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The Recovery Movement:

As the Mental Health Community Shifts to a More Patient-empowered Model, Clinicians Find New Ways to Provide Services, Support

By Dennis Morrison, Ph.D.
and Roy Starks, M.A.

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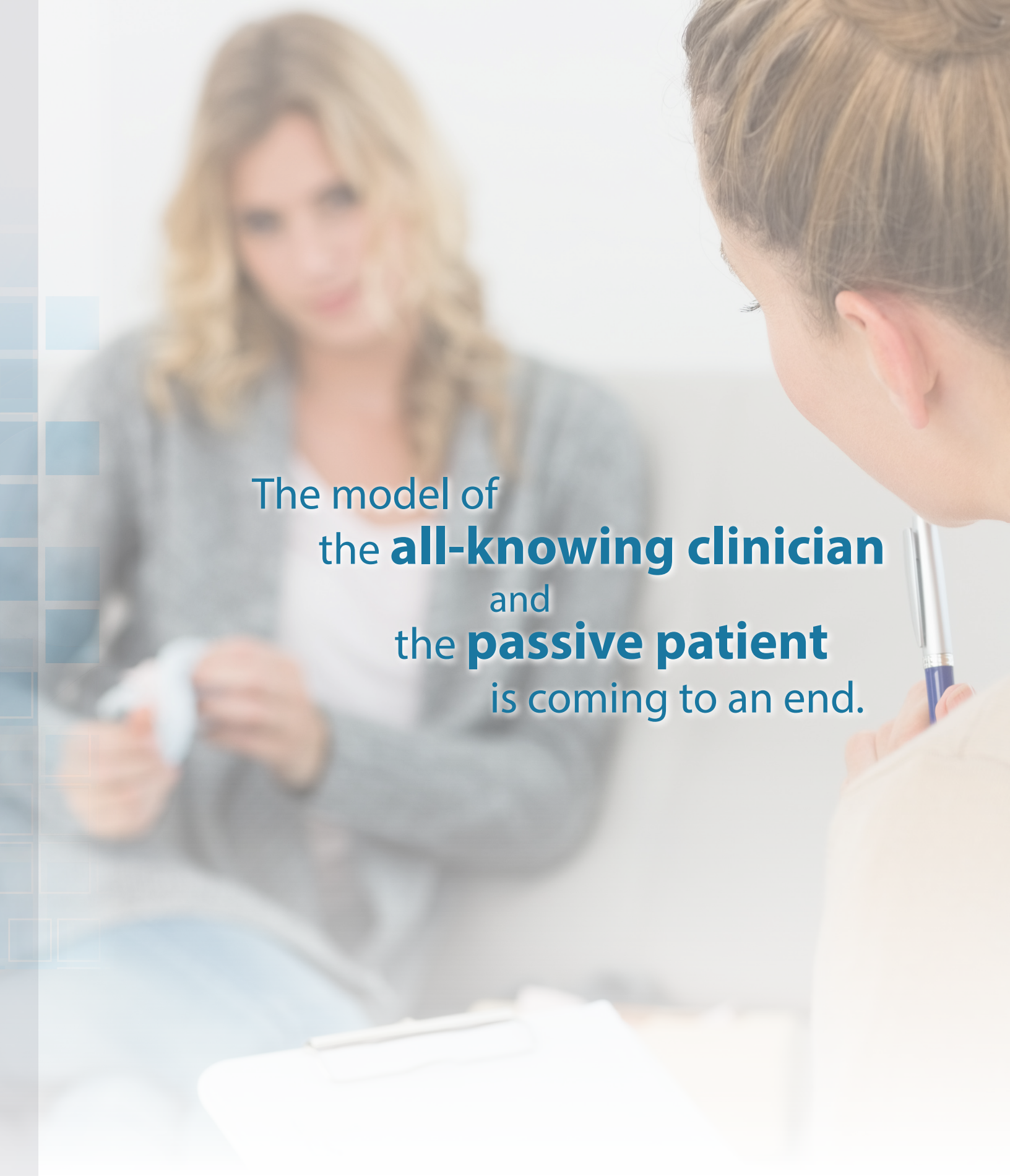


As the mental health community shifts to a more patient-empowered model, clinicians find new ways to provide services, support

We're in the "me age." The age of the individual. The age of the consumer. Healthcare and healthcare information technology (IT) communities are not immune to this shift. There is a growing realization in the arena that care needs to be more patient-centric and patient empowering.

In the behavioral healthcare space, this is called the Recovery Movement. "Recovery-oriented practices," according to an article by Kendall Atterbury, are those that recognize the strengths of service users and empower them within the mental health system. … Recovery-oriented practices emphasize shared decision-making, respect for service user goals and the recognition of the full humanity of persons in care relationships" (Atterbury, 2014).

The traditional model of healthcare was paternalistic, driven by professionals in a hierarchical model in which clinicians believed they and the staff knew what was best for the patient. The relationship was about maintaining control. Treatment planning and charting activities were usually done behind closed doors and with no patient involvement. It was common for clinicians to communicate using professional jargon, especially around diagnostics. Decision-making was largely the purview of the clinical professionals. The power resided with the staff.

It can be argued that this paternalistic system was not ideal clinically, especially when it came to behavioral health. Patients ran the risk of becoming overly dependent upon their care providers and could even display behaviors signifying institutionalization in outpatient settings. Those who experienced a significant loss of power in their lives either through trauma or some other means, could become re-traumatized inadvertently by their care providers. Treatment effectiveness could be compromised because the power dynamic prevented non-assertive patients from participating in their own care.

The model of the all-knowing clinician and the passive patient is coming to an end.

Digital-Driven Healthcare

There are many reasons why this change is occurring now. One is the advent of direct-to-consumer healthcare marketing, especially by pharmaceutical companies. People are now bombarded on TV, radio, and in print and social media with messages encouraging self-diagnosis and "asking your provider" about the latest medication or joining a free trial. Sometimes, these ads go so far as to incentivize consumers with coupons. However, these ads, though certainly not a replacement for a clinician's diagnosis, encourage patients to ask questions and be more assertive with their providers (U.S. Government Accountability Office, 2006).

The accessibility of home-testing and treatment devices is increasingly growing. Starting in 1977[1] with the introduction of the home pregnancy test, followed by the introduction of the blood glucose monitor in the 1980s (Hughes, 2009), a whole new set of resources started becoming available for people to assess and manage their own healthcare.

Today, individuals can measure, monitor and modify their bodily functions. The fitness industry is perhaps the most obvious example of this. Companies like Fitbit, Jawbone, Nike, Samsung, Adidas and Garmin have all developed bracelet devices that will track calories, steps, distance, sleep and, in some cases, heart rate.

[1] The first recorded use of a pregnancy test actually occurred in 1350 B.C.E. In 1963, that test was evaluated and found to be accurate 70 percent of the time. (Kennedy, 2012)

However, the growth of the Internet has arguably had the most significant impact on the patient-centered movement in general and the mental health recovery movement, in particular. The Internet provides unbridled access to health information. It has become rare that a patient goes to a doctor's office before having first researched his or her problem online. According to a 2013 study by the Pew Internet & American Life Project (Duggan, 2013), 72 percent of Internet users say they searched online for health information in the past year. Of those who searched, the majority (77 percent) started their search from a general web browser; only 13 percent started with a dedicated health website such as WebMD, which has become the most popular medical Internet site (eBizMBA, 2014).

In the behavioral health arena, there are also numerous websites, including those selling tools to improve brain functionality. These sites have found ready audiences. For example, baby boomers, concerned with losing their cognitive abilities, frequent sites run by companies such as Luminosity (luminosity.com) and Brain Resource (brainresource.com), which promote related products. The research has not yet established the efficacy of these types of interventions, but nonetheless they are popular.

There is a wealth of websites devoted to mental health and substance abuse disorders. One of the most popular is that of Dr. John Grohol, PsychCentral (psychcentral.com). He offers a list of websites one can go to for additional mental health support.

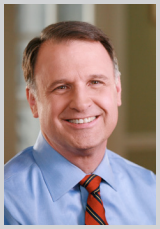
Websites, such as Beating the Blues (nrepp.samhsa.gov/ViewIntervention.aspx?id=318), which considers itself "computer-based cognitive behavioral therapy," have been offering online treatment for depression for some time with good results. A new type of online intervention has been established in the form of "clinical social media," in which patients can interact online with others with similar concerns for support and advice. One of the better ones is called Big White Wall (bigwhitewall.com). These peer-to-peer networks have been around in the United States for a while, but they have usually taken the form of a chat room experience. In other countries, such as in the United Kingdom and New Zealand, they have become more mainstream. This is likely due in part to the reimbursement systems in these countries – they have single-payer systems -- as compared to that in the U.S. With the introduction of the Affordable Care Act (ACA), also known as "Obamacare," and other forms of capitation, we will likely see greater adoption of these kinds of tools as providers look to drive down costs and better empower clients.

Get Involved in Your Recovery

- **luminosity.com**
- **brainresource.com**
- **psychcentral.com**
- **nrepp.samhsa.gov/ViewIntervention.aspx?id=318**
- **bigwhitewall.com**
- **https://www.mystrength.com**

Could Patient Empowerment Be Taken Too Far?

While the Affordable Care Act and other legislation have helped shift the behavioral and mental health community toward a more patient-centered, patient-empowered and patient-engaged model, there are some who believe that laws should exist that allow caregivers or the government to require that one seek mental health support if he or she refuses. This is especially in cases where the person might be a danger to himself or others, though the argument is that "being a danger" has become increasingly hard to prove – often until it is too late.



Take for example the case of Virginia State Senator Creigh Deeds, who was attacked by his son before shooting himself to death in 2013. Deeds told a reporter in January 2014 that it was not his son that the problem, but that "the system failed Gus. It killed Gus."

Gus Deeds was a student at the College of William and Mary. He was diagnosed with bipolar disorder when he was 21. In Nov. 2013, Creigh Deeds became concerned that his son might kill himself. He gained a court order to take his son to the emergency room to check him into a psychiatric ward, but the court order expired after six hours. In that time, staff had not been able to find him a bed. So instead, he was simply sent home with his father. The next morning, he stabbed his father and shot himself to death (Warren, 2014).

Deeds said he now plans to dedicate his public life to reforming a state mental healthcare system he has called 'irresponsible' and which he blames for allowing his sick son to be able to come home. Among the changes he would like to see is an increase in the maximum time of an emergency custody order, from six hours to 24 hours.

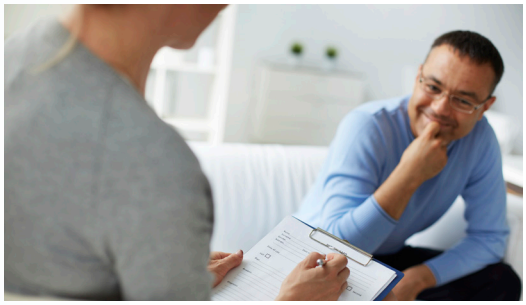
A different but related article published in the *Washington Post*, recounts the story of a man that everyone is worried about but that no one can do anything about.

"He has been alone in the house in suburban Maryland for two years. No one knows what he is doing. No one knows what he is thinking, what he is eating or how he is surviving. In two years, since his frightened

The younger generation will also help drive the Recovery Movement. Millennials are considered "digital natives," as the generation that has grown up in a world where computers and other online tools are the norm. This group has very different expectations of their healthcare providers and of healthcare in general. Accustomed to operating in an online world, they question the necessity, for example, of going into a mental health provider's office when they can "discuss" their problems online in a similar but virtual environment.

The Personal Health Record

The government has taken an active role in pushing for consumer-directed healthcare. In addition to ACA, the Office of the National Coordinator (ONC) (HealthIT.gov) has several initiatives in place to get consumers more and easier access to their own health information.



One example is the requirements outlined in the Meaningful Use standards promulgated by the ONC. Among other standards, the Meaningful Use requirements stipulate that electronic health records must be able to summarize a patient's electronic medical history, supply that to the patient in an electronic format, and assure that that information can be read by a different provider using a different electronic health record (EHR). This format was originally known as a Continuity of Care Document (CCD), but is now called the Consolidated Clinical Document Architecture (C-CDA). The ONC's philosophy is summarized in opening paragraph of the ONC Policy Brief, "Individuals Access to Their Own Health Information:" "Individuals who engage in their healthcare achieve better health outcomes and benefit from lower healthcare costs. Having ready access to health information held by healthcare providers and health plans allows patients to be better managers of their health and care by, for example, making more informed treatment decisions, adopting healthy behaviors related to diet and exercise, or taking medications as advised by their providers" (Skipper, 2012).

One way the ONC's initiatives are starting to gain traction among consumers is in the development of personal health records (PHRs). PHRs are not new. Both Microsoft and Google developed free PHRs several years ago. Google's ceased to exist, but Microsoft's HealthVault is still available and continues to be enhanced. Many electronic health record vendors have developed PHRs, but these have historically been "tethered" or linked only to that vendor's EHR and they had somewhat limited functionality. This is starting to change.

While the field shifts, there will be friction. Few clinicians were trained to provide care under these evolving models. Some will easily embrace technology and this new way of thinking, and others will cling to the past. But the environment will continue to change in terms of both technology and attitude.

wife took their three young boys and left him there alone, he has not spoken to anyone for more than a few minutes. He has not let anyone beyond the front door, which he has fortified with a new lock, a piece of plastic bolted over the window, and a piece of plywood bolted below that, all of which he has painted a bright shade of yellow. He keeps the living room curtains shut.

"The man in the house, a 42-year-old who once earned six figures working on Capitol Hill and was a devoted husband and father, tells his family that he is not sick, even though a psychological evaluation found he had "a schizoaffective disorder, depressive type with persecutory delusions" (McCrummen, 2014).

The man's ex-wife, his mother or father have not been able to intervene and get him help because whereas in the past one might have handled the situation through involuntary commitment to a psychiatric institution, since the law changed in 1975, it has become the burden of the family and psychologist to prove the person is a danger to self or others before action can be taken.

But 40 years after that standard was established, some people are asking whether society's concern for the constitutional rights of people with mental illness and for patient-driven healthcare has led to patient abandonment. According to the *Post*, one-quarter of the homeless population suffers from mental illness, and the number of mentally-ill prison inmates is higher than ever. Recent mass shooting incidents have been followed by stories that the shooter heard voices or was known to have abandoned a mental illness treatment plan.

Legislators – and mental health community leaders – will have to find a middle ground.

"Informed, engaged and empowered patients and their families make our jobs much easier in dealing with the clinical, ethical and risk tensions inherent in severe mental illness," wrote Gibson (Gibson, 2014) about the changing industry, calling it a "significant juggle." The new legislation and general shifts in the healthcare arena are "a positive step," he said, "but the hard work lies ahead."

Case Study: Mental Health Center of Denver

Research suggests that the resistance surrounding the Recovery Movement will have a positive impact on patient outcomes. Studies demonstrate that patient engagement is essential to improving health outcomes across all disciplines, and further, that patient engagement and the lack of such engagement is a major contributor to preventable deaths. It is estimated that 40 percent of deaths in the U.S. are caused by modifiable behavioral issues, such as smoking and obesity (Parekh, 2011).

In the behavioral and mental health community, strong patient-provider communication has been associated with improved patient comprehension and retention of information, increased patient satisfaction and increased compliance, reduced anxiety and improved treatment outcomes (Center for the Advancement of Health Information Technology, 2012). For example, a recent Canadian study (Rosemarie McCabe, 2012) looked to determine if a better therapeutic relationship (TR) between patient and physician predicts more positive attitudes towards antipsychotic medication and can be associated with adherence to antipsychotics in patients with schizophrenia. The study found as much as a 65 percent increase in medication adherence for patients with a better TR.

Focus groups conducted by the Mental Health Center of Denver found that patients prefer to be engaged with their recovery process and are more likely to comply with clinician-driven care if they feel engaged in the decision-making process. MHCD carried out a series of focus groups, interviewing patients about this notion as it relates to treatment through MHCD in an effort to help move its own facility toward becoming the national center of excellence in recovery-focused community mental health.

One client, Joe, shared that for more than 20 years he had a poor patient-provider relationship, which resulted in his taking medications that had negative side effects. He also noted that he felt there was much more of stigma to receiving mental health support when he first began treatment. Joe said that today he feels this current treatment at MHCD is more collaborative and that his case manager works with him to achieve his goals. He related the importance of this collaboration to his ongoing recovery.

Another client, Helen, noted that she struggled in her recovery when she had a provider that did not understand her history or "treat her like a person." Since she found a new, "good case manager" that listens, she feels she is better able to engage in her therapy and deal with past traumas.

A third client, Jack, related the importance of being his own advocate. He tells a story of having five prescribers in five years and eight case managers in the same period, all who he felt were dictating treatment that was ineffective. Since he decided to "take control" five years ago, he has connected with a good physician and case manager and has moved forward on a positive path.

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MHCD has developed a set of seven surveys to measure the extent to which its providers promote people's recovery. These surveys ask clients to respond "always," "usually," "sometimes" or "never" to questions such as:

- My medical staff members talk to me about recovery (or making progress toward my goals).
- My medical staff members help me to guide my own treatment.
- My case manager and I make decisions together regarding the desired goals of our work.

87%

MHCD clients who believe their therapeutic staff always or usually make decisions in conjunction with them

These survey results are compiled and the data is used by MHCD to improve its program. MHCD, for example, now knows that 87 percent of clients believe their therapeutic staff always or usually makes decision in conjunction with them; only 2 percent reported never. This result has been enhanced overtime as MHCD has developed its program.

While MHCD continues to talk with patients to get anecdotal feedback, the data from a formal client survey is more helpful for tracking trends. The data is collected in a 10 percent stratified random sample on an annual basis. The organization hires a team of clients to conduct the surveys and pays the clients who complete the survey with a gift card. This way, clients are always reporting to clients and don't feel pressured to answer in a certain way because a staff member is present.

As healthcare reform moves forward, it will become increasingly important to report data on recovery focus and consumer involvement.

MHCD has found that making the transition to a recovery-focused program has been challenging. It created the need for staff training at all levels of the organization and led to the re-design of the treatment plan to support a true partnership between clinician and client. There are many resources available to behavioral and mental health organizations to assist in this transition. For example, the Psychiatric Rehabilitation Association developed the Academy for "training and growing the recovery workforce." It offers webinars and an annual Recovery Summit, as well as scholarly articles through the "Psychiatric Rehabilitation Journal." (Additional resources can be found in the accompanying side bar, "Recovery Movement Resources.")

Recovery Movement Resources

"The Florida Self-Directed Care Program: A Practical Path to Self-Determination" by Patrick Hendry, *National Empowerment Center, Inc.,* Feb. 2008.

Psychiatric Rehabilitation Association: PRA, uspra.org

Recovery Library by Patrician Deegan Ph.D., recoverylibrary.com

"Seven key strategies that work together to create recovery based transformation" by Olmos-Gallo PA, Roy Starks, KD Lusczakoski, S. Huff and K. Mock, *Community Mental Health Journal,* June 2012.

In addition to staff training, MHCD has developed additional measures of recovery, which are used to drive clinical practice. Clinicians complete the Recovery Markers Inventory on a quarterly basis, which tracks progress on eight dimensions of care. Likewise, clients complete the Consumer Recovery Measure on a quarterly basis (Lusczakoski O.-G. M., 2014) (Lusczakoski K. O.-G., 2014). The results of both of these surveys are analyzed and used in treatment planning and other clinical processes to ensure a strengths-based, recovery-focused treatment plan. MHCD has also developed a Recovery Needs Level instrument, which is used as clients transition from more intensive to less intensive care.

The work of MHCD to transform to a recovery-focused organization is ongoing and requires a commitment from all levels. All new staff receive training in the 10 principles of recovery and the six principles of strengths-based work, whether previously trained in recovery focused work or from traditional training backgrounds. There is also Hope training, which focuses on the importance of hope for the provider and for the service user. New clinical staff also receive training on the recovery measures developed and used by MHCD.

Providers have regular reminders of the importance of being recovery focused during clinical supervision, staff retreats, team meetings, company written communications, and workplace messaging, signage and interactions. The staff has responded positively, noting there has been a shift from looking at clients as treatment resistant or non-compliant, to seeing them as experts in their own lives and having the capacity to change and grow.

While some clinicians may resist (overtly or subtly) the move to consumer-directed care, others overreact in the other direction. When the broad concept and then the Recovery Movement was first introduced, it caused somewhat of a whiplash effect among some providers. Some clinicians interpreted empowerment as a mandate to abdicate clinical judgment for whatever the client wants. This was not the intention. Increasing patient empowerment and

engagement is the goal, the clinician still has professional and ethical responsibility to bring knowledge and expertise to treatment. It is about improving the dialog, having the consumer's voice heard and coming to mutually-agreed upon goals.

"This is … not always about agreeing on diagnosis or treatment decisions, but it's about walking beside the person as they negotiate often life-changing illnesses," wrote Dr. Nathan Gibson (Gibson, 2014). There's great value in that."

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DENNIS MORRISON, PH.D.
Chief Clinical Officer
Netsmart

Dr. Dennis Morrison leads our clinical team in transforming clinical care in behavioral healthcare settings. Morrison focuses on research-based practices and the need for better coordinated and integrated behavioral health and primary care.

Prior to joining Netsmart in 2012, Morrison served as chief executive officer of the Center for Behavioral Health (CBH) in Bloomington, Ind. Under Morrison's leadership, CBH was the first behavioral health company to win the Joint Commission on Accreditation of Healthcare Organizations Ernest A. Codman Award, recognizing excellence in the use of outcomes measurement to achieve healthcare quality improvement. In addition, CBH won the HIMSS Nicholas E. Davies Award for Excellence in the implementation of Electronic Health Records (EHR) and the Negley Chairman's Award for Excellence in Risk Management.

In May 2008, CBH merged with three other community mental health centers, creating a $120-million, multistate provider organization serving 70,000 consumers annually. To integrate and manage research and information technology services for the merged entities, a new corporation, Centerstone Research Institute (CRI), was formed; Morrison was named its CEO. He was responsible for integrating four EHRs across two states into a single, homogeneous, internally-managed EHR, utilized by 1,800 employees (1,400 clinicians) and serving 70,000 clients.

Morrison was an officer in the U.S. Navy. He is the co-inventor of a patented behavioral healthcare outcomes software product.

Morrison holds a doctorate in counseling psychology, a master's degree in psychology and a master's degree in exercise physiology from Ball State University. He sits on the board of Grafton Integrated Health Network, the advisory board of Indiana University's Department of Psychological and Brain Sciences and is vice chair of the board of the International Initiative of Mental Health Leadership.

He is married with two children, ages 26 and 27. Morrison says he makes everyday matter by, "changing the way healthcare is delivered."

ROY STARKS, M.A.
Vice President, Rehabilitation Services & Reaching Recovery
The Mental Health Center of Denver (MHCD)

Roy Starks has enjoyed his career in psychiatric rehabilitation, including direct service and management, for 40 years. As the VP of Rehabilitation Services, Starks has worked to develop the 2Succeed in Employment and Education and the Wishing Well Resource Center. 2Succeed has become a nationally recognized program for supported employment combined with supported education.

As the VP of Reaching Recovery, Starks works to partner with other mental health providers around the country to partner with MHCD to measure recovery. The goal is to develop a network of providers who are learning more about what promotes the recovery of people with mental illness and to develop centers which are recovery focused.

Starks is passionate about promoting the recovery of people with mental illness. His greatest accomplishment has been helping to create the 2Suceed program and developing the recovery focus of MHCD's work. He enjoys working for the organization because of the commitment to recovery and the great teams with whom he has the privilege to work.

Starks has served on the Board of Psychiatric Rehabilitation Association for three years and is currently the Chair Elect.

ABOUT NETSMART

Netsmart is committed to helping health and human services providers deliver effective, outcomes-based care with Netsmart's CareFabric™ solution, a tightly woven framework of innovative clinical and business solutions and services that supports integrated, coordinated delivery of health services across the spectrum of care.

More than 23,000 client organizations, including 450,000 care providers and more than 40 state systems, use Netsmart solutions to help improve the quality of life for more than 25 million people each day.

Netsmart is pleased to support the EveryDay Matters Foundation, which was established for behavioral and public health organizations to learn from each other and share their causes and stories. For more information, visit www.everydaymatters.com

Learn more about how Netsmart and the CareFabric solution are changing the face of healthcare today. Visit www.ntst.com, call 1-800-472-5509, follow us on Twitter, like us on Facebook or visit us on YouTube.

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