hospital setting is focused around medication stabilization and symptom reduction. Within that context the “patient” is also encouraged to engage in adult daily living skills, or “ADL’s” such as getting dressed, personal hygiene skills, attending groups, and managing interpersonal communication. In many hospital settings, this is considered to be a sufficient goal. A supervisor of such a unit can, however, introduce a Recovery Oriented approach by teaching staff to treat patients in a more adult manner, instilling hope, and encouraging clients to manage their recovery more independently. This could involve the patient coming to get meds independently and participating actively in their discharge plan, and even inviting trained Peer Advocates to visit or give talks at the hospital.

The ACT Assertive Community Treatment Model essentially is designed to treat persons with sub-acute conditions in the community (i.e. a hospital without walls). This is a highly effective rehabilitative and recovery oriented treatment modality, combining a high degree of medical model goals (stabilization and medication monitoring) with a greater emphasis on developing independent living skills (managing medications, living in supported housing with family or program supports); increased problem solving and decision making, and developing meaningful activities and relationships.

Using the percentage allocations this model may look like:

45% medical model, 40% rehabilitative, and 15% recovery oriented.

Services are determined by level of care appropriate or intensity of services needed for each individual, in accordance with that person’s level of recovery. . Those who are not yet engaged in services would require a higher level of care than those who are moderately engaged and require less intensive field based services including a Clubhouse or Wellness Center program. In California, under the Mental Health Services Act of 2004 these programs are called FSP Full Service Partnership (the higher and more intensive level of care), and FCCS Field Capable Clinical Services(less intensive) The services gradually promote and foster a greater emphasis on acquiring independent living skills, and the client engaging in meaningful and purposeful activities (such as supported housing, educational/ vocational options, peer support, and greater community integration). At each level of service, more recovery-oriented interventions are utilized to encourage greater and greater autonomy on the part of the consumer.

Other program models (e.g. a Clubhouse model) places a priority value on membership and self-directed governance or services. A typical clubhouse model may look like this:

50% rehabilitative services, 30% recovery oriented and 20% medical model

The Clubhouse model, by its nature of everything being done “by consumers, for consumers”, has been limited in that until recently it tended to be a closed system or safe haven within but separated of the community. Members develop and utilize their skills primarily within the confines of their “membership community”. In contrast to this model, California has now developed the Wellness Center concept which includes a proactive focus on wellness, recovery and community integration.

The essential difference is that the new model encourages the participants from the start to use and practice the skills they develop in the Wellness Center out in the mainstream community. This includes pre-vocational skills, leisure skills, peer relationships, and interpersonal skills. A typical Wellness Center model might have the following distribution:

70% recovery oriented; 25% PSR; and 5% medical model.

A Wellness Center utilizes person-centered and individually developed Wellness Recovery Action Plans to promote a person’s recovery with emphasis on integration into the mainstream community. In a Wellness Center, the goal is to de-emphasize replicating activities which are already available in the larger community. Specific examples of this concept might include encouraging participants to attend exercise classes/yoga at the local YMCA, rather than bringing a trainer into a “mental health” facility. Rather than building a library onsite, clients might be encouraged to go to their local community library.

Work and job functions are of course an important skill-building function, but within a Wellness Center it is seen as a transitional step toward “real” mainstream jobs in the community rather than an end unto itself.

Those activities which are provided at the Wellness Center are by design meant to be short term, as a bridge to the equivalent community based activities, such as school, work, and leisure. The Wellness Center is 50% staffed by clients. Those who would best benefit from the Wellness Center model are clients who are in the early stages of recovery. As such, the recovery oriented program supervisor needs to understand the goals of the program, the level of services needed to address a consumer’s needs, and the supervisor must continually educate the staff on the Recovery Model. Also the supervisor needs to support a successful blending between consumer and non consumer staff.

Likewise, Vocational Services programs, such as the one at the San Fernando Valley Community Mental Health Center, has community employment services as a goal, and permits each client to engage in whatever level of vocational support that fits them best, be it volunteer, supported/transitional employment, and or mainstream competitive employment.

Vocational programs vary depending on funding or program emphasis, and may be comprised of:

70% Recovery Oriented, 25% PSR, and 5% medical model.

Vocational service programs place a high priority on skill-building using the strengths model, but also on the client determining their own career goals and developing their personal maximum potential. This may have little to do with traditional mental health treatment, but rather focusing on resume building, managing stress, navigating community resources, career related dress standards and building one's self-image as key recovery-focused goals.

Finally the California Adult System of Care has developed "Client Run Centers" which are fully staffed and (100%) run by mental health services clients. The CRC is 90% recovery focused and 10% rehabilitative focused.

A Client Run Center provides ongoing support for as long as needed, even life-long, for individuals who are re-integrating or have re-integrated into the mainstream community, but still want a place to come to where they can connect with and be supported by their peers. In keeping with the fundamental concept of mainstream integration, the CRC Recovery Specialists all receive salaries and benefits commensurate with entry level (and above as earned) mental health staff. Recovery Specialists are consumers who have studied and passed a rigorous Peer Counseling curriculum, sign oaths of confidentiality and pass HIPAA tests. In other words, they have chosen and pursue a career path in the mental health field, working side by side (and on par) with other staff. They often see their mission, their personal experience and their strengths as the ability to give back and help others to recover.

Knowing the various parameters of these different services, and being cognizant of the different levels of recovery and care needed at each stage of recovery, is paramount for a Recovery-Oriented supervisor. The supervisor determines the program goals, based on the consumers' needs, and then must continually introduce greater opportunities and interventions that move the program and its participants more toward integration into the mainstream community.

The responsibilities of the Program Supervisor are to ensure that the program services include:

- Recovery Model Orientation
- Education and training of staff in recovery principles
- Meeting program goals and objectives
- Constant adjustments to tailor the program's services to meet the changing needs of the consumers.
- Management and mitigation of staff burnout

The Program Supervisor needs to be the leader in identifying and determining the type of services and interventions most suitable to the program and level of care needed. For example, in a Wellness Center there would be less service from outside treatment providers, and more reliance on the community and peers. Supported employment, education and housing are primary goals whether immediate or near-term. Peer support and recovery presentations are an integral part of the services.

Clinical Supervision

Clinical supervision has its roots in a more medical model, with a focus on diagnosis and symptom reduction. The supervisor also has the responsibility of clinically supervising staff, and insuring the program meets the staff training requirements for educational, ethical, licensing and clinical needs, as well as the staff's professional growth and development. This includes appropriate training on interventions, diagnosis, EBP's and ethical dilemmas that arise in this work. The clinical supervision of staff is most successful when the supervisor follows a parallel process that the staff is being asked to do with clients. Therefore, the supervisor must adapt to many roles; building a mutual relationship with, and yet being willing to learn alongside their supervisee.

A recovery oriented practitioner understands that mental health recovery is a personal journey and the practitioner becomes a partner in that journey. Part of the clinical supervision "tool kit" includes the supervisor teaching staff that they have to:

- Think person-first not diagnostically;
- Building trust means building a mutual partnership with the client regarding their needs;
- Utilizing the strengths model means emphasizing the persons strengths not limitations;
- Normalize communication e.g. flattening the hierarchy by decreasing the "expert and client" inequity in the relationship;
- Assist the consumer in combating stigma within themselves and externally.

The supervisor needs to be aware of common pitfalls or counter-transference issues that their staff can run into, such as;

- Taking too much responsibility for the consumer and doing too much
- Assuming the role of parent, enabler, or policeman
- Being too much of a peer and losing their focus as the mentor or facilitator role

In the Recovery-based Supervision model, the clinical supervisor's task is to educate, inspire, model, teach, discover and listen to both the staff they supervise and the clients the staff is serving. Of the greatest importance, the supervisor must also constantly inspire their staff to increase the clients' exposure to non-disabled roles, using natural supports to decrease stigma, and to use peer supports and self-help.

An additional challenge to Clinical supervisors is the need to discuss unchartered areas in clinical supervision, such as:

- Personal boundaries and physical touch
- Self-disclosure
- Meeting each other in public places to talk or do an activity
- Going into client's homes
- Meeting at personal celebrations
- Working together as peers and colleagues.

These new issues are a vital part of the recovery-oriented models, and present many challenges to clinicians who have been trained in more traditional educational institutions. A clinician's blending together of their personal and professional boundaries (which is in fact crucial to becoming successful as a recovery-oriented professional) takes a great deal of skill, individual strength and personal awareness or maturity. The clinical supervisor's job is to instill these qualities in their staff, and help the clinician to build confidence in this otherwise counterintuitive pursuit. A supervisor needs to examine their own beliefs and comfort level with non-traditional vs. traditional approaches, and then transfer confidence and comfort to the clinicians they are responsible for.

To do this, the supervisor actually needs to follow a parallel process, including forming a mutual partnership, valuing the clinicians goals, identifying their strengths and supporting them as a recovery practitioner. The supervisor must be willing to learn with their supervisee about the persons served, and encourage both healthy boundaries and risk-taking. Of paramount importance is the supervisor's duty to help their clinicians to understand that they are not responsible for the outcomes of the client's actions, but only for staying engaged with and supportive of the client through the recovery process.

Therefore, the responsibility of a supervisor in a Recovery Focused Model is twofold; to first know the parameters of the programs they are supervising, the level of consumer needs, and then to provide a role model and serve as the teacher/supervisor for the clinical needs of the recovery practitioner.