Inventory of Transformation Characteristics for Recovery-Oriented Systems of Care

Rate your system on each of the following items, noting the degree to which the system has moved from a pre-transformation stance to one that is oriented toward promoting recovery and resilience.

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

	Pre-Transformation	Degree to which …	Post-Transformation
1	People with behavioral health conditions are viewed as "chronic mental patients," "addicts," or "the mentally ill." They may commonly be referred to as "schizophrenic," "bipolar," or "borderline." The diagnosis comes before the person and is thought to be permanent and to take over the person. Recovery is considered to be extremely rare, if possible at all.	People with behavioral health conditions are viewed and treated as people 1 2 3 4 5	Research on outcomes in mental illnesses and addictions has been disseminated to staff. Staff understand that these conditions do not define people and recovery is not only possible, but is more common than long-term 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/or the new recovery advocacy movement in addiction. They view issues of civil rights and discrimination as irrelevant to behavioral health conditions, services, and systems. People being served and their families are treated as "less than" by staff, are viewed as being one down in relation to staff expertise and power, and are expected to "comply" with staff instructions.	Civil rights are respected 1 2 3 4 5	Staff have been educated about the mental health consumer and new addiction recovery advocacy movements. They are aware of how persons with these conditions were treated as "second class" or less than human in the past and attend to the civil rights dimension of recovery/resiliency in their work both inside and outside of the behavioral health system. People being served and their families are held in high regard and treated with dignity and respect. They are viewed as active agents in their own recovery and as partners in collaborative relationships with staff.
3	Staff are not aware of success or recovery stories in their local community. They do not know people who are open about their recovery or about being in recovery. Staff have low expectations for the people they serve. They assume that these persons' lives will forever be limited or diminished by the presence of a mental illness and/or addiction, and cannot imagine the person thriving or flourishing. The basic message conveyed by staff is: "Mental illnesses and addictions are life-long, chronic conditions from which you will never recover."	Staff know about and expect resilience and recovery 1 2 3 4 5	Success stories of local people who have been resilient and entered into recovery are made public and are commonplace. Staff invite such people back to share their recovery narratives with current service users to instill hope and encouragement. Staff view each person they serve as a unique individual who is contending with a mental illness and/or addition, but who also 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 …	Post-Transformation
4	People with behavioral health conditions have little to no voice in services, programs, or the system as a whole. There is little interest in or support for their involvement, and when people do become involved they often feel exploited or treated as a token.	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. 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 and recommendations are largely ignored or dismissed. Few efforts are made to invite recovery communities into partnership 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, it is done by administrators and practitioners, with 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 among less experienced peers and families at the local level. Peer and family advocacy organizations are supported and assisted in developing a shared platform for transformation. Their views and recommendations are actively solicited and afforded substantial influence.
6	Little input is sought from service users or family members other than the routine collection of "satisfaction" data. The tools used for satisfaction measurement and other quality improvement data have not been informed by service users or family members, and data are not collected by service user or family representatives. Data are analyzed and interpreted primarily, if not solely, by practitioners, with no service user or family input.	Input is sought from service users and families 1 2 3 4 5	Broad input is sought from youth, persons with behavioral health conditions, and families who do not participate in advocacy through focus groups, surveys, town hall meetings, etc. On-going mechanisms are institutionalized for the eliciting, collecting, analyzing, and incorporating youth, service user, and family feedback through satisfaction surveys, continuous quality improvement initiatives, and peer and family-based monitoring 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 or self-help groups, and little community education provided about recovery.	Service users and families 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 and self-help groups; and to run a speakers' bureau to educate the public about behavioral health.
8	Peer support is actively discouraged, lacking altogether, or under-funded.	Peer supports are integrated within the system of care 1 2 3 4 5	Funds are provided for peer-run programs and for the development of peer-operated businesses. Substantial efforts are devoted to the training, hiring, supervision, and promotion of a growing cadre of peer staff in a variety of roles and at a number of levels throughout the system.

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

	Pre-Transformation	Degree to which …	Post-Transformation
9	The system is oriented primarily to reducing symptoms and maintaining people outside of institutional settings. The emphasis of care is on illness, pathology, and dysfunction, considered within a narrow medical model that relies heavily, if not exclusively, on the use of medications. People are not expected to self-manage their condition(s), but to rely on the knowledge and expertise of practitioners to tell them what to do and not to do.	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 people's abilities to live self-determined lives. The whole person is the focus of care, integrating biological, psychological, social/cultural, and spiritual dimensions of life. Within the context of holistic care, medications are used judiciously and in combination with other approaches such as psychosocial interventions, community supports, and self-care tools such as Wellness Recovery Action Planning (WRAP) and psychiatric advance directives.
10	Care remains primarily hospital-based, with other services often available only in crisis situations, so that people have to remain ill or deteriorate in order to receive care. Access to services is difficult and the system is complex, with little guidance or support offered to help people navigate their way.	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"; people are helpful and provide guidance for navigating the system. There is coordination and integration of care across services, programs, and agencies based on each person's individualized recovery plan.
11	Hope is diminished by negative prognosis, stigma, and practitioners' low expectations. People lack the information and tools they need to learn about and understand 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 the information and resources they need to understand their condition(s) and are taught to self-manage the condition(s).
12	Treatment plans are generic and focus solely on illness, symptoms, and problems. Planning is not coordinated or integrated across programs or agencies, and does not engage the person and/or family in an active, 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 across life domains.
13	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 persons' 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.
14	Crisis services rely heavily on coercion, involuntary treatment, seclusion, and restraint. Crisis services are experienced as re-traumatizing, and service users are not offered the opportunity 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 readily available. Staff have been trained in de-escalation and trauma-informed approaches for avoiding the use of seclusion and restraint.

	Pre-Transformation	Degree to which …	Post-Transformation
15	Staff do not pay attention to basic needs. People are viewed as service recipients, with little life, and few roles, outside of formal services. Discouraged from taking risks or taking on responsibilities, people are also not assisted in moving out of poverty, while built-in structural disincentives for recovery are not identified or 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 and civil rights, income, health care, and transportation. Success in various roles like worker, tenant, parent, and student, along with activities to reclaim valued social roles, are emphasized. People are encouraged to stretch and grow, and responsible risk taking is viewed as necessary to the recovery process.
16	Staff pay little attention to the cultivation of trusting relationships, there is lack of continuity in helping relationships, and staff have high caseloads which do not allow them adequate 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, support, rehabilitation, and recovery.
17	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 and supported 1 2 3 4 5	People are assisted to obtain reasonable accommodations and are assisted and supported in succeeding in school and work. They are encouraged to pursue careers that interest them.
18	Services are time-limited and transitional and/or there are long waiting lists or delays in getting help. Graduations from care are not considered.	Services are continuous and responsive 1 2 3 4 5	Services are accessible and responsive to individuals' needs and can increase or decrease in intensity over time as needed.
19	The criminal justice system is relied upon as an acceptable route for ensuring access for people to housing and mental health care (which they would not otherwise have).	People are diverted from the criminal justice system 1 2 3 4 5	Diversion from the criminal justice system is viewed as a priority, care is readily available in jails, and staff link people to services in the community prior to their release.
20	People with co-occurring mental health and substance use conditions are served by two systems that are parallel and often are in conflict.	Services address co-occurring disorders 1 2 3 4 5	Persons with co-occurring conditions are seen as the rule rather than as the exception. Integrated and enhanced services are available for them.
21	Homelessness is common and unaddressed, and temporary shelter placement is viewed as an acceptable disposition from inpatient care.	Homelessness is addressed effectively 1 2 3 4 5	Homeless outreach is conducted, supported housing is available, and priority is given to each individual having a sense of home.

	Pre-Transformation	Degree to which …	Post-Transformation
22	The prevalence of trauma is ignored or under-appreciated and trauma treatment is not available.	Presence of trauma is addressed 1 2 3 4 5	All services and supports are sensitive to trauma and trauma treatment is readily available.
23	Services are primarily offered in institutional settings. People are placed routinely in nursing homes, board and care homes, and congregate sites.	Institutional settings are avoided 1 2 3 4 5	Services are socially integrated and offered in community settings. Institutional settings are avoided whenever possible.
24	Little attention is paid to social support, people are socially 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.
25	Families are left out of the treatment/rehabilitation enterprise, 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 and mediation are readily available, and people are encouraged to include their families in care planning.
26	Health disparities are not identified and system leaders do not work with local stakeholders to address the needs of under-served communities.	Health disparities are addressed 1 2 3 4 5	Health disparities are identified and addressed. In collaboration with local stakeholders, the system has developed culturally-specific or responsive interventions for under-served communities.
27	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 as "difficult."	Staff ask for feedback 1 2 3 4 5	Practitioners routinely ask individuals and family members for feedback about the services and supports they are using. Staff ensure that service users and family members do not suffer repercussions for giving feedback.
28	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 practitioners, programs, and agencies and incentives are offered for improving outcomes.
29	Performance measures, quality improvement tools, and outcome measures are developed without input or feedback from service users or family members.	Tools are developed with service user and family input 1 2 3 4 5	Performance measures, continuous quality improvement tools, and outcome measures are developed with youth, service user, and family input and implemented widely.

	Pre-Transformation	Degree to which …	Post-Transformation
30	The results of performance measurements, quality improvement initiatives, and outcomes monitoring are not made public or easily available to youth, adults, family members, or practitioners.	QI and PM results are made public 1 2 3 4 5	Results of on-going performance measurements, quality improvement initiatives, and outcomes monitoring are publicized in order to educate youth, adults, families, and practitioners about the quality and effectiveness of care.
31	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 the care provided.

D. How transformation is led and managed

	Pre-Transformation	Degree to which …	Post-Transformation
32	Leadership remain in a "maintenance" mode with respect to the system and do not see any reasons for changing current practice. To the degree that they are aware of the concepts of recovery and resilience, they believe that the care provided already embodies these concepts and no changes are needed to improve the quality of care provided.	Degree to which leadership are engaged, inclusive, and action-oriented 1 2 3 4 5	Leadership review and revise or replace key documents to promote resilience and recovery (e.g., mission and vision statements, policies, contract language). Leadership develop infrastructure to support desired changes (e.g., modifying care planning protocols, identifying necessary HR procedures for hiring peer staff), including quality improvement, contracting, and auditing divisions.
33	Leadership manage the system in a distant and/or punitive manner, blaming provider agencies and practitioners for any difficulties that arise. Risk and the avoidance of risk is viewed as a primary mission of the system, and leadership do not believe that youth, service users, or family members have anything to contribute to system management.	Degree to which leadership are strength-based and encourage risk taking 1 2 3 4 5	Leadership initiate long-range strategic planning to identify and build on existing local strengths and pockets of innovation using an inclusive, strength-based approach. Youth, adults, families, direct care staff, and program, agency, and system leaders are engaged in an inclusive process of identifying and building on system strengths as well as identifying and addressing structural disincentives to adopting recovery-oriented principles and practices.
34	The system does not offer any educational curricula for youth, adults, or families on resilience, recovery, or self-care strategies. The system has no trained recovery educators or parent educators, and does not train staff in the use of any self-care tools.	Degree to which system educates youth, adults, and families on self-care 1 2 3 4 5	System has developed and offers educational curricula for youth, adults, and families on resilience, recovery, and self-care strategies. System has developed and deploys a cadre of trained recovery educators, including peer staff and coaches, to teach Wellness Recovery Action Planning, *Pathways to Recovery*, and other educational and self-care materials. System also has developed and deploys a cadre of trained parent educators to teach and support parents in their family management and advocacy roles.

	Pre-Transformation	Degree to which …	Post-Transformation
35	System remains wedded to provider-driven and program-focused care.	Degree to which shared decision-making and collaboration are used 1 2 3 4 5	System has shifted its emphasis from provider-driven and program-focused care to highly individualized, strength-based care based on person and family-centered recovery/ resiliency planning. Infrastructure has been developed for the implementation and use of psychiatric advance directives and other personal recovery planning tools. Shared decision-making tools and decisional support technologies are readily available and used to foster collaboration with service users and families.
36	Staff lack knowledge, training, and/or skills to promote and support resilience and recovery. There is little supervision provided to staff, and it is not typically strength-based. Little consideration is given to the promotion of wellness and self-care among staff.	Degree to which workforce has been retrained 1 2 3 4 5	The workforce has been retrained at all levels through a combination of didactic presentations, skill development, and exposure to recovery stories and recovery role models. The workforce is trained in the application of resilience and recovery values and principles to clinical and rehabilitative practice and the provision of person and family-centered, strength-based, trauma-informed, and culturally competent care. Supervisors and program leaders have been trained in the delivery of recovery-oriented supervision and in the promotion of wellness and self-care among staff.
37	Staff pay little attention to the physical health status of service users, do not encourage service users to access primary care, do not promote health lifestyles, and do not coordinate their care with primary care providers.	Degree to which 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 and by promoting healthy lifestyles, including nutrition, exercise, and wellness.
38	The workforce has received no education about health disparities and the role of culture, race, ethnicity, and sexual orientation in behavioral health.	Degree to which services are culturally responsive 1 2 3 4 5	The workforce has been educated about the role of culture, race, ethnicity, and sexual orientation in behavioral health, including their impact on patterns of help-seeking, service utilization, care planning, and self-care.

Thank you for taking the time to complete this survey.

Hopefully, it will provide you with valuable information and guidance in your transformation process.