A Story of

Transformation

An agency fully embraces recovery

*Agency making
the 'impossible'
a misnomer*

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Six years ago, META Services was a traditional behavioral health organization. META's mission statement articulately described our commitment to help people "stabilize" and "maintain," and we were proud of how well we did this.

We had been in business for nearly 10 years and had a reputation for providing high-quality services in our community. The year was 1999, the place was Phoenix, Ariz., and there was as yet no talk about the vision of recovery from mental illness guiding our operations (Anthony, 1993; President's New Freedom Commission on Mental Health, 2003), nor the need to transform the mental health system and its programs with respect to mission, basic values, principles and assumptions (Mazade, 2005).

The story of META's transformation provides an example of the many strategies agencies might use to align their practices more closely with the vision of recovery.

Changing the mission

In the spring of 1999, CEO Eugene Johnson and several members of our leadership team attended a national workshop where people with mental illnesses talked about how discouraging it was to be continually discounted, disempowered and disrespected by the very service systems that were supposed to be helping them. Our team walked out of the workshop agreeing that this was indeed the case, and that the speakers had every right to be disappointed and discouraged.

Then our CEO had one of those moments he calls a "crisis of conscience." He realized that the "system" described by the workshop participants was, in fact, us — our company.

Many practitioners in our agency could relate with what people with mental illnesses said at the workshop. Deep down, we knew something was wrong, missing, and that there must be a better way to do our business. But since we didn't know a better way, or how to change, we were tempted to cling to what we were trained to do. But it was too late. The change process had already started and most of us decided to go with it.

Our CEO reread our mission statement, and decided that creating a new one would be a good place to start. We spent a whole day rewriting our mission statement before we came up with something that seemed to fit our new vision:

"To create opportunities and environments to empower people to recover, to succeed in accomplishing their goals, and to reconnect to themselves, others, and meaning and purpose in life." (Johnson, 2002, p. 1)

Figuring out a way to actually implement this statement required a huge leap of faith, but we seemed to be taking it, even though some of our staff were more or less being dragged along kicking and screaming, mostly because they didn't know where we were going with this or what it would mean for them. Would they lose their jobs if everyone got better? Would peer employ-

ees take their jobs? Would their licenses be affected?

Starting a recovery-oriented program

Next thing we knew, our CEO hired a person with a mental illness and put her on the management team. Just her presence started changing the way we talked, and even what we thought. Then the CEO and some of the leadership team spent a week in Vermont with Mary Ellen Copeland (Copeland, 2005). They came back with ideas of opening a Recovery Education Center (Hutchinson, 2004 and 2005). Soon we had rented additional space and Lori Ashcraft, Ph.D., was hired to develop and direct the yet-to-materialize center.

"We decided to use education as the model for promoting recovery, rather than develop more traditional treatment alternatives. We did this because we wanted our Center to be about reinforcing and developing people's strengths, rather than adding to the attention placed on what was 'wrong' with them. The guiding vision we had for the Recovery Education Center is reflected in the mission statement: 'People will discover who they are, learn skills and tools that promote recovery, what they can be, and the unique contributions they have to offer.'" (Ashcraft, 2000, p. 8)

Hiring peer support specialists

We didn't really have any additional financing to cover the costs of the Recovery Education Center, but since recovery was not yet part of the culture of the larger mental health community, we knew we would have to create results before we would be able to convince funding sources to invest in our new services. Since we had benefited so much from our first hire of a person with a mental illness, we applied for a grant to train people who had been diagnosed with serious mental illnesses to work as Peer Support Specialists, thinking that this would further our ability to shift our culture.

We deliberately created "Peer Support Specialist" as a new discipline because we wanted the new staff to be equal members of our teams and we wanted to ensure that the power of their peer experience would not be lost. Their credential was their lived experience with psychiatric symptoms and their experience of using services in our system.

Since we wanted the new staff to make a powerful contribution to transforming our culture, we decided to develop a rigorous training program. We took this proposal to our state Rehabilitation Services Administration, which gave us an establishment grant. Not long after, we hired several more people with mental illnesses to develop and deliver the training; soon the first 15 Peer Support Specialists graduated.

As the Peer Support Specialists began to work on our teams, miracles began to happen. Their recovery continued. Those with whom they worked began to recover. Our culture began to change, and we moved closer to our recovery mission.

Today, the curriculum has been rewritten several times. Over 500 Peer Support Specialists have been trained, and 65 percent have been employed in our agency and other agencies throughout our community. Peer support became a Medicaid-reimbursable service in Arizona, and now META delivers over $5 million a year in peer services.

Over half of the 350-person META workforce are peers who have graduated from the training program (Ashcraft, Johnson & Zeeb, 2004). Following are examples of Peer Support Specialists describing their recovery and their work:

"Peer Employment training class changed my life. I made lots of close friends and learned to look at myself honestly for the first time. I gave myself permission to begin to know who I really was. Afterwards, I still did not have enough confidence to work, so I volunteered at the next Peer Employment class. My confidence was still very low and I was scared to death. I also kept attending WELL (Wellness and Empowerment in Life and Living) classes and Wilma and Keith, the facilitators, made a big difference in my recovery. I got my own apartment after that and continued to live with my dog, who is my life. When I got hired to work at WELL it changed my life even again. I truly love it and the people in my group. The reward is making close friends and supporting and watching people progress. I have gained self-esteem and learned to be resilient." (Sheree Rudd)

*"Every day at work is rewarding. I thought that when I started working I would be counseling people and teaching them how to deal with their mental health issues. That couldn't have been farther from the truth! I work side by side with others, peer to peer. I offer strength, support, experience, lend a listening ear, but most of all, I get paid to spread **hope**."* (Suzanne Knutson)

Eliminating seclusion, restraint

With the Recovery Education Center well under way, CEO Johnson turned his attention to the part of our company that

had been most unsettling to him — crisis services. Once a source of pride, these programs were on the verge of being an embarrassment due to the fact that we often resorted to seclusion and restraint as a means of "treating" people. He couldn't stand it any longer.

Johnson sat down with the staff and told them that we would no longer be using seclusion and restraint. This was a huge culture shift, since their use had always been seen as a necessary part of this business. Staff threatened to quit. Some threatened to call the Occupational Safety and Health Administration (OSHA) because they believed the company was putting them at risk. Some claimed that the company didn't care about them anymore.

Our CEO held his ground, and because his genuine beliefs and concerns were evident, staff had the courage to try this with him, even though they didn't believe it would work. Here's how Johnson describes it:

"I was enthusiastic and excited about the possibilities of our new recovery mission. I wanted the people we served to really have the opportunity to recover, but where could we start? Then it came to me. If we could

Guiding principles

Over the past five years, officials at META Services report having learned a great deal about becoming a recovery-oriented organization. As in most cases of major change, the "everyday" management of things has been what promotes a constant stream of positive changes.

Following is a list of principles that helped keep META staff moving in a recovery direction:

- Learn to use language that promotes hope. Avoid language that relates to sickness.
- Raise expectations of what people are capable of accomplishing.
- Stay focused on strengths no matter what.
- Build everyone's hope, because hope is the energy that moves transformation forward.
- Move people to the "helper" role as soon as possible so they don't get stuck in the "helpee" role.
- Celebrate accomplishments with graduations and social events.
- Find ways to listen to our customers. They are the real teachers.
- Re-engineer forms, procedures and processes to help staff focus on recovery instead of stability and maintenance.
- Re-create existing services to an educational approach model wherever possible, helping people to move from the role of "mental patient" to the roles of student, learner and teacher.
- Try not to write about the people we serve. Have them fill out their own progress notes and service plans whenever possible.
- See recovery as something that happens to staff and organizations, not just people receiving services.
- Create a community where everyone has a valued role.
- Provide lots of opportunities for staff to get good training in recovery practices and principles.
- Find ways to say "yes."
- Focus on results. Teach everyone accountability principles. Become a creator of the future rather than a victim of the system stuck in too many rules, too much paperwork, and not enough funding. Help everyone "rise above their circumstances to get the results they want."

stop the violence of takedowns and restraints in our Crisis Centers, that would be a demonstration that what we had thought was impossible is possible. That could begin to shift our beliefs and attitudes and jumpstart the transformation of our culture. I made a public declaration for 'zero restraint.' That got us busy. We educated ourselves, developed new policies, redesigned our training, and measured our progress. It was a big job since we see over 1,200 people a month at our two Centers; 30 percent brought by police and 40 percent brought involuntarily. After eight months at the first Center, restraints had been eliminated. The other Center, busier and overcrowded, took 18 months, but we got there. And we celebrated. And those we serve celebrated. Now, whenever there is something to do that is really hard, we remember that we have already done the impossible. 'Zero Restraint' has become our metaphor for transformation." (Johnson, 2003, p. 1)

Implementing a culture of recovery

From early in the transformation process to the present, the leadership has considered the vision of recovery to be the driving force for change. We stressed repeatedly in staff meetings and individual discussions that recovery, in fact, is neither a "treatment" nor a service being given by an outside party. The recovery process is initiated and carried out by the person with the mental illness. An agency with a recovery culture offers a way for people to take control of their life, to move beyond the consequences of their circumstances and the effects of prejudice and discrimination.

Our preferred method of supporting this change is through an educational process, which is available to people who are interested in recovery. In the context of recovery, the role of the person with a mental illness is significantly expanded beyond that of waiting to be cared for, to that of learning how to take charge of his or her own healing process.

The person is seen as a "whole person" instead of a "collection of symptoms." People with mental illnesses are no longer "cases to be managed," but rather are the key informant in their quest for wellness. The educational approach avoids positioning the person in a "patient role" and focuses on each person's inherent strengths, abilities and capacity to learn new skills for living and for developing personal growth, mutuality and recovery.
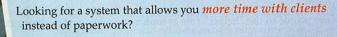
Developing policies and procedures

We soon realized that our move to a recovery culture needed to be reinforced by more formal guidelines to help us stay on track.

In the past we had taken a traditional approach to policy

and procedure development. We pretty much created a rulebook with instructions (our Policy and Procedure Manual). This was fine for auditors and surveyors, but we realized that it was not relevant to how staff practiced. We found that staff made decisions based on their personal and professional beliefs and values. So we wanted to find a way to teach our team our new values and beliefs.

As our culture was changing, we decided to develop our "policies" based on the following principles:

1. Practice and procedure should be value-based, not rule-based.
2. Following the principle that recovery is a personal and individualized process, policies should be guidelines, flexible enough to allow practice and procedure to be individualized to each situation.
3. Policies should be person-centered, not business-centered, and examined in the context of what will support the recovery of everyone we serve and everyone in our organization.
4. Rather than liability and risk management being the focus, our policies should encourage our organization to find ways to support each other as we take the risk to create new solutions.
5. Policies should be friendly, easy to understand, and easy to remember.

Using these principles, we took an unusual approach to developing and communicating policies and procedures. Our Policy and Procedure Manual is essentially a folder containing a series of letters sent periodically to employees that shows them how their behavior, attitudes and the agency environment can reinforce our values and mission. In essence, our agency was grounded in what is now referred to as value-based practices (VBP; Anthony, 2004). Initially in our transformation process policy letters were sent out weekly. The focus of the policy letters is unique for most policy manuals.

META Services is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), cer-

tified by Medicaid for Title 19 reimbursement, and licensed by the State of Arizona Department of Health. As our culture and our way of doing business changed, we have always been able to find a way to work within accreditation standards and licensing regulations. There have been times when we have had to be good advocates with the "regulators," but we have always been able to find a solution that honored our recovery values.

Continuing the agency's recovery

Our company is in a very different place from where it was six years ago. The evolution has been an exciting and rewarding experience. We have now graduated more than 500 people from our 70 peer support training classes. They are making a powerful contribution to transforming our services, our community, and our culture.

As we focused on creating recovery results, our funding and programs have grown. Sometimes our funding source delighted us by funding proposals we developed that were a real departure from "business as usual." Many times our funding sources have come to us saying, "Could you develop this?" or, "We are impressed by the results of that new program; could you do some more?" Following are some examples of our progress:

- Over 350 WRAP and WELL class sessions are taught every month, helping people learn self-help and wellness tools.
- We created a new supported housing program, Community Living, that not only has been successful in helping people have a home of their own in the community, but has helped 80 percent of participants achieve "housing self-sufficiency" by being able to pay for their own housing costs through employment, sharing with a roommate, or reuniting with family. Funding for this program has been expanded twice to $2 million, because it helps people leave expensive, traditional residential and group living and reduces the long-

term cost of housing "entitlements."

- Our Recovery Education Center is licensed by the state as a Post Secondary Vocational Institution, and through a partnership with our community college system offers courses in recovery for college credit and an Associate of Arts degree in Mental Health Recovery.
- Our Peer Support Training curriculum has been shared with others and is now being used in several places in the country to train Peer Support Specialists.
- Employment has become a focus in our Recovery Education Center, with new opportunities to help people find meaningful careers through peer-supported job development and job coaching.
- Peer Advocates have been added to inpatient settings, where they provide peer support and work on "Discharge Recovery Plans."
- Peers working as Recovery Coaches have been incorporated into the case management system to provide peer support and help people develop "Self-Directed Recovery Plans."
- A Mental Health Power of Attorney (advance directive) program has been created to help people direct their services even when they are having a hard time and might not be able to make good choices about their care.
- Our Crisis Centers have been renamed Psychiatric Recovery Centers and now are being expanded to alleviate overcrowding.
- We have created a partnership with the Boston University Center for Psychiatric Rehabilitation to evaluate our services and share what we have learned (Hutchinson, Anthony, Ashcraft, Johnson, Dunn & Lyass, in press)
- With Boston University we have embarked on a randomized controlled trial (RCT) of Peer Support Services (Center for Psychiatric Rehabilitation, 2004) ❧

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