RECOVERY PLAN INTRODUCTION in RESPONSE to INSPECTOR GENERAL:

Western State Hospital

August 1, 2007

Introduction:

It is the mission of WSH "to provide safe and effective treatment in a recovery focused environment." From the beginning of the Recovery initiative WSH has framed our task as one of incorporating what has been learned from those who have largely recovered, as this is what the recovery literature is primarily based, into our work with a primarily involuntary inpatient population of variably diminished capacity. What can be distilled from the relevant literature is the usefulness of hope, esteem, confidence, connection to help others, purpose, choice/control, empowerment, and, ultimately responsibility and accountability for managing one's own life. Approaching treatment holistically in terms of using treatment and support to restore or build a more engaged, satisfying life (versus simply treating an illness) is an essential point and one we have been building on for some time now. The concept of a healing environment may better describe what we are trying to accomplish than "treatment environment" so long as the vital importance of multi-modal treatment is not lost. The crucial importance of interactions between individuals, between staff and patients and families underpins much of the pragmatic implementation of recovery principles: listening, reflecting, using choice language, "coaching/teaching", etc. that generally lean in the direction of assisting hope, esteem, purpose, control, choice, etc. versus "doing for", "telling what to do", etc. . Other items such as peer support and services or the inclusion of consumers on various decision making committees or boards are other aspects of the "recovery movement".

According to the President's Freedom Commission: "***Recovery*** refers to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual's recovery". In our setting these principles can inform the spirit with which our services are delivered. In some ways it is more useful to think of them as dimensions of our services and can affect the way services are delivered, the way individuals are treated, and their experience of that service or treatment. To the extent to which services are consistently delivered in a manner that facilitates the restoration of hope and self-esteem, the development of purpose in one's day to day life, the experience of being connected to

someone who is trying to help, the experience of having choices and making them, and the sense of increasing their control over their lives (versus being tossed around by their illness, symptoms, problems, family, or system) then the likelihood is greater that the individual will take more personal control over managing their illness to achieve more satisfying life results. It is important to recognize that recovery is a process that will continue after a person no longer needs intensive hospital services. It is expected that the recovery process begun in the hospital will continue in community settings through peer support, WRAP Plans, and the inclusion of consumers on decision making panels and committees.

With respect to choice, a critical but operationally complex element in our setting, we have proceeded within the following frame. Life is a limited menu for all of us. To have choice does not mean all choices all the time nor does it mean choices independent of consequences or opportunities. However, the fact that the menu of choices is limited does not mean that there are no choices. For example, a person may not have the choice to not take medications, but may well be able to contribute to what medication they will take. Or, a person may not know what charges have been placed against them, but certainly may know what they prefer to wear or who they prefer to hang out with. This frame is readily understandable and therefore useful. Our staff is a remarkable in their ability to generate hope for people who have lost it, to connect to people who have isolated themselves, or to help people have a purpose today or this morning if not for next week or next year. This is what we need to build on.

Our task is, as it has been, to increase the consistency and effectiveness of interventions and interactions along the dimensions of hope, esteem, purpose, connection, and choice in a very real, non-ideological way.

We have previewed the Inspector General's findings related to WSH and sought to develop ideas and proposals that would have the most helpful and useful impact in helping us provide better service and meet this task. We have not attempted to address each and every item, nor been focused specifically on achieving a better "score" when the review is performed next time. It is my belief, as it has been, that this is an adjustment in our service provision, more in how we conduct certain things than what we do. I think we can move maybe 10%, maybe 15%, in terms of increasing the aggregate individual patient experience of hope, connection, choice, and purpose and in doing so increase the likelihood of a better outcome when they return to the community. We have to do this within the context of our other demands related to census, acuity, forensic work, risk management, skill building, budget, and other mandates so that what we do relative to recovery is integrated rather than disconnected from these other matters. In that way the changes will impact all services and be integral in our operation. It is through treatment that we reduce risk and facilitate improvement and recovery. Treatment is best done holistically, based on priorities, in an

integrated fashion, with due attention to risks and realities, and with as much collaboration as can be attained.

Time frame: We expect this project, despite already being underway, will require a number of years. Indeed, it is conceivable that it will never be completely finished as each step forward seems likely to inform and suggest subsequent steps. For various reasons we are conceptualizing this process as a developmental one and, within the limits of a civil bureaucracy, trying to keep it as organic as possible. While we believe that after the first 12 – 18 months we will have to add more focused training, performance monitoring for some aspects of the process, adjusting practices, and further expanding and refining the roles of peer support individuals we believe those subsequent actions will be more effective if based in our assessment of progress conducted during the fall of 2008.