Inventory of Transformation Characteristics for Recovery-Oriented Systems of Care

Please rate your system on each of the following items on the degree to which it has moved from a pre-transformation stance to one oriented toward promoting recovery.

A. How people with behavioral health conditions are viewed and treated by staff

	Pre-Transformation	Degree to which …	As part of Transformation
1	People with behavioral health conditions are viewed as "mental patients" or "addicts." They may commonly be referred to as "bipolars," "schizophrenic," or "junkies." The diagnosis comes before the person and is thought to be permanent. Recovery is thought to be rare, if possible at all.	People with behavioral health conditions are viewed and treated first and foremost as unique individuals 1 2 3 4 5	Research on outcomes of mental illnesses and addictions are disseminated to staff. Staff know that these conditions do not define people and that recovery is not only possible, but is more common than permanent impairment. Staff use person-first language to indicate that the person is more important than the condition.
2	Staff are largely unaware of the mental health consumer movement and new recovery advocacy movement in addiction. They view issues of civil rights, stigma, and discrimination as irrelevant to behavioral health conditions, services, and systems. Those being served and their families are treated as "less than" by staff, viewed as being one down in relation to staff expertise and power, and expected to "comply" with staff instructions.	Civil rights are respected 1 2 3 4 5	Staff are educated about mental health consumer and new addiction recovery advocacy movements. They are aware of how these persons were treated as "second class" citizens or less than human in the past and attend to the civil rights dimension of recovery in their work both inside and outside of the behavioral health system. People being served and families are held in high regard and treated with dignity and respect. They are viewed as active agents in their recovery, full collaborators with staff, and members of their communities.
3	Staff are not aware of recovery stories in their local community. They do not know people who are open about their recovery or being in recovery. Staff have low expectations for those they serve. They assume that these people's lives will forever be limited or diminished by the presence of a behavioral health condition, and cannot imagine the person thriving. The basic message conveyed by staff is: "Mental illnesses and addictions are life-long chronic illnesses from which you will never recover."	Staff know about and expect recovery 1 2 3 4 5	Success stories of local people who have entered recovery are made public and are common-place. Staff invite people back to share their recovery narratives to instill hope and offer encouragement. Staff view each person they serve as a unique individual who has hopes, dreams, and aspirations and is worthy of being loved and capable of loving others. The basic message conveyed by staff is: "People can recover. You can overcome or live with this condition and have a full and meaningful life."

B. How people with behavioral health conditions are included in the design, delivery, and evaluation of care

	Pre-Transformation	Degree to which …	As part of Transformation
4	People with behavioral health conditions have little to no voice in services, programs, or the system as a whole. When such people become involved they may feel exploited or tokenized. There are few people in recovery in senior, administrative or supervisory positions or, when present, such administrators are isolated from their colleagues or have little power.	People in recovery have a voice in the system 1 2 3 4 5	There is visible, active involvement of persons in recovery on planning councils and boards, and in program and system-level advocacy roles. They are present in administrative and supervisory positions, and have a strong voice in deciding on service and system objectives. That is, the dictum of "nothing about us without us" is honored in practice at all levels of the system.
5	Recovery advocacy communities are viewed primarily as critics of the system and their input is largely ignored. Few efforts are made to invite recovery advocates into partnerships with the system, and little information is shared with them about the system's needs, strategic plans, or direction. When lobbying of political representatives is called for, or grant applications are written to improve or add to existing services, there is little to no involvement of the recovery community.	Recovery advocacy community is a valuable ally 1 2 3 4 5	Long-standing or established advocates have been invited to the table to honor and build on their previous efforts. Public venues are offered for peer and family leaders to inspire others to action. Efforts are made to identify and cultivate additional leaders. Peer and family advocacy organizations are invited to collaborate in developing a shared platform for transformation. Their views and recommendations are actively solicited and afforded substantial influence in relevant policy initiatives and grant applications to add or improve services.
6	Little input is sought from service users or family members other than routine collection of "satisfaction" data. Tools used for quality improvement have not been informed by service users or family members, and data are analyzed and interpreted primarily by staff, with no service user or family input.	Input is sought from service users and families 1 2 3 4 5	Input is sought from service users and families using focus groups, surveys, or town hall meetings, etc. On-going mechanisms are in place for eliciting and incorporating service user and family feedback through quality improvement initiatives, and peer and family-based monitoring, quality improvement, and evaluation activities.
7	There are few opportunities for interested youth, adults, or family members to learn about advocacy or develop leadership skills. There are few peer/family support groups and little education provided about recovery.	Youth, adults, and family members are engaged in advocacy 1 2 3 4 5	On-going efforts are made to offer leadership and advocacy training to interested youth, service users, and family leaders, to sponsor peer/family support groups, and to run a speakers' bureau to educate the public about behavioral health.

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8	Peer support is actively discouraged, lacking altogether, or under-funded, and no concrete plans and efforts are in place to change this.	Peer supports are integrated 1 2 3 4 5	Funds are provided for peer-run programs and peer-operated businesses. Efforts are devoted to training, hiring, supervision, and promotion of a growing cadre of peer staff in a variety of roles in the system.

C. How care is planned, delivered, and improved on a continuous basis

	Pre-Transformation	Degree to which …	As part of Transformation
9	The system is oriented to reducing symptoms and maintaining people outside of institutions. The emphasis of care is on illness, pathology, and dysfunction, considered within a narrow medical model that relies heavily, if not solely, on medications. Terms such as social or community inclusion are not used, may be seen as giving "false hope," or are considered irrelevant to behavioral health care.	Focus of care is on building a healthy, self-determined, and full life in the community 1 2 3 4 5	The system is oriented to strengthening service users' abilities to live self-determined lives. The focus of care is the whole person, integrating biological, cultural, personal, and spiritual dimensions. Terms such as social and community inclusion are in common use and are considered important to people's behavioral and overall health and well-being. Within this broad context, medications are used judiciously and in combination with psychosocial interventions, community supports, and self-care tools.
10	Care remains primarily hospital-based, with other services often available only in crises, so that people have to remain ill or deteriorate in order to receive care. Access is difficult and the system is complex, with little guidance offered to help people navigate their care.	Care is community-based and focused 1 2 3 4 5	Access to services is easy and flexible and people do not lose supports as their conditions improve. There is no "Wrong Door," and the people at the door are respectful and responsive. People provide guidance for navigating the system. There is coordination and integration of care across services, programs, and agencies based on each person's recovery plan.
11	Crisis services rely heavily on involuntary treatment, coercion, seclusion, and restraint. Crisis services are re-traumatizing, and service users are not offered opportunities to debrief.	There are trauma-informed crisis alternatives 1 2 3 4 5	Crisis alternatives such as warm lines and peer staffed respite programs are available. Staff are trained in de-escalation and trauma-informed approaches for avoiding the use of seclusion and restraint.
12	People do not have the assistance or support needed to succeed in school or work, they are directed to low level and unskilled jobs and discouraged from aiming "too high."	Community life is encouraged 1 2 3 4 5	When interested, people are helped to obtain reasonable accommodations and are assisted and supported in succeeding in school and work. They are encouraged to pursue careers that interest them.

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13	Hope is diminished by negative prognosis and practitioners' low expectations. People lack the information and tools they need to learn about their condition(s) and what they can do.	Hope is instilled 1 2 3 4 5	Hope is instilled by realistic prognosis, visible role models, and recovery education. People are offered information and resources they need to understand their condition(s) and are taught to self-manage.
14	Treatment plans are generic and focus solely on illness, symptoms, and problems. Planning is not coordinated or integrated across levels of care, programs or agencies, and does not engage the person in a collaborative process.	Care plans are based on each person's life goals 1 2 3 4 5	Each person is actively involved in developing his or her own individualized recovery plan that is based on his or her unique life goals. This plan is not limited to symptoms and treatment but includes a broad array of interventions, action steps, and supports.
15	Coercion and involuntary interventions are common, staff often act "in locus parentae," and there is a high utilization of guardianship, conservatorship, representative payeeship, and other mechanisms that restrict autonomy.	Coercion is avoided 1 2 3 4 5	Coercion and involuntary interventions are avoided and substitute decision makers are used only as necessary. Advanced directives and other means are used to ensure that people continue to have a say in their lives and care even when in crisis situations.
16	Staff pay little attention to the cultivation of trusting relationships, there is no continuity in helping relationships, and staff have high caseloads which do not allow them time to be responsive to individuals' needs and goals.	Access to trusting relationships is emphasized 1 2 3 4 5	Staff place core emphasis on the cultivation of trusting and helpful relationships. Continuity in relationships is given priority in considering the next steps in a person's treatment, rehabilitation, and recovery.
17	Prevalence of trauma is under-appreciated and trauma treatment is not available.	Trauma is addressed 1 2 3 4 5	Services and supports are sensitive to trauma and trauma treatment is readily available.
18	Families are mostly left out of the care process, they receive little information about recovery, and there is little family support available.	Families are involved 1 2 3 4 5	Families are informed and educated about recovery, family support is readily available, and people are encouraged to include their families in care planning.
19	Little attention is paid to outcomes of care. The system only measures services provided and practitioners, programs, and agencies receive no feedback on their performance.	Outcomes are assessed 1 2 3 4 5	Outcomes of care are regularly assessed and used to measure performance. Feedback is given to staff, programs, and agencies and incentives are offered for improving outcomes.

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20	Findings from performance measurements, quality improvement initiatives, and outcomes monitoring are not used to make any changes in the system.	QI and PM results are used to improve quality of care 1 2 3 4 5	Leaders take strategic actions based on findings of performance measurement, quality improvement, and outcomes monitoring activities in order to increase the quality and effectiveness of care.
21	Staff pay little attention to the physical health status of service users, do not encourage them to access primary care, do not promote healthy lifestyles, and do not coordinate their care with primary care providers.	Physical health is attended to 1 2 3 4 5	Staff have been trained to address the physical health status and needs of service users through integrating primary care with behavioral health care and by promoting healthy lifestyles, including nutrition, exercise, and wellness.
22	Little attention is paid to social support, many people are isolated, and practitioners assume that this is due to service users' behavioral health conditions.	Attention is paid to social support 1 2 3 4 5	Attention is paid to social network development and social inclusion. People are offered opportunities and supports to develop friendships and romantic relationships.
23	Staff do not pay adequate attention to basic needs, including the need for valued social roles. They are discouraged from taking risks or taking on responsibilities, and are not assisted in moving out of poverty. Built-in structural disincentives to recovery are not addressed.	Staff pay attention to basic needs and social roles 1 2 3 4 5	Staff pay immediate, focused attention to basic needs, including housing, human rights, income, health care, and transportation. Success in various roles—like worker, tenant, parent, and student—along with activities to reclaim social roles, are emphasized. People are encouraged to stretch and grow.
24	Health disparities are not identified and leaders do not work with local stakeholders to address the needs of under-served communities.	Disparities are addressed 1 2 3 4 5	Health disparities are identified and addressed. In collaboration with stakeholders, the system develops culturally-responsive interventions.
25	Practitioners rarely ask individuals or family members for feedback about care. Service users or family members who raise concerns about care are ignored, ostracized, or labeled difficult.	Staff ask for feedback 1 2 3 4 5	Practitioners routinely ask individuals and family members for feedback about the care they use. Staff ensure that service users and family members do not suffer repercussions for giving feedback.
26	The system does not offer any educational curricula on resilience, recovery, or self-care strategies. There are no trained recovery or parent educators, and staff are not trained in the use of any self-care tools.	System educates youth, adults, and family members on self-care 1 2 3 4 5	The system has developed and offers educational curricula on resilience, recovery, and self-care strategies. There is a cadre of trained recovery and parent educators, including peer staff, who teach the use of an array of self-care tools.

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D. How transformation is led and managed

	Pre-Transformation	Degree to which …	Post-Transformation
27	Leadership do not see any reasons for changing current practice. To the degree that they are aware of the concepts of recovery and community inclusion, they believe that the care provided already embodies these concepts and no changes are needed to improve the lives of the people being served.	Leadership are engaged and action-oriented 1 2 3 4 5	Leadership review and revise or replace key policy documents to promote recovery and social inclusion. New infrastructure is developed to implement desired changes (e.g., modifying care planning protocols, identifying HR procedures for hiring peer staff), including contracting, monitoring, and auditing.
28	Leadership manage the system in a distant and/or punitive manner, blaming provider agencies and staff for any difficulties that arise. The avoidance of risk is viewed as a primary mission of the system, and leadership do not view service users or family members as having anything to contribute to system management.	Leadership are strength-based and encourage risk taking 1 2 3 4 5	Leadership initiates long-range strategic planning to identify and build on pockets of innovation using an inclusive, strength-based approach. Service users, families, direct care staff, and agency leaders are engaged in an inclusive process of identifying and building on system strengths as well as identifying and addressing structural disincentives to change.
29	System remains wedded to provider-driven and program-focused care. Service users and families are expected to be passive recipients of the care and guidance of others.	Shared decision-making and collaboration are used 1 2 3 4 5	System offers highly individualized care based on person and family-centered planning. Infrastructure has been developed for use of advance directives and other personal planning tools. Shared decision-making tools and decisional support are available.
30	Staff lack knowledge, training, and/or skills to promote and support resilience, recovery, and social inclusion. Little supervision is provided to staff in these domains, and consideration is seldom given to promotion of wellness and self-care among staff.	Workforce has been retrained 1 2 3 4 5	The workforce is trained in the application of resilience, recovery, and social inclusion values and principles to clinical and rehabilitative practice and the provision of person-centered, strength-based, trauma-informed, and culturally, socially, and structurally competent care.
31	The workforce has received no education about health disparities and the role of culture, race, ethnicity, and sexual orientation in behavioral health care, service use, or recovery.	Services are culturally responsive 1 2 3 4 5	The workforce is educated about the role of culture, race, ethnicity, and sexual orientation, including their impact on patterns of help-seeking, service utilization, care planning, and self-care.

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