



ENGAGING & EMPOWERING

PEOPLE IN RECOVERY

A PROVIDER'S GUIDE

to supporting people to embrace their own potential

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The Community Technical Assistance Center of New York (CTAC) of New York is a training, consultation, and educational resource center serving all behavioral health agencies in New York State. We help agencies strengthen their clinical infrastructure through training opportunities focused on implementing evidence-based practices and addressing the challenges associated with the recent changes in regulations, financing and overall healthcare reforms.



New York Association of Psychiatric Rehabilitation Services

NYAPRS is a change agent dedicated to improving services, public policies and social conditions for people with mental health, substance use and trauma-related challenges, by promoting health, wellness and recovery, with full community inclusion, so that all may achieve maximum potential in communities of choice.

ADVOCATE, EDUCATE, DEMONSTRATE & CELEBRATE

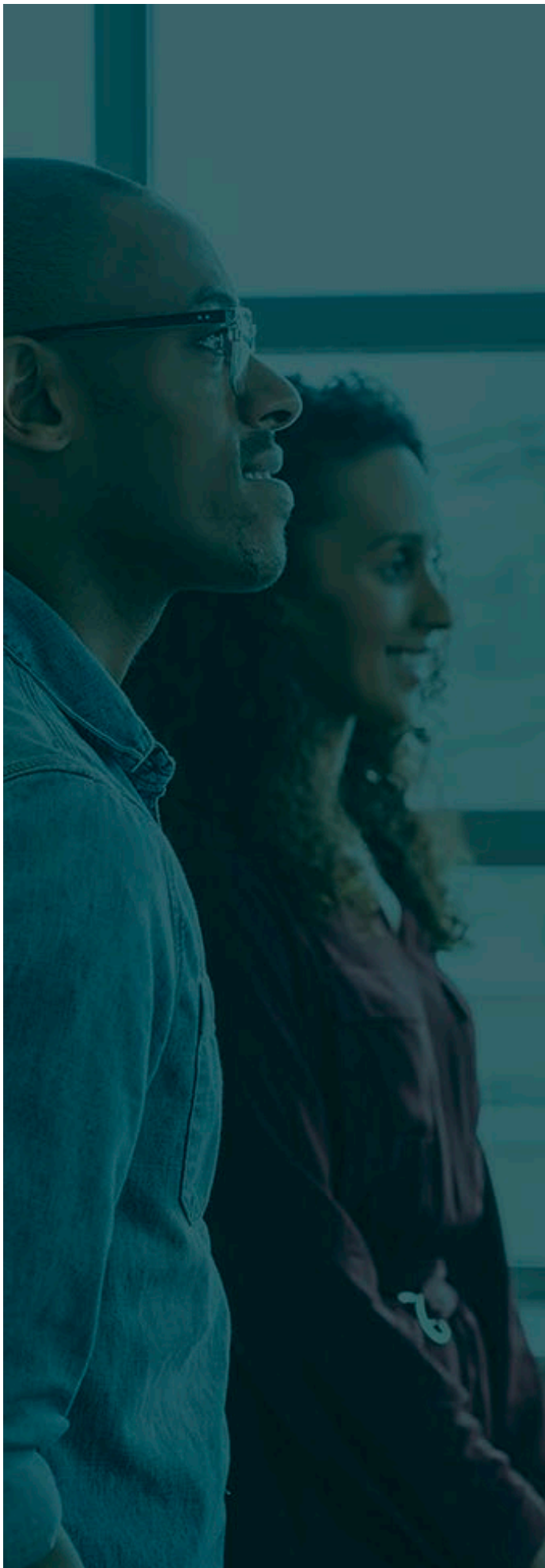


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I. INTRODUCTION TO GUIDE

As provider's, one of our greatest privileges is to support people on their recovery journeys. On occasion, when there is misalignment between our plans and the participant's plans for themselves, success can seem very far away. Our efforts become almost akin to pushing the proverbial boulder uphill. It's just not possible.

This Guide is designed to serve as a resource for engaging and empowering people in their own mental health recovery by supporting them to embrace their own potential. This Guide will support your practice, as you work in collaboration with individuals, in the achievement of their goals. By aligning our work with their preferences, we create an environment that empowers them to lead their recovery journey.

This Guide will provide you with a variety of information resources. Individually, each are gems in their own right, however, when taken collectively, they synergize to become a powerful force to help people make lasting change in their life.

*Your work is your own private
megaphone to tell the world what
you believe.*

— Simon Sinek

2. INTRODUCTION TO RECOVERY-ORIENTED CARE

RECOVERY CULTURE SHIFT: A BRIEF HISTORY

Recovery-Oriented Care was broadly introduced in 1999, when Dr. David Satcher, the Surgeon General from the Clinton administration, said that all services for those with mental health condition should be consumer-oriented and focused on promoting recovery.¹

While this was over 20 years ago, it didn't immediately take root in our mental health service system. The charge was later reiterated in 2003, in the President's New Freedom Commission² under the Bush administration, which made a bold claim that everyone with a mental illness **will** recover. Specifically, the Commission said that mental illness can be prevented and cured.

The 1999 statement was focused on the need to change the way we practice. The 2003 statement was more about our philosophical approach and our belief system. Instead of teaching us about how to practice in a recovery-oriented fashion, the President's New Freedom Commission supported changing the hearts and minds of all Americans, thus addressing stigma and the way in which each of us approaches our work. If we believe that people can recover from mental illness, then we will automatically work in a way that promotes recovery.

We can all learn how to practice in a particular way, but recovery-oriented care is the first practice that requires us to believe in the power of the human spirit and in our resilience to overcome our challenges.

BELIEVE?

Our belief systems are strong and impact who we are personally and professionally. You may not be ready to "believe" that a person can recover from a mental health condition, but we are

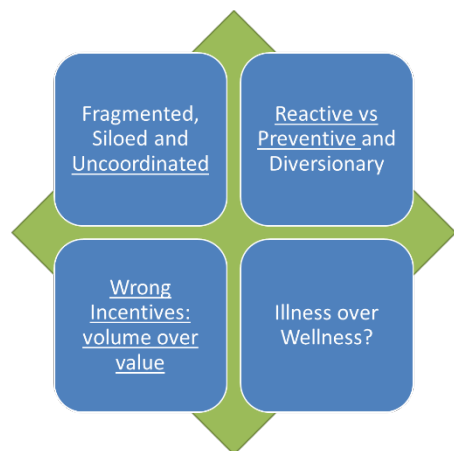
not the definers of what that means. For as many persons we work with, there is an equal number of definitions of recovery.

For many years, I did not believe that people could recover. I placed an over-reliance on the medical approach to care which focuses on symptom management. Unfortunately, it took years of exposure and education to come to believe that people can find recovery. However, the immediate impact was powerful. As an administrator, I had the ability to affect change not just in my practice, but in the practice of every staff person in my department. One can appreciate the magnitude of that influence, when you realize that each staff person works with about 60 to 100 people a year. By their believing in recovery, my clinicians were able to maximize the success of each of them. Projecting out, over the lifespan of a practitioner's career, the numbers would be in the thousands.

*Greatness is only possible if you
believe, without any doubt, that
the future is bright.*

— Simon Sinek

FIXING A BROKEN SYSTEM



There are a few critical reasons for us to practice recovery. First, and foremost, are the clinical benefits to the people with whom we work. Second, are the financial benefits to our services. While our current system is not perfect today, we are moving in the right direction to accomplishing both goals.

We are working to not be fragmented, siloed and uncoordinated. There has been a true separation of mind and body care. Now, we use a whole-person approach as we know that a person's adverse experiences and mental health impact their physical health. Similarly, a person's physical health condition impacts their mental health.

We used to be reactive instead of preventative. In taking a preventative approach, we can support people to help themselves and to find what helps them heal in their everyday lives instead of forming an attachment to services to do this for them.

We are fixing the system to focus on wellness instead of illness; to help people to become healthier; to find what is useful in their overall mental and physical wellness. In my previous work, when people who were very ill came into our services, we would facilitate hospitalization by calling 911. It was so common, that we had a relationship with the EMT's and police officers. Over time, we learned to be more helpful to the overall wellness process and work as best we could to prevent the next emergency. In this way, we helped to mitigate future trauma and reduce the overall cost of care to the mental health system.

With *volume over value*, the focus was on increasing census and increasing visits. Now, it's about people's positive outcomes. *Are the people we work with reaching their goals?* This is how success is now determined. Financially, this is driven by managed care companies that pay for our services. If they determine we are not doing as good or better than our competitors, they can redirect their members to other services and / or reduce our reimbursement rates.



Triple Aim

In 2010, under the Obama administration, the Triple Aim came out of the Affordable Care Act³ where the goals were and are: For people in this country to be healthier; for us as providers to improve the quality of our service delivery; and to accomplish these two goals while reducing overall costs. Value-Based Payments grew as a result of this. Essentially, we will get paid based on our success with helping people achieve their goals. The more improvement, reduced lengths of stay, reduced hospitalizations and ER visits, the higher reimbursement rate we receive.

Practicing recovery improves the quality of care we provide, thus helping people to live a more purposeful and fulfilling life. It also keeps our services financially afloat so that we can continue to practice quality care.

Why care about any of this?

There are two motivations that support our move to creating and sustaining a recovery-oriented practice. The first is our internal desire to help people find meaning and purpose and the second, the external motivator requiring us to work differently to achieve greater outcomes.

3. HOW TO PRACTICE RECOVERY

SELF-ASSESSMENT

First, conduct an internal review by asking yourself these questions:

- **What does recovery mean to me?**
- **What is it not?**
- **Does anything about it conflict with the way I have been trained? If so, how?**
- **Am I willing or interested in practicing recovery?**

This assessment will provide you with a baseline from which to understand your internal landscape and how the rest of this Guide will align with your approach and values.

RECOVERY DEFINITIONS

There are a few definitions of recovery. Some more eloquent than others. We will review two definitions. The first is from the Substance Abuse and Mental Health Administration (SAMSHA) and the second from Boston University.

Recovery is “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.”⁴ – SAMHSA

and

“Recovery is a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and or roles. It’s a way of living a satisfying, hopeful and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the effects of mental illness.”⁵ – Boston University’s Center for Psychiatric Rehabilitation

SAMHSA's definition is adequate and helps us to understand recovery. However, Boston University's definition is impactful on an emotional level. It was this definition that helped to get me over my hurdle into finally believing that people can find recovery. Despite all my years in the field, I finally believed that people can and deserve to live a life of their choosing. I asked myself, "Who was I to deny them that?" But I did it all the time when I (or my team) told people to "wait until you get better."

"AHA" MOMENT

I am a recovery-convert.

Many years ago, at a NYAPRS conference, there was a presenter, Dr. Mark Ragins, and he was the first psychiatrist I ever met that talked about recovery. For the entire workshop, there was no discussion about diagnosis or medications or chronicity or acuity or compliance or programming. His talk was so inspirational in its basic take on human dignity and autonomy that it became my "aha" moment. In that one single, powerful moment in time, I became a recovery enthusiast.

BASIC PRINCIPLES

Here are a few basic principles of recovery-oriented care⁶:

- Recovery is possible, even from the most tragic of circumstances.
- Recovery is the expectation. We are to have an expectation that people will find recovery and by working in this fashion, they will also come to have that expectation of themselves.
- Recovery can occur without professional intervention. Many people never walk through our doors and find recovery through other means.
- Recovery involves more than symptom reduction and can occur even though symptoms reoccur. Recovery is not linear. Setbacks will occur but when we believe in people and provide them with the hope and expectation of recovery, they are able to be resilient and bounce-back from adversity quicker.

- Recovery is a highly individualized process. What works for one person, works for one person. By practicing recovery, we support a person's uniqueness and their unique recovery path.
- Recovery occurs in the presence of someone who believes in and stands by the person. In understanding this, it becomes even more critical that we help people to build a natural support system. Where there are frayed relationships, we can help them to mend them, thus increasing their recovery success without the ties to services. However, until this is possible, we can be that person who believes in and stands by them.
- Recovery from the consequences of the illness is sometimes more difficult than recovering from the illness itself. Consequences can be damaging and life changing. They can include frayed relationships, substance use, prison or other judicial system involvement, debt, having your children removed and your parenting rights terminated, etc.

*We should never let reality interfere with
our dreams. Reality can't see
what we can see.*

— Simon Sinek

4. CHANGE OF FOCUS

Let's take a look at a side-by-side comparison of the traditional medical model approach to care and a recovery person-centered approach. It shows us the most fundamental areas to change our focus as we move away from the medical model.



TRADITIONAL MEDICAL MODEL

System/Provider Focus

Focuses on symptoms

Participants are seen in context of 'the system'

Emphasizes deficits and needs

1 expert in the room – the provider

RECOVERY-ORIENTED

Person-Centered Focus

Looks at a person's uniqueness

Individuals seen in context of their communities and lives

Emphasizes strengths and capacities

2 experts in the room – participant and provider

Let's begin with the move from focusing on symptoms. Instead of focusing primarily on stabilization, level of acuity, and medication management, we can focus on a person's uniqueness and their life goals. As we do this, we will provide care regarding their symptoms as one way we assist, but when we take a whole-person approach to care, understanding a person's life outside of treatment, we can support them to find meaning and purpose.

Context of the System vs Context of Life – Historically, we see the person within the context of the system. By changing our focus, we will see them from the context of their lives. A clinician’s approach to care can often be determined by the progress notes they write. Here are two examples about the same person:

Context of the System Progress Note:

“Jane is 54 years old and a schizophrenic for 25 and has been hospitalized 9 times. Jane occasionally is not compliant with her medications and does not attend program regularly. Jane is not putting effort into her mental health.”

Context of Life Progress Note:

“Jane is 54 years old and has 5 adult daughters and 3 grandchildren. Jane has attended our program for 5 years and in that time, she has achieved many objectives while experiences challenges in others. Jane is a grandmother, and she finds great pride in babysitting her grandkids. This expression of purpose has fortified Jane and helped her to be resilient when she experiences challenges.”

When Jane is seen in the context of her life and community, one is taken with how her life is not one dimensional and consists of various interests and passions where she finds purpose. We can engage people by truly seeing them. This is a strong aspect of relationship-building that builds trust and safety.

It is understandable to see the two progress note entries and favor the one with an economy of words approach. However, that approach is filled with jargon, pathologizing and judgmental language. With a few additional typing strokes, we can bring Jane to life.

Next, instead of placing an emphasis on a person's deficits and needs, we can emphasize their strengths and capacities. We don't ignore deficits, or for that matter ignore symptoms or diagnosis. However, by taking a strengths-based approach to care, we are actively engaging them, which in turn, maximizes their success.

The last row in this chart shows the shift from one expert in the room to two in the room. The professional is the expert in terms of their discipline and / or work role. When we value and respect the other person as an expert, we recognize their expertise in themselves and in their life experiences. When we value their opinions and ask them what it is they want and need, we collaborate and align our focus. We value their experiences and by doing so, support the development of self-determination and empowerment.

Recovery-Oriented Cognitive Behavioral Therapy

Dr. Aaron Beck, the creator of the evidenced-based Cognitive Behavioral Therapy (CBT) and founder of the Beck Institute, has researched and developed Recovery-Oriented CBT to address the unique presentation of people who have lived with their condition for a long time. As you review this Guide, you may have thought,

“But you don’t know the people I work with.”

The Beck Institute researched the idea that people with long-term psychiatric disabilities do not respond to recovery-oriented treatments. From their research, they created and published “Recovery-Oriented Cognitive Therapy for Serious Mental Health Conditions”⁷. This therapy model was developed to support clinicians who work with people with schizophrenia so that they can achieve recovery that many have believed is elusive to this population. These individuals may have the following challenges:

- problems with motivation and connection
- constant hallucinations
- entrenched delusions
- thought disorder
- question whether they have an illness at all
- aggression
- self-injury
- reactions to trauma

The Beck Institute found the answer for achieving recovery to be a CONNECTION TO LIFE, a basic human need. People are socially isolated. This may be because they have asocial beliefs, thinking, “it’s too much effort and not worth the effort to be with other people.” They may have defeatist beliefs, thinking that “nothing they can do will change their life or nothing about them is good or worthy.” The Beck Institute says, “let’s capture their interests.”

Why should you get out of bed? It’s probably not for medication or because you have to go to program. Find out what motivates and interests them.

How to connect the unconnected – there is something, some activity or topic that pulls people out of social isolation to connectedness. It can be a connection to their grandkids, or music, or dancing, or fishing, etc. As an example, some people react when there’s a discussion of music, or they hear music playing and they come alive, or they like organizing CD’s. One might deduce that this person likes music. The Beck Institute says to use that interest to connect the person to life.

We can support recovery by:

- Using their interest to expand their learning and to engage in more activities having to do with their interest. Their functioning improves and they are less disorganized.
- Helping people to experience success and have less time for symptoms.
- Supporting their employment or being useful in some way that is meaningful for them. We used to think that people needed to recover before going into the workforce. But working heals! Staying at home, with no purpose, no schedule – that’s what’s debilitating.

The value of experimentation is not in the trying.

It’s in the trying again after the experiment fails.

– Simon Sinek

5. STRENGTHS-BASED LANGUAGE

An easy and practical way to begin to practice recovery, is to use strengths-based language. The language we use is paramount toward building recovery relationships. Every day we have an opportunity to foster hope, resilience and recovery through the language we choose. Don't underestimate the power of words as people are influenced by our language. This section on language will provide you with the tools you can use to make every day conversations filled with hope, resilience and recovery.

DO



- Do put people first. Say, “A person with a behavioral health condition” or “a person diagnosed with...”.
- Do emphasize a person’s abilities. Focus on the positives, e.g., the person’s strengths, skills, and passions.
- Do focus on language that is respectful, clear and understandable, free of jargon, confusing data and speculation. Focus on language that is non-judgmental and carries a sense of commitment, hope and opportunity.

DO NOT

- Don't label people.
- Don't say, "he or she is mentally ill". Instead, replace "ill" for "challenged" as that is a more neutral word that, by its very definition, promotes hope that the challenge can be overcome.
- Don't define the person by their struggle.
- Don't emphasize their limitations and instead, focus on what they would like changed.
- Don't use condescending terms, e.g., "low-functioning" or "chronic". By their very nature, these words imbue limitations, the idea that the person will never be more than what they are. That message is disempowering and brings on helplessness instead of hopefulness.
- Don't equate the person's identity with a diagnosis, e.g., "she's bi-polar" or "he's schizophrenic" or "she's borderline". They are a person first with many identities, one of which is a diagnosis. Therefore, if you need to identify the diagnosis, your statement can be, "Mary has a diagnosis of bi-polar disorder". When we speak in this way, the diagnosis is separated from the individual's identity.
- Don't sensationalize a behavioral health condition. This means, not using terms such as "afflicted with", "suffers from", "victim of", etc. Instead, we can simply use, "Mary has a diagnosis of..." without inferring whether she's afflicted, suffering from it, or victimized. These labels can take root into our psyche making it more difficult to find hope and expect recovery.
- Don't portray successful persons with behavioral health challenges as super-humans. This carries the assumption that it is rare for people to do great things.
- Don't presume a person wants to be called by a particular term (consumer, client, patient, etc.). Instead, ask.





EXAMPLES⁸

INSTEAD OF THIS

SAY THIS

Sam is mentally ill	Sam has a mental health challenge
Sam is schizophrenic	Sam has schizophrenia
Jerome is a bipolar	Jerome has been diagnosed with bipolar disorder
Kylie is manic	Kyle is exhibiting symptoms of mania
Sam is paranoid	Sam is experiencing a lot of fear/ Sam is worried that his neighbors want to hurt him
Li has a chronic / persistent mental illness	Li has been working toward recovery for a long time Li has experienced depression for many years
Kylie is decompensating	Kylie is having a rough time Kylie is experiencing...
Kylie is resistant to treatment	Kylie is choosing not to...
Kylie is non-compliant	Kylie would rather... Kylie seems unsure about....
Javier is manipulative	Javier is trying really hard to get his needs met
Sam has challenging/complex behaviors	Sam may need more effective ways to get his needs met
Li is very compliant	Li is excited about the plan we have worked out together Li is working hard toward the goals she has set
Javier is low functioning	Javier has a tough time at ...
Sam is high functioning	Sam is really good at... / Sam's strengths include...
Sam is dangerous	Sam tends to (describe actions) when he is upset
Jerome is very difficult	I find it challenging to work with Jerome
Amy is mentally ill chemically abusing	Amy is experiencing co-existing mental health/substance use issues
Javier is a drug addict	Javier is experiencing alcohol/drug addiction
Instead of drug abuse	Say drug use/misuse
Instead of habit	Say active addiction
Instead of clean/dirty lab results	Say negative/positive lab results
Sam is unmotivated	Sam is not inspired to...
Abby committed suicide	Abby died by suicide
Li is a frequent flyer/high user	Li accesses services frequently

Changing our language starts with each of us. You can begin as a team, each working on moving from deficit-based language to strengths-based language. Many people begin changing their language when working directly with people. It is also recommended that you challenge yourselves to use strengths-based language during treatment teams meetings or other meetings where participants are discussed in their absence. In this way, you go beyond improving your own practice, but in collaboration with everyone else, you become part of a larger, more impactful, recovery culture change process.

*It doesn't matter when we start. It doesn't
matter where we start. All that matters is
that we start.*

— Simon Sinek

6. PROMOTING SELF-DETERMINATION & EMPOWERMENT

Relationship Building

Building a therapeutic alliance with the people you work with is the foundation of everything else to come. Carl Rogers, the American Psychologist and the founder of the Humanistic Approach to Psychology, said that in providing mental health services, we must be genuine, honest, empathetic and respectful⁹. He broke this down into three areas:

CONGRUENCE: genuineness & honesty

EMPATHY: the ability to feel what the person feels

RESPECT: acceptance & unconditional positive regard



As human beings, we are not always compassionate and empathetic. We get tired, frustrated, irritated and other emotions that are not helpful to building and sustaining positive working relationships. With this in mind, we can work towards building rapport with a goal of genuinely caring about the person. We could all do our work without going this extra step, however, if we are to be genuine, honest, empathetic and respectful, we will need to attend to all of our interactions and interventions assuring they come from a place of genuine caring. If we don't, our weariness, agitation, exhaustion and frustration may come through. We know that people pick up on the emotions of others. Once this happens, we will no longer be in control of the narrative they create. Some may internalize

it and blame themselves or inadvertently mirror the emotions they are sensing, or worse, choose not to “check-in” on the accuracy of what they are sensing.

Lastly, we may not normally think of ourselves in the “customer service” industry and while we are not, there are many aspects of quality customer service that are easily transferable to our work. Customer service is designed to help create a welcoming atmosphere and improve the person’s experience. We, regardless of our discipline or title, need to attend to the quality of customer service we are providing. This includes all staff, for example, reception staff, office staff, maintenance, kitchen staff, psychiatrists, peers, clinicians, nurses, etc. We all benefit when people feel welcomed and feel that they are stepping into a welcoming and healing environment.

CREATING A CULTURE OF FEEDBACK

A significant amount of our energies are spent attending to engagement and each person’s experience of care (remember the Triple Aim) with the charge of helping them to achieve their goals. This happens more quickly and successfully when clinician and participant are working in concert.

Creating a culture of feedback allows this to happen by building in the expectation that we want to know how we are doing; that we care about their experience of care, and that we are improving our performance in terms of our overall helpfulness. By using this approach, people will gain confidence in us and in themselves. When we provide open and honest feedback that is welcomed and respected, their empowerment develops.

We can create this culture of feedback by weaving it into our processes. Some clinicians choose to do this at the end of every session, other’s choose different timeframes. Whenever you choose to do this, you create the expectation that we will seek their opinions so as to keep us in alignment and always in forward motion.

Here’s a document created by the McSilver Institute for Poverty Policy & Research¹⁰ and CTAC to support a clinician in this feedback process.



SESSION FEEDBACK FORM

Please rate each item based on **today's session** using a 1–5 rating scale.

1 = never 2 = rarely 3 = sometimes 4 = often 5 = all of the time

The therapist listened to me.

We are making progress toward our goals.

Our session focused on the treatment plan.

The therapist worked with me to help me get to my appointment.

I feel more prepared to handle my problems.

I know what I need to work on between now and our next session.

What was the best thing about the session today?

What would you have changed about the session?

Creating a culture of feedback has many other positive effects as it:

- Increases progress towards the person's goals
- Reduces the overall length of stay and reliance on services
- Reduces the need for a higher level of care
- Reduces crises
- Increases the person's confidence
- Supports recovery and empowerment

By building this culture of feedback, you increase achievement of both participant outcomes and your organization's outcomes to be competitive in a managed care environment.

EXPLORING ASPIRATIONS

What if the person has no goals or what if they say their goal is to “take my medication?”

In the same way we have transformed our practice by learning about recovery-oriented care and we engaged in the work of changing our belief system to do this successfully, we should also engage the participants in a similar transformational process. Not everyone will automatically respond to our different approach as they may not understand. They may wonder “Why is it that ‘to be compliant with my medication’ no longer a viable goal?”

Engage people to expand their understanding of treatment to be about them achieving a life of their choosing, not just goals within the context of the system. Recovery is about life. An easy technique to try is to simply ask, “why?”. “Why do you want to be compliant with

your medications?” Over the course of this conversation, continuing to ask “why”, the person will identify a life-role goal. Through your skills and the relationship and safe environment you create, you will help them home-in on identifying a goal and the steps needed to achieve it.

THE GOALS OF SETTING GOALS

- Assist the person in promoting control over their own life
- Increase opportunities for participation in the community
- Recognize individual desires, interests and dreams
- Through team effort, develop a plan to turn goals into reality

OBSTACLES TO OVERCOME

Recovery is not linear – Recovery is not a step-by-step process but one that’s based on continual growth, occasional setbacks, and learning from experience. We know this through our professional and personal experiences. Some familiar examples might be attempting weight loss, quitting smoking, promoting healthier lifestyles or healthier relationships, etc. Occasional setbacks are an expected part of every person’s journey. Professionally, we’ve seen people come and go and then come and go again. This back and forth is natural as one works on their recovery. When such setbacks happen, we should stay steadfast and committed to supporting and encouraging them. Some people who have lived with their condition for longer periods of time may have a slower time in achieving recovery and their “bounce-back” may be slower as well. Your unconditional support and hope for them can be what helps them to persevere.

Learned Helplessness – is a concept born from people “doing” for others to the extent that the person no longer feels competent to do for themselves. Let’s review this example to have a deeper understanding.

When a baby elephant is in captivity, one hind leg is chained to a stake in the ground to prevent it from wandering off. When the elephant grows up, the practice is unchanged. The adult elephant is chained to a stake in the ground to prevent it from wandering off. However, he’s now a large and powerful adult elephant with the strength to easily pull the stake out of the ground and walk away... but it doesn’t. It’s been conditioned to believe, since it was a baby, that no matter how hard he tries, he will not be successful. Therefore, he does not try.

Learned helplessness is debilitating but it can be dismantled. Many people have spent most, or all of their life in highly-supervised institutions. This lifetime of conditioning can make it very challenging to break free. It’s also referred to as an “institutional mindset” because in institutions people are subjected to many restrictions, not only of personal liberties, but also of choosing when to engage in activities irrespective of their choice. With support and encouragement and being the person who believes in and stands by them (principles of recovery), people can increase their confidence to begin doing for themselves.

How do we help people to move beyond this?

- We can explore control and dependency issues by asking the person to imagine how life could be different than it has been in the past.
- We may ask exploratory questions such as: “What would life be like if you could make your own choices, your own decisions?”
- We may ask questions to create awareness to help people identify any dissatisfaction with the *status quo*. We can ask the following:
 - “What would you have imagined your life to be like if you weren’t in this place?”
 - “What would be different every day for you?”
 - “What is it about your life right now that isn’t happening because you are here?”



Am I my illness?

“Once a person comes to believe that he or she is an illness, there is no one left inside to take a stand toward the illness. Once you and the illness become one, then there is no one left inside of you to take on the work of recovery...”

Dignity of Risk¹¹ – is a term coined by Dr. Pat Deegan and is the belief that self-determination and the right to take reasonable risks are essential for dignity and self-esteem. To clarify this concept, we will review a scene from the movie, *Finding Nemo*¹². This movie takes place in the Pacific Ocean and the characters are fish. The son, Nemo, gets lost and the story follows the father and his friend as they journey to find him.

Background on Nemo

- Lives in a single parent household
- Experienced trauma with the killing of his mother and siblings
- He has a disability (one fin is small and less functional)

Nemo becomes lost during a school trip and his father, Marlin, is frantic about losing his son and is beginning to blame himself. He is talking to his spacey yet insightful friend, Dory. They have gone through many harrowing situations to get to this point. They've fought sharks, jelly fish, and swam the vast Pacific Ocean... until now... when they find themselves in the belly of a whale and all chance of reaching his son seems lost.

*Marlin is frantic and hyper with fear. In an instant, you can see it in his eyes when he loses all hope with the certainty of his imminent demise. In shock and devastation, he says to Dory (maybe even more to himself), **"I promised him that I'd never let anything happen to him. I promised him that I'd never let anything happen to him. I promised him..."**. Dory responds, **"Huh, well, that's a funny thing to promise him. You can't never let anything happen to him cause then nothing will ever happen to him!"***

If nothing ever happened to us, we would not be the people we are today. If we didn't take the chance of applying for college or didn't take the chance of loving someone or didn't take the chance of applying for the jobs we have now, we would not be the people we are today. We were strong enough to take risks and we had people in our lives that believed in us.

There is no life without risk, no success without risk, no pride without risk. This lesson is taught to us as children when our parents not only exposed us to love and happiness, but also to disappointment. We won't experience gratitude, fulfillment and find our purpose if we don't take risks.

In the traditional medical model approach to care, we encouraged people to “get better first” before embarking on life goals like finding a job or pursuing an education, etc. Participation in life, working, for example, helps people heal by giving them meaning, purpose, feelings of accomplishment, the excitement of learning something new, meeting new people. It decreases their focus on symptoms, improves creativity and mental alertness, increases energy and boosts their self-confidence. According to a study by Psychology Today, Dr. Annie Varvayan¹³ shares that, “staying busy gives us the opportunity to reduce rumination and worry over things that we can't go back and change, or things we can't control about our future.”

Self-Determination – we can support a person's self-determination by advancing the following:

1. Setting recovery as the expectation and when needed, teach, guide and hold the expectation that they will be an active participant in carrying out their plan.
2. Always seek the least restrictive environment and intervention. Prevention is key as we know that crisis and the interventions that follow add to a person's trauma.
3. Strive for full community inclusion¹⁴. The right and expectation that each person lives in the community and partakes in the community like everyone else. If people want and ask for a “pizza social” or an “knitting group”, suggest they find these things in the community and when needed, aid them in gaining the skills to accomplish this goal.
4. Use a Shared-Decision Making approach where, if needed, you would contribute to the decision-making process and come to a consensus on treatment decisions.

However, remember, that the person drives their treatment. Your skills are needed to help guide them in this process by exploring pros and cons.

5. Use Psychiatric Advance Directives¹⁵ (PADS). They are legal documents that detail a person's preferences for future mental health treatment or names an individual to make decisions on their behalf when they are in crisis and unable to make decisions for themselves. This advances a person's self-determination as the treatment they will receive in times of crisis, will be in keeping with their wishes.
6. Introduce people to Wellness Recovery Action Planning WRAP[®]¹⁶. WRAP[®] is a voluntary relapse prevention plan that is self-directed and designed to empower people to do what they find helpful in moments when they feel unwell. WRAP[®] is a practical and useful document that allows the person, in times of crisis, to engage in activities they have previously determined to be helpful to them. This is not a legal document but can be very helpful in supporting a person's resilience, as well as their overall wellness and independence from services.
7. Lastly, help people to make connections. Relationships are fundamental to supporting people outside of services. Sources of relationships strength can come from family, friends, mentors, co-workers, caring of others, and the faith community.

*You may not control all the events
that happen to you, but you can
decide not to be reduced by them.*

- Maya Angelou

7. VALUES OF PEER SUPPORT

People in mental health recovery find great value in connecting with individuals who share similar experiences and who have persevered. Peer Support staff have long been seen to positively impact the people with whom they are working; so much so, that Peer Services are now a recognized reimbursement model through Medicaid and Managed Care. Peers work in a recovery-oriented fashion and they are guided by the following key values:

Trusted, Safe Relationships

Person Driven and Directed

Acceptance, Empathy and Example

Honesty and Shared Accountability

Hope, Respect and Dignity

Empowerment and Choice

Peers are in a unique position through the sharing of mutual experiences, they can help a person move more quickly and purposefully on their recovery path. They represent a unique relationship. Peers can provide:

- Mutual support that promotes each other's recovery
- A safe space to challenge each other when they are "stuck"
- The ability to teach and learn from each other
- A relational way of being with each other
- A balance of power in their relationship

If your organization has hired or has connections to Peers, it is highly recommended that you embrace them as part of your multi-professional team. The way in which they work is different and sometimes misunderstood. They work for the person and encourage them to share information themselves. The Peer will never share on their behalf. It's a truly empowering relationship and Peers have been seen to be highly successful.

8. MY PRACTICE

Throughout this Guide, we have made reference to Your Practice. Simply stated, “your practice” is everything you do and say in your daily work. It is your approach to care. As Simon Sinek said, “your work is your own private megaphone to tell the world what you believe.” We learned that to truly practice recovery-oriented care, there is a need to integrate a belief system where you believe that people with a mental health condition can, and do, recover.

Now that you have concluded the Guide, I ask you to answer the following questions for yourself:

- ☐ Do I believe people can recover from a mental health condition?
- ☐ Am I willing to change my focus from the traditional medical model to a recovery-oriented and person-centered focus?
- ☐ Am I willing to integrate strengths-based language and leave pathologizing and stigmatizing language behind?
- ☐ Can I create a culture of feedback and be open to hearing it?
- ☐ Can I see people within the context of their lives?
- ☐ Now that I’ve learned about Learned Helplessness and the Dignity of Risk, will I be able to support a person’s unique recovery-journey?
- ☐ What changes can I make right now to shift my practice to recovery?

Recovery
It's work
It's a process.
It's worth it.
It's possible.

Thank you,
Ruth Colón-Wagner, LMSW
NYAPRS

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