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Action Planning Recovery at Oregon State Hospital

Corey Baechel
Pacific University

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Abstract
This is a study of a proposed theoretical model change to the Oregon State Hospital system. The Oregon State Hospital has proposed to change from the current model of treatment in which the client is viewed as chronically challenged and described by his/her symptoms, to the recovery model. The recovery model is based on continued treatment with collaborative engagement between the patient, hospital and community. The Oregon State Hospital contracted with Pacific University consulting team to examine the current state of the hospital system in an effort to develop a working definition of recovery. This information will also be applicable for implementation of recovery at Oregon State Hospital. The information presented in this report was informed through the process of conducting 31 focus groups on both the Salem and Portland Campuses. These focus groups included staff, consumers, administration and physicians. Both campuses (Portland, Salem) currently have many principles of recovery in various parts of these hospitals. These include hope, respect, nonlinear thinking and approach, self-direction, individualized responsibility, peer support, strengths-based, holistic elements and levels of empowerment. The working definition of recovery, which is determined by administration, must be clearly defined and incorporate information about how recovery can happen given that this is a locked facility with consumers who are mandated to be there. It would likely be beneficial for the organization as a whole, if all information about decisions being made were public. It would also likely be beneficial for the consumer and staff to have some decision-making ability in the future of recovery at Oregon State Hospital.

Degree Type
Dissertation

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ACTION PLANNING RECOVERY AT OREGON STATE HOSPITAL

A DISSERTATION

SUBMITTED TO THE FACULTY

OF

SCHOOL OF PROFESSIONAL PSYCHOLOGY

PACIFIC UNIVERSITY

HILLSBORO, OREGON

BY

COREY BAECHEL, M.A., M.S.

IN PARTIAL FULFILLMENT OF THE

REQUIREMENTS FOR THE DEGREE

OF

DOCTOR OF PSYCHOLOGY

JULY 24, 2009

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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>iii</td>
</tr>
<tr>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>The Recovery Model</td>
<td>1</td>
</tr>
<tr>
<td>Consumer/ Survivor/Ex-patient Movement</td>
<td>2</td>
</tr>
<tr>
<td>Psychiatric Rehabilitation</td>
<td>2</td>
</tr>
<tr>
<td>Recovery Model</td>
<td>3</td>
</tr>
<tr>
<td>Recovery Versus Rehabilitation</td>
<td>4</td>
</tr>
<tr>
<td>Conceptualization of Recovery</td>
<td>5</td>
</tr>
<tr>
<td>Recovery Model in the United States</td>
<td>8</td>
</tr>
<tr>
<td>Transitioning to the Recovery Model (State Level)</td>
<td>9</td>
</tr>
<tr>
<td>Transitioning to the Recovery Model (Organizational Level)</td>
<td>10</td>
</tr>
<tr>
<td>MODEL</td>
<td></td>
</tr>
<tr>
<td>Figure 1</td>
<td>4</td>
</tr>
<tr>
<td>Figure 2</td>
<td>17</td>
</tr>
<tr>
<td>Figure 3</td>
<td>32</td>
</tr>
<tr>
<td>METHOD</td>
<td>15</td>
</tr>
<tr>
<td>Research design</td>
<td>15</td>
</tr>
<tr>
<td>Procedure</td>
<td>18</td>
</tr>
<tr>
<td>RESULTS</td>
<td>23</td>
</tr>
<tr>
<td>DISCUSSION</td>
<td>28</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>35</td>
</tr>
<tr>
<td>APPENDICIES</td>
<td></td>
</tr>
<tr>
<td>Appendix A: Continuous Improvement Plan</td>
<td>38</td>
</tr>
<tr>
<td>Appendix B: Ten Principles of Recovery</td>
<td>49</td>
</tr>
<tr>
<td>Appendix C: OSH Focus Group Slides</td>
<td>52</td>
</tr>
<tr>
<td>Appendix D: OSH Recovery Report</td>
<td>64</td>
</tr>
</tbody>
</table>
Abstract

This is a study of a proposed theoretical model change to the Oregon State Hospital system. The Oregon State Hospital has proposed to change from the current model of treatment in which the client is viewed as chronically challenged and described by his/her symptoms, to the recovery model. The recovery model is based on continued treatment with collaborative engagement between the patient, hospital and community. The Oregon State Hospital contracted with Pacific University consulting team to examine the current state of the hospital system in an effort to develop a working definition of recovery. This information will also be applicable for implementation of recovery at Oregon State Hospital. The information presented in this report was informed through the process of conducting 31 focus groups on both the Salem and Portland Campuses. These focus groups included staff, consumers, administration and physicians. Both campuses (Portland, Salem) currently have many principles of recovery in various parts of these hospitals. These include hope, respect, nonlinear thinking and approach, self-direction, individualized responsibility, peer support, strengths-based, holistic elements and levels of empowerment. The working definition of recovery, which is determined by administration, must be clearly defined and incorporate information about how recovery can happen given that this is a locked facility with consumers who are mandated to be there. It would likely be beneficial for the organization as a whole, if all information about decisions being made were public. It would also likely be beneficial for the consumer and staff to have some decision-making ability in the future of recovery at Oregon State Hospital.
Introduction

The Recovery Model

The concept of recovery has long been used in the medical field to describe the physical alleviation of symptoms to a pre-morbid state. For many years this definition of recovery has been the primary goal for most health professionals (Jacobson & Curtis, 2000). Yet in the years past many mental health professionals have come to question this definition of recovery. Throughout the course of this document the terms client, patient and consumer will be used interchangeably to describe people who are obtaining services. Oftentimes there are clients who are able to accept their traumatic pasts or accept their disabilities and continue in life with a new standard of living. Would these people be in recovery? With questions such as these the term of recovery has been recognized in many facets of the health field, including drug and alcohol recovery. This use of recovery means the person has learned to live life without the use of alcohol or drugs. The term for recovery currently has many different meanings including the restoration to normal functioning and health for that person, taking back one’s life from a chronic illness, and developing strength to survive tough times (Jacobson & Curtis, 2000). The model of recovery that will be represented here is based on multiple dimensions of information dating back to the 1960’s and earlier.

The concept of recovery used here originates from two interrelated sources: the consumer/survivor/ex-patient movement, a self-help/advocacy initiative (Brown 1981; Chamberlin 1984; Chamberlin 1990; Everett 1994) and psychiatric rehabilitation, a professional approach to mental health services provision (Anthony, 1991; Anthony, 1993). To best understand the recovery model it is important to understand the roots that developed this model.
The Consumer/ Survivor/ Ex-patient Movement

The consumer/ survivor/ ex-patient movement began with what was regarded as a broad acknowledgement of the lack of civil rights granted to people who had mental health diagnoses during and following the period of deinstitutionalization (Fakhourya & Priebea, 2007). The process of deinstitutionalization started as society began to understand what detractors termed as “horrible treatment” individuals received in institutions. Clifford Whittingham Beers, founder of the American Mental Hygiene Movement, was a previous resident in an asylum who was released and then became an advocate for those still in the institutions (Beers, 2004). As it became recognized that mental institutions were not operated in a way that encouraged inmates to take responsibility for themselves, an empowerment model took hold. With this change in approaches to helping people, the patients and health care providers developed a newfound sense of being empowered. The empowerment was spread to both the people in authority, by allowing them to have additional methods of helping the clients, and those who were formally institutionalized, who now had a say in their own treatment. With this change, the institutionalized people were allowed to take back control of their care and become active participants in their psychological development toward optimal health (Jacobson & Curtis, 2000).

Psychiatric Rehabilitation

The psychiatric rehabilitation movement was created for professionals and mental health advocates to help create resources that would coincide with the best possible treatment for clients with mental health care disabilities (Jacobson & Curtis, 2000). The National Institute of Mental Health (NIMH) created the concept of Community Support Systems (CSS) during the 1970’s.
This system of support was designed to provide services in the community for people with long term mental health needs (Anthony, 1993). The development of the CSS was in response to the cries for help by people who were released from the institutions who were not receiving services and the communities in which these people lived. The CSS was a major contributing factor to the development of the core principals of rehabilitation services.

Recovery Model

The implications of bringing the factors of empowering the client to make decisions (The Consumer/Survivor/Ex-patient Movement) and providing them with the supports to succeed (Psychiatric Rehabilitation), created a unique situation for the population of psychiatrically challenged people. Within this combining process there was, and is, political and personal implication, including but not limited to, these people reclaiming their own lives and once again becoming competent individuals in the world (Jacobson & Curtis, 2000). Within this model, people are able to maintain a level of functioning in various domains that include home, relationships, recreation and work-life. This contributes to a satisfying life and helps develop new meaning in their life (Anthony, 1993; Jacobson & Curtis, 2000). Figure 1 illustrates the recovery model.
Recovery Versus Rehabilitation

With the presentation of recovery there is often question about the differences between recovery and rehabilitation. Patricia Deegan (1988) is a clinical psychologist and an activist who identifies herself as a person with a psychiatric disability. In her own experience she reflects on the terminology that people have used for many years. She states that rehabilitation is a reference to the types of services that a person receives, whereas the term recovery is related to the process that a person is undergoing. If a person is in recovery and is continuing to work on his/her challenges, then this term more accurately accounts for his/her continued efforts (Jacobson & Curtis, 2000). Anthony (1993) indicates that recovery is a time consuming and complex process.

Note: Adapted from information presented in Jacobson & Curtis (2000).
that people with disabilities do while in treatment; case management and rehabilitation are what the helpers do to facilitate recovery.

**Conceptualization of Recovery**

When conceptualizing the idea of recovery, there are five main themes that are present: *process, responsibility, choice, hope* and *purpose/direction*. As presented previously, it is always important to understand that recovery is presented as a *process*, the first major theme in recovery (Jacobson & Curtis, 2000). The person who is in recovery is not attempting to reach a final goal of a cure, but rather the idea of a goal is to continue along the path. This path may be understood to be highly singular or unique, because no two people’s challenges are exactly the same and thus no two people’s paths, measurements or benchmarks will be the same (Jacobson & Curtis, 2000).

The second major theme within the recovery model is the understanding of *responsibility* and how this relates to the individuals with psychological challenges. Under previous models, people with the psychological problems are not the same people who are making the decisions about their care, and thus the people who were receiving the care did not share the responsibility. Under the recovery model, the clients make decisions about their lives and their treatment, therefore clients are required to take not only an active role in their progress, but they are also *responsible* for their short comings (Jacobson & Curtis, 2000). With that being said, it is very important to mention that most interventions are collaborative efforts of family, friends and other people who help to support the person as he/she is progressing along his/her path of recovery.

The third major theme within recovery is *choice*. In the recovery model, people have a *choice* about what they would like to do concerning their treatment. This theme (choice) is not
only about having the ability to make the decisions, but also being informed about the *choices* available to them (Jacobson & Curtis, 2000). The patients are expected to have knowledge about the various different types of treatments that are available so they can make an informed decision with the help of professionals and non-professionals alike.

The fourth major theme of the recovery model is the emotional emphasis on *hope*. This message of *hope* is necessary for the advocates, friends and families of the recovering people to convey in an effort to help these people remember that things can and do change (Jacobson & Curtis, 2000). Cline and Minkoff (2006) described a five-step process of developing hope under the recovery model. These steps include:

1. Establish the goal of having a happy life.
2. Empathize with the reality of the client’s challenges in an effort to identify hope.
3. Establish legitimacy of need to ask for extensive help.
4. Identify meaningful, attainable measures of successful progress.
5. Emphasize a hopeful vision of pride and dignity to contour self-stigmatization.

The fifth major theme in the recovery model is giving meaning to the person through a defined *direction or purpose* for the psychological work that is being done in his/her life. This search for meaning is usually a very personal one that can be reflected through work or social relationships, while others may find it in political activation, religious affiliation or advocacy for others with similar challenges (Jacobson & Curtis, 2000).

In conjunction with these five original major themes, the most current core principals as presented by The International Association of Psychological Rehabilitation Services (2008), include:
1. Recovery is the ultimate goal of psychiatric rehabilitation. Interventions must facilitate the process of recovery.

2. Psychiatric rehabilitation practices help people re-establish normal roles in the community and their reintegration into community life.

3. Psychiatric rehabilitation practices facilitate the development of personal support networks.

4. Psychiatric rehabilitation practices facilitate an enhanced quality of life for people receiving services.

5. All people have the capacity to learn and grow.

6. People receiving services have the right to direct their own affairs, including those that are related to their psychiatric disabilities.

7. All people are to be treated with respect and dignity.

8. Psychiatric rehabilitation practitioners make conscious and consistent efforts to eliminate labeling and discrimination, particularly discrimination based upon any disabling conditions.

9. Culture and/or ethnicity play an important role in recovery. They are sources of strength and enrichment for the person and the services.


11. Psychiatric rehabilitation services are to be coordinated, accessible and available as long as needed.

12. All services are to be designed to address the unique needs of people consistent with the individual’s cultural values and norms.
13. Psychiatric rehabilitation services actively encourage and support the involvement of people in normal community activities, such as school and work, throughout the rehabilitation process.

14. The involvement and partnership of people receiving services and family members is an essential ingredient of the process of rehabilitation and recovery.

15. Psychiatric rehabilitation practitioners should consistently strive to improve the services they provide.

*Recovery Model in the United States*

A majority of the mental health hospitals in the United States have engaged in viewing the mental health patients they worked with from several models that describe clients as their diagnosis and consider their conditions to be “chronic” in nature. Over the past 10 years a movement in the mental health field toward using the recovery model has begun to gain momentum (Manderscheid & Henderson, 2004). This movement, while currently moving at a slower pace, has been sited as one of the primary focuses of development in the mental health field during the past five years (Jacobson & Curtis, 2000; Powers & Manderscheild, 2004). This model is currently being implemented in many mental health hospitals throughout the United States and the world (Ramon, Healy & Renouf, 2007). In an effort to establish a recovery program, there are many different changes that are likely needed to occur in the hospital and at the state level.


Transitioning to the Recovery Model (State Level)

In many states the change to a recovery model has been a parallel process with the shift toward managed care, a multitude of different techniques used to reduce cost and provide healthcare benefits that improve the quality of services at the same time (Robinson & Yegian, 2004). Within this frame, it is possible for most mental health settings to use the recovery principals as guidelines for implementation of more cost effective and appropriate services (Robinson & Yegian, 2004). At the state level there are many different steps that often occur to help develop the statewide use of a recovery model. In most cases, state run program change requires funding, development and implementation or action of the desired change.

In most states that have implemented the recovery model, the first step that is taken is often the investigation into, and identification of, funding to carry this project through. In an effort to do this, it is required that a recovery vision statement be created to outline the necessity for this change and demonstrate the commitment to this change (Schmook, A. (Undated); AACP Guidelines, 2004). Often times this vision statement is created by a task force, assigned to review the literature and develop a plan (Jacobson & Curtis, 2000).

Once the vision statement is in place, the next common step is to implement the actions outlined in the action statement. In the past, some states have renamed their medical system without making changes to the actual system. This is obviously not the preferred method of creating change in the system (Jacobson & Curtis, 2000). This form of cosmetic change to state health care systems has certainly not developed the changes required to truly be considered a recovery model system.
Transitioning to the Recovery Model (Organizational Level)

The previous programs’ lack of true change toward a recovery model drove a development of strategies to implement the recovery model at institutions. The common elements of multiple models include: education, consumer and family involvement, support for consumer operated services, an emphasis on relapse prevention, management of relapse, incorporation of crisis planning, advanced directives, innovations in contracting, financial mechanism, definitions and measurements of outcomes, review and revision of key policies, and stigma reduction initiatives.

Education

Most models of creating change in an organization include providing some information to the clients, family members, staff and administrators at the hospital and in the system as a whole. This information is presented in a number of different ways including but not limited to educational initiatives, posters, classes, newsletters, meetings and changes to academic initiatives.

The education that is presented to the clients and their family members includes general information about recovery, basic information on mental illness, basic information on mental health systems, self-management systems, development of peer and other community supports, and self-advocacy skill training.

The educational information that is presented to the staff and administrators in the medical settings include: the concept of recovery, the recovery model, the roles of the workers in the model and the possible assumptions made by the workers. Additionally, it is important that the workers know about the orientation process, trainings and continued educational
programming along with the significant goals and benchmarks of the work they are beginning (AACP Guidelines, 2004; Jacobson & Curtis, 2000).

Jacobson and Curtis (2000) also have stressed the importance that training groups contain people from different areas and disciplines of the hospital. The diversity of cultural backgrounds, consumers, administrative positions and the involvement of clients’ family members adds to the educational experience and may raise questions and perspectives that might not be available without this format. In addition to the education that clients and the people in their lives receive, it is also important to educate the general public about recovery and mental health.

**Consumer and Family Involvement**

All models that have been reviewed to this point indicate that a major element of the recovery model includes having the client’s family and the direct consumer be a part of the decision making process (AACP Guidelines, 2004; Anthony, 1993; Bellack, 2006; Jacobson & Curtis, 2000). In many models of recovery the consumers are incorporated into research and development models to help obtain data about the transition and evaluate the effectiveness of the services (Serbeck, Robinson & Tanzman, 1990; Ferry, 1996; Campbell 1997; Jacobson & Curtis, 2000). Certain states such as California, Nebraska, New Hampshire, Rhode Island and Vermont all require that consumers be on the board of directors and other decision making bodies to ensure that families and consumers are represented in the decision making processes of the hospitals (Jacobson & Curtis, 2000).

**Consumer Run Services**

The induction of consumer run services emerged during the consumer survivor/ ex-patients movement and is described as a user controlled alternative service. This service is made available to the consumer, by the consumer. In this instance, the consumer is responsible for and
conducts supportive services including peer-support groups, self-help networks, drop-in centers, wellness programs, hospital alternatives, and crisis and respite care (Chamberlin, 1990, Jacobson & Curtis, 2000). These supports are often developed with the help of local community and hospital outreach supports, but are often run by the consumers in a nonhierarchical format with an emphasis on mutual support and aid (Gartmen & Reissman 1997, Jacobson & Curtis, 2000).

Relapse Prevention and Management

The relapse prevention and management model is an extension of the educational piece that is present for all consumers. This process consists of plans made with hospital staff to indicate the best possible ways for people to handle potential relapse. This occurs through specific recognition of triggers for each consumer, and a complete model around steps that the consumer, their family/friends and their care providers can do to help the person during a relapse (Jacobson & Curtis, 2000).

Crisis Planning and Directives

Crisis planning and directives are an extension of the relapse prevention model presented above. The specific steps for the crisis plan often include information gained while the consumer is doing well and best able to make decisions about his/her care if she/he experiences relapse. The information that should be considered includes the type of care, placement of services and the planning given specific situations or terms of relapse (Jacobson & Curtis, 2000). One such example of this is if a client has a severe disorder that requires additional medication to help him/her stay safe, he/she may appoint a family member to help coordinate different care needs prior to such an episode. This ensures the most appropriate care is being given to the client. Crisis plans can be formed as legal documents and in some states are only overturned by legal action from a judge to provide different care (Jacobson & Curtis, 2000).
Contracting and Financing Mechanism

As the managed care medical movement has moved throughout the states, the hospitals are required to indicate the necessity for each level of care provided to the client. While this helps to ensure that previously unneeded or unwanted services are being provided to the client, this also may restrict the client from gaining access to items that may be helpful but not recognized by the managed care system as medically necessary. The recovery model is designed so that people can advocate for seeking the expansion of the definition of what is medically necessary such as employment, housing, educational support, wellness programs, spiritual opportunities, recreational opportunities, and other interventions that may help the client, and in return diminish the costs to the health-care system over time (Torrey, Drake, et al. 2001).

Outcomes

Due to the shift toward managed care throughout most medical systems, there is now a strong emphasis on measuring the outcomes as a method of ensuring the accountability of mental health providers. Yet due to the nature of the recovery model and the absence of a final goal, there needs to be continued research that occurs over time with repetitive testing to track progress (Harding, 1994; Jacobson & Curtis, 2000). Within this form of research, the participants and the researchers collaborate to create a living experience of the recovery model and not a fixed point that they are attempting to reach. Harding (1994) explains that the use of research within the recovery model must work toward benchmarks. Without these waypoints, the treatment often overlooks the patient’s developmental and cultural aspects on the way to a final end point.
Policy Revision

The implementation of the recovery model into any system will require the need for revisions. Every hospital or medical center has its own method of operation. When a new system enters a pre-existing system it is very important that continued revisions are made to ensure the combination of these models works well together. The need for ongoing assessments, such as action research, can offer such an opportunity for any hospital willing to engage in this formal change.

Stigma Reduction Initiatives

There continues to be a stigma about mental health and the people who have mental health challenges. Unfortunately these individuals often internalize this stigma and this can exacerbate challenges (Jacobson & Curtis, 2000). It is possible that through educating the public about mental health disorders and recovery, the stigma will fall and this too will help those attempting to engage in recovery.

Recovery and Rehabilitation at Oregon State Hospital

When considering the five themes presented and the 15 core principals of rehabilitation, it is also important to relate these themes/principals to the current Continuous Improvement Plan (CIP) set forth by the Department of Justice following evaluation of Oregon State Hospital. Within the CIP the plan has multiple goals that parallel the themes/principals presented in Appendix A.

As the Oregon State Hospital (OSH) begins the process of moving toward a recovery model, Pacific University, School of Professional Psychology (SPP) consulting team will be
assisting this process through a series of assessing and reassessing steps described as action research. Researchers do not specify what exactly is going to be done, as this is a collaborative process between Oregon State Hospital and the consulting team. Therefore no hypotheses will be formulated at this time.

Methods

Research Design

The research design for this project is termed “action research.” This is an approach for developing ongoing information gathering and feedback. Action research was first designed by John Collier and Kurt Lewin who created this process, with the intent of having ongoing research continue throughout a change process while the information gathered is able to influence the progress of the future research (French & Bell, 1999). The action research model is a collaborative model of change that includes the interaction of the individuals in the system (staff and administration at OSH) and the researchers (this researcher and the SPP research team). The process of using an action research format to test the development of an organization begins with data gathering and diagnosis by the consultant at the project site followed by further data gathering. The feedback is given to specific clients or groups, in this case OSH, and a joint action plan is created. The process begins again with data gathering and then feedback to OSH, with incorporation of discussion and the emergence of new attitudes, followed by a new action plan and the action is then carried out. After the new action is carried out, the data gathering begins again and the feedback is given to the OSH for further discussion and a new action plan is created, then carried out. This process is likely to continue long after the termination of this project and thus the creation of a firm foundation will be essential to the ongoing progress of this
recovery model at the Oregon State Hospital. Figure 2 illustrates the action research plan intended for implementation of the research described for this project.
FIGURE 2. THE ACTION RESEARCH MODEL

Phase 1
- Consult with OSH
- Gather Data/ Diagnose
- Further Gather Data
- Feedback to Key Clients And Key Groups

Phase 2
- Data Gathering
- Feedback to Clients With Team Building
- Discussion & Work Feedback and Data
- Action Planning

Phase 3
- Action
- Action Planning
- Discussion and Work On Emerging Data
- Feedback
- Data Gathering
The role of the consultants in this project is to work collaboratively with the Oregon State Hospital in the development and integration of recovery and presenting measures of recovery that may be applicable. The Recovery Oriented Services Evaluations by The American Association of Community Psychiatrist, (2001) is a measure that has been used by previous hospitals in their movement toward a recovery model. This measure will be presented to OSH for consideration as a utility in the development of a measure that will help to identify the Oregon State Hospital’s progress.

The purpose of this study is to identify a means for the integration of recovery into the model of care by following the above-mentioned steps of action planning and feedback system. This process will assist the Oregon State Hospital in their development of moving into a recovery model of care.

Procedure

Throughout the course of this project the Pacific University consulting team, including Chris Adair, Christina Gerteis, Heidi Meeke and supervisor Jay Thomas Ph.D., ABPP, and the author followed the action research model stated above. The consulting team moved through phase one and phase two of the project continuing to monitor and provide feedback to ensure the project continued to obtain the most valuable and appropriate information given the requests of the hospital administration, including defining recovery and performing focus groups.
Project Development:

This project began with development of focus group material describing 10 basic principles of recovery and then presenting two basic questions to the focus groups to gather information about the state of recovery at OSH. The 10 principles of recovery are described in Appendix B. Over the course of the data collection it became apparent that the questions being used were not clearly defined, thus the team was not obtaining the information needed, and minor changes to the questions were made within the first 5 focus groups (phase 1).

- Initial questions:
  1. What is working with recovery at Oregon State Hospital?
  2. What barriers or impediments do you see in implementing recovery at Oregon State Hospital?

- Revised questions:
  1. Do you see any of the principles of recovery currently at Oregon State Hospital? If so, where?
  2. How do you see recovery taking shape at Oregon State Hospital?

Additional changes that were made to the focus group power point presentations included withdrawing personal contact information of consultants and withdrawing information about rehabilitation model. In an effort to insure the consumers could provide Pacific University consulting teams with comments following the focus groups, the consumers were able to contact the consulting team through staff and management. While performing the focus groups in Portland, information about the sanctuary model of
care, which is part of the current model of care, was incorporated into the slides for staff, administration, and physicians. Some of the sanctuary model’s basic principles include social immunity/justice, social learning, non-violence and development of safety for staff and consumers alike. All final versions of slides are available in Appendix C.

Division 13 of American Psychological Association

In an effort to obtain the most up to date and accurate information about helping organizations make cultural shifts, the author attended the midwinter conference for Division 13 (i.e. Society for Consulting Psychology) of the American Psychological Association. While at this conference the author had an opportunity to informally present this project to 65 consultants who deal with organizational culture shifts. The feedback received from these professionals aided in the development of a concise understanding for how to proceed with this challenge. The consultants urged continued buy-in from major stakeholders at OSH and helped to organize what tasks would be most difficult to complete. The consultants at the conference agreed that it would likely be most advantageous continue using psychological consultation with Oregon State Hospital to reach their desired goals.

Groups:

Oregon State Hospital administration and the Pacific University consulting teams agreed upon the use of focus groups. An effort to gather initial information was needed to inform the development of a working definition for recovery at Oregon State Hospital. Focus groups on both campuses were designed to gather information from all areas of the
organization. A total of 31 focus groups were performed between Portland and Salem campuses. The groups ranged in size from 1 person to 13 people. There were more than 160 participants who attended these groups. Due to the nature of this setting there were many participants who had to leave during focus groups or were unable to attend.

Table 1. Total Focus Groups Performed on Each Site

<table>
<thead>
<tr>
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<th>Consumer</th>
<th>Staff</th>
<th>Administration</th>
<th>Physicians</th>
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<tr>
<td>Salem</td>
<td>6</td>
<td>10</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Portland</td>
<td>5</td>
<td>6</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Phase 1:

During Phase One of this project the Pacific University consulting team started a dialogue with the Oregon State Hospital research department and discussed the hospital’s request for consideration of the development of recovery at the Oregon State Hospital. Following this discussion the consulting team conducted research to look at recovery and develop an understanding of how recovery has been implemented in other hospital settings. The team then brought this information to the first official meeting with Oregon State Hospital Research Division and Strategic Planning Division. At this meeting all participants discussed how this project could move forward and what steps would be necessary for the implementation of recovery at Oregon State Hospital. All participants in this meeting agreed that the first step should be to develop a definition of recovery that would be specific to Oregon State Hospital. Following the meeting the consulting team started conducting focus groups at the Salem campus and obtained information. The
Pacific University consulting team made changes to the focus group slides during the first 5 groups in an effort to better obtain the information that would best aid in the development of a working definition of recovery. Following the completion of most Salem focus groups, the consulting team was involved in a planning meeting with Salem and Portland campuses. During this meeting the consulting team was informed that the Portland campus would also be moving to a recovery system of care and there would need to be additional focus groups done on the Portland campus.

Phase 2:

During Phase Two of the action plan the consulting team continued to complete the focus groups at Salem while planning for a presentation to professionals at Salem. During the feedback presentation participants had the ability to present ideas and contribute to the development of this project. The members of this presentation/meeting, appeared excited about the information gathered by the focus groups and stated they were looking forward to seeing the final results. Following this, the Pacific team then completed the focus groups at Salem and moved on to the Portland campus. Within the first five focus groups the consultants realized that there was a need again to make changes to the focus groups slides. The consulting team added information about sanctuary model of care because many of the administration and staff had reported that they were currently working from a mixture of sanctuary and rehabilitation models of care. Following this change the consultants completed all of the focus groups and the information was compiled for the future-planning meeting (Phase 3).
Phase 3:

Phase Three will include a feedback meeting that will also act as the planning meeting. Within this meeting the consulting team will engage in the process of aiding and evaluating the necessity of the consulting team’s involvement in this project for future planning. Nearing the completion of Phase Two, members of OSH had requested that the consulting team continue to aid them in development of recovery at the hospitals, thus it is likely that the consulting team will continue throughout Phase Three.

Results

Throughout the course of performing the focus groups it became apparent that there are differences in the information gathered from the Portland campus and the Salem Campus, therefore the information will be presented with respect to the particular campuses. The information in the tables is presented from the most representative or most commonly reported (top) to least representative or least commonly reported (bottom). Items are presented from the perspective of participants; items, which state that certain resources or changes are needed, are taken from participant comments and are not derived from additional analyses regarding the feasibility of implementing these items. The results from focus groups are presented in tables 2 thru 5.
Table 2. Staff Focus Groups

<table>
<thead>
<tr>
<th>Questions/Campuses</th>
<th>Portland Oregon State Hospital</th>
<th>Oregon State Hospital Salem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1: Do you see any of these principles of recovery currently at Oregon State Hospital? And if so where?</td>
<td>• Empowered- solo and buddy passes in the community. • Peer support- Peer run groups and community reintegration programs. • Treatment Mall has all of the elements of recovery. • Treatment care plans are strengths based and individualized. • All principles are present at POSH but not identified. There is a feeling of respect between staff and patients.</td>
<td>• The most principles of recovery are found in the recovery ward. • Minimum and Medium Security have many principles of recovery • Geriatrics has few principles including hope and strengths based. • Maximum wards have the least amount of recovery principles: • Empowerment through developing education</td>
</tr>
<tr>
<td>Q2: How do you see recovery taking shape at Oregon State Hospital?</td>
<td>• We need more community supports (groups, hobbies, volunteer opportunities, groups homes) • Need more education for staff, patients, and community • Need a plan for working with unmotivated consumers. • Need a clear definition of recovery and explain how this applies to a lock down facility. • Need behavior support plans for all consumers • Need more recovery experts. Need to develop the relationship with the community.</td>
<td>• There needs to be clear communication between administration and staff. o Staff stated they have little or no information about changes happening in the hospital. • There needs to be a clear, public plan for recovery implementation • Need more recovery experts • Education for staff, consumers and community about recovery • OSH needs to develop the relationship with the community. • More Community supports are needed for consumers (jobs, groups, group homes). • Need changes in the legal system to account for recovery (felons can’t work with other felons). • The definition must account for the fact that consumers are held against their will. • Staff and consumers should have say in organization changes • Not all consumers are motivated to change • Consumers need more self direction and responsibility</td>
</tr>
<tr>
<td>Questions/Campuses</td>
<td>Portland Oregon State Hospital</td>
<td>Oregon State Hospital Salem</td>
</tr>
<tr>
<td>--------------------</td>
<td>--------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Q1: Do you see any of these principles of recovery currently at Oregon State Hospital? And if so where?</td>
<td>• Hope is a prevalent factor  • Individualism in treatment care  • Holistic aspects of care available  • Supported by staff and other patient  • Treatment plans are developed with lifetime orientation.  • Empowerment through buddy passes  • Strength based approach with treatment  • Empowerment in recovery storied group.  • Psycho-educational information and coping skills</td>
<td>• Self-direction in treatment and treatment planning.  • Empowerment in choice of groups at treatment mall.  • Holistic wellness groups  • Cottages have many of the principles of recovery in their programming.  • Peer support groups in the treatment mall.  • Staff and administration are listening to consumers more.  • The level of respect is good Staff/Consumers</td>
</tr>
<tr>
<td>Q2: How do you see recovery taking shape at Oregon State Hospital?</td>
<td>• Hope is getting out of the hospital  • We need resources  • Jobs, funding and Gov’t Support  • Need to develop peer supports  • Need more community integration  • Increase treatment variety  • We want the choice to participate in groups or not.</td>
<td>• Need more WRAP services and choices of group homes.  • Need a better relationship with Salem Community  • Need more individualized treatment planning.  • Need jobs to develop hope.  • Need to educate and train staff more  • Need to let staff and consumers know what will happen because of budget cuts.  • Staff doesn’t value consumer input and advocacy.  • Need more therapy options, expressive therapies, etc.</td>
</tr>
</tbody>
</table>
Table 4: Administrative Focus Groups

<table>
<thead>
<tr>
<th>Questions/Campuses</th>
<th>Portland Oregon State Hospital</th>
<th>Oregon State Hospital Salem</th>
</tr>
</thead>
</table>
| **Q1: Do you see any of these principles of recovery currently at Oregon State Hospital? And if so where?** | - We’re currently 25% of the way to working from a recovery model of care. We have:  
  o Hope, tolerance of choice and peer groups.  
  - All staff buy into need for Hope  
  - Respect/empowerment-Buddy passes  
  - Good relationship with the close community. | - Peer-Bridger programs are helpful with patients’ recovery.  
- Transitional programs are working in line with the basic principles of recovery |
| **Q2: How do you see recovery taking shape at Oregon State Hospital?** | - Empowerment and choice is taken away from the consumers and this must be addressed.  
- Assertiveness training for consumers is needed.  
- Staff need to praise consumers for being assertive  
- Physician’s focus on medications and are not doing enough med-education with consumers.  
- Some people believe that if a consumer has more self-direction then the safety will decrease.  
- People who have information/knowledge are not sharing it.  
- Need to tailor information for individuals  
- Need more training for staff:  
  o Long term goal development and group facilitation  
- Need Community Support  
- Need alternatives to medications | - Containment verses Treatment  
- Need more peer support groups.  
- Increase levels of available care  
- Need support from the public  
- Need to educate staff, patients and community.  
- Difficult to manage recovery in multiple sites.  
- Safety of patients and staff need consideration.  
- Need more patient accountability  
- Limitations in the “empowerment center”  
- Instituting Recovery without a plan would be a challenge.  
- Need to define a clear philosophy or vision of the organization.  
- Need a clearer communication of roles and values. |
## Table 5: Physician Focus Groups

<table>
<thead>
<tr>
<th>Questions/Campuses</th>
<th>Portland Oregon State Hospital</th>
<th>Oregon State Hospital Salem</th>
</tr>
</thead>
</table>
| **Q1**: Do you see any of these principles of recovery currently at Oregon State Hospital? And if so where? | • Psychiatry is practicing from a recovery framework | • Peer support is happening through ex-addicts and people in recovery implementing groups.  
• The here and now focus is meeting patients where they are at and helping them create stability in their lives.  
• We’re helping patients understand their goals and work toward them.  
• Strength-Based work is happening in geriatric wards where they are using a person-centered approach to help develop hope. |
| **Q2**: How do you see recovery taking shape at Oregon State Hospital? | • The recovery definition needs to account for patients being held against their will.  
• Currently the patient is forced to take the diagnosis and treatment dictated to them by the psychiatrist at intake. This is where recovery needs to start first.  
• There needs to be some form of rehabilitation in the recovery model to get the person to a stable place prior to moving into recovery.  
• How will the recovery model account for the coercion that occurs in OSH system?  
• Diagnoses are given to quickly. Their needs to be more time for the diagnoses to be accurate.  
• Currently the patient is forced to take the diagnosis and treatment dictated to them by the psychiatrist at intake. This is where recovery needs to start first.  
• Staff need to learn recovery and think in terms of recovery. | • Needs to be clear guiding principles that translate into practice.  
• Consumers are sometimes not aware that they have challenges  
• The definition needs to account for the patients being mandated for treatment.  
• The stigma of mental illness is a big problem for people who are returning to OSH.  
• We need administration to support consumer self-direction.  
• The patients’ criminology and substance abuse is part of their mental illness.  
• “Stages of change” framed in recovery is needed.  
• Need more treatments, not only evidenced based.  
• Patients need more services to prep them for life outside OSH.  
• The definition of recovery needs to account for the scientific portion of a patient getting better. |
Defining Recovery

When presented with the data from the focus groups and information gathered through observations while working at both sites it is apparent that recovery principles are currently at both the Salem and Portland campuses of OSH. These campuses are different on some fundamental levels that will likely require different methods for implementing recovery. The most common themes found across all groups and both campuses include a need for the definition of recovery to account for the fact that people are incarcerated. This is a particular concern because most of the staff are under the impression that recovery includes the consumer’s right to choice, including choosing to leave. Further, a decision must be made regarding whether or not the definition of recovery will incorporate all of the principles set forth by National Consensus Statement. The definition will need to be very clear and accessible for both staff and consumers. In an effort to help define recovery at the Oregon State Hospitals the Pacific University consulting team included some of the commonly found definitions for administration to review.

Common definitions of recovery include:

- Recovery is a process, a way of life, an attitude, and a way of approaching the day’s challenges. It is not a perfectly linear process. (Deegan, 1988)

- Recovery is a reawakening of hope after despair. (Ridgeway, 2001)
Recovery is breaking through denial and achieving understanding and acceptance. (Ridgeway, 2001)

Recovery is moving from withdrawal to engagement and active participation in life (Unzick, 1989)

A deeply personal, unique process of changing one’s attitudes, values, feelings, and goals, skills, or roles. It is a way of living a satisfying, hopeful, and contributing life even with the limitations caused by mental illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness (Anthony, 1993).

Implementing Recovery

When looking at the possible ways of implementing recovery at Oregon State Hospitals there are specific recommendations that the Pacific University consulting team included in the report given to the hospital. The recommendations presented to the hospital system were divided into two categories: strong recommendations and recommendations. These categories were developed in an effort to emphasize the importance of the recommendations formulated by the consumer, staff, administrative and physician’s information combined with the consulting team’s knowledge of the project.

Strong Recommendations

The recommendations presented are from the most to least important given the information gained throughout this project. The first recommendation is for OSH is to develop a clear definition of recovery that will be universal for both campuses. This
would likely be done with representatives from each campus with Pacific University consulting team facilitating.

As recovery models of care have many roots in the community based systems, Oregon State Hospital differs from community-based organizations in both mission and constraints and the hospital will need to determine if it is feasible to have recovery in the hospital and if so, at what levels. Oregon State Hospital would also benefit from determining if recovery will be used in all parts of the Salem campus. The current belief among many staff and consumers is that recovery may not be applicable for the maximum security (max) wards. If it is determined that not all portions of the Salem campus will use recovery, then the hospital should determine what areas will not be following a recovery model of care. Once a definition of recovery is determined, and the hospital has decided what portions of the hospital will use this definition, the practice of recovery needs to be followed and reinforced by administration and staff of all levels.

Given that a plan has been established for where and how recovery will be implemented the administration must provide consumers and staff with the definition of recovery and the plan for implementation at the same time. This will ensure that consumers and staff will be able to make connections between the changes that will be happening and how those changes will be affecting them.

Due to all of the changes made to develop recovery in an existing system there will need to be more recovery experts to make recommendations and explain recovery on both campuses. Staff and consumers reported that they did not know what the recovery experts’ roles were but many reported they felt that the recovery experts are patient advocates. For an organizational change of this magnitude to take shape in a setting such
as Oregon State Hospital there will need to be appropriate participation for all groups of people in the organization through recovery experts (e.g. recovery consumer advocates, recovery staff advocates, recovery physician advocates, and recovery administrative advocates).

An additional recommendation is to inform all staff and consumers and the surrounding communities of Salem and Portland about recovery and what changes will be made. Pacific University consulting team and the recovery expert panel in Salem can help in implementing this program, given that funding is made available for posters and other media related items.

In planning for the implementation stage of recovery, it would likely be very helpful for those planning the changes to approach staff and consumers with a stage-by-stage approach. The utilization of this approach will enable OSH to develop slowly into this new culture and increase the likelihood that recovery will be accepted by the whole organization. The changes made on each campus will need to be different. At Portland campus the staff is currently operating on both a Sanctuary model and Rehabilitation models of care, therefore it would be best to identify this fact and identify how changes to recovery will be different. In Salem, due to the size and diversity of approaches currently being used, it would likely benefit this campus for administration to determine if certain wards will remain in rehabilitation or if all wards will move to recovery. In either case it would be very helpful for the decision to be transparent to all staff and consumers so they have an understanding of what direction the organization is going and they feel informed.

It would likely be helpful to frame the idea of recovery for people with a visual image by utilizing either the pre-existing knowledge of stages of change (Prochaska,
DiClemente, & Norcross, 1992) or a model of recovery stages. One such image presented by the Recovery Advisory Group (Ralph & Corrigan, 2005) indicates the different stages of recovery a consumer may go through:

FIGURE 3.
RECOVERY ADVISORY GROUP RECOVERY MODEL

Note: Adapted from information presented in Jacobson & Curtis, (2000).

Within this model the consumer may come into care at any stage and may move throughout many of the stages depending on his/her process of recovery. The Anguish stage includes despair because of mental illness. Awakening stage includes awareness where the consumer understands things can change. Insight-Understanding stage is where the consumer sees that change can happen for that consumer. During the Action Planning stage the consumer starts searching and planning for making changes in his/her life. The Determined and Commitment to Becoming Well stage is where the
consumer makes a firm commitment to make changes in her/his life and treatment. During the Well-Being/ Empowerment stage the consumer feels a sense of empowerment and is actively working in their recovery.

Recommendations

Throughout the course of this project it was apparent that many line staff and consumers have little information about the changes that were happening. Pacific University consulting team helped to evaluate the current methods of information sharing at Portland and Salem campuses to help develop new method of conveying information in the Oregon State Hospital system.

Due to the stress of the multiple changes that are happening at the hospital, it is apparent that all level of employees and consumers are currently being stressed. It may be helpful to implement additional consumer and employee recognition programs to help all members of this professional community to feel valued and encouraged to continue positive growth.

Limitations and Future Directions

The information that has been acquired throughout this project will be taken into account in future planning for development of recovery in all Oregon State Hospitals. This project could have also been improved by having additional Pacific Consulting team members and additional OSH staff involved on this project. Considering the size of these two campuses (Salem and Portland) and the challenges that came about, it would have been helpful to have a larger staff to help with facilitation of focus groups. Another consideration to improve this project is, it to complete all of the focus groups in a one month time period. Oftentimes when information is brought back to administration
months after it has been collected, the administration is then making decisions based on old information. It is likely that OSH would benefit from an accurate snapshot of the hospital system and thus providing the administration with the ability to make decisions based on the state of the project at that time would allow this to happen. Finally, implementing incentive programs with the people who participated in the focus groups might allow for greater recruitment of participants both for this and future Pacific University consulting team projects.
References


Schmook, A. (Undated). Creating a Recovery Vision Statement. *Distributed by the National Association for State, Mental Health Program Directors*.


Appendix A

Recovery and Rehabilitation at Oregon State Hospital

Continuous Improvement Plan (CIP) information concerning recovery, set forth by the Department of Justice following their evaluation of Oregon State Hospital.

6. FORMULATION AND TREATMENT CARE PLANNING

6.1. Generally. All patients shall have an individualized treatment plan formulated by the patient, family and the interdisciplinary treatment team. The treatment care plan will be contemporary, relevant, and continuously updated. All efforts directed by the treatment care plan will focus on improving the patient’s ability to successfully recover, develop, and maintain the skills necessary to return to and remain in the community as life and legal circumstances allow.

6.2. Consultant and Training. OSH has retained a consultant to assist in the continuing process of revision and development of a new treatment care planning structure, content, and process. OSH will provide education and training of interdisciplinary treatment team staff as it relates to the implementation of a revised treatment care plan.
6.3. **Structure**

6.3.1. As the central member of the treatment team, every effort will be made to include the patient in meaningful participation in treatment care planning meetings.

6.3.2. The psychiatrist is the clinical leader of the interdisciplinary treatment team. Unit staff and clinical administrative leadership will work together to define and support the development of this role for the interdisciplinary treatment team.

6.3.3. OSH staff and patients will define the core members of the treatment team and require their attendance at all relevant patient treatment care planning meetings.

6.3.4. OSH will include other direct care staff as needed. They will be provided the resources and scheduling flexibility that supports their necessary attendance at individual treatment care planning meetings.

6.3.5. OSH will define external members of the treatment team and encourage attendance at treatment care planning meetings when indicated (e.g., significant others, family members, cultural specialists, advocacy organizations, community case managers, primary care providers).
6.4. **Content**

6.4.1. The patient’s self described life goals, aspirations, strengths, spiritual and cultural identity and values are priority building blocks for the treatment care plan.

6.4.2. Treatment care plans will be focused, pragmatic, individualized recipes for action, will be written in naturalistic language, with minimal use of abbreviations, acronyms, and jargon, and will reflect an ultimate goal of discharge, preparing patients not to return for readmission, but to remain in the community.

6.4.3. All treatment care plans will be individualized and patient centered; will be informed by objective, relevant symptom and behavior data; and will incorporate the patient’s stage of change.

6.4.4. The treatment care plan will clearly state specific, achievable goals in the service of preparing the patient for discharge and sustained successful community reintegration.

6.4.5. All treatment care plan objectives will reflect specific evidence-based interventions, where possible.

6.4.6. All treatment care plan goals will have well-defined timelines for
accomplishment.

6.4.7. All treatment care plan interventions will have clearly identified staff responsible for them.

6.4.8. In rare cases, treatment teams may identify patients for whom discharge from the hospital and sustained community tenure are not currently assessed as realistic or safe goals given currently available treatment technologies and systems resources. These cases will be reviewed at a clinical executive level; treatment teams will develop active, in-hospital treatment care plans to maximize safety and quality of life. Regular clinical executive level and treatment team review will be conducted to determine whether new treatment technologies or systems resources have become available to allow transition to the community.

6.5. **Process**

6.5.2. Treatment care plans will be reviewed every 30 days, or more frequently as clinically indicated, and will be revised according to the changes in the patient’s status, and implemented according to the revisions.

6.5.3. The treatment care planning meeting process will include a review of admission assessments, frequent reassessments, patient progress, case formulation and reformulation including applicable cultural issues, leading
to a prioritized list of strengths and problems including barriers to discharge, treatment goals, and treatment interventions with target dates and review for completion.

6.5.4. Treatment care plans will be continuously revised in the treatment team meeting, and reprinted and posted for communication immediately after every treatment team meeting including copies to the patient.

6.5.5. Unit staff and clinical executive leadership will work together to define and support the organization of the treatment team meetings.

7. ACTIVE CARE AND TREATMENT

7.1. Generally. Active care and treatment will be based on rehabilitation and recovery concepts including engagement, trauma informed care and motivational interviewing. Evidence based treatment interventions will be used when at all possible, and fidelity checks of these treatment interventions will be performed at specified intervals. All active care and treatment will be directed by the treatment care plan and culturally informed. Patients will receive active care and treatment off the unit to the maximum extent possible. All patients will have at least 20 hours per week of active care and treatment.
7.2. Consumer advocacy, empowerment and peer support. OSH will:

- Enhance and expand existing advocacy program;
- Develop ways to incorporate advocacy into active treatment;
- Develop a peer support program including culturally relevant groups; and
- Develop ways to incorporate peer support program into active treatment

7.3. Psychosocial rehabilitation. OSH will:

- Establish multiple treatment malls;
- Expand and improve vocational services for forensic patients;
- Develop vocational services for civilly committed patients;
- Expand educational services;
- Expand community rehabilitation opportunities;
- Expand cognitive rehabilitation programs; and
- Focus on community reintegration and discharge preparation.

7.4. Medication

7.4.2. OSH will improve individual and group patient medication
education

7.4.4. OSH will develop medication dosage/schedule utilization review and management to maximize therapeutic benefit and minimize cost

7.4.6. OSH will implement a Quality Improvement initiative regarding medication reconciliation hospital-wide.

7.5. Psychotherapies. OSH will:

- Expand Dialectical Behavioral Therapy services;
- Expand Cognitive Behavioral Therapy services; and
- Expand supportive psychotherapy and patient and family psychoeducation groups.

7.8. Behavioral Plans

7.8.1. OSH will train psychologists to develop and implement behavioral support plans.

7.8.2. OSH will establish a Behavioral Support Plan Committee (consisting of Psychology department designees) who will be responsible for training and consultation.

7.8.3. OSH will establish an interdisciplinary Behavioral Support Plan
Review Group (BSPRG) to be determined by clinical executive leadership.

The BSPRG will:

- Review proposed individual behavior plans
- Monitor the implementation and effectiveness of individual behavior plans.

7.9. Training and evaluation. OSH will:

7.9.1. Continue legal skills education;

7.9.2. Develop a standardized curriculum, individualized for each patient;

7.9.3. Emphasize the development of individualized relapse prevention plans utilizing evidence based practices; and

7.9.4. Develop a continuous updating process for Risk Assessment.

8. TRANSITION, DISCHARGE, AND COMMUNITY REINTEGRATION

8.1. The Interdisciplinary Treatment Team (IDT) shall begin discharge assessment and planning upon admission and continue it throughout hospitalization.

8.2. Patient preferences will be an integral part of discharge planning at OSH.
8.3. OSH will work with community service agencies, guardians, and families to promote continuity of care by improving:

- Communication between OSH and outpatient providers;
- Timeliness of providing hospital records, specifically discharge summary;
- Timely dissemination of reliable treatment care plan meeting schedules; and
- Participation from remote locations.

8.4. OSH will explore methods of staff sharing between the hospital and community based providers.

8.5. OSH will work with community agencies and organizations to increase access to guardians.

8.6. Discharge planning will consider issues of culture, language and immigration status.

8.8. IDTs will assist patients in developing Wellness Recovery Action Plan (WRAPs) or similar plans for community transition.
8.9. OSH will establish clinical and legal discharge criteria in the patient’s treatment care plan; the patient’s progress toward discharge will be reviewed at least every 30 days by the treatment team.

8.10. All interventions described in the treatment care plan will be directed toward improving the patient’s level of functioning, and successful community reintegration.

12. QUALITY ASSURANCE AND IMPROVEMENT

12.1. OSH’s performance improvement will include the continuous study and adaptation of its functions and processes to better meet the needs of patients and to increase desired outcomes.

12.2. Continuous Quality Improvement (CQI) will be based on organized, strategic data collection and analysis integrated with patient, staff and advocacy input, risk management and peer review data. These integrated data will provide performance improvement feedback and direction to IDTs and Education and Development.

13. STAFF EDUCATION AND DEVELOPMENT

13.12. Continuing staff development will occur during the trial service period, annually, and as informed by identified outcome-measured, staff development needs.
13.16. Outcome measures particular to disciplines, departments and programs will inform the OSH continuing in-service training plan.
The ten principles of recovery, as stated by the National Consensus Statement on Mental Health Recovery (2004), and presented in the focus groups included:

1. **Self-Direction:** Consumers lead, control and exercise choice over and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique life path.

2. **Individualized and Person-Centered Care:** There are multiple pathways to recovery based on individual’s unique strengths and resilience as well as his or her needs, preferences, experiences and cultural background, in all of its diverse representations. Individuals also identify recovery as being an ongoing journey, and an end result as well as an overall paradigm for achieving wellness and optimal health.

3. **Empowerment:** Consumers have the authority to choose from a range of options and to participate in all decisions – including the allocation of resources – that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires and aspirations. Through empowerment, an individual gains control of his or her
own destiny and influences the organizational and societal structures in his or her life.

4. **Holistic**: Recovery encompasses an individual’s whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.

5. **Non-Linear**: Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.

6. **Strengths-Based**: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.

7. **Peer Support**: Mutual support—including the sharing of experiential
knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.

8. **Respect:** Community, systems, and societal acceptance and appreciation of consumers—including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one’s self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.

9. **Responsibility:** Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.

10. **Hope:** Recovery provides the essential and motivating message of a better future—that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process.
Appendix C
OSH Salem Staff Slides

Plan For Today
- Action Research
- Rehabilitation Vs. Recovery
- Principles of Basic Recovery
- Information Gathering for Recovery

THE ACTION RESEARCH MODEL

Rehabilitation
- People have an under-utilized capacity
- All people can be equipped with skills
- People have a right/responsibility for self-determination
- Provide Support
- Staff are deeply committed
- Emphasis on here and now

Basic Principals of Recovery Model
- Non-Linear or Process
- Self Direction
- Individualized
- Empowerment
- Responsibility
Basis Principals of Recovery

- Strengths Based
- Peer-Support
- Respect
- Holistic
- Hope

Do you see these principals of recovery in your areas of OSH?

- Self Direction
- Individualized and Self Directed
- Empowerment
- Holistic
- Non-Linear or Process
- Strengths Based

How would you see Recovery being implemented into OSH?

- Self Direction
- Individualized and Self Directed
- Empowerment
- Holistic
- Non-Linear or Process
- Strengths Based

Contact Information

- Corey, Sonia, Christina, Chris
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- Phone: (503) 352-2400 Ext. 2403
- Limitations of Confidentiality (Mandated Reporters)
Basic Components of Recovery Model

- Non-Linear or Process
- Self Direction
- Individualized
- Empowerment
- Responsibility

Basis Components of Recovery

- Strengths Based
- Peer-Support
- Respect
- Holistic
- Hope

Have you experienced any of these components of recovery while at OSH?

- Self Direction
- Individualized and Self Directed
- Empowerment
- Holistic
- Non-Linear or Process
- Strengths Based

- Peer-Support
- Respect
- Responsibility
- Hope

OSH Salem Consumer Slides
What do you think would need to happen for Recovery to be implemented into OSH?

- Self Direction
- Individualized and Self Directed
- Empowerment
- Holistic
- Non-Linear or Process
- Strengths Based
- Peer Support
- Respect
- Responsibility
- Hope
**Plan For Today**
- Action Research
- Rehabilitation Vs. Recovery
- Why Recovery
- Basic Components of Recovery
- Questions

**THE ACTION RESEARCH MODEL**

**Rehabilitation**
- People have an under-utilized capacity
- All people can be equipped with skills
- People have a right/responsibility for self-determination
- Provide Support
- Staff are deeply committed
- Emphasis on here and now

**Basic Concepts of Recovery**
- Non-Linear or Process
- Self Direction
- Individualized
- Empowerment
- Responsibility
Basic Concepts of Recovery
- Strengths Based
- Peer-Support
- Respect
- Holistic
- Hope

Do you see these principles of recovery in your areas of OSH?
- Self Direction
- Individualized and Self Directed
- Empowerment
- Holistic
- Non-Linear or Process
- Strengths Based

How would you see Recovery being implemented into OSH?
- Self Direction
- Individualized and Self Directed
- Empowerment
- Holistic
- Non-Linear or Process
- Strengths Based

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Plan For Today
- Action Research
- Rehabilitation Vs. Recovery
- Principals of Basic Recovery
- Information Gathering for Recovery

Rehabilitation
- People have an under-utilized capacity
- All people can be equipped with skills
- People have a right/responsibility for self-determination
- Provide Support
- Staff are deeply committed
- Emphasis on here and now

THE ACTION RESEARCH MODEL
- Planning
- Reflection
- Action
- Monitoring

Basic Principals of Recovery Model
- Non-Linear or Process
- Self Direction
- Individualized
- Empowerment
- Responsibility
**Basis Principals of Recovery**
- Strengths Based
- Peer-Support
- Respect
- Holistic
- Hope

**Do you see these principals of recovery in your areas of OSH?**
- Self Direction
- Individualized and Self Directed
- Empowerment
- Holistic
- Non-Linear or Process
- Strengths Based
- Peer-Support
- Respect
- Responsibility
- Hope

**How would you see Recovery being implemented into OSH?**
- Self Direction
- Individualized and Self Directed
- Empowerment
- Holistic
- Non-Linear or Process
- Strengths Based
- Peer-Support
- Respect
- Responsibility
- Hope

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Basic Components of Recovery

- Non-Linear or Process
- Self Direction
- Individualized
- Empowerment
- Responsibility

Basis Components of Recovery

- Strengths Based
- Peer-Support
- Respect
- Holistic
- Hope

Have you experienced any of these components of recovery while at OSH?

- Self Direction
- Individualized and Self Directed
- Empowerment
- Holistic
- Non-Linear or Process
- Strengths Based
- Peer-Support
- Respect
- Responsibility
- Hope
What do you think would need to happen for Recovery to be implemented into OSH?

- Self Direction
- Individualized and Self Directed
- Empowerment
- Holistic
- Non-Linear or Process
- Strengths Based

- Peer-Support
- Respect
- Responsibility
- Hope
Plan For Today
- Action Research
- Rehabilitation Vs. Recovery
- Why Recovery
- Basic Components of Recovery
- Questions

THE ACTION RESEARCH MODEL
- Planning
- Action
- Monitoring
- Reflection

- Rehabilitation Model
  - People have an under-utilized capacity
  - All people can be equipped with skills
  - People have a right/responsibility for self-determination
  - Emphasis on here and now

- Sanctuary Model
  - Increase social learning
  - Increase community cohesiveness
  - Improve staff/leader job satisfaction
  - Improve client satisfaction

Basic Concepts of Recovery
- Non-Linear or Process
- Self Direction
- Individualized
- Empowerment
- Responsibility
Basic Concepts of Recovery
- Strengths Based
- Peer-Support
- Respect
- Holistic
- Hope

Do you see these principles of recovery in your areas of OSH?
- Self Direction
- Individualized and Self Directed
- Empowerment
- Holistic
- Non-Linear or Process
- Strengths Based

How would you see Recovery being implemented into OSH?
- Self Direction
- Individualized and Self Directed
- Empowerment
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Appendix D

Oregon State Hospital Consultation Project
Recovery Focus Group Information
Corey Baechel, M.A., M.S.
Jay C. Thomas, Ph.D., ABPP (Faculty Supervisor)
Executive Summary

The Oregon State Hospital has contracted with Pacific University consulting team to examine the current state of the hospital system in an effort to develop a working definition of recovery. This information will also be applicable for implementation of recovery at Oregon State Hospital. The information in this report was informed through the process of conducting focus groups on both the Salem and Portland Campuses. These focus groups included staff, consumers, administration and physicians. Both campuses (Portland, Salem) currently have many principles of recovery in various parts of these hospitals. These include hope respect, nonlinear thinking and approach, self-direction, individualized, responsibility, peer support, strengths based, holistic elements and levels of empowerment. The working definition of recovery, which is determined by administration, must be clearly defined and incorporate information about how recovery can happen given that this is a locked facility. It would likely be beneficial for the organization as a whole if all information about decisions being made were public. It would also likely be beneficial for the consumer and staff to have some decision-making ability in the future of recovery at Oregon State Hospital. There are many ways that Pacific University consulting team can support Oregon State Hospital throughout this process.
Method

Action Research Design:
Throughout the course of this project the Pacific University consulting team utilized an action research model\(^1\). This research design is an approach for developing ongoing information gathering and feedback. Action Research was first designed with the intent of having ongoing research continue throughout a change process while the information gathered influences the progress of the future research (French & Bell, 1999). The action research model is a collaborative model of change that includes the interaction of the individuals in the system (staff and administration at OSH) and the researchers. The process of using an action research format to test the development of an organization begins with data gathering and diagnosis by the consultant at the project followed by further data gathering. The feedback is given to specific clients or groups and a joint action plan is created. The process begins again with data gathering and then feedback to clients with incorporation of discussion and the emergence of new attitudes, followed by a new action plan and the action is then carried out.

Project Development:
This project began with development of focus group material describing 10 basic components of recovery and then presenting the focus groups with two basic questions to gather information. The 10 principles of recovery are described in Appendix A. Over the course of the data gathering it became apparent that the questions being used were not clearly defined and minor changes to the questions were made within the first 5 focus groups.

- Initial questions:
  1. What is working with recovery at Oregon State Hospital?
  2. What barriers or impediments do you see in implementing recovery at Oregon State Hospital?

- Final changes made to questions:
  1. Do you see any of the principles of recovery currently at Oregon State Hospital? If so, where?
  2. How do you see recovery taking shape at Oregon State Hospital?

Additional changes that were made to the focus group power point presentations include:

- Personal contact information and information about rehabilitation model taken out of consumer focus groups.
  - Alternate methods of information sharing with the Pacific University consulting team were present during these groups.
- Information about the sanctuary model of care was incorporated into the slides for staff, administration and physician focus groups at Portland Oregon State Hospital.

\(^1\) As an action research project this work was designated as “exempt” by the OSH Institutional Review Board.
Groups:

A total of 31 focus groups were performed between Portland and Salem campuses. The groups ranged in size from 1 person to 13 people. There were more than 160 participants who attended these groups. Due to the nature of this setting there were many participants who had to leave during focus groups or were unable to attend. The use of focus groups was agreed upon by Oregon State Hospital administration and the Pacific University consulting teams in an effort to gather initial information needed to inform the development of a working definition for recovery at Oregon State Hospital. Focus groups on both campuses were designed to gather information from all areas of the organization.

Focus Groups:

<table>
<thead>
<tr>
<th>Campus/Groups</th>
<th>Consumer</th>
<th>Staff</th>
<th>Administration</th>
<th>Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salem</td>
<td>6</td>
<td>10</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Portland</td>
<td>5</td>
<td>6</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Results

Throughout the course of performing the focus groups it became apparent that there were differences in the information gathered on the Portland campus and the Salem Campus, therefore the information will be presented with respect to the particular campuses. The information in the tables is presented from the most representative or most commonly reported (top) to least representative or least commonly reported (bottom). Items are presented from the perspective of participants; items, which state that certain resources or changes are needed, are taken from participant comments and are not derived from additional analyses regarding the feasibility of implementing these items.
### Staff Focus Groups

<table>
<thead>
<tr>
<th>Questions/Campuses</th>
<th>Portland Oregon State Hospital</th>
<th>Oregon State Hospital Salem</th>
</tr>
</thead>
</table>
| Q1: Do you see any of these principles of recovery currently at Oregon State Hospital? And if so where? | • Empowered - solo and buddy passes in the community.  
• Peer support - Peer run groups and community reintegration programs.  
• Treatment Mall has all of the elements of recovery.  
• Treatment care plans are strengths based and individualized.  
• All principles are present at POSH but not identified. There is a feeling of respect between staff and patients. | • The most principles of recovery are found in the recovery ward.  
• Minimum and Medium Security have many principles of recovery  
• Geriatrics has few principles including hope and strengths based.  
• Maximum wards have the least amount of recovery principles:  
• Empowerment through developing education |
| Q2: How do you see recovery taking shape at Oregon State Hospital? | • We need more community supports (groups, hobbies, volunteer opportunities, group homes)  
• Need more education for staff, patients, and community  
• Need a plan for working with unmotivated consumers.  
• Need a clear definition of recovery and explain how this applies to a lock down facility.  
• Need behavior support plans for all consumers  
• Need more recovery experts. Need to develop the relationship with the community. | • There needs to be clear communication between administration and staff.  
  o Staff stated they have little or no information about changes happening in the hospital.  
• There needs to be a clear, public plan for recovery implementation  
• Need more recovery experts  
• Education for staff, consumers and community about recovery  
• OSH needs to develop the relationship with the community.  
• More Community supports are needed for consumers (jobs, groups, group homes).  
• Need changes in the legal system to account for recovery (felons can’t work with other felons).  
• The definition must account for the fact that consumers are held against their will.  
• Staff and consumers should have say in organization changes  
• Not all consumers are motivated to change  
• Consumers need more self direction and responsibility |

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### Consumer Focus Groups
<table>
<thead>
<tr>
<th>Questions/Campuses</th>
<th>Portland Oregon State Hospital</th>
<th>Oregon State Hospital Salem</th>
</tr>
</thead>
</table>
| Q1: Do you see any of these principles of recovery currently at Oregon State Hospital? And if so where? | • Hope is a prevalent factor  
• Individualism in treatment care  
• Holistic aspects of care available  
• Supported by staff and other patient  
• Treatment plans are developed with lifetime orientation.  
• Empowerment through buddy passes  
• Strength based approach with treatment  
• Empowerment in recovery storied group.  
• Psycho-educational information and coping skills | • Self-direction in treatment and treatment planning.  
• Empowerment in choice of groups at treatment mall.  
• Holistic wellness groups  
• Cottages have many of the principles of recovery in their programming.  
• Peer support groups in the treatment mall.  
• Staff and administration are listening to consumers more.  
• The level of respect is good Staff/Consumers |
| Q2: How do you see recovery taking shape at Oregon State Hospital? | • Hope is getting out of the hospital  
• We need resources  
  ○ Jobs, funding and Gov’t Support  
• Need to develop peer supports  
• Need more community integration  
• Increase treatment variety  
• We want the choice to participate in groups or not. | • Need more WRAP services and choices of group homes.  
• Need a better relationship with Salem Community  
• Need more individualized treatment planning.  
• Need jobs to develop hope.  
• Need to educate and train staff more  
• Need to let staff and consumers know what will happen because of budget cuts.  
• Staff doesn’t value consumer input and advocacy.  
• Need more therapy options, expressive therapies, etc. |

Administrative Focus Groups
<table>
<thead>
<tr>
<th>Questions/Campuses</th>
<th>Portland Oregon State Hospital</th>
<th>Oregon State Hospital Salem</th>
</tr>
</thead>
</table>
| Q1: Do you see any of these principles of recovery currently at Oregon State Hospital? And if so where? | • We're currently 25% of the way to working from a recovery model of care. We have:  
  o Hope, tolerance of choice and peer groups.  
  • All staff buy into need for Hope  
  • Respect/empowerment-Buddy passes  
  • Good relationship with the close community. | • Peer-Bridger programs are helpful with patients’ recovery.  
• Transitional programs are working in line with the basic principles of recovery |
| Q2: How do you see recovery taking shape at Oregon State Hospital? | • Empowerment and choice is taken away from the consumers and this must be addressed.  
• Assertiveness training for consumers is needed.  
• Staff need to praise consumers for being assertive  
• Physician’s focus on medications and are not doing enough med-education with consumers.  
• Some people believe that if a consumer has more self-direction then the safety will decrease.  
• People who have information/knowledge are not sharing it.  
• Need to tailor information for individuals  
• Need more training for staff:  
  o Long term goal development and group facilitation  
• Need Community Support  
• Need alternatives to medications | • Containment verses Treatment  
• Need more peer support groups.  
• Increase levels of available care  
• Need support from the public  
• Need to educate staff, patients and community.  
• Difficult to manage recovery in multiple sites.  
• Safety of patients and staff need consideration.  
• Need more patient accountability  
• Limitations in the “empowerment center”  
• Instituting Recovery without a plan would be a challenge.  
• Need to define a clear philosophy or vision of the organization.  
• Need a clearer communication of roles and values. |
<table>
<thead>
<tr>
<th>Questions/Campuses</th>
<th>Portland Oregon State Hospital</th>
<th>Oregon State Hospital Salem</th>
</tr>
</thead>
</table>
| **Q1:** Do you see any of these principles of recovery currently at Oregon State Hospital? And if so where? | Psychiatry is practicing from a recovery framework | Peer support is happening through ex-addicts and people in recovery implementing groups.  
• The here and now focus is meeting patients where they are at and helping them create stability in their lives.  
• We’re helping patients understand their goals and work toward them.  
• Strength-Based work is happening in geriatric wards where they are using a person-centered approach to help develop hope. |
| **Q2:** How do you see recovery taking shape at Oregon State Hospital? | The recovery definition needs to account for patients being held against their will.  
• Currently the patient is forced to take the diagnosis and treatment dictated to them by the psychiatrist at intake. This is where recovery needs to start first.  
• There needs to be some form of rehabilitation in the recovery model to get the person to a stable place prior to moving into recovery.  
• How will the recovery model account for the coercion that occurs in OSH system?  
• Diagnoses are given to quickly. Their needs to be more time for the diagnoses to be accurate.  
• Currently the patient is forced to take the diagnosis and treatment dictated to them by the psychiatrist at intake. This is where recovery needs to start first.  
• Staff need to learn recovery and think in terms of recovery. | Needs to be clear guiding principles that translate into practice.  
• Consumers are sometimes not aware that they have challenges  
• The definition needs to account for the patients being mandated for treatment.  
• The stigma of mental illness is a big problem for people who are returning to OSH.  
• We need administration to support consumer self-direction.  
• The patients’ criminology and substance abuse is part of their mental illness.  
• “Stages of change” framed in recovery is needed.  
• Need more treatments, not only evidenced based.  
• Patients need more services to prep them for life outside OSH.  
• The definition of recovery needs to account for the scientific portion of a patient getting better. |
Discussion

Defining Recovery

When presented with the data from the focus groups and information gathered through observations while working at both sites it is apparent that recovery principles are currently at both the Salem and Portland campuses. These campuses are different in some fundamental levels that will likely require different methods of implementing recovery. The most common themes found across all groups and both campuses include:

- The definition of recovery must account for the fact that some consumers are incarcerated.
- A decision needs to be made about whether the definition of recovery will incorporate all of the principles set forth by National Consensus Statement used to describe recovery in the focus groups.
- The definition needs to be very clear.

Common definitions of recovery include:

- Recovery is a process, a way of life, an attitude, and a way of approaching the day’s challenges. It is not a perfectly linear process.
- Recovery is a reawakening of hope after despair.
- Recovery is breaking though denial and achieving understanding and acceptance.
- Recovery is moving from withdrawal to engagement and active participation in life.
- Recovery is active coping rather than passive adjustment.
- Recovery means no longer viewing oneself primarily as a person with a psychiatric disorder and reclaiming a positive sense of self.
- A deeply personal, unique process of changing one’s attitudes, values, feelings, and goals, skills, or roles. It is a way of living a satisfying, hopeful, and contributing life even with the limitations caused by mental illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness.” (DMHS Wellness and Recovery Transformation Statement dated February 2006, citing W.A. Anthony (1993)).

Implementing Recovery

When looking at the possible ways of implementing recovery at Oregon State Hospitals there are specific recommendations that the Pacific University consulting team have including:

- Strong Recommendations
Develop a clear definition of Recovery for OSH that will be universal for both campuses. This can likely be done with representatives from each campus with Pacific University consulting team facilitating.

It needs to be determined if recovery will be used in all parts of the Salem campus, and if not then what areas will not be following a recovery model of care.

The definition and practice of recovery needs to be followed and reinforced by administration and staff of all levels wherever recovery is implemented.

Provide consumers and staff, the definition of recovery and the plan for implementation at the same time.

There will need to be more recovery experts on both campuses.

Most community recovery models include consumer involvement at all levels of decision-making. Oregon State Hospital differs from community-based organizations in both mission and constraints and needs to determine if this is feasible and, if so, at what levels.

The role of recovery experts needs to be defined for all staff and consumers:
- Staff and consumers reported that they didn’t know what the recovery experts’ roles were but many reported they felt that the recovery experts are patient advocates.
- For an organizational change of this magnitude to take shape in a setting such as Oregon State Hospital there will need to be appropriate participation for all groups of people in the organization (e.g. recovery consumer advocates, recovery staff advocates, recovery physician advocates, and recovery administrative advocates).

Develop an educational campaign that will inform all staff and consumers and the surrounding communities (Salem and Portland) about Recovery and what changes will be made. Pacific University consulting team and the recovery group (Salem) can help in implementing this program, given that funding is made available for posters and other media related items.

Utilize a step-by-step approach to making the changes.

Changes made on each campus will be different:
- POSH: Due to the fact that POSH is currently operating on both a Sanctuary model and Rehabilitation model of care it would be best to identify this fact and identify how changes to recovery will be different.
- Salem: Due to the size and diversity of different approaches currently being used, it would likely benefit this campus for administration to determine if certain wards will remain in rehabilitation or if all wards will move to recovery. In either case it would be very helpful for the decision to be transparent to all staff and consumers.

It would likely be helpful to frame the idea of recovery for people with a visual image. Either utilizing the pre-existing knowledge of stages of change (Prochaska, DiClemente, & Norcross, 1992) or a model of recovery stages. One such image presented by the Recovery Advisory Group indicates the different stages of recovery a consumer may go through:
Within this model the consumer may come into care at any level and may move throughout many of the stages depending on there process of recovery. The stages here are:

- Anguish - Experience of despair because of mental illness.
- Awakening - Awareness that things can change.
- Insight - Understanding that change can happen for that consumer.
- Action Planning - Searching and planning for making changes.
- Determined and Commitment to Becoming Well - Consumer makes a firm commitment to make changes in her/his life and treatment.
- Well-Being/ Empowerment - The consumer feels a sense of empowerment and is actively working in their recovery.

- Recommendations:
  - Throughout the course of this project it was apparent that many line staff and consumers have little information about the changes that are happening. Pacific University consulting team can help to evaluate the current methods of information sharing at POSH and Salem campuses to help develop new methods of conveying information in the Oregon State Hospital System.
  - Implement new employee recognition programs. Due to the stress of multiple changes that are happening at the hospital it is apparent that all levels of employees are currently being stressed.
  - Implement a consumer recognition program. Due to the stress of multiple changes that are happening at the hospital it is apparent that many consumers are currently being stressed.
Appendix A

The ten principles of recovery, as stated by the National Consensus Statement on Mental Health Recovery (2004), and presented in the focus groups included:

11. **Self-Direction:** Consumers lead, control and exercise choice over and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique life path.

12. **Individualized and Person-Centered Care:** There are multiple pathways to recovery based on individual’s unique strengths and resilience’s as well as his or her needs, preferences, experiences and cultural background, in all of its diverse representations. Individuals also identify recovery as being an ongoing journey, and an end result as well as an overall paradigm for achieving wellness and optimal health.

13. **Empowerment:** Consumers have the authority to choose from a range of options and to participate in all decisions – including the allocation of resources – that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires and aspirations. Through empowerment, an individual gains control of his or her own destiny and influence the organizational and societal structures in his or her life.

14. **Holistic:** Recovery encompasses an individual’s whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.

15. **Non-Linear:** Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.

16. **Strengths-Based:** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.
17. **Peer Support**: Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.

18. **Respect**: Community, systems, and societal acceptance and appreciation of consumers—including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one’s self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.

19. **Responsibility**: Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps toward their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.

20. **Hope**: Recovery provides the essential and motivating message of a better future—that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process.