# RECOVERY COACHING PRACTICE GUIDELINES

***Revised July 2021***

Montgomery County
Office of Mental Health

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## ACKNOWLEDGEMENTS

These Guidelines were developed during the Recovery Coaching transformation effort that took place in 2012. Learning was incorporated from a variety of sources, including: executive sponsors; agency change teams implementing the new Recovery Coaching model; and the input of Directors, Team Leaders, participants, peers, and clinicians.

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# INTRODUCTION

## PURPOSE

The Montgomery County vision of Recovery Coaching is that it is a *time-limited service* aimed at supporting and promoting the recovery journeys of individuals with mental illnesses and other challenges. These Practice Guidelines are meant to build on required Recovery Coaching training and the ongoing education and experience of Recovery Coaches. They contain fundamental key topics for Recovery Coaching, with strategies and links to resources to support participants to move forward in their recovery. The strategies are not designed to be prescriptive or directive step-by-step directions. They represent suggested responses to challenges experienced by Recovery Coaches and their participants; team discussions will help Recovery Coaches assess their work and plan better ways to achieve goals. It is expected that Directors and Team Leaders will incorporate these guidelines into their leadership and supervisory practices.

While these Practice Guidelines are not meant to be a complete checklist of required practices, they do represent an expected commitment to practices and strategies aligned with a recovery and community orientation to services. They will remain a *work in progress* as Recovery Coaching teams, participants, and other stakeholders refine methods that demonstrate positive, life-enhancing outcomes that will inform future versions of this document. The creativity, inventiveness, and imagination of Recovery Coaches, participants, their supporters, and other providers of services will undoubtedly raise the bar for practices and strategies.

## ORGANIZATION

These Practice Guidelines are built around the primary aspects of an individual's life that are central to a recovery process and the approaches and resources that will support Recovery Coaching practice. They are intentionally short and succinct for ease of use. The Practice Guidelines help Recovery Coaches to identify individuals with high risk and high needs so they can increase service intensity in urgent situations and use more routine support as participants move towards recovery and transition out of services.

Each guideline has an introductory paragraph with the core concepts related to the guideline. This is followed by a section of strategies, with links to resources that support Recovery Coaches and participants to achieve goals related to the guideline.

Core themes and service principles that infuse every guideline include the use of formal and informal peer support, person-directed care, "people first" approaches, empowerment through education and self-advocacy, expanding natural supports, community connection, and use of mutual aid.

# FOUNDATIONAL LEARNING

## MONTGOMERY COUNTY RECOVERY VISION STATEMENT

*"To promote wellness and recovery by creating an environment where all people are empowered to have freedom to make choices about their lives, to pursue their personal goals, and to do so with dignity, and the respect of others."*

Montgomery County's Office of Mental Health (OMH) is committed to providing individuals with the highest quality health care services, which are easily accessible, respectful of the individual and family, welcoming, and focus service delivery on the unique needs of each individual. OMH ensures this commitment through demonstrable and sustained improvement in projects concerning significant aspects of clinical care that can be expected to affect individual's mental health status, satisfaction, and overall functioning. OMH's Quality Management Program is based on the principles of recovery and every individual's right to the highest quality of life.

In recent times, the mental health field has learned much about successful treatment and recovery support for individuals with mental illnesses and co-occurring disorders (COD). Treatment is often most effective when provided within a psychosocial framework, with an understanding that individuals with mental illness may benefit from psychiatric, clinical, and psychosocial interventions. Recovery-oriented treatment and support addresses all three critical domains through a team providing integrated treatment and services. Services and supports are structured to facilitate recovery over time, recognizing that individuals with mental illness may require long term supports; that their needs wax and wane with their illness and life circumstances; and that recovery is not linear. Using stages of change and motivational interviewing to support engagement and motivation, Recovery Coaching services empower participants to help themselves, define their own recovery goals, and look to peers to demonstrate recovery's possibilities.

In 2005, Montgomery County transitioned Intensive Case Management and Resource Coordination to Blended Case Management, in the form of team-based Recovery Coaching teams. Recovery Coaches develop integrated recovery plans incorporating best practices and offer hope for recovery. Recovery Coaching support depends on establishing relationships, engagement, and motivation. With this focus, the Recovery Coach's job is to build trust, support hope, hold out the possibility of change, and motivate the person toward it.

These Practice Guidelines were informed by Montgomery County's transformation to a recovery-oriented system and by the transition to the Blended Case Management model of Recovery Coaching.

## KEY CONCEPTS OF RECOVERY

*"Recovery does not mean cure. Rather recovery is an attitude, a stance, and a way of approaching the day's challenges. It is not a perfectly linear journey. There are times of rapid gains and disappointing relapses. There are times of just living, just staying quiet, resting and regrouping. Each person's journey of recovery is unique. Each person must find what works for them. This means that we must have the opportunity to try and to fail and to try again. In order to support the recovery process mental health professionals must not rob us of the opportunity to fail. Professionals must embrace the concept of the dignity of risk and the right to failure if they are to be supportive of us."*[1]

**Hope, individuality, choice, peer support, community connection, personal responsibility, a meaningful life, advocacy, and resources are the core recovery supports.**

- Hope is essential; it is the foundation for recovery and supports the belief in the individual's potential to experience a full and satisfying life.
- Recovery is a process; it is not linear.
- The work of recovery may begin at any time in one's unique and personal journey.
- Recovery focuses on the individual, not the illness.
- Recovery refers not only to the process of moving forward in addressing the illness, but also the stigma and catastrophic events that may occur as a byproduct of having a mental illness.
- A recovery-oriented system uses outcome measures that are oriented to an individual's achievement, functioning, choice, and quality of life – not just relief of symptoms.
- Individuals have personal responsibility, accountability, and control. They are entitled to make their own informed choices in order to live individually determined and meaningful lives.
- Access to community resources – mental health services, education, employment, advocacy groups, and peer support – is essential to promote wellness and recovery.
- Cultural competency supports respect for individuals' cultural and spiritual differences as well as their special needs.
- Peer support and mutual aid are highly valued, offering hope through the unique empathy and understanding that come from peer relationships.

[1] Deegan, P. (1996). Recovery as a journey of the heart. *Psychiatric Rehabilitation Journal, 19*(3), 91-97.

## RECOVERY COACHING PRINCIPLES

**Relationship is Primary**

- The relationship between Recovery Coach and participant is central to recovery.
- Recovery Coaches support individuals as they develop goals, build their own relationships, and gain skills in self-management – by “doing with” rather than "doing for” the individuals they serve.

**Services are Strengths-Based and Person-Centered**

- Recovery Coaches use a person-first approach: individuals are *people* first and foremost, with unique qualities, hopes, and needs.
- The individual’s hopes, dreams, and aspirations drive goals, recovery plans, services, and supports.
- Each person’s personal and cultural preferences, strengths, needs, and stage of change determine the pace (frequency, intensity, and time) and place of service.

**Resources and Supports are Integrated into Team Practice**

- Clinical consultation and collaboration with therapists, psychiatrists, and nurses enriches service quality.
- Resources are used to grow competency and infuse services with evidence-based practices.
- Recovery Coaches assure coordination and continuity of care to support health and wellness.

**Peer Support**

- Peer support (both formal and informal) helps both team members and individuals receiving services.
- Individuals are encouraged to connect to formal peer support, provided by Certified Peer Specialists (CPSs), who act as bridges to the community and help individuals achieve their recovery goals.
- The Recovery Coaching service values the expertise that comes from lived experience. Agencies hire individuals whose own experience relates to the individuals they serve, and who are willing to use their experience in their work as they share their life lessons in support of recovery.

**Assertive Outreach and Referrals**

- Teams establish personal relationships with key community organizations and referral sources as they assertively identify and engage the community and potential service recipients.
- Service begins when a person is identified as needing or wanting service. Engagement billing allows time for individuals to discover the merits of Recovery Coaching and sign onto the service.

**Access and Availability**

- There are no barriers and no wrong door to access prompt service for new or returning individuals.
- Individuals with urgent needs are seen quickly; 24/7 on-call support is available.

- Individuals who are hospitalized are seen within 72 hours of admission and again within 7 days of discharge.
- Hours of operation are flexible and services are mobile. Recovery Coaches support individuals in real-life settings where they can best learn and practice new skills, providing evening/weekend services when needed to support individual goal attainment.

**Recovery Plans**

- Every individual seeking services develops a recovery plan that reflects individual goals, the steps needed to help attain those goals, and responsible parties.
- Plans are living documents modified as services evolve and goals are attained or changed.

**Community**

- Recovery Coaching is part of the community and helps create relationships that improve knowledge, engagement, public health, safety, civic involvement, and access to resources.
- Recovery Coaches support individual's lives in their communities of choice to enhance the experience of belonging.
- Recovery Coaching services act as a bridge to community life, not a replacement for it. Recovery Coaches, collaborating with participants, find existing community opportunities to support growth in interests, e.g., bicycle clubs, walking clubs, crafts circles, reading clubs, etc.

**Natural Supports and Mutual Aid**

- Recovery Coaches help individuals to build or expand their networks or "circles of support" – friends, family, peers, etc., who become part of the fabric of each person's day-to-day life.
- Recovery Coaches identify available mutual aid resources and help individuals connect with appropriate supports.

**Empowerment**

- Recovery Coaches help participants identify personal goals and build skills to attain those goals.
- Recovery Coaches help participants develop coping strategies and access resources to use their strengths and manage their challenges.
- Recovery Coaches help participants with primary wellness areas:
    - To obtain and maintain safe housing
    - To pursue employment and a career path, using education to improve life circumstances
    - To pursue health and wellness goals
    - To pursue leisure, recreational, civic, and spiritual interests
- Recovery Coaches encourage participants to support one another, experience competency as leaders, and give back to their communities.

## SELF-CARE

Self-care is a way for social service professionals to balance activities and preserve longevity and happiness in their careers and at home. **To promote long-term sustainability in the profession and avoid burnout, it is essential that self-care techniques be developed and put into regular practice.** It can be challenging to practice self-care in the workplace, but there are small things that can be done that have a large impact. Self-care strategies include:

- Plan ahead and be prepared. Meals, restroom breaks, breast pumping, etc. can be difficult to balance due to the mobile nature of RC work.
    - Know where local public restrooms are located. If breast feeding, identify places that are comfortable for pumping needs.
    - Schedule breaks into the day – consider if you need to heat up your lunch, and plan around having microwave/stove access.
    - Always have adequate water and snacks on hand.
    - Bring protective/hygienic gear: masks, hand sanitizer, sanitizing wipes, etc.
    - If carrying heavy equipment (large laptops, etc.) consider using a backpack to reduce any bodily pain and strain.

- Establish healthy boundaries:
    - Start and stop your day as scheduled. While emergencies occur that may lead to a longer work day than normal, it is important to make holding to your schedule the norm.
    - Likewise, always take your lunch break.
    - Let individuals receiving services know your boundaries ahead of time:
        - How you will handle calling out sick, taking vacation, or emergency re-schedules
        - Your personal safety needs (i.e. meeting in public, asking that certain family or friends not be around during scheduled visits, having the dog put away, etc.)
        - How you plan to respond to anger/aggressive behavior
        - Time limitations for each visit or phone call, if needed

- Create an individualized self-care plan:
    - First, take a self-care assessment
    - Next, create a maintenance self-care worksheet
    - Finally, be prepared with an emergency self-care worksheet

- Keep your self-care worksheets with you, and *practice using them.*
    - For further reading on self-care, see the University at Buffalo School of Social Work Self Care Starter Kit.

- Practice grounding techniques:

- Mindfulness is a skill that allows individuals to observe thoughts, emotions, and sensations without judging or reacting to them. Just watch and take in details of something without attaching a story or judgement to it.
- Somatic awareness is being aware of what is going on in your body. If you "scan" your body and notice changes, it can help you to gauge what your nervous system is doing and will help you to be aware of ways your body may be reacting to situations.
- Narrative strategies are stories created with meaning and intention. Try to create narratives about your role as a Recovery Coach (e.g. What am I responsible for? What am I not responsible for?). This can help to reduce the stress experienced when entering a workspace or feeling the pain of others.
- Additional techniques to reduce stress can be found here.

- Engage in self-advocacy. Practicing self-advocacy skills at work is beneficial in raising awareness of the problems RCs face, ensuring rights aren't violated, and helping to decrease stress. Self-advocacy includes:
  - Establishing your personal boundaries, as listed above
  - Expressing your needs to your direct supervisor.
    - Consider taking an aptitude test (like the one found here) so your supervisor can better understand your individual communication style.
  - At times, external entities (landlords, family members, probation officers, etc.) may misdirect blame towards an RC when an individual receiving services isn't progressing the way they expect. Prepare a firm but professional response for this, and be ready to use it when necessary.

## *UNDERSTANDING VICARIOUS TRAUMA*

Recovery coaches, through the very nature of the work, may be exposed to traumatic situations. Vicarious trauma (sometimes referred to as secondary trauma or compassion fatigue) is "the emotional residue of exposure" from bearing "witness to the pain, fear, and terror that trauma survivors have endured." Vicarious trauma may present in the following ways:

- Physical: Rapid pulse/breathing, headaches, impaired immune system, fatigue, aches
- Emotional: Hypersensitivity, feelings of powerlessness, numbness, anxiety, guilt, fear, anger, depletion
- Behavioral: Irritability, sleep and appetite changes, isolation from friends and family, self-destructive behavior, impatience, nightmares, hypervigilance, moodiness, startling or frightening easily
- Spiritual: Loss of purpose, loss of meaning, questioning goodness versus evil, disillusionment, questioning prior religious beliefs, pervasive hopelessness
- Cognitive: Diminished concentration, cynicism, pessimism, preoccupation with individuals receiving services, traumatic imagery, inattention, self-doubt, racing thoughts, recurrent and unwanted distressing thoughts
- Relational: Withdrawal, isolation from friends and family, minimization of others' concerns, projection of anger or blame, intolerance, mistrust.

If you are experiencing the impact of vicarious trauma in the workplace, consider the following:

- Ask your supervisor what the agency's policy is on supporting employees, or reach out to your human resources office to see if you have access to an Employee Assistance Program (EAP). An EAP is a voluntary, work-based program that offers free and confidential assessments, short-term counseling, referrals, and follow-up services to employees who have personal and/or work-related problems.
- Always debrief with a supervisor or trusted colleague after exposure to secondary trauma.
- Use the self-care tips listed in the previous section.
- Review SAMSHA's Tips for Healthcare Professionals: Coping with Stress and Compassion Fatigue

## TRAUMA-INFORMED CARE

The majority of individuals served by Recovery Coaching have experienced significant trauma in their lives. Traumatic experiences are often precipitants to the onset of illness. Triggers, that have their roots in earlier trauma, may precipitate current crises. Involuntary treatment, such as seclusion and restraint, exacerbate the impact of early trauma. **The service of Recovery Coaching is trauma-informed, emphasizing the need to support safety and empowerment, especially in the Recovery Coaching relationship. Recovery Coaches advocate for and link to trauma specific treatments.**

The following trauma-informed strategies are employed by Recovery Coaches:

- Assume the presence of trauma.
- Take training about the neurobiology of trauma.
- Expect that a traumatic past impacts trust and a sense of safety in relationship.
- Value the Recovery Coaching relationship as an opportunity to heal.
- Prioritize **respect**, **choice**, and **acceptance** in all interactions.
- Identify the strength and resilience of survivors.
- Educate about trauma and identify resources for managing stress.
- Listen empathically to survivor stories and identify evidence of their resilience.
- Support the development of self-management tools **–** wellness plans (sometimes referred to as crisis plans), Wellness Recovery Action Plans (WRAP), etc.
- Be knowledgeable about grounding techniques and be prepared to utilize when needed.
- Understand behaviors, especially self-injurious behaviors, as adaptive attempts to survive challenging life experiences.
- Utilize self-care strategies to minimize vicarious traumatization.

## SOCIAL DETERMINANTS OF HEALTH

According to the World Health Organization, the social determinants of health (SDOH) are conditions in the environments where people are born, live, learn, work, play, and age that influence health, functioning, and quality-of-life outcomes. These conditions also include forces and systems (e.g., social and economic policies, development agendas, and political systems). The SDOH contribute to a wide range of health disparities and inequities. **Understanding the impact that these determinants have on health and the relationship between how population groups experience their environments is fundamental. It is important to note that countries at all levels of income, health, and illness follow a social gradient: the lower the socioeconomic position, the worse the health.**[2]

Review Montgomery County's 2019 Health in All Policies Implementation Policy to learn about the ways the County plans to address the SDOH in all future policy development and implementation, budgeting, and delivery of services.

Healthy People 2030 groups SDOH into five domains:

**Economic Stability**

- Understand the importance in supporting individuals to earn steady incomes, or a living wage, that allows them to meet their needs. Factors that affect economic stability include:
    - Employment and work environment
    - Affordable housing
    - Food access to address food insecurity
    - Access to transportation
    - Income/poverty and financial resources

- For more information and resources related to economic stability:
    - Refer to the Income and Employment & Education sections of these Guidelines.
    - Review Healthy People 2030's economic stability objectives.
    - Review the County's employment and education resources for individuals receiving services.
    - Use RHIhub's evidence-based toolkit.

**Education Access and Quality**

[2] World Health Organization. (n.d.). *Social determinants of health*. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

- Understand the importance in increasing educational opportunities as individuals with higher levels of education are more likely to be healthier and live longer. **Education is the most important modifiable social determinant of health in reducing socioeconomic inequalities.** [3]

- For more information and resources related to education access and quality:
  - Refer to the Employment & Education section of these Guidelines.
  - Review Healthy People 2030's education access and quality objectives.
  - Review the County's employment and education resources for individuals receiving services.

**Healthcare Access and Quality**

- Understand the importance in increasing access to comprehensive, high-quality health care services which includes mental health services. Factors that affect healthcare access and quality include:
  - Financial means to pay for services
  - Ability to take paid time off of work to use services
  - Ability to communicate with healthcare providers

- For more information on healthcare access see the following:
  - Refer to the Physical Health section of these Guidelines
  - Review Healthy People 2030's healthcare access and quality objectives.

**Neighborhood and Built Environment**

- Understand the importance of neighborhoods and environments that promote health and safety as the neighborhoods that individuals live in have a major impact on their health and well-being. Examples of the built environment include:
  - Environmental health (e.g., air quality, safe drinking water, access to green spaces, access to healthy food, and noise exposure)
  - Housing (e.g., building accessibility, lead exposure, proportion of families that spend more than 30% of income on housing, impact of housing on mental health, housing insecurity and homelessness)
  - Transportation (e.g., motor vehicle safety, walkability, and mass transit)

- For more information and resources related to neighborhood and built environment:
  - The Social Needs Screening Tool is a similar screening tool developed by the American Association of Family Physicians to identify health-related social needs.

[3] Education: a neglected social determinant of health. (2020, July). *The Lancet Public Health, 5*(7). [Editorial]. DOI: https://doi.org/10.1016/S2468-2667(20)30144-4

- Review Healthy People 2030's neighborhood and built environment objectives.
- The Accountable Health Communities Health-Related Social Needs Screening Tool is a screening tool developed by the Centers for Medicare & Medicaid Services (CMS) to identify health-related social needs.

**Social and Community Context**

- Understand the importance of social and community support as individuals' relationships and interactions with family, friends, co-workers, and community members can have a major impact on their health and well-being. Factors that affect social and community support include:
  - Civic participation
  - Discrimination and racism
  - Incarceration and crime
  - Social cohesion and social connectedness

- For more information and resources on social and community context:
  - Refer to the Strengthening Social Networks section of these Guidelines.
  - Review Healthy People 2030's social and community context objectives.

## COVID-19

COVID-19 is an infectious disease that is caused by the virus called SARS-CoV-2. **It is mainly spread via respiratory droplets such as those released when a person coughs, sneezes, or talks.** While everyone is at risk of getting COVID-19, older adults and those with certain medical conditions are at an increased risk of developing severe illness from COVID-19. There are currently two COVID-19 vaccines that are authorized for emergency use and others are being developed; however, it is still important to stop the spread by **taking precautionary measures such as wearing a mask, hand washing, cleaning frequently touched surfaces, and social distancing**.

Some preventive measures and strategies that can help stop the spread are:

- Wear a mask that covers your nose and your mouth. More information on how to properly wear a mask is here.

- Wash your hands for at least 20 seconds, or if soap and water are not readily available, use an alcohol-based hand sanitizer that contains at least 60 percent alcohol.

- Clean and disinfect frequently touched surfaces such as doorknobs, light switches, and cell phones.

- Practice social distancing by maintaining at least 6 feet (about 2 arms' length) of distance from people not in your household both indoors and outdoors.
    - The CDC further suggests maintaining 10 feet of distance from people not in your household when indoors to avoid transmission due to poor air flow.

- Best practices for screening individuals entering the agency include:
    - Encourage individuals to self-monitor for symptoms of COVID-19 before arriving at an agency's site.
    - Ask these general screening questions and then guide the individual toward the appropriate next steps based upon their answers.
    - Contact your agency's supervisor for specific screening policy guidelines.

- If exposure occurs, monitor for symptoms such as fever, cough, shortness of breath or other symptoms of COVID-19 and then act accordingly to whether you have no, mild, or severe symptoms.
    - While monitoring for symptoms, begin the 14-day quarantine.
    - Guidance about ending quarantine can be found here and further quarantine recommendations can be found here.

- If an individual has been exposed, has symptoms, or tests positive for COVID-19:

  - Cancel your in-person appointment.
  - Talk to the individual about how to monitor for symptoms of COVID-19.
  - Guide the individual on how to clean and disinfect their home.
  - Encourage or assist the individual in contacting their healthcare provider
  - Consider using ExpressMed Transport or TransNet, which are transportation services available for medical appointments – including COVID-19 testing.
  - Look for more information on how to support an individual when they've been exposed here.

- COVID-19 testing is free, for all ages, at six sites across Montgomery County.
  - Tests are available to any Montgomery County resident through same day appointments **only**.
    - Online registration for same-day appointments opens at 7 a.m. every Monday–Friday. The registration link for each of the six sites is listed under "Register for a Test."
    - Alternatively, you can call to schedule an appointment at 610-970-2937. The phone line is open from 8:30 a.m. until all appointment slots are filled every Monday–Friday.
    - Language line interpretation is available for phone registration.
  - Tests are self-administered via a nasal swab kit that is given at the time of the appointment. A video further explaining what to expect during your appointment can be found here.
  - Alternate testing sites can be found here.

- Policies about traveling with individuals during COVID-19 will differ by agency. However, general guidelines include:
  - Wash your hands before and after the ride. If soap and water are not readily available, use an alcohol-based hand sanitizer.
  - Wear a mask. Both the RC and the individual must wear a mask for the entirety of the ride.
  - Encourage the individual to sit in the backseat in order to maintain as much distance as possible.
  - Lower windows to increase air flow if the weather permits.
  - Avoid using the recirculated air option for the vehicle's ventilation.
  - Sanitize frequently touched surfaces such as the steering wheel and door handles before and after a ride. More information on how to properly sanitize a vehicle's interior can be found here.

# PRACTICE GUIDELINES

## ACCESSING SERVICES THROUGH BEHAVIORAL HEALTH INSURANCE

The Office of Mental Health (OMH) is responsible for the implementation and oversight of HealthChoices, Pennsylvania's Medicaid managed care program, through a partnership with Magellan Behavioral Health Services. **Recovery Coaches actively seek additional clinical support and coordination through Magellan Care Managers.**

RCs can access Magellan Care Managers for the following:

- Clinical advocacy for members
- Strategize about changes in approach when there is a lack of treatment progress
- Coordinate with the Magellan networking department to identify and expand access to needed treatment options (either within the network or beyond)
- Address needs of members with challenging issues. In this collaborative process, Magellan coordinates activities including but not limited to:
    - Treatment Team meetings
    - Contact with all outpatient treatment providers
    - Information sharing (review of claims data, pharmacy data, etc.)
    - Development of a plan for "at risk" individuals
    - Liaison between inpatient and outpatient providers
- Discuss unsuccessful linkages to Recovery Coaching services; Magellan can provide additional background and demographic information
- Notify of and discuss closure to services

## *MAGELLAN INTENSIVE CARE COORDINATION – "HIGH OPPORTUNITY"*

Intensive Care Coordination (ICC), sometimes referred to as the "High Opportunity" program, is a case management program offered by Magellan for individuals who have been admitted to acute inpatient care for either 25 consecutive days or two admissions within 60 days. Magellan Care Managers regularly meet with Recovery Coaching Teams from the Community Behavioral Health Centers (CBHCs) to review the services and supports that may aid in recovery for these individuals. **Recovery Coaches recognize the value of this collaborative approach and regularly consult with Magellan Care Managers when individuals they support are enrolled in ICC.**

## TEAM APPROACH

**The use of a team approach is a developing practice in Recovery Coaching and fundamental to the transformation of Recovery Coaching. Utilizing the availability and expertise of all team members makes the service more able to provide urgent, timely, and skill-based service in addressing participant needs and wants. When all team members have first-hand knowledge of a participant, they are better able to support their colleagues with other perspectives and by lending manpower.**

Some team guidelines and strategies are:

- Teams consist of 3-5 Recovery Coaches; a maximum of three teams are supervised by a single Team Leader.

- Teams assign each person a primary Recovery Coach who is responsible for making sure the service meets participant needs.

- Teams assess the strengths, talents, and skills of each team member (team inventory) so that these strengths can be tapped into, when needed, to meet challenges and provide better service to participants.

- The team inventory is used in engagement to develop ways to promote a person's connection to Recovery Coaching.

- Team members connect daily (phone, email, face-to-face) to identify urgent needs of participants and/or team members and plan strategies to meet these needs.

- Team members meet weekly with supervisors to review their work and focus on methods and practices to advance the recovery of participants.

- Team members, using participant input, identify when a relationship is not working. Teams allow for ease in changing a Recovery Coach when needed.

- Team members support the primary Recovery Coach in increasing the frequency and availability of contact when the participant's needs require greater service intensity.

- Team members support each other by providing coverage when a Recovery Coach needs respite and relief. This strategy helps to provide time to gain a renewed perspective and to re-engage with a participant.

- Team members collaborate on providing the evening and weekend coverage needed to engage more actively in the community, an important component of a recovery process.

- Teams support participants in later stages of change by bringing together groups of individuals who are actively working toward a particular goal, e.g., employment.

## BEGINNING & ENDING SERVICES

### *ENGAGEMENT*

The goal of engagement is to develop a relationship to support a person in living a meaningful life. Engagement is a process, not an event. **Recovery Coaches understand that engagement is the responsibility of the service and recognize the need for assertive outreach – actively and persistently trying to engage individuals into service. Recovery Coaches listen carefully to individual's stories to find nuggets for connection and issues that might be resolved quickly, to help with engagement.**

Some strategies for engagement into service are:

- Discuss discharge from the first meeting. Make the participant aware of the time-limited nature of the services, and frame discharge as an achievement. Asking what "successful discharge" means to the participant will help inform recovery goals.

- Inquire about the best ways to connect with the individual. Are they more comfortable meeting at home, in the community, or in an office setting? Do they prefer to communicate though calls, texts, or emails? Let them know the agency policy for outreach if they begin to disengage in services.

- Be aware of the person's stage of change in recovery; use motivational interviewing as a tool to engage and move individuals forward.

- Meet individuals in places where they feel comfortable, including their homes. Meet individuals at times that work best for them. Offer choices, even small ones.

- Always use the chosen name and pronouns with which the individual has identified, regardless of what their formal documentation (identification cards, insurance cards, etc.) may list.
    - Do not make assumptions about gender identity; instead, ask what pronouns each individual uses during the first conversation, and offer yours.

- Avoid questions that can be answered with one word or a brief factual reply. Use open-ended questions and statements/observations to move conversations forward: "tell me how…," "tell me what…," or "I noticed that…"

- Start with a conversation, actively listening to the individual's story without judgment. Convey empathy, a positive attitude, and an appreciation of the willingness to share.
- Address the individual's goals, not staff or system goals.

- Strive to end the initial contact with a tangible sense that there is hope and the person can be helped. Providing concrete assistance with a pressing life challenge during engagement demonstrates responsiveness and increases the likelihood of a firm connection to Recovery Coaching.

- Understand that individuals have reasons for choosing not to engage. Have direct conversations to acknowledge their reluctance, e.g., fear of losing independence; past history of poor service or disappointment with relationships; lack of hope; history of losses related to illness, etc.

- Explore the pros and cons of enrolling in the service, and ask what might help them to decide on a trial period for the service.

- When individuals are connected to other agency services, build on relationships to introduce the service.

- When individuals disengage before reaching a relatively sustainable level of self-management, return to assertive outreach strategies, including calls, personal notes, home visits, and/or communication with other agency service providers.
    - Be non-judgmental; keep the door open for conversation.
    - Recognize that individuals may move to an earlier stage of change, and implement appropriate strategies.

## *TRANSITIONS*

Our recovery-oriented service approach expects that a person's support needs can be met by increased involvement with the community and the resulting expansion of natural supports**. Recovery Coaching is a time-limited service that strives to keep the service goal focused, so that progress and success in goal attainment is at the forefront of care. The documentation of goal attainment through the use of recovery planning indicates when the need for the service is diminishing. In Recovery Coaching, as in all mental health services, the seeds for ending are planted in the beginning of service. At the same time, Recovery Coaches create pathways back to the service, when the need arises, that are free from administrative barriers.**

Some strategies that support a time-limited service are:

- Explain the time-limited and goal-focused nature of the service when describing Recovery Coaching. This includes written descriptions.

- Include the person's vision of the end of service in the initial assessment process, asking how the individual will know when it's time to transition. Review throughout the process and amend as needed.

- Understand that relationship is the service vehicle for supporting individuals in goal attainment. Creating relationship, while critically important, is not the outcome.

- Set goals for expanding informal networks of support. For example, Mary Ellen Copeland recommends developing five key supporters.

- Celebrate service accomplishments and service completions; e. g., parties, graduations, newsletter articles, special announcements, etc.

- Encourage each person to develop his or her "recovery story" as an action step in preparation for discharge.

- In discharge planning, include the person's vision for re-engagement by asking them how they will know if they need to re-engage with services.

- Plan out other interventions to tackle anticipated problems; e.g., Wellness Recovery Action Plan (WRAP) plans; mutual aid and other community groups; peer support talk lines, etc.

- Understand and acknowledge that the relationship involves an emotional tie for the person and the Recovery Coach. Openly discuss change and how hard that may be.

  - Recognizing the person's accomplishments while reducing service intensity helps the person to understand that his or her success is not due to the relationship but to acquiring skills and confidence.
  - Help the individual transfer the connection to others in their day-to-day lives.

- Develop ways for individuals to reconnect without experiencing a problem, e.g. an annual open house, phone calls to check-in, alumni events, etc.

- Develop an easy way to re-engage the service post-discharge, if the need develops. Understand, and communicate, that re-engagement does not imply a "relapse." Reconnecting to services may be short-term and solution-focused.

- It is helpful to have individuals who have successfully used mental health care and self-identify as being in recovery to visit programs and speak to Recovery Coaching participants. Create pathways that enable those who have successfully used the service to give back; e.g., speak at monthly gatherings, escort someone to a mutual aid group, help edit a newsletter, etc.

## RELATIONSHIPS

The relationship between the Recovery Coach and the individual is central to recovery – establishing trust, building motivation to engage in service, and supporting hope and the possibility of change. **Recovery Coaches are open, curious and responsive, showing a genuine desire to learn about the individuals they serve. Recovery Coaches hold hope and support individuals as they develop goals, build their own relationships and gain skills in self-management – by "doing with" the persons they serve.**

Some Recovery Coaching strategies that support relationships are:

- Allow time for the relationship to develop. Respect the person's pace and timing. Understand that past experiences may make it difficult for the person to feel safe and trust others.

- Understand that the relationship is reciprocal; you and the participant will learn about each other and from each other.

- Use easy-to-understand language when communicating with individuals.

- Use a "person-first" approach. Participants are individuals with unique strengths, interests, knowledge, skills, and special talents.

- Respond with urgency to pressing needs; this helps build trust in the relationship.

- Actively listen and build on strengths. Provide feedback and encourage continued communication about topics raised by the person, for example:
    - "Tell me more about what it was like for you when…"
    - "It must have been very stressful when…"
    - "You really worked hard at that job; it couldn't have been easy to travel such a long distance each day…"

- Adopt a non-judgmental attitude; accepting beliefs, cultural, and spiritual heritage and preferences.

- Acknowledge the strength shown by individuals when they share painful or stressful experiences.

- Respect individual choices and right to self-determination, even when decisions may have adverse consequences (other than imminent danger to self or others). Use motivational interviewing to engage in a respectful discussion of pros and cons with regard to planned decisions/actions that may be of concern.

- Model and encourage respect for others with whom the participant has personal or professional relationships.

- When conflicts arise between the participant and others:
    - Clarify the issue(s) with the participant; be sure you understand their goal.
    - Brainstorm different approaches to resolve the problem; identify past successes in resolving conflicts that may be useful in the current situation.
    - Role-play how these different approaches might affect resolution; help the participant use active listening; be sure they play both roles – self and adversary – to increase their ability to see another's point of view.
    - Help them select a strategy and plan how and when to try it out.
    - Meet with them after to analyze results; this cycle can be continued until the problem is resolved.
    - Sometimes it can help to include the other party in your meeting with the participant.

- When conflicts arise between yourself and other providers:
    - Adopt the same problem-solving approach.
    - Assess your own role in the conflict and acknowledge mistakes that were made; this can often be therapeutic and helpful to the relationship.
    - Discuss this with your supervisor so that you are clear about possible resolutions.

## PEER CULTURE

Individuals with lived experience of mental health challenges prove every day that they possess a powerful ability to engage, persuade, and teach individuals receiving services that living a full, rich, connected life in the community is not only possible, but desirable. Whether acting within multidisciplinary Recovery Coaching teams, or other connections, peer staff and leaders bring wisdom not acquirable through traditional professional preparation. **Recovery Coaches recognize the value of formal and informal peer support, and model this through discussion of their own lived experience (when applicable) and/or through frequent consultation and engagement with peer leadership and peer services.**

Some practices and strategies for Recovery Coaches to embrace peer culture include:

- Embrace and learn how to share your own lived experience, if applicable, through consultation with peer leadership and supervisors.
- Link interested participants to Certified Peer Specialists (CPSs). Meet as a team with the participant and their CPS, coordinating recovery goals and activities.
- Seek peer input and feedback frequently.
- Attend monthly Community Support Program (CSP) meetings with interested individuals and encourage their participation in the socialization, conference, or advocacy subcommittees. Likewise, attend the annual CSP Conference and Mental Health Awards and nominate staff and participants at your agency.
- Encourage participants to engage with peer-run agencies, such as Hopeworx and the Pottstown Recovery Learning Center.
- Embrace mutual aid groups as a recovery tool for participants.
- Attend Intentional Peer Support trainings when offered by the Behavioral Health Training Institute.
- Learn from experts who have lived experience:
    - Pat Deegan
    - Marsha Linehan
    - Elyn Saks
    - Lori Jo Bach (formerly Lori Schiller)
    - Kay Redfield Jamison

## USING HOME VISITS & OBSERVATION TO GUIDE PRACTICE

**Recovery Coaches develop strategies and interventions to promote wellness by paying attention to the way individuals take care of themselves. This is best done through developing and nurturing the relationship and partnering with individuals in their home environments. Recovery Coaches utilize their knowledge about a person's healthy lifestyle, gained through discussion, observation, and interpersonal experience, to expand the recovery focus of the work to include healthy living.**

Some strategies aimed at assessing and fostering healthy living include:

- Pay attention to the individual's appearance, including hygiene, evidence of skin conditions, bruises or wounds, dental care, cleanliness, and if their clothing is appropriate for the weather.

- Use your relationship to explore making changes related to what you observe. The timing of these observations is based on having first created a partnership of acceptance and support. Talking about personal appearance is a sensitive issue for most individuals.
    - Gently share your observation by asking a question, for example, "do you have enough changes of clothing to meet your needs?"
    - Gently share your observation by tying it to the person's goals, for example, "I know you really want to find a job and a lot of employers rely on first impressions. I am curious about what impression you might be giving…"
    - Gently share your observation by exploring its meaning, for example, "it seems you may not have showered recently. I know that can sometimes mean someone is having a hard time. How are things going for you?"

- Assess the kind of intervention needed. For example, if the person eats poorly because they don't know how to cook or they are afraid to go food shopping, consider offering healthy lifestyle information, literature, and/or classes in areas that seem to pose a challenge.

- Use all your senses to understand an individual's situation, and follow up with your observations as you explore the person's needs. This includes scanning the neighborhood surroundings as well as the home, paying attention to sights, sounds, smells, etc.

- Use a home visit to explore the person's environmental needs. If there are safety concerns – inside or outside the home, try to develop a wellness plan (sometimes referred to as a safety or crisis plan). If you don't feel safe in the environment, the participant may feel the same.

- Take action to help individuals with extreme conditions, e.g., excessive heat in summer or cold in winter, lack of electricity or water, bug infestations, etc.

- If the person shares a concern about cleanliness, tie that to the person's goals and develop action steps to problem solve the issue, including: obtaining cleaning products, breaking the task

into manageable steps rather than tackling the entire space at once, making a cleaning/laundry schedule, etc.

- Ask about diet and nutrition. If the person has recently lost weight or expresses concern about lack of food, ask permission to explore the contents of the refrigerator and cupboards together. With the participant, find and discuss information about healthy eating, taking into account medical conditions that impact nutrition and/or food allergies. Understand that this may raise a number of related topics, such as lack of money or transportation for shopping, lack of cooking skills, etc. Each topic can become an action step toward the larger goal of healthy eating.

- If the individual has co-occurring substance use disorder:
    - Notice whether there are empty bottles in sight.
    - Notice the location of neighborhood bars.
    - With the help of motivational interviewing, use this information to begin a discussion about connecting to Drug and Alcohol (D&A) treatment or mutual aid.

- If you see signs of smoking, begin a discussion about smoking cessation and link the participant to smoking cessation resources if they are interested.

- Observe sleeping arrangements and provide education about the importance of sleep. Help the participant access improved sleeping arrangements as well as information about sleep hygiene or sleep apnea, if needed.

- Discuss physical exercise, using motivational interviewing to move the person toward action steps. Brainstorm strategies for improving activity and fitness. Start small, e.g., a walk around the block twice a week, and build success. Many individuals have access to fitness programs through their insurance plans; help them explore these resources.

## TELEHEALTH

While telehealth and its technologies are not new, the COVID-19 pandemic has significantly increased its use. Unique challenges to this mode of delivery include limited access to technology or connectivity issues, time sensitivity, engagement, and levels of comfort with technology. However, the benefits are also multiple: convenience, no need to travel, no waiting room, etc. With its growing utilization, special considerations must be made in regard to how telehealth services are carried out.

Telehealth technology requires connection to a broadband network (high speed internet). Strategies that can minimize access barriers to telehealth technology include:

- Help an individual acquire a phone with a data plan:
  - This can be done by applying for Lifeline, a government program that provides free or discounted data plans.
  - SafeLink Wireless and Assurance Wireless are federal Lifeline programs in which individuals who are enrolled in other government programs like Medicaid or Supplemental Nutrition Assistance Program (SNAP) can acquire free data plans and, in some cases, free phones/SIM cards.

- Find internet providers who offer low-cost or free programs to individuals who are eligible:
  - Internet Essentials from Comcast is a program that gives members 60 days of free internet access, regardless of any outstanding charges owed to Comcast.
  - human-I-T and PCs for People are non-profits that provide low-cost internet and low-cost, refurbished computers.

- Locate organizations that offer free internet access. (Note: the confidential nature of services must be considered before pursuing this option and should be discussed with the individual.) Common places that have free internet access include:
  - Montgomery County libraries
  - Coffee shops and cafes
  - Laundromats
  - National fast-food chains
  - Stores that have print centers (e.g., Staples)

- General public Wi-Fi safety measures include:
  - Avoid entering sensitive information.
  - Use “https” (secure) websites as much as possible.
  - “Forget” the network, so the device cannot leave personal information exposed.
  - Enable “two-factor authentication” on frequently visited websites.
  - Learn more about Public Wi-Fi safety.

Strategies that can support the delivery of quality virtual services include:

- Consider both actual and perceived privacy issues during direct sessions with individuals receiving services.
    - Choose a space that is private and try to avoid open air settings.
    - Make sure that doors in the viewpoint of your camera are closed.
    - Encourage the individual to choose a particular place during a set time so that they can focus on the session.
    - If necessary, help the individual explore ways to keep members of their household engaged for the length of the session or shorten the length of the session to accommodate dynamic living situations.
    - Learn more tips and tricks for telehealth from the American Counseling Association.

- Use general best practices when engaging with individuals during virtual meetings.

- Reduce both auditory and visual distractions.
    - Avoid typing, sneezing, or coughing while your microphone is on as it can pick up these noises.
    - If you are not talking in a meeting or conference, mute or turn off your microphone.
    - If you are around others, consider using headphones to ensure privacy.
    - Turn off notifications such as email or messaging applications and close unnecessary tabs if screen sharing.
    - Consider what you are comfortable with sharing in the background of your video and what needs to be kept private and separate from work.
    - Keep your background clear of distractions.
        - If using Zoom, consider adding a virtual background.
    - Make sure that the lighting in your video is front facing.
    - Look at your webcam, not the screen, to assure the individual that you are actively listening.

- To keep individuals engaged, consider implementing the following techniques into sessions:
    - Use ice breakers.
    - Use prompts that help facilitate conversation.
    - Try physical activities like walking or other mindful exercises that those found on Headspace.

- Check the Office for Civil Rights' (OCR) announcements regarding HIPAA and COVID-19.

- Review SAMSHA's Using Technology-Based Therapeutic Tools in Behavioral Health Services.

- Establish boundaries. It can be difficult to separate your work life from your personal life – especially when working remotely. Consider establishing firm work hours and make sure that

you are not checking your work email outside of these hours. Think about supporting this boundary by setting up an automatic out-of-office email message during the hours you are not working.

## RECOVERY PLANNING

The paperwork used to guide recovery planning varies among services; however, the principles involved in recovery planning apply to all services. Recovery planning goes beyond the problem or obstacle that brought a person into service. It embraces a holistic view of the person and explores a variety of life domains that may be addressed in order to achieve a meaningful quality of life. **Recovery planning is an individualized, person-centered process that is guided by the hopes and dreams of the person who is supported by Recovery Coaching and actively involves the participant in every step of the planning process. Recovery planning is a dynamic process, one that is continually revised and deepened in the process of Recovery Coaching support.**

Some principles and strategies for recovery planning are as follows:

- Recovery planning happens after a thorough assessment of strengths, which inform potential needs and desires.

- The planning process begins with eliciting the hopes and dreams of the individual by asking what they want their life to look like.
    - For those who have lost the ability to hold dreams, ask what they had hoped for earlier in their lives.
    - Explore why the dream has changed (such as stigma) and expose the person to peers who have rekindled or developed new dreams.

- The Recovery Coach and participant brainstorm all the components of the vision – "what will it take to have the life you want?"
    - Brainstorming may produce goals as well as action steps. The Recovery Coach helps sort out what big accomplishments (goals) will support attainment of the vision and which ideas are action steps that will be involved in those big accomplishments.

- In this process the Recovery Coach and participant prioritize the results of the "big accomplishment," brainstorming by asking what steps need to happen first.

- The "big accomplishment" priorities become the initial goals for the recovery plan work.
    - The Recovery Coach is thoughtful about not listing so many goals as to overwhelm, but includes a sufficient number of goals to keep building hope for the desired future. It is recommended not to exceed three goals.
    - Frequent plan revisions also help keep the work moving in a positive direction.

- Achieving the goals will require a series of action steps which are prioritized in a similar way. For example, if a person wants to go to the grocery store, the associated supporting action steps may include any or all of the following:
    - Preparing for a visit to the store by assisting the person to complete a shopping list.

  - Doing a behavioral rehearsal or role-play with the individual that mimics the visit.
  - Visiting the store with the individual if they have anxiety about going in.
  - Lessening the amount of support as the individual acquires skills and experience until they go to the store independently.

- Measureable action steps are designed in ways that ensure success within short time frames so as to build a foundation of achievement for the work of Recovery Coach and participant.

- Actions steps will include responsibilities for both the participant and the Recovery Coach. Personal responsibility for participant and Recovery Coach is expected.

- Action steps utilize the individual's strengths; i.e., someone who has a goal of making more friends and is very spiritual (strength) may consider joining a faith community or a bible study group as a way to meet people.

- Both Recovery Coach and participant keep copies of the plan which are reviewed during every interaction and revised as tasks are accomplished.

- If the task is not accomplished, both the participant and Recovery Coach explore the barriers and revise. The initial steps may need to be further broken down, or the step may not have had the genuine commitment of both parties.

- The inability to accomplish a task provides the Recovery Coach with the opportunity to explore concerns that the Recovery Coach may have but the participant has not identified as goals.
  - For example, "if voices prevented you from going to get a job application, do we need to think of ways to manage your voices so they don't interfere?"
  - These conversations may lead to new goals that weren't in the original brainstorming, but which now have a clear connection to the participant's vision.

- Achieving the vision for a quality life is a lifelong process for most people. As the participant becomes more self-motivating and self-initiating in relation to goal attainment, the Recovery Coach and participant begin to identify the goals that need to be accomplished prior to discharge from Recovery Coaching.

- Recovery Coaching develops ways the community can celebrate major goal attainment as a motivator toward greater individual achievement and an inspiration for others, e.g. newsletters, social gatherings to celebrate accomplishments, etc.

## CLINICAL SUPPORTS

Individuals with mental illnesses may benefit from clinical supports to help them understand their illnesses, develop strategies to manage their symptoms, and cope with the stress they experience. Individuals may participate in individual therapy, group therapy, and/or medication management. Clinical services use evidence-based practices targeted to specific challenges. **Recovery Coaching supports participants to pursue treatment and coordinates services with clinical supports. Recovery Coaching strives to help participants become more engaged in and empowered about directing their treatment.**

Some strategies related to clinical supports are:

- Listen without judgment to the person's experiences, thoughts, and feelings about participating in clinical services.

- If the person has no clinical supports, explore the pros and cons of engaging in treatment; identify barriers and develop strategies to address the barriers.

- Be familiar with the array of services available to participants; explore options that best fit their preferences.

- For individuals with clinical supports, become familiar with the services they use and the clinicians they see. Get authorizations to release and receive information, and communicate frequently.

- Set up a recovery planning meeting with the participant and their treatment team.
    - Be sure that the treatment goals and the recovery goals are "on the same page" and mutually supportive.
    - Discuss action steps, responsible parties, and communication pathways.

- Encourage mutual learning (Recovery Coach and participant) about mental illnesses and symptoms and related best clinical and support practices.

- Use team clinical consultation meetings to increase your knowledge about mental illnesses, symptoms, challenging behaviors, and Recovery Coaching techniques to support participant's with issues they are experiencing.

- Call the participant's therapist or psychiatrist directly for urgent needs; ask specific questions.

- Accompany the individual to an appointment if requested, or if there is a need for greater collaboration. With the participant, clarify your role in the meeting.

- Support strategies learned in treatment sessions and skill-based groups by helping participants practice new skills in the community.

## *MEDICATION AS A RECOVERY TOOL*

Recovery Coaching supports a holistic approach to managing life challenges, which, for some, may include medication as an important wellness tool. **Recovery Coaching strives to help individuals become more empowered about medication as a tool in recovery and utilizes interventions derived from motivational interviewing.**

Some Recovery Coaching strategies are:

- Listen without judgment to the participant's experiences, thoughts, and feelings about medication.
- Clarify desired medication use strategies (no use; temporary use; commitment to use indefinitely).
- If no medication is desired, ask for reasons and strive to understand what losses medication use will create, for example, ask: "help me understand how hearing voices is important to you," and brainstorm other ways to achieve the desired effect.
- Support participants in identifying pros and cons of taking medication and identify barriers that go beyond physical side effects: money, memory, family attitudes, sexual side effects, etc.
- Explore whether the medication regimen itself is a barrier: time(s) of day, number of pills, where participants are, who they're with, and what they're doing when they take their medications.
- Develop action plans to address barriers and to determine if the medication is helpful.
- Identify medication as an action step toward a desired recovery goal; develop methods to evaluate the effectiveness of medications in supporting goal attainment.
- Encourage and support learning about prescribed medications, including benefits and side effects.
- Identify medications that have worked in the past and that may be preferred. Similarly, identify medications that have been unhelpful and are to be avoided.
- Help prepare for a meeting with the doctor, including developing a list of questions and concerns.
- Role-play conversations between the participant and psychiatrist.

- Partner with participants in developing other strategies to support wellness, such as Personal Medicine, to be used in lieu of medicines or in conjunction with medicines. (Examples: exercise, diet, meditation, Tai Chi, sleep hygiene, activity, volunteerism, music, hobbies, prayer, support groups, etc.)

## CRISIS PREVENTION & INTERVENTION

Crisis is not simply the moment when things become intolerable. Crises build over time, and often can be recognized and managed in advance. General signs of current or impending crisis may include a threats or acts of harm towards oneself or others, increase in mental health symptoms and/or substance use, and/or catastrophic life events, to name a few. However, Recovery Coaches recognize that what constitutes a crisis is unique to each individual and informed by their personal experiences, culture, spirituality, and much more. **It is helpful to view crisis as a continuum, so that individuals are not seen as "in crisis" or "out of crisis," but rather at some point along a continuum. Recovery Coaches pay close attention to the crisis continuum and respond with the level of urgency required.**

Strategies for **CRISIS PREVENTION** begin when the person **is not** in crisis, and include:

- Explore the individual's history of crisis experiences, what happened, what it felt like, where it was, and who else was present.

- Help the participant identify triggers, e.g., the anniversary of a significant loss, spending time with particular people, experiencing failure, feeling financial stress, impending loss of housing, etc.

- Ask the person to try to identify warning signs of impending crisis, such as lack of sleep or difficulty falling asleep, increased irritability, increased or decreased physical activity, eating more or less than usual, trouble concentrating, pacing, unwanted ruminating thoughts, etc.

- Help participants develop actions that may help to reduce the stress or avert the crisis, such as relaxation techniques, calling someone to talk about the issue, taking a walk, listening to music, etc. They can try out the actions to see how they work.

- Help individuals to create a wellness plan (sometimes referred to as a crisis or safety plan): write down triggers and warning signs, helpful actions or coping strategies, and people they would ask to support them.

- Connect individuals to Wellness Recovery Action Plan (WRAP) groups to support further development of wellness plans. WRAP plans include a crisis and post-crisis section.
- Help individuals communicate their wellness plans to professional and natural supports that will be needed if the plan needs to be executed. Clarify the Recovery Coach's role in carrying out the plan, and role-play what might happen in a crisis.

- Recognize that individuals in acute distress are often unable to muster the resources needed to carry out the wellness plan. Participants may disengage just at the point when they need more support. Assertive but gentle outreach may be very helpful when crisis seems to be building.

- Adopt a "non-failure" approach. When the participant is ready, use the opportunity to analyze what happened just before the event, identify lessons learned, and apply them going forward, to prevent the next crisis.

- Sometimes individuals in distress access emergency or crisis services and are evaluated and discharged without being hospitalized. This may be known as "Treat and Release." Intensify service at this time, since participants are at heightened risk for crisis and hospitalization. A good strategy is to have multiple contacts with the person, including at least one face-to-face visit, each week for at least 30 days after the incident.

Strategies for **CRISIS MANAGEMENT** require immediate attention and an urgent response:

- Recognize that a person in crisis may not be able to follow a wellness plan, and respond quickly to the person's needs.

- Understand that a person in crisis may be disengaged and require careful outreach and re-engagement.

- Signs that someone is in crisis include thoughts or behavior that show greater disconnection or isolation. Individuals may not be able to articulate their feelings but may appear to be in distress. Pay attention to individuals who appear or act differently from their usual selves.

- To stabilize a crisis, respond to the immediate issue. Actively listen to the participant's description of the current situation without judgment, exploring possible interventions that may calm the situation:
    - Talking to a peer specialist
    - Talking to a therapist
    - Talking to a psychiatrist about a change in medication
    - Using natural supports to help the individual feel connected and safe

- Some **Dos** and **Don'ts** of crisis management include:
    - **Do** listen, validate the individual's experience, empathize, model a calm affect an, provide as many choices as possible.
    - **Don't** make judgements, express impatience, give ultimatums, take away control, or make promises you cannot keep.

- Maintain close contact with the participant during the crisis; daily face-to-face visits are preferred until the person is no longer in crisis.

- Call Mobile Crisis for assistance if the crisis continues despite efforts to stabilize, meet them during their initial assessment and maintain ongoing, active follow up communication afterward.

- Avoid calling 911 unless there is an immediate threat to safety. Always seek support from a supervisor immediately after a 911 call is made.
    - If police become involved, advocate on behalf of the participant to avoid further escalation. Inform the police about the situation, name potential triggers, and suggest de-escalation methods. Offer to provide follow-up support and connection to treatment in place of more restrictive options, such as hospitalization or incarceration.

## *EXPECTATIONS FOR ON-CALL*

**All Recovery Coaching Services provide 24/7 On-Call as an early intervention crisis response. Recovery Coaching On-Call most typically provides support to individuals before issues of physical safety characterize the crisis. Recovery Coaching On-Call Best Practices incorporates the following features of crisis intervention best practice as outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA):**

- Offers timely access – 24/7 availability and capacity for outreach.
- Encourages all participants to contact On-Call when professional support is needed.
- Suggests the use of On-Call when additional support could help avert the development of a crisis.
- Meets the needs of anyone who accesses the service:
    - Encourages participants to seek support at the earliest possible time in order to discourage escalation of crisis
    - Embraces the approach that there is no "wrong reason" to reach out to On-Call
    - Envisions its role as preventing crisis escalation
- Honors existing support relationships:
    - Outreach by familiar staff is preferred
    - Accesses natural supports
- Outreaches to the person in their natural environment:
    - Includes face-to-face involvement as preferred response
- Focuses on helping the individual regain self-control:
    - Utilizes wellness plans (sometimes referred to as safety or crisis plans)
    - Elicits what is needed to develop a sense of security
    - Identifies and reinforces personal resources
    - Assumes the person is an active partner in the intervention
- Helps the individual identify issues underlying the crisis.
- Generates agreement to prepare for future crisis by developing/updating the participant's wellness plan (sometimes referred to as a crisis or safety plan).
- Connects the caller to their usual support the next business day (or earlier if contact furthers de-escalation) to further explore underlying issues and initiate development of wellness planning.

- Responds to recurrent crisis with a reappraisal of the current approach to care

- Partners with Mobile Crisis when call indicates crisis has already escalated:
    - Makes the crisis visit in partnership with Mobile Crisis team, recognizing the importance of the familiar support in times of crisis
    - Proactively follows up with Mobile Crisis after the event

## *HOSPITALIZATION*

**Individuals admitted to hospitals are in an acute state of illness or distress. Although their needs are high, their desire and ability to connect to Recovery Coaches at the time of admission varies. Recovery Coaches recognize the need for support and tailor their responses to individual situations.**

Some strategies to support participants during and after hospitalization are:

- Reach out and provide face-to-face support within 72 hours of admission as well as within 7 days of discharge.
    - Anticipate community needs that must be addressed while the person is in the hospital, e.g., assure that pets are cared for, discuss bill paying arrangements, etc.

- Begin the engagement process for those not enrolled in the service, using motivational interviewing as a tool.

- Visit individuals who are hospitalized twice weekly. Focus on how to help the individual and hospital staff with discharge planning and reintegration:
    - Mobilize family and other supports desired.
    - Take care of the basics – assure that the person will have a safe place to go, with clean clothes, food, medication, and other necessities.

- Serve as a bridge between the community and the inpatient team; support treatment planning by helping to understand the life circumstances and precipitating events that preceded hospitalization.

- Participate in coordinated discharge planning with the person, inpatient/outpatient treatment teams, natural supports, and other supports to help facilitate a smooth discharge.

- Recognize that individuals have increased vulnerability and increased need for support when leaving the hospital's relatively safe and structured environment.

- Connect frequently with individuals in the first month after discharge; at a minimum, call daily and visit 2-3 times per week.

- Work with the person to understand: "why this admission, why now?" Were there triggers or warning signs, did substance use play a role, etc.?

- Review the individual's wellness plan (sometimes referred to as a crisis or safety plan), if they had one, to see whether the plan needs to be changed. Create interest and motivation to develop a wellness plan if there is none.

- Facilitate connection to new supports or clinical services needed.

- Explore crisis prevention supports, including connection to Recovery Coaching On-Call and Mobile Crisis.

- Respond with urgency to individuals with multiple hospitalizations; seek consultation with clinical, peer, and other supports to develop and try out new strategies or services.

- Build supports and community connections that enrich individual's lives and desire to remain in the community.

## PHYSICAL HEALTH

According to the World Health Organization, individuals with serious mental illnesses (SMI) die 10 to 25 years earlier than the general population, on average. The vast majority of these deaths are due to chronic physical medical conditions, such as cardiovascular, respiratory and infectious diseases, diabetes, and hypertension.[4] **Recovery Coaches understand that lives depend on paying close attention to physical health**.

Some strategies for managing physical health and wellness are:

- Gather information on the participant's medical history and current concerns:
  - Take all complaints seriously.
  - Listen and refrain from judgment.
  - Assess current health and healthcare, including the present relationship with providers.

- Provide support to the participant around physical health complaints and needs:
  - Help organize concerns and develop a record for the person to use.
  - Find out what has already been tried and what the results were.
  - Help person develop the context for the complaints – whether there is anything else that is going on, has changed, or is possibly related to the issue.

- Enlist help of natural supports:
  - Determine ability and interest in assuming some coordinating roles and responsibilities.
  - Continue a coordinating role even when family or other supports become involved, until a high level of self-management is attained.

- Enlist help of peers:
  - Use individuals with similar healthcare issues as sources of information and support.

- If the need is urgent or complex, enlist the help of a Clinical Wellness Recovery Team (CWRT or WRT) or other agency medical support to:
  - Review concerns and determine whether there should be a referral to CWRT.
  - Provide information about a healthcare condition.
  - Contact a physician when a medical conversation would be helpful.

- Help develop or strengthen the participant's relationship to their primary care physician (PCP) or other health care provider.
  - If the person does not have a PCP, help them to access a PCP office that maintains good relations with CBHCs.

[4] World Health Organization. (2014). *Premature death among people with severe mental disorders.* https://www.who.int/mental_health/management/info_sheet.pdf

- Build relationships with healthcare providers:
    - Write a letter to introduce yourself and your team to medical offices that serve your participants briefly explaining the Recovery Coach's role in providing support to mutual clients.
    - Offer support to navigate the mental health system when needed.
    - Be a resource for mental health education and information.
    - Serve as an intermediary, when needed, between participant and healthcare provider, "translating" issues of concern to both.

- If many participants go to the same PCP practice, schedule a time to go to the office to discuss challenges faced by participants and create a pathway for improved communication:
    - Bring an agency nurse or CWRT resource, if possible.
    - Ask for an office contact person and provide a Recovery Coaching team contact person to facilitate access and better care coordination.
    - Establish preferred communication method (phone, fax, or email).

- Prepare participants for healthcare appointments by writing a list of questions and concerns.

- Role-play visits, from office check-in and form completion to examination and clarification of instructions.

- Accompany participants to appointments, if desired, to advocate, assist in organization, and track information:
    - Clarify with individual your role in the visit ahead of time, e.g. taking notes, writing answers to questions, etc.
    - Tell the office in advance that you plan to attend.
    - Tell the healthcare provider at the beginning of the visit that you have a list of questions.
    - Repeat and/or write down healthcare provider instructions to be sure they are clearly understood and remembered by the participant.

- Help participants become educated about their medical issues and learn to become managers of their healthcare and wellness through Magellan, their Medicaid HMOs' member websites, or WebMD:
    - Access information about good management of chronic conditions and healthy living.
    - Attend informational sessions and peer groups available through hospitals, Medicaid HMOs, and Magellan.
    - Explore low-cost options to improve fitness, including reduced rates or scholarships to join local YMCAs, gyms, fitness centers, etc.

## HOUSING

Safe, quality, affordable housing is a primary social determinant of health. Given the United States' ongoing affordable housing crisis, maintaining housing and preventing homelessness is a critical role for the Recovery Coach. **Recovery Coaches understand the importance of housing stability in supporting participant's physical and emotional wellbeing and embrace a Housing First philosophy.**

Some strategies to support securing and maintaining housing are:

- Assess the housing preferences of each person served, including where and what kind of housing is desired.

- Incorporate preferences and other housing goals in the recovery plan and outline action steps that address barriers to achieving desired housing.
    - Actions steps may include obtaining an income, saving for a security deposit, purchasing furniture and household supplies, etc.

- Maintain a current resource guide of housing options, landlords, and subsidized housing locations in the geographic service area.
    - Use the Department of Housing and Urban Development's Resource Locator and Low Income Housing Search to locate affordable housing in Montgomery and surrounding counties.
    - Monitor the Montgomery County Housing Authority for openings in their Housing Choice Voucher Program (formerly Section 8) or to apply for Public Housing.
    - PA Housing Finance Agency has a PA Housing Search site where many affordable housing sites and market-rate landlords advertise.
    - Locate local Subsidized Housing Applications with the Montgomery County website.
    - Look into PA Section 811 Project Rental Assistance, which is permanent supportive housing for individuals with disabilities and low income.
        - The 811 wait list is managed by Self-Determination Housing Project of PA (SDHP). Webinars about this program are offered regularly.
        - Individuals may only be referred by an agency who has signed a simple memorandum of understanding (MOU) with the SDHP and the "Local Lead Agency" (Montgomery County Department of Health and Human Services). If your agency is interested in signing an MOU, please contact Tim Pirog at the Office of Mental Health (OMH).

- Utilize guides from the Housing Equality Center of Pennsylvania as an advocacy tool for tenants:
    - Know Your Rights as a Renter in Pennsylvania
    - Fair Housing Guide for Consumers
    - Fair Housing Guide for People with Disabilities
    - Fair Housing Guide to Reasonable Accommodations and Modifications

- Utilize the Quarterly Housing Check-In document (available at your agency or by contacting the Office of Mental Health) to keep a focus on maintaining housing that is safe and adequate.

- Encourage the individual you are supporting to participate in renter's training. Certificates of completion from these trainings may make landlords more open to renting to an individual that has no rental history or who has had an eviction in their past.
    - PA Link to Aging and Disability Services has a free six-module Become a Great Tenant webinar.
    - Self-Determination Housing Project of PA (SDHP) hosts Prepared Renters Education Programs (PREP) on a regular basis.

- Create opportunities for individuals who have a shared interest in locating new or improved housing to meet and expand the possibilities for shared housing.
    - Attend a Roommate Matching Party (contact the Office of Mental Health for details) with a participant and follow up with potential matches.

- For individuals interested in homeownership, consider reaching out to the following for support:
    - Genesis Housing Corporation
    - Habitat for Humanity of Montgomery and Delaware Counties

- PA Section 811 Project Rental Assistance
    - The Pennsylvania Housing Finance Agency (PHFA) and the Department of Human Services (DHS) collaborated to develop permanent supportive housing for extremely low-income persons with disabilities, to afford those persons an opportunity to live in safe, affordable, accessible housing that is integrated into the community.
    - The 811 wait list is managed by SDHP (Self-Determination Housing of Pennsylvania, a Program of Inglis Community Services). SDHP (https://www.inglis.org/programs-and-services/inglis-community-services/self-determination-housing-of-pennsylvania-sdhp) also works closely with Local Lead Agencies (LLA's) to identify and establish stakeholder groups to refer eligible applicants to the 811 program.
    - Information about the program can be found here…
        - https://www.phfa.org/mhp/section811pra/
    - To sign up for webinars to learn more about the program, email SDH811@inglis.org .
    - Individuals can only be referred by an agency who has signed a Memorandum of Understanding (MOU) with the SDHP and the "Local Lead Agency" (Montgomery County Dept. of Health and Human Services). If your agency is interested in signing an MOU, please contact tpirog@montcopa.org .

Some strategies to support individuals when housing is jeopardized include:

- Intensify frequency of contacts:

  - Assume increased responsibility for activities and the relationship, recognizing that a housing crisis increases the need for support and changes the relational balance.

- Offer support to landlords when a person is struggling to meet tenant obligations; work with the participant to develop creative strategies to meet those obligations.

- If budgeting is an issue, refer the participant to Clarifi or Genesis Housing Corporation for free financial counseling.

- For individuals whose landlords have threatened eviction:
  - Immediately contact Legal Aid of Southeastern PA to obtain legal support *prior* to eviction filing.
  - Contact Your Way Home to learn about the Eviction Prevention and Intervention Coalition (EPIC), available in select areas
  - Attend court hearings and advocate on behalf of the individual; oftentimes, a "pay and stay" may be arranged if the individual is able to develop a plan to pay back their landlord.
  - Contact 2-1-1 for housing counseling support.

- For homeowners that are struggling, consider contacting the following:
  - Genesis Housing Corporation
  - Habitat for Humanity of Montgomery and Delaware Counties

## *HOMELESSNESS*

As of the 2018 Point-in-Time Count, there were 291 individuals experiencing "literal homelessness" (based on the federal definition) in Montgomery County. Furthermore, there are only 65 single adult shelter beds and 133 family shelter beds available in the County. The discrepancy between shelter bed availability and individuals experiencing homelessness highlights the importance of focusing efforts on maintaining housing whenever possible. **Thus, homelessness and the risk of homelessness trigger urgent action on the part of the Recovery Coach. Embracing Housing First principles, Recovery Coaches know that addressing issues that led to housing loss are secondary to the aim of securing housing. Recovery Coaches know the importance of a building a strong, collaborative relationship with Your Way Home and their partners, including the Homeless Street Outreach Team, shelters (such as the Coordinated Homeless Outreach Center [CHOC]), and Housing Resource Centers.**

Steps and strategies for supporting individuals experiencing or at risk of experiencing homelessness include:

- Contact the Your Way Home Call Center at 2-1-1. This is a centralized system for screening and intake. Wait times may be lengthy; try calling during non-peak hours.

- Callers will receive an initial screening to determine eligibility based on the federal definition of "literal homelessness."
    - Callers who are not eligible are provided housing counseling and may be referred to other community resources.
    - **If shelter beds are full (as they often are), individuals who meet the definition of "literal homelessness" will be placed on a list based on *vulnerability*, rather than on a first come, first served basis.**

- Individuals who have been assessed as experiencing street homelessness by 2-1-1 are linked to Access Services, Inc.'s Homeless Street Outreach Team. Outreach workers verify "literal homelessness" and conduct additional assessment and screening to identify and prioritize needs and available resources.
    - Outreach workers may also enhance that individual's capacity to shelter in place safely by providing sleeping bags, clothing, hygiene products, access to needed medical care, and support with safety concerns.

- Depending on the individual's prioritization and shelter capacity, they may immediately or eventually be selected to enter shelter – such as CHOC, a family shelter, or Laurel House (for individuals fleeing domestic violence).

- Based on prioritization, some individuals will be referred to the Rapid Re-housing Program. Rapid Re-housing offers housing-focused case management and financial assistance to literally homeless households, to quickly find and move in to permanent housing, and then to obtain the supports needed to maintain that housing long-term.
    - Rapid Re-housing is conducted by Housing Resource Centers, including:
        - Carson Valley Children's Aid

        - Keystone Opportunity Center
        - Pottstown Cluster of Religious Communities
    - Case managers at these agencies provide financial assistance in a progressive manner, providing only the assistance necessary to stabilize in permanent housing.
    - Within the limits of the participant's income, Rapid Re-Housing helps households access units that are desirable, sustainable, and in neighborhoods where they want to live.

- In addition to close coordination with the Homeless Street Outreach Team and/or Rapid Re-housing providers, RCs can support individuals in the following ways:
    - Refer individuals who are homeless to drop-in day programs, such as the Norristown Hospitality Center.
    - Every agency has limited Code Red and Code Blue funding to support individuals in the event of extreme weather. This may include temporarily hoteling vulnerable individuals.

## TRANSITIONAL RESIDENCES & OTHER CONGREGATE LIVING

Transitional residential programs, often referred to as Transitional Residential Rehabilitation or Community Residential Rehabilitation (TRR or CRR), are aimed at providing intensive psychiatric rehabilitation for individuals who are experiencing significant barriers to their recovery. Thus, residential programs are not to be used as housing for the sake of shelter, but rather a place to build skills towards recovery. Residents in these programs will develop skills in areas that have been identified via the assessment tool on the Montgomery County Mental Health Residential Rehabilitation Referral Application (contact your Clinical Liaison). Skill areas assessed in the referral screening tool align with Psychiatric Rehabilitation (Psych Rehab) domains, which are infused within each residence. Domains assessed in the referral include:

**Priority Domains**
- Living
- Wellness

**General Domains**
- Social Connection
- Vocational
- Educational

**Safety Domains**
- Personal Safety
- Safety of Others

Residential programs are designed to be transitional in nature; that is, individuals who move into residential programs should aim to transition to more independent living after one year, unless they are moving into a program intended to support longer-term residents. Types of residential programs include:

**Transitional/Community Residential Rehabilitation** (CRR)
- Time-limited (one year)
- Active rehabilitation aimed at securing housing in the community
- Emphasis on community inclusion and building peer and natural supports

**Supported Independent Living** (Supported Living)
- Transitional programs
- Support services vary
- Staff off-site with on-call availability
- Independent living skills required

**Supportive Care Residences** (Personal Care Home/PCH or Specialized Supported Residential)
- Length of stay varies
- Emphasis on building motivation for change
- Transitions to more active rehabilitation when possible

**Treatment Rehabilitative Residences** (Long-Term Structured Residential [LTSR] or All Inclusive Residence [AIR] – Office of Mental Health approval required)
- Length of stay varies based on support needs
- Rehabilitation and treatment on-site
- Transitions to community-based mobile support

## *RESIDENTIAL ASSESSMENT & REFERRAL*

Recovery Coaching maintains a critical role in identifying individuals who are at-risk and in need of increased support. When strategies for maintaining an individual in the community have been unsuccessful, residential programs may be explored by the individual and their team. If the individual and their team agree to pursue an opportunity to participate in a residential program, the Recovery Coach partners with them throughout the process – from completing the referral, to interviewing at prospective programs, to providing ongoing support once they have moved in. The assessment process generally occurs as follows:

- The Recovery Coach identifies an individual:
  - Who is at-risk for losing their community housing for reasons other than financial circumstances. (Residential programs are **not** meant to be used as emergency shelter.)
  - Who is in need of more intensive support to develop the skills necessary to successfully maintain housing long-term.
  - Whose safety or the safety of others may be compromised in their present living situation.

- The Recovery Coach discusses the possibility of a residential program with the individual, their treatment team (mobile/clinical supports), and their natural supports to determine interest and appropriateness.

- If the individual is interested and agreeable to considering a residential program, the Recovery Coach notifies their Clinical Liaison and/or clinical team.

- Together, the Recovery Coach and Clinical Liaison and/or clinical team schedule a team meeting to include the interested individual, the treatment team, their natural supports, and a Magellan Care Manager (if the individual is a member). This is called as a Recovery Support Team Session (RSTS) and will continue to occur regularly if an individual is accepted into a residence.

- The team first explores opportunities for diversion from residential, if appropriate. Diversion strategies may include one or more of the following:
  - Increased clinical services, such as medication management, therapy, intensive outpatient programs, and/or partial hospitalization.
  - Increased mobile support services, such as the addition of a Certified Peer Specialist (CPS) or other mobile support.
  - Transition to a higher level of mobile support, such as Mobile Psych Rehab or an ACT Team.

- If it is determined that the individual's needs require intensive support in several of the listed Psych Rehab domains, and/or if the individual's personal safety or the safety of others is a significant concern, then the team may recommend referral to a residential program. The Clinical Liaison and/or clinical team will identify which of the listed residential categories is most appropriate for referral.

- The Recovery Coach will review the Residential Vacancy Tracking List (username: montgomery / password: county) to check for openings and waitlist availability in the appropriate residential category. The Recovery Coach will inform the individual of their residential options.

- The individual and the Recovery Coach will complete the Montgomery County Mental Health Residential Referral together, utilizing the referral as an opportunity to identify strengths and needs in the identified Psych Rehab domains. The Recovery Coach Team Leader will review for accuracy and completeness and sign off. The Clinical Liaison and/or clinical team will then review for appropriateness prior to submission.

- The Recovery Coach will support the individual in collecting all collateral information required for applications; most importantly, a psychiatric evaluation and physical. If the individual does not have recent evaluations, the Recovery Coach will support in scheduling these appointments as soon as possible. **Note that all residences have varying timeframes for submission of required documentation; communication with residential leadership is essential in making certain an application is submitted correctly.**

- The Recovery Coach communicates with staff at prospective residences in order to:
    - Verify receipt of application and submit supporting documentation
    - Maintain monthly contact if the individual is on a waitlist.
    - Notify the residence if the individual has secured alternative placement or no longer requires residential support.
    - Facilitate tours and/or interviews of each residence as offered by residential program leadership.

- If the individual is selected for a residence, the Recovery Coach supports the individual in identifying tasks and responsibilities prior to move-in and assists them in completing those tasks as needed.

- If the catchment area has changed due to the location of the residence, the Recovery Coach should complete a Recovery Coaching Referral and direct it to the corresponding CBHC. Notify the Clinical Liaison and/or clinical team so they may communicate with the corresponding liaison for the new catchment area. The Recovery Coach is expected to continue engaging with the individual and the new Recovery Coach for a 30-day warm handoff period. The Recovery Coach should schedule an RSTS meeting during this time of transition so that all team members may coordinate and collaborate appropriately.

## *RESIDENTIAL SUPPORT & ENGAGEMENT*

**A residential program is an intervention that requires the active involvement of the Recovery Coach to assist the resident's ongoing recovery process. During a resident's stay, the Recovery Coach continues to provide intensive services as a member of the team.** Ongoing support activities include:

- Participation in RSTS meetings occurring within the first 30 days of residence and at least every 110 days thereafter. If a residence offers more frequent RSTS meetings, the Recovery Coach is expected to attend these as well. The Recovery Coach will bring their recovery plan so they may coordinate goals and make sure services are complementary, rather than duplicative or conflicting. This requires all members of the team to identify tasks and follow up activities and maintain ongoing communication. RSTS agenda items include:
    - Admission Date
    - Residential Service Plan Period
    - Current Phase
    - Updates from Previous RSTS
    - Review of Current Goals (Residential, RC/Mobile Support, Clinical, Personal)
    - Strengths/Areas for Improvement
    - Transition Plan
    - Next Steps (who is responsible, date/time of next meeting, communication plan)

- The Recovery Coach prioritizes their support activities to augment each of the four residential phases, which reflect the resident's accomplishment of skills during their stay. Each residential phase focuses on several of the following skill areas:

    - Orientation
    - Healthcare/Medication Management
    - Housekeeping/House
    - Safety Skills
    - Nutrition
    - Mobility
    - Money Management
    - Interpersonal Skills
    - Vocational/Educational
    - Leisure Time/Time Structuring
    - Self-Care Skills
    - Community Participation
    - Housing

- As a resident nears time to transition back into community living, the Recovery Coach increases frequency of contact. This helps the resident to reduce reliance on residential staff and increase confidence in community integration.

**Engagement is critical before, during, and after residential placement.** Common challenges and potential resolutions to engagement include:

- **Perceived resolution of the crisis/crises that led to residential placement**. Often, moving into a residential program will effectively reduce or even end the stressors that led to placement. Likewise, the resident's access to 24/7 residential staff may make the Recovery Coach and/or the resident feel as if Recovery Coaching Services are no longer needed. However, it is quite

often the case that the resident now has a **limited** amount of time to develop the skills necessary to return to independent community living. The support of the Recovery Coach is essential in engaging the resident out in the community so that they may continue to develop and improve upon independence, without reliance on residential program staff.

- **Lack of rapport with a newly referred Recovery Coach.** If the Recovery Coach was linked after the resident moved into a residential program (or if the Recovery Coach is new due to transfer of catchment area), it will take time and patience to develop rapport and determine how to best support the newly assigned resident. The resident will likely feel more comfortable with their residential staff, with which they spend a majority of their time. Additionally, the residential staff has likely been stepping in to take on a task a Recovery Coach would normally complete while waiting for the Recovery Coach to be assigned. **This does not mean Recovery Coaching services are unnecessary**; rather, this is an opportunity to have an RSTS meeting and collaborate with the team to develop strong, complementary RC goals that augment the residential skill-building activities already occurring.

- **Resident refusal or lack of interest in Recovery Coaching services.** For a variety of reasons, a resident is an older adult and/or has moved into a longer term program, they may not be interested in community integration. In some instances, a resident may simply choose to refuse Recovery Coaching services. In these cases, the Recovery Coach should schedule an RSTS meeting with the team in order to determine how to move forward with supporting the resident. If the resident and their team are in agreement that Recovery Coaching services are no longer needed, alternative mobile supports should be considered and referred to as appropriate. The Recovery Coach may make these referrals and overlap services with the new support for a 30-day warm handoff period to ensure a smooth transition.

## INCOME

Income alone does not guarantee a fulfilling life in the community, but income that is sufficient at least to eliminate food and housing insecurity affords individuals the opportunity to focus on other wellness goals. Individuals with mental illness may rely on government benefit programs, such as Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) for subsistence-level income that poses challenges to meeting basic needs. Individuals with psychiatric disabilities are the largest group receiving these types of benefits, and remain on them the longest amount of time.[5] With the best intentions, support networks and service providers tend to encourage enrollment in such programs prior to exploring other options, inadvertently reinforcing the belief that mental illnesses is a barrier to work**. Recovery Coaches understand the need to explore all avenues to increase income in order to meet basic needs and improve quality of life.**

Some strategies to address income are:

- Explore current income and expenses with participants; write list of all expenses, noting basic needs (housing, food, utilities, etc.) and discretionary expenses (recreational, entertainment, etc.).

- Review satisfaction with current situation: what are they happy with versus what would they like to change.

- Determine the person's stage of change in relation to employment. Use motivational interviewing to assess pros and cons.

- Create an expectation of employment tailored to the individual's stage of change.

- Understand that participants may choose to remain in their current situations for a variety of reasons: fear of losing benefits; doctors, therapists, or family members and friends discouraging them from working; fear of stress, lack of skills, or symptoms interfering with work; etc.

- For individuals who are truly unable to work or are in pre-contemplation, focus on basic needs. Introduce the possibility of reducing expenses, e.g., using LIHEAP, finding free or low-cost leisure activities, using food banks, grants for assistive technology, etc. Explore financial supports available from family or other supports – temporary or permanent.

- Arrange for representatives from the Disability Rights Network to meet with individuals receiving services at your agency.

[5] Livermore, G. A. & Bardos, M. (2017). Characteristics of adults with psychiatric disabilities participating in the federal disability programs. *Psychiatric Rehabilitation Journal, 40*(2), 153-162.

- For individuals in contemplation, use exposure to information about the benefits of employment, and stories about individuals with mental illness who are working. Ask about education, skills and past experiences with work. Help individuals understand Medical Assistance for Workers with Disabilities (MAWD).

- For individuals in preparation and action, link to career supports, support individuals towards getting a job, or explore educational opportunities to develop skills that lead to better employment options with a potential career path.

- Respect the individual's decisions, whether they cannot work – i.e., compromised or very fragile medical situations or severe disabilities – or genuinely prefer not to work. Continue to help them connect with resources to increase self-management and support life in the community.

## EMPLOYMENT & EDUCATION

Employment offers the possibility of an improved quality of life, and education offers potential career pathways for those in recovery. Participants directly benefit from employment through increased income, expanded relationships and social roles, greater meaning, and structure in daily life. **Recovery Coaches understand that work enhances recovery. Recovery Coaches support employment and recognize that serious mental illness does not prevent individuals from working or obtaining education as a path toward employment of choice.**

Some strategies to support employment and education are:

- Understand that the onset of mental illness often occurs during late adolescence or early adulthood, when people are beginning to acquire the skills needed for work. Many may not have participated in school or work for a long time.

- Connect young adults to education and employment resources and help them learn about the benefits of career development **before** applying to entitlements.

- Assess basic skills related to employment, e.g., reading and math fluency, high school diploma or GED, resume building, job interviewing, etc.

- Actively explore aspirations and help individuals connect to old dreams and skills as they consider entry or re-entry to employment.

- Create opportunities for exposure to a hopeful work-oriented environment, with information about employment services, employment support groups, education, and other resources.

- Become familiar with and link individuals to a variety of career supports, including those within the mental health system and those available to the community at large.
- Become familiar with and link individuals to educational opportunities, including Federal Student Aid and educational accommodations offered through college offices that serve students with disabilities, such as the POWER Program at Montgomery County Community College.

- Become familiar with and provide accurate information about Social Security benefits, work incentives, and Medical Assistance for Workers with Disabilities (MAWD).

- Coordinate with career resources and educational supports resources to assure a unified team approach to help individuals navigate the challenges of pursuing employment.

- Become familiar with the Americans with Disabilities Act (ADA) and support individuals to acquire knowledge about their rights under the act.

- Use key strategies to help individuals apply and interview for jobs:
    - Help the person develop a list of skills and strengths.
    - Help the person understand past successes and challenges.
    - Help the person develop a resume and search for a suitable job.
    - Role-play the interview process, including questions that elicit self-disclosure regarding history of mental illness to prepare for the interview.
    - Conduct post-interview discussions to help the person analyze interview results and improve interview skills.

## TRANSPORTATION

Providing transportation to participants via Recovery Coaching is often a necessity given Montgomery County's lack of public transportation. It may also facilitate the engagement of a participant in an early stage of change. At the same time, it is critical that Recovery Coaches support participants in learning ways to get their transportation needs met if they are going to transition out of the service. **Recovery Coaches understand that the transportation of participants by Recovery Coaches is an essential, albeit non-billable, component of the service. Transportation by Recovery Coaches is a resource that is used strategically and intentionally to support the growth of recovery.**

Some ideas to foster the thoughtful use of transportation:

- Be knowledgeable about the availability of public transportation in the area.
    - Orient all Recovery Coaches to the use of public transportation so they can transfer this knowledge to participants.
    - Distribute bus, train schedules with fares and cab company information with fee schedules.

- During assessment with new participants, ask how they meet their travel needs. If some things are consistently harder to get to, identify barriers and brainstorm ways to overcome them.
    - For example, if a participant consistently can't get to the doctor because appointments are only available during the day and their natural support(s) is/are working, is a change of doctor possible; will family help with cab/rideshare fare; does the appointment need to be strategized around public transportation schedules, etc.?

- If there are issues related to the cost of public transportation, explore ways to reduce costs.
    - Times of travel, Medicare cards, insurance reimbursement, etc.

- Access government subsidized transportation programs
    - TransNet
        - Senior Citizen Shared Ride
        - Medical Assistance Transportation Program
        - Persons with Disabilities Program
    - CTT Connect

- Encourage the development of ride sharing among agency participants. This may also be a way for alumni to give back to the community.
    - Post "shared ride" notices on a board in an area of community focus; include notices in agency newsletters.

- Encourage the use of teaming and consider geographic proximity when planning transportation. Develop a "map" of neighborhoods where participants live, have appointments, shop for food, and participate in community events.
    - Can multiple individuals living in a particular apartment complex or the same neighborhood have their psychiatry appointments or other important appointments on the same days, and can Recovery Coaches rotate the responsibility for transportation?

- If participants are anxious about using public transit, offer to help them become more comfortable:
    - Start by checking schedules, going to the transit stop, observing the process of riders getting on and off buses or trains.
    - Accompany them on public transit, beginning with a short ride, and then gradually lengthening the ride until they are comfortable with using transit to get themselves to a desired location.

- Understand that transportation provided by the Recovery Coach can be a valuable tool used to foster engagement.

- Offer to transport when the person is ambivalent about an activity, especially in earlier stages of recovery.

- Offer to transport when the individual has trouble talking. Not looking at each other may help someone open up.

## ENHANCING CONNECTION TO THE COMMUNITY

**Recovery Coaches recognize that improving connections to the community both enhance recovery and enrich the community. Recovery Coaches partner with individuals to promote community engagement and help them experience a sense of belonging in the communities of their choice. Recovery Coaches also partner with community organizations, offering coordinated service and mental health education.**

"Community" includes places and organizations that help to create relationships and advance recovery through participation: places where individuals live, work, or connect (neighborhoods, jobs, community centers, places of worship, etc.); gatherings that support individual's interests (reading circles, gardening clubs, etc.); assemblies where citizens meet for a purpose (political parties, civic organizations, etc.); organizations and resources that support a person's ambitions (schools, jobs, libraries, etc.).

Some strategies for supporting participants in the community are:

- Understand that participants' knowledge of and experience with the community varies.

- Identify past interests and activities, and community supports that already exist within individual's day-to-day experience, and build on those supports and connections.

- Avoid creating artificial settings within a program that mimic the real world; **if it exists in the community, don't create it in the program!**

- Follow the process of **exposure**, **inclusion**, and **connection**:
    - Use **exposure** to new opportunities as the first step in discovering interests, preferences, and strengths. Identify community activities and events and accompany participants to a variety of exposure experiences. Build on interests to create motivation to explore community life and become familiar with potential opportunities.
    - Help individuals participate in community activities that match their interests (**inclusion**). Support participants to prepare for new inclusion experiences.
    - After **exposure** to a variety of experiences and **inclusion** in new activities, help individuals deepen their involvement in selected organizations or activities to experience a sense of belonging and move toward meaningful community **connection.**

- Act as a bridge to community life, rather than a replacement for it.

- As you explore the community with participants, find opportunities to broaden relationships with organizations that participants choose to connect with, e.g.:
    - Explore reduced membership fees or scholarships at local YMCAs or fitness centers.
    - Explore volunteer opportunities.

  - Help facilitate library cards and use of library facilities.

- Support the participant to confront possible stigmatizing attitudes, behaviors, and expressions by the public.

- Understand that individuals with mental illness may be isolated and eventually may become "self-stigmatizing," believing themselves to be unworthy of community participation. Work with each individual to determine whether and to what extent this is occurring. A direct discussion with careful planning will help to ease the individual into the community.

- Role-play in advance the skills needed to successfully utilize community resources; teach and practice skills in actual community situations; and analyze successes and challenges afterward.

## STRENGTHENING SOCIAL NETWORKS

Research has demonstrated that having a diverse network of support is linked to improved quality of life, while less social connection is associated with poorer health and increased risk of early mortality. Unfortunately, research also indicates that individuals with mental illness tend to have "smaller and poorer quality" social networks than that of the general population.[6] Often, these networks consist primarily of paid professionals who provide formal support. **Recovery Coaches are instrumental in helping participants build genuine, lasting connections to family and other natural supports; thus improving quality of life.**

[6] Degnan, A., Berry, K., Sweet, D., Abel, K., Crossley, N., & Edge, D. (2018). Social networks and symptomatic and functional outcomes in schizophrenia: A systematic review and meta-analysis. *Social Psychiatry and Psychiatric Epidemiology, 53*(9), 873-888.

## *INVOLVING FAMILIES*

Family members can be a tremendous support to an individual who is experiencing mental health challenges. In many situations, these supports may be uncertain about how to provide care, and may need direction from participants, peers, or other support persons. Recovery Coaching participants may be reluctant to involve their families, in particular, because of past hurts, feelings of shame, or ideas about what it means to be "independent." It is vital that Recovery Coaches explore the meaning and nature of family support with each participant. Assessing how family has helped (or failed to help), and what type of family involvement is desired, are critical questions in the assessment process. Recovery Coaches approach families with an understanding that the participant's family members may have experienced shame and alienation that has impacted their family member with mental health challenges. **Growing the availability of support for the entire family system is fundamental to Recovery Coaching involvement. Likewise, Recovery Coaches are instrumental in helping individuals connect to their community in order to grow a diverse network of natural supports.**

Some strategies to enhance positive family involvement are:

- Develop a plan for family engagement that includes information obtained in the assessment, along with an awareness of the person's developmental stage.
    - Developmental considerations are especially important for individuals who are experiencing their first mental health crisis in young adulthood. Often, the natural response to crisis is increased parental involvement. However, prolonged or too much involvement with family can delay the maturation process. Finding other natural supports to step in and meet needs, while helping parents understand the need for greater independent development, may be critical to the recovery process, e.g., increasing "short run" reliance upon friends, siblings, teachers, neighbors, etc.
    - Assessment includes the perspectives of the participant and the family. When developing a goal for family participation, these multiple perspectives help the person determine what may be best for him/her in relation to the family group.
      Involving the entire family in the change process may lead to the person choosing to change in relationship to family members or family members understanding the need to interact differently. When family and Recovery Coaching participants recognize their separate needs for growth and change, recovery is advanced. Recovery Coaches can be instrumental in developing a family perspective about change.

- Recovery Coaches recognize that key recovery concepts apply to family members as well as participants and strive to connect families to needed resources.
    - **Hope** – Find opportunities to expose family members to individuals sharing their recovery stories. Connecting participants to peer supports may provide hope to participants and family members alike. Trail Guides has been especially helpful in this way for younger participants.

- **Support** –Help families understand the critical role of support in their own lives. With increased support, families often experience decreased stress and increased empathy for loved ones. Offer information about groups like NAMI Family to Family. Recovery Coaches identify and connect families that may want to informally support one another.
- **Education –** Information can go a long way to supporting individuals in becoming more effective with their family members. Encourage families to use the internet to get more educated about illness and recovery. The Temple Collaborative on Community Inclusion, the Substance Abuse and Mental Health Services Administration (SAMHSA), the Training and Education Center of Mental Health Partnerships (TEC), and the National Alliance for the Mentally Ill (NAMI) will provide an abundance of information.

- Support families in trusting the power of a loving relationship in making a difference in individuals' lives
  - Encourage acceptance, empathy and good communication skills.
  - Connect to trainings and groups that help families develop these skills.
  - Provide families with information about relevant family support groups.

- When a family is disengaged, recovery planning may include goals and action steps related to family connection:
  - If the person has been estranged, the first step may be exploring the roots of the estrangement. Are there issues to be discussed, amends to be made?
  - Exploring the perceived benefits and potential negative consequences to increased involvement is essential to decision-making.
  - Helping the person develop a plan for empowerment in relationship to family members is critical to changing dynamics in a family.
  - With the participant's permission, similar discovery with an estranged family can be very helpful – what would they like; what would need to be different; what has worried them in the past?
  - Sometimes families have felt alone with the challenges they experienced, and have disengaged from a family member out of "not knowing what to do." The presence of a Recovery Coach may make a renewed connection possible.

- There are times when relationships among family members may trigger crises in a participant's life. Despite interventions, family members may be unable to find ways to change their interactions. When family contact is intense and prolonged, Recovery Coaches help the participant recognize the consequences of familial stress and support the person in taking action related to harmful triggers.
  - Wellness Recovery Action Plan (WRAP) is a helpful tool in developing a range of action plans that reflect the seriousness of the impact on a person's wellness, e.g. participants can decide how and when to limit contact or strategize how to handle common triggers like holiday dinner.

## *NATURAL SUPPORTS*

Some strategies that support growth in social networks are:

- Help individuals identify their current social networks and why these individuals are important to them.
- Support individuals in figuring out what they have done to sustain these relationships.
- Explore the pros and cons of making more friends and ask what kinds of friends they would like to make.
- Strategize about the best ways to meet people and support the person in taking a step toward his or her goal.
- Bring together individuals served by the team, around shared goals and interests, using structured activity to foster interaction.
- Develop a monthly get together open to anyone in the service.
- Encourage participants to identify their peers as potential supports in recovery planning and action step development.

## PEER SUPPORT & MUTUAL AID

Individuals with lived experience of mental health challenges prove every day that they possess a powerful ability to engage, persuade, and teach individuals receiving services that living a full, rich, connected life in the community is not only possible, but desirable. Peer staff and leaders bring wisdom not acquirable through traditional professional preparation. **Recovery Coaching embraces the power of peer support and mutual aid in developing hope, motivation, and engagement in recovery.**

Some strategies for embracing peer support and mutual aid as a Recovery Coach are:

- Learn about and embrace Certified Peer Specialist (CPS) values and competencies.
- If eligible, attend a CPS training to improve your ability to connect with participants you serve.
- Refer participants to CPS and regularly hold joint meetings to coordinate support.
- Expose participants to support groups by providing information about the group; connecting them to peers that use mutual aid and accompanying them to a meeting or group.
- Refer to mutual aid groups, such as:
    - Wellness Recovery Action Plan (WRAP) groups
    - Circle of Hope
    - Taking Back Our Power
    - Alternatives to Suicide
    - Alcoholics Anonymous (AA)
    - Narcotics Anonymous (NA)
- Demonstrate support for peer-led services by attending Community Support Program (CSP) meetings and/or other activities at Hopeworx as well as the Pottstown Recovery Learning Center (RLC).
- Attend the annual CSP Conference and nominate peers and staff for Mental Health Awards.

## SUPPORTING SPECIFIC POPULATIONS

### *TRANSITION-AGE YOUNG ADULTS*

The transition from youth to adulthood is emotionally demanding as youths begin to focus on relationships, education, and employment in new ways. This time period, from 18 to 26, is especially challenging for youth with emotional and behavioral difficulties who, statistically speaking, experience high rates of school dropout, arrest, and unemployment. [7] While some young adults have already spent time in systems of care that can have adverse consequences like institutionalization, others are first diagnosed with a mental illnesses in late adolescence or early adulthood. In addition, they may lack safe housing, funds, life skills, and social skills while simultaneously facing judgment about appropriate conduct. **Recovery Coaches recognize that young adults with histories of intensive mental health services may have insufficient skills, knowledge, or family support for successful independent living. Recovery Coaches focus on helping young adults build skills and knowledge so they become productive adults with independent lives in the community. Recovery Coaches demonstrate a sense of urgency with young adults who are new to mental health services to decrease the likelihood of them losing hope and feeling system dependent.**

Some strategies to support young adults:

- Understand that services provided at this age are critical to creating a path toward resilience, wellness, cognitive, and social maturity. This is when youth can develop new life patterns to forge relationships, manage emotions, and pursue education, employment, and leisure activities as they become self-sustaining adults.

- Focus on age-appropriate activities and programs, rather than trying to find “one size fits all” activities that include young adults and older adults with long-term involvement in mental health services.

- Be developmentally appropriate – meet the youth where they are. Build on strengths and use available supports.

- Assess individual’s current status across their life domains; focus on goals that will build skills to enable youth to take their places as responsible adults.

- Help them find safe and secure housing and gain the skills to maintain that housing.

[7] Stars Behavioral Health Group. (2018). *Theory and research underpinnings supporting the Transition to Independence Process (TIP) model.* https://www.starstrainingacademy.com/wp-content/uploads/2019/12/TIP-Model-Research.pdf

- Help them access developmentally appropriate mental health services, e.g., individual or group therapy, medication management, Trail Guides peer support services, substance abuse treatment, or Central Behavioral Health's Transition to Independence Process (TIP) case management services.

- Connect young adults to career supports and educational opportunities to learn about the benefits of career development **before** applying to entitlements. Help them understand the impact of pay with benefits over reliance on government subsidies on lifetime earning capacity.

- Support them as they pursue a high school diploma or GED, enroll in education to obtain a degree or gain job skills, and find competitive employment.

- Use problem solving methods to develop skills to analyze the challenges they encounter and the impact of their responses on themselves and those around them.

- Allow young individuals to try out behaviors and experience the natural consequences of their behaviors. Through discussion, support learning about choices that lead to successful goal attainment.

- Help them deal with stigma they may experience in educational, social, or work settings.

- Help them to develop social networks and activities that improve the quality of their lives and foster social responsibility.

- Explore mutual aid groups that would meet their needs.

- Help them transition to greater independence and less use of mental health services as they develop more skills and become more self-managing.

## *FAMILIES WITH CHILDREN*

Parents with mental illness have a greater likelihood of involvement with child protective services, out of home placement of their children, and loss of custody. Children in these families are at risk for behavioral and emotional challenges and may benefit from prevention services. **Recovery Coaching believes in the capacity of individuals with mental health challenges to raise their children, believes that intact families are in everyone's best interest, and collaborates with family supports to enhance parental effectiveness and build family resilience.**

Some strategies to support family integrity and development are:

- Express a commitment to supporting the entire family.
- Ask about parenting wishes and goals during recovery planning; prioritize parenting goals and action steps in recovery planning.
- Identify parental strengths and challenges.
- Address basic needs: food, shelter, clothing, etc.
- Identify strategies to improve parental coping capacity; e.g., Wellness Recovery Action Plans (WRAP) and treatment interventions.
- Improve parenting skills through community education and support groups; e.g., Child and Family Connections Parent Support Group.
- Educate about resilience and help build family resilience using Forty Developmental Assets.
- Expand the network of support, both formal and informal:
    - Refer to other mental health and family services.
    - Connect to churches and community groups.
    - Identify ways that relatives can support family cohesion, such as Family Group Decision Making (contact the Office of Children and Youth for more information).
    - Recommend use of Mobile Crisis services to diffuse significant family conflict.
- Become familiar with other human service systems which may interface with families, such as the OCY and the Juvenile Probation Office.
- Determine if the family is involved with OCY:
    - Collaborate with the case worker to support the family staying together.
    - Ask to see the service plan.

  - Support and accompany participants to meetings with the case worker and to court proceedings.
  - Recognize that loss of custody or threatened loss of custody is a significant trauma and recommend clinical support.

- Support parents in taking positive roles related to their children's education:
  - Encourage attendance at Parent Teacher Association meetings, accompany if needed.
  - Practice participation in Back to School nights and teacher conferences.

- If families are separated, support parents in maintaining contact with their children.

## *OLDER ADULTS*

The population in Montgomery County is aging and living longer. As individuals age, their life and healthcare needs change. Adults with mental illness are especially prone to chronic disease such as diabetes and high blood pressure. In addition to diminishing health, people face many losses as they age, and are at risk for substance use, depression, and suicide. When seeking treatment from their health care providers, they may not disclose important information about their symptoms or behaviors because they fear institutionalization, loss of control, or stigma. Mental illnesses and serious emotional needs may go undiagnosed and untreated. **Recovery Coaches recognize the vulnerabilities and losses of older adults, help them understand their changing needs, and support connections to resources that will help them live as independently as they choose.**

Some Recovery Coaching strategies to support older adults are:

- Take time to build the relationship; longer visits may be needed to establish a level of comfort with Recovery Coaching services.
- Listen to stories, old and new.
- Assess the participant's current physical and mental health issues and treatment, medications, and supports for these issues.
- Pay attention to recent changes in physical health, mental status, self-care, and self-management
- Ask about losses: personal and professional relationships; work; diminished memory, attention or other cognitive function; energy, stamina, physical health deterioration, etc.
- Observe for signs of depression.
- Find out how much time the participant spends alone, and what connections they would like to increase. Provide information about social groups for seniors.
- Ask when the person last saw his or her primary healthcare provider, what symptoms or illnesses were addressed, what the results were, and what medications were prescribed.
- Observe the individual's behavior and home environment; ask about self-care and substance use.
- With permission, include family or caregivers in the assessment and planning process.

- Communicate with mental health and physical health providers to share observations and coordinate care.

- Accompany individuals to healthcare visits, if needed, to be an advocate and assure that instructions are understood and can be managed.

- Help individuals access appropriate mental health services, e.g., individual or group therapy, medication management, peer support, substance use treatment, etc.

- Help individuals develop self-care skills and problem-solve issues that impact their ability to negotiate activities of daily life.

- If individuals are at risk of institutionalization but wish to remain in their homes, help them access resources that will support them to remain in their homes.

- Work closely and collaboratively with the Office of Senior Services (previously Aging and Adult Services) to help individuals understand the home and community based services available to them.

- Help individuals and family/caregivers access information and community-based resources for older adults that will increase understanding of mental illness and knowledge of available health and social services, and decrease their isolation.

- Report suspected elder abuse or neglect to the Office of Senior Services.

### *LGBTQIA+*

Individuals who are engaged in Recovery Coaching have experienced societal discrimination related to their mental illnesses. For individuals who are lesbian, gay, bisexual, transgender, questioning, intersex, asexual, etc. (LGBTQIA+) the discrimination and stigma have often been greatly exacerbated by societal attitudes about their sexual orientation, gender identity, and gender expression. **Recovery Coaches strive to understand the attitudes and values they bring to their work about individual's sexual orientation, gender identity, and gender expression and are committed to creating an accepting and supportive relationship which encourages others to express their genuine selves.**

- Recovery Coaches understand the difference between sexual orientation, gender identity, and gender expression.

- Recovery Coaches consistently use the individual's self-identified name and pronouns.

- Recovery Coaches understand that individuals who are LGBTQIA+ may have kept their gender identity and/or sexual orientation secret for fear of social stigma.
    - Acknowledging the fear and avoidance you observe may enable participants to share their experiences

- When individuals share about their sexual orientation, gender identity, and/or gender expression, explore their support systems and the availability of acceptance.
    - Ask about family – family of origin and family of choice?
    - Ask about peers – who is supportive, and in what ways?
    - Ask about their faith-based community – is it accepting and embracing?

- Encourage connection to empowering LGBTIA+ groups, such as those offered at the Sexuality and Gender Acceptance Center (SAGA).
    - Access information about LGBTIA+ activities via the internet.
    - Find out whether there are other LGBTIA+ individuals who want to provide support.

- Ask about their experience with their clinical providers, and help them assess whether they are getting the help they want.

## *SPIRITUALITY & CULTURAL HERITAGE*

Individuals have unique cultural heritages and experiences. Participants in Recovery Coaching may live in or relate to larger communities with which they share similar backgrounds and values. Spiritual practices may be guided by cultural, ethnic, and/or familial identities, all of which may provide important recovery resources. **Recovery Coaches learn about participants' cultural and ethnic backgrounds, their values and beliefs, and the role of spirituality in their lives. They also identify ways to engage community support for individual's beliefs and preferences. Religious organizations like churches, temples, and mosques are often important sources of spiritual and community comfort to individuals. They may also provide access to faith-based groups which expand social connections. Recovery Coaches support individuals to maintain significant customs and to participate in spiritual practices and communities of choice.**

Some Recovery Coaching strategies that support spirituality and cultural heritage are:

- Explore and support individual's cultural heritage.
    - Ask how their ethnicity was expressed as they were growing up.
    - Explore cultural expression in their current lives.
    - Identify traditions they would like to reclaim and develop ways to do this.

- Identify places and communities that may share cultural and ethnic backgrounds.
    - Ask if individuals are connected to these communities or wish to become connected; explore ways to make additional connections if desired.

- Explore whether a person's culture or language presents challenges or barriers to community participation.
    - Help the person connect to resources to overcome these challenges, e.g., ESL classes.

- Explore the person's religious and spiritual preferences:
    - When identifying an interest, help find a welcoming place of worship.
    - Prepare participants for first visits; offer to accompany them if that helps their comfort levels.
    - Consider other ways to increase comfort; for example, visits when attendance is not overwhelming, sitting in an area of preference, having a way to signal when the participant wants to leave.
    - When possible, find a peer who attends services or who is interested in exploring the option to accompany you and the participant.

- Be open to identifying other ways to access spirituality: a traditional healer, meditation, massage, yoga, prayer, nature, etc.

- Ask how individuals have come to understand their lives and the meaning of their lives.

- This may lead to conversations that have their roots in religious upbringings.
- It may also lead to other philosophies and ethical ways to organize and understand life.

## *CO-OCCURRING DISORDERS*

Many individuals with mental illness also have a co-occurring substance use disorder. The risks involved in substance use are increased for individuals who have a co-existing mental health challenge. **Recovery Coaches understand the impact of substance use, assess the presence of use, determine the individual's interest in change, and identify resources for recovery.**

Some Recovery Coaching strategies that support individuals with co-occurring disorders are:

- Explore the individual's history of drug and alcohol use during the assessment process. This may include a formal assessment tool, conversational exploration, and /or observation of the person and environment.

- Determine the person's stage of change regarding present use.

- Understand the positive and negative impacts of use from the person's perspective and from the perspective of natural supports.

- Begin to strategize about other ways to achieve the identified positive impact.

- For participants in pre-contemplation, focus on relationship development, safety, and basic needs.

- For participants in contemplation, help access information regarding drugs of abuse, health impact, and addiction as a disease. Consider attending information based training together.

- For participants in preparation and action, partner in identifying recovery resources including EBP for treatment. Consult with team clinical consultant about treatment needs such as detox and/or rehab.

- Expose individuals to mutual aid: Dual Recovery Anonymous; Alcoholics Anonymous (AA); Narcotics Anonymous (NA). Accompany participants to open meetings to foster connection, an intervention for individuals in all stages of change beyond pre-contemplation.

- Expose participants to stories of recovery using formal and informal peer support.

- Strategize with participants about things they can try, using harm reduction thinking and instituting harm reduction based action. Incorporate in recovery plans.

## *FORENSIC INVOLVEMENT*

According to the national Stepping Up Initiative, adults with serious mental illnesses are admitted to jails approximately 2 million times each year. Almost three-quarters of these adults have co-occurring disorders. Once incarcerated, these individuals tend to stay longer in jail; upon release, they are also at higher risk of returning to incarceration.[8] In 2017, Montgomery County became a Stepping Up County, demonstrating its commitment to reduce the number of individuals with mental illnesses in jails. The four aims of the Stepping Up Initiative are as follows:

1. Reduce the number of individuals with mental illnesses booked into jails
2. Reduce the length of stay in jail for those with mental illnesses
3. Increase the number of individuals with mental illnesses connected to treatment
4. Reduce recidivism for individuals with mental illnesses in jails

**Recovery Coaches understand that they play a key role in helping Montgomery County improve upon these measures. Recovery Coaches advocate to divert individuals who have become involved with the criminal justice system from jail as well as to advocate for shorter sentences when they have become incarcerated. After incarceration, Recovery Coaches link individuals to treatment and monitor their progress to reduce recidivism.**

Some strategies to support individuals **before court** include:

- Communicate and create a plan with the participant and their public defender or lawyer.

- Support the individual in linking to supports and resources that may help a judge/jury lesson their sentence:
    - Clinical supports, such as therapy, psychiatry, and group therapy
    - Mutual aid groups
    - Securing employment
    - Securing housing

- Write a mitigating letter for your participant, describing their strengths and progress since the offense occurred.

- With permission, collect mitigating letters from their other supports (clinicians, supervisors, faith leaders, etc.).

- Encourage Behavioral Health Court (BHC) as an option for sentencing, if appropriate

Some strategies to support individuals **at court** include:

[8] CSG Justice Center. (2020*). The problem.* The Stepping Up Initiative. https://stepuptogether.org/the-problem

- Support the individual in obtaining court-appropriate clothing, if needed.

- Attend court hearings with the individual, taking notes and asking clarifying questions.

Some strategies to support individuals **during incarceration** include:

- Obtain clearances and visit the individual in jail.

- Learn who their lawyer or public defender is and begin to communicate with them early.

- Learn what needs to be done in order to support their early release; often, a home plan is the primary barrier.

- If the individual will be incarcerated long-term, consult with and then link them to Justice Related Services for ongoing support prior to discharge from Recovery Coaching.

Some strategies to support individuals **after incarceration** include:

- Support the individual in linking to supports and resources:
    - Clinical supports, such as therapy, psychiatry, and group therapy
    - Mutual aid groups
    - Employment
    - Housing

- Develop a plan to pay court costs and fees:
    - Formal employment
    - Informal employment – lawn mowing, childcare, etc.
    - Financial support from family, friends, or faith-based communities

- Link to or reinstate previous benefits: Medical Assistance (MA), SNAP, SSI/SSDI, etc.

- Meet with their probation officer and treatment team **early and often** to develop a participant-centered plan to avoid recidivism.

- If the individual is not in Behavioral Health Court, support them in inquiring about applying. If they are not eligible, you may still advocate for an Adult Probation Officer in the Mental Health Unit.

## *BEHAVIORAL HEALTH COURT INVOLVEMENT*

In 2009, the Montgomery County Office of Mental Health collaborated with the county's criminal justice system (probation, jail, and courts) to create a Behavioral Health Court (BHC) to more effectively address the needs of participants with serious mental illness cycling through the court and prison system. The mission of the BHC is to enhance public safety and reduce recidivism of participants by connecting them with community treatment services and supports and to find appropriate dispositions to their criminal charges by considering the participant's mental illness and the seriousness of the offense.

In order to participate in BHC, individuals must have a serious mental illness (SMI) diagnosis (schizophrenia, major mood disorder, psychosis NOS, or borderline personality disorder) that contributed to the criminal behavior. Although the court prefers to address non-violent offenses, applications for other offenses will be taken into consideration on a case-by-case basis. The process of BHC consists of three phases of engagement. While movement through the phases is individualized, the average length of participation in the court is generally 12-24 months. With the successful completion of the program, participants may be eligible to have their charges reduced, dropped, or dismissed per the court team's decision. **Recovery Coaches support participants through the BHC process, collaborating with the BHC team (including the Clinical Liaison) and their other clinical supports.**

Some Recovery Coaching practices that support BHC participants include:

- Explain the relationship between the Recovery Coaching team and probation officers to court participants.
    - This cross system collaboration is aimed at assuring the participant's success.
    - By agreeing to court participation, the individual has waived confidentiality between the systems; however, the participant must still sign release forms.

- At least once per week, communicate with the Clinical Liaison, who is responsible for preparing weekly summaries highlighting participant treatment involvement and concerns.

- Attend and support participants at court as needed.

- Support participants with filling out the phase change applications to identify their goals and barriers in order to advance to the next phase of BHC.

- With the Clinical Liaison, act as a bridge to clinical services, bringing information from the court to clinical services and information from clinical services to the court.
    - This requires a system within the agency to share and update information across services.
    - Engage in collaborative communication between therapists, the psychiatrist, and the court team.
    - Support the participant in attending all scheduled clinical appointments, urine analysis testing at probation, and BHC treatment requirements.

- Collaborate with the participant and the treatment court team if the participant is going to be sanctioned. Recovery Coaches may need to support the participant with completing the sanction request.

- Respond with urgency when individuals are unable to meet the expectations of the court, using a range of options developed to address ongoing challenges.
  - Seek supervisory support and direction.
  - Seek consultation from the individual's therapist and/or Magellan Care Managers.
  - Request a treatment team meeting with the participant, Clinical Liaison, clinical supports, and probation.

## *INTELLECTUAL & DEVELOPMENTAL DISABILITIES*

Some individuals with mental health diagnoses have comorbid intellectual and/or developmental disabilities (IDD), often referred to as dual diagnosis. Having an IDD does not exclude individuals from eligibility for treatment, nor does it prevent them from benefiting from the full range of treatment resources. **Recovery Coaches understand that participants who are dually diagnosed can successfully engage in treatment and service, develop and attain goals, and live fulfilling lives in the community. They support individuals to participate in the community, connect to supported education or employment, expand their social networks, live healthy lifestyles, and access resources adapted to their needs. Modifications are not about *what* is done, but *how* it's done.**

Some Recovery Coaching strategies that support individuals dually diagnosed with an IDD are:

- Find out whether the participant is "open" to the IDD system (qualified to receive Supports Coordination and other services) by contacting the Office of Developmental Disabilities.

- Become knowledgeable about the person's level of understanding and preferred learning style.

- Use appropriately graded reading materials for support. Check understanding of concepts by asking the person open-ended questions rather than yes or no questions, e.g., "What feelings upset you most last week?" is better than "Were you upset last week?" Listen carefully; you may need to define terms such as "being upset" to get to a meaningful discussion. Use of pictures may be helpful.

- Explore the individual's history of past treatment and service during the assessment process, including hospitalizations.

- Find out the individual's current living arrangements and level of independence; explore their desired living arrangements and level of independence.

- Ask about formal (paid) supports and natural supports, including friends, family, faith communities, clubs, etc. With permission:
    - Communicate and coordinate with treatment and residential supports.
    - Include selected natural supports in wellness plans (sometimes referred to as crisis plans) and planned activities.

- Understand the participant's goal – or help to develop the goal, breaking it down into small manageable action steps.
    - Be clear about what the action steps are and identify any supports needed to help the participant complete the action steps.
    - Review the goal and action steps frequently; understand that this process may be lengthy.

- Help the participant understand their mental illness and symptoms. Offer choice of service, if available.
    - Indian Creek Foundation offers specialized therapy services for individuals with dual diagnoses.
    - Merakey offers a Dually Diagnosed Treatment Team (DDTT).

- Support the participant to access and effectively use psychiatric, clinical, substance use treatment, and mutual aid as needed.
    - Become familiar with specialized resources for individuals with mental illness and IDD.

- Help prepare for a meeting with the doctor or therapist, including developing questions and concerns.

- Role-play conversations between participant and provider, using easily understood language.

- Accompany the individual to appointments if desired, to advocate, assist in organization, and track information:
    - Clarify your role in the visit, e.g., taking notes, writing answers to questions.
    - Tell the office in advance that you plan to attend.
    - Tell the provider at the beginning of the visit that you have a list of questions; keep questions brief.
    - Repeat provider instructions to be sure they are clearly understood by the individual.

- Help individuals practice coping and social skills in community settings as they move forward in recovery.

## *VISION LOSS, HARD OF HEARING, & DEAF*

Some individuals referred to Recovery Coaching experience multiple barriers to full community inclusion, such as challenges posed by impairment or absence of sensory input. While the needs of individuals who are deaf differ from those of individuals who are blind, there are some general guidelines for best practice. **It is essential that the initial evaluation process includes an assessment of the significance of the visual or hearing loss, particularly asking how the hearing or vision loss impacts the person's life.**

Some things to do when working with a person who has one of the above life experiences:

- Educate yourself about the difference with which the individual lives
    - Connect with other providers who know them, especially those who may have an area of expertise about the challenge.
    - Explore information available online for the following challenges:
        - Blind: American Foundation for the Blind (AFB)
        - Deaf: National Association for the Deaf (NAD)
        - Hard of Hearing: Hearing Loss Association of America (HLAA)

- For individuals who have hearing loss, ask directly how they communicate (i.e., sign language, written communication, speech reading, etc.). When possible, include a trusted and involved family member, friend or other service provider for feedback.

- Find out how individuals identify themselves and the language they use to understand and describe their experiences.
    - Use the individual's language.
    - Do not assume the individual experiences their difference as impairment or as a disability.

- Understand that the extent of the sensory difference may produce differences in the individual's identity and culture.
    - This is especially true for individuals who are deaf and clearly identify in ways that are markedly different from individuals who are hard of hearing.

- When assessing a person who is deaf and uses ASL, utilize an interpreting referral service to guarantee competent interpreting:
    - Deaf Hearing Communication Center
    - The Communication Connection

- Offer choice of service, if available.
    - For individuals who are deaf, specialized deaf mental health services are available through PAHrtners Deaf Services.

- Determine the individual's connection to the Office of Vocational Rehabilitation (OVR):
    - If not previously referred, help explore the benefits to referral.
    - If already connected, establish coordination of care with the OVR counselor.

- Ask about use of assistive devices and/or interest in use:
    - Acquaint yourself with the variety of assistive devices, using information available through:
        - Blind: American Foundation for the Blind (AFB)
        - Deaf: National Association for the Deaf (NAD)
        - Hard of Hearing: Hearing Loss Association of America (HLAA)

- Explore interest in forming connections with others who share similar life experiences. This may involve connecting to social groups, mutual aid groups, and advocacy organizations:
    - Meetup.com lists social groups for individuals who are deaf and/or blind.
    - Individuals with speech difficulties may find connection based on the etiology of their speech difficulty. For example, there are support groups for stroke survivors, individuals with amyotrophic lateral sclerosis (ALS), Huntington's Disease, etc.

# RECOVERY COACHING LEADERSHIP

## CREATING & SUSTAINING A LEARNING CULTURE

For many employees in Recovery Coaching this job represents their first post-college professional employment experience and first experience in the mental health field. Others come to the job with invaluable lived experience with a mental health diagnosis, but may lack meaningful work experience or experience in the role of providing support**. Developing an identity as a worker and a set of skills useful to the work will be important tasks for all Recovery Coaches and this effort will require the attention and commitment of Recovery Coaching leadership. Learning is not the task of Recovery Coaches alone; Team Leaders and Directors must to stay current in the field of mental health and organizational management in order to design meaningful programs and provide quality supervision.**

Some methods that support a culture of learning in Recovery Coaching services are:

- Model ongoing learning and professional development by:
  - Keeping current with regard to developments in the mental health field.
  - Sharing what you've learned through taking courses, attending trainings, internet research, etc.

- Establish basic competencies for Recovery Coaches and identify skills needed for competency; e.g. competency in engagement requires basic communication skills and motivational interviewing skills.
  - Use these Practice Guidelines and the Behavioral Health Training Institute to develop core competencies.
  - Ensure that staff and leadership have access to training that will support skill development.

- Include a professional development plan in the orientation of all new employees. This plan identifies what the new Recovery Coach will need to learn in the first year and how the learning will be supported. Learning supports may include:
  - Shadowing another seasoned Recovery Coach.
  - Individual mentoring by a supervisor.
  - Attending internal trainings.
  - Use of the Behavioral Health Training Institute's foundation series as a core training guide.

- Encourage utilization of available training/courses from a variety of sources that relate to areas of interest/need in professional development plan.

- Formally update the professional development plan for all employees with the annual evaluation.

  - Set new targets that reflect the needs and interests of the Recovery Coach.
  - Build on existing knowledge to create expertise in your team; i.e. if a Recovery Coach self-discloses they are in addiction recovery, encourage continued learning in this area to promote service excellence.

- Incorporate learning goals in ongoing supervision. If supervision occurs in groups, focus on competency development goals shared by members of the group.
  - Use supervision to reference how the Recovery Coach/team is increasing skill in desired areas and by making suggestions of new things to try.
  - Be vigilant about keeping skill development and learning, rather than administrative issues, at the core of supervision.

- Build on the learning opportunity presented by clinical consultation:
  - In addition to case presentation and discussion, ask the clinical consultant to recommend articles, websites, and videos that may be helpful in expanding upon topics discussed.
  - When possible, have the consultant accompany a Recovery Coach on a visit to clarify challenges and target consultation to meet specific needs.

- Develop ways to learn from the individuals you serve:
  - Host regular focus groups addressing participant perceptions of the service.
  - Use quarterly group surveys seeking feedback, then plan for ways to incorporate learning that is needed.
  - Consider incorporating a standard interaction at the end of each Recovery Coach-participant interaction that asks similar information, e.g., “how are we doing?; what can we do differently/better?”

- Develop an internal quarterly learning collaborative approach:
  - Set topics of interest to your service.
  - Arrange for some educational component (speaker, mini-training, group reading) followed by small group work aimed at action planning for the service.
  - Follow through on learning and recommendations for change.

- Attend and participate in quarterly Recovery Coaching Leadership Meetings:
  - Generate topics of interest.
  - Provide expertise from your agency when appropriate to the learning topic.
  - Follow through on action plans developed and recommendations for change.

## SUPERVISION & CONSULTATION

**Supervision focuses on helping Recovery Coaches develop relationships with participants that promote recovery and wellness, goal attainment, self-management and community connection. Recovery Coaching assists individuals to achieve their recovery planning goals, reduce hospitalizations, improve symptom management, facilitate sobriety, create a life in the community, and prepare for transition from service.**

Guidelines for Recovery Coaching supervision include:

- The Recovery Coaching Director supervises Team Leaders at least weekly, and assures the integrity and quality of service delivery and outcomes.

- The Recovery Coaching Director monitors and maintains direct responsibility for access, community involvement of the service and its participants, and relationships with referral sources and other entities serving individuals in recovery.

- Team Leaders supervise up to three teams of 3-5 Recovery Coaches each, with no more than nine supervisees per Team Leader. Each Recovery Coach serves a maximum of 20 individuals.

- Team Leaders maintain daily contact with Recovery Coaches. Each team member receives supervision on a weekly basis (in small teams or individually).

- Team Leaders create clinical connections between Recovery Coaches and clinical/psychiatric consultants to increase general clinical knowledge and to assist with specific client urgent needs:
    - Twice monthly clinical/psychiatric consultation with teams
    - Recovery Coaches and Team Leaders contact clients' therapists/psychiatrists directly for advice

- Team Leaders maintain a broad perspective – keeping track of participants, the urgency of their needs, and progress in recovery. They assure that:
    - New referrals are seen promptly by Recovery Coaches skilled in engagement
    - The amount of time spent with participants is based on their current needs
    - Activities are related to the individual's recovery goals
    - Team members meet with individuals when and where needed, based on risk and urgent situations that arise

- Use the following guidelines and develop change strategies as needed:
    - Rapid connection to service – wait lists are obstacles to enrollment
    - Service intensity – frequency of service and amount of time spent with participants
    - More frequent contact and added consultation/resources are urgent responses to participants with increased risk and vulnerability

  - Maintaining a mix of participants with different levels of urgency helps teams organize their time to meet individual needs for service intensity
  - Progress in stages of change indicates strong Recovery Coaching support across wellness areas
  - Length of service measures the rate of movement toward self-management and eventual discontinuation of service

- Directors and Team Leaders build best practices, using Plan-Do-Study-Act or Rapid Cycle Process Improvement, tracking results and implementing successful processes throughout agency Recovery Coaching services.

- Directors and Team Leaders model engagement skills and positive relationships.

- Team Leaders use group supervision to develop Recovery Coaching practices and make the best use of individual team member strengths.
  - Focus on strategies and activities that help individuals meet their goals and improve self-management – incorporating stages of change/motivational interviewing
  - Plan for transitions out of Recovery Coaching service

- Team Leaders use shadowing to evaluate individual Recovery Coaches and provide feedback about strengths and areas for improvement.

- Directors and Team Leaders assist agencies to create a welcoming environment and sense of respect for staff and individuals who come to the agency for service.

## *PROMOTING TEAMWORK AND SELF-CARE*

**Supporting employee well-being and encouraging teamwork helps to increase engagement and productivity, prevent burnout, and improve staff retention rates.**

- Team Leaders use Reflective Supervision, which combines the administrative and clinical aspects of supervision with careful listening and mutual exploration. This deepens relationships, builds trust, and allows supervisees to better understand their own roles and responsibilities.
    - Team Leaders shouldask supervisees to describe thoughts and feelings in detail, using who, what, where, when, and why.
    - Team Leaders are always mindful and respectful of the supervisee's feelings.

- Team Leaders use group supervision to foster teamwork and promote well-being.
    - Celebrate the strengths and successes of individuals receiving services to foster hope and promote a sense of a "job well done"
    - Practice relationship-building exercises during team meetings.

- Team Leaders use personal assessments to learn about each Recovery Coach's supervisory needs, personal strengths, and professional goals.

- Team Leaders model and promote self-care:
    - Use the Professional Quality of Life Scale to measure Recovery Coaches' compassion satisfaction and fatigue. Make this a point of ongoing discussion during supervision.
    - Promote the use of self-care assessments and ask employees to create a maintenance self-care worksheet and an emergency self-care worksheet.

## REFERRALS & WAITLISTS

Recovery Coaching leadership understands that rapid connection to service at the time of need enhances engagement and progress toward goals. Wait lists present obstacles to service enrollment and recovery. Availability for new Recovery Coaching referrals is the responsibility of the Director, who plans staffing based on past history, population growth and characteristics, and increased demand due to greater access to coverage and benefits. Directors set staffing goals that assure timeliness in hiring new Recovery Coaches. **Directors and Team Leaders actively manage new referral assignments and monitor potential new referrals, while minimizing wait lists and assuring connection to supports for high priority needs.**

Some Director and Team Leader strategies for rapid assignment of referrals and managing wait lists are:

- Develop a system to assure that all referrals are closely monitored; record and track timeframes between date of receipt of referral, date of assignment to team, date of first contact with referral source and person. Set goals for rapid assignment of new referrals and monitor results.

- Initiate personal contact with individuals, prioritize referrals by urgency of need and presence of risk, and link to needed supports for treatment or service, such as therapists, psychiatrists, peer specialists, and self-help resources.

- Maintain close contact until individuals are connected to Recovery Coaches.

- Maintain a flow of participants transitioning out of service through close oversight of each team's participants. Assure that supervision focuses on assisting transitions out of service for participants with strong self-management skills. This creates room for new referrals.

- Recognize that referrals are not static. Responding with urgency to increased demand requires leadership creativity, and not being constrained by physical space limitations. Consider the following possibilities:
    - Increasing the number of Recovery Coaches who work different shifts and provide more flexible hours.
    - Deploying more Recovery Coaches who are based "off-site" and provide most services in the community while communicating through mobile devices.

- Remove barriers to service, including paperwork:
    - Use engagement service units to bill for service prior to completing required documentation.

- Prioritize participants who may be at risk:
    - Individuals who are homeless or inadequately housed.

  - Individuals who are frequently hospitalized or experience repetitive emergency/acute events.
  - Individuals who have frequent emergency department visits or hospitalizations for chronic medical conditions.

- Establish personal relationships with local psychiatric hospital social workers and other key referral sources to help introduce individuals to the service and to the Recovery Coaching team.

- Regularly attend community events and meetings to explain services and answer questions.

- Use a “Welcome Wagon” approach – put together resources for Recovery Coaches to use when first meeting participants, bringing packets of useful resources.

- In extreme situations (as seen during the COVID-19 pandemic), agencies may be understaffed and referrals may be high. In these situations, it is advised that:
  - RC Leadership triage referrals, ensuring those with the highest needs are prioritized while others are referred to Administrative Case Management (ACM) as appropriate
  - ACMs may assist in covering emergency needs for individuals who remain on waitlists
  - RC Leadership supports RCs in determining which individuals may be appropriate for transition to a lower level of care (this is best practice and should be done at all times)
  - RC caseloads may be extended beyond 20 individuals receiving services, but not beyond the state guideline of 30
  - RC Leadership can support their teams by temporarily taking on small caseloads

## POPULATION-BASED PLANNING

**Recovery Coaching leadership uses a strategic population-based planning process for the growth and management of the service. The Director scans the geographic area and the environment to estimate service needs over an extended time period and develops staffing plans accordingly. The goal is to provide effective time-limited service that contributes to improved public health.**

Some guidelines for population-based planning are:

- Maintain updated information about general population growth in your service area. Drill down to include age groups, ethnicity, and income levels.

- Find out projected Medicaid population growth in the County.

- Use information about prevalence of mental illness in both the population at large and in the Medicaid population, to estimate the number of individuals in the service area who may require Recovery Coaching service.

- Contact local emergency rooms, hospitals, and health centers to estimate the number of people with chronic physical conditions that may have co-existing untreated mental illnesses. Develop relationships to build easy access for referrals to service; assure immediate responses to urgent situations.

- Access information through the Montgomery County Planning Commission and other resources to better locate specific areas of need: hunger, aging, healthcare, safety, employment, housing, and availability of basic services. When contacting the Planning Commission, be specific about which municipality and what information you are looking for.
    - Recovery Coaches outreach to individuals in these pockets may increase enrollment and lead to targeted services that benefit participants and improve the overall health of the population.
    - Food insecurity is a growing problem in Montgomery County; be aware of the needs in your area.

- Locate information sessions in areas of need where people congregate; include hospitals, healthcare centers, and food banks. Broadly advertise the informational sessions.

## ENHACING CONNECTIONS TO THE COMMUNITY

"Community" includes places and organizations that help to create relationships and advance recovery through participation: places where people live, work, or connect (neighborhoods, jobs, community centers, places of worship, etc.); gatherings that support people's interests (reading circles, gardening clubs, etc.); assemblies where citizens meet for a purpose (political parties, civic organizations, etc.); organizations and resources that support a person's ambitions (schools, jobs, libraries, etc.). **Recovery Coaching leadership understands the need to establish mutually beneficial relationships within the community, to enhance coordinated and collaborative service to individuals and strengthen community connections and civic involvement. Recovery Coaching leaders "spread the face" of Recovery Coaching throughout the community.**

Some strategies for Recovery Coaching Leadership are:

- Attend the monthly CSP meetings to keep the pulse on stakeholder strengths, preferences, and needs. Distribute written information about Recovery Coaching services in community settings where people convene.

- Conduct open houses to highlight services and accomplishments.

- Develop personal relationships with other health or service organizations and entities that serve individuals in recovery – including health centers, police departments, libraries, food banks, etc.

- Become a consistent presence at local community hospitals: attend meetings; make presentations about services; meet and support enrollment of admitted individuals into Recovery Coaching services.

- Become familiar with key community leaders and organizations to learn about the culture of the area and places where people congregate. This will help to focus outreach activities in neighborhoods of need.

- Be prepared to provide education to support community needs. This improves the overall health of the community and contributes to public safety. For example, speak at Parent-Teacher organizations; community centers, places of worship, health clinics and community hospitals, etc.

- Along with other departments in your agency, participate in community projects and endeavors as a way to increase your profile in the community and to serve the community as a whole.

## PEER CULTURE

Recovery Coaching recognizes the power of peer support and mutual aid in developing hope, motivation, and engagement in recovery. The service develops a variety of informal ways to bring stories of recovery and peer fellowship to participants. For many individuals in pre-contemplation and contemplation, the need for consistent and persistent engagement exceeds the informal network of peer support. This need is best met through utilizing formal peer support services as a complementary service to Recovery Coaching, as well as formal mutual aid groups. **Directors and Team Leaders establish and support a positive and hopeful peer culture. They assure that teams encourage the expression of peer leadership and advocacy for important civic causes and for the improvement of the services.**

Some practices and strategies for Recovery Coaching leadership to develop a peer culture include:

- Use existing peer advocate resources to assure that your services are peer-informed and recovery-oriented.

- Help teams to systematically develop multiple avenues for peer-initiated activity, from service start to transition out of Recovery Coaching. This includes fostering informal peer relationships among participants, peer led groups and activities, peer-led mutual aid groups and peer advisory groups or peer governments.

- Provide administrative and relationship support to peer activities that enhance individual's experience of and connection to community.

- Assure that Recovery Coaching creates frequent opportunities for Certified Peer Specialists (CPSs) to help individuals recognize how their mental health challenges impact their day-to-day life.

- Build early and ongoing exposure to Peer Specialists and other forms of peer supports into regular Recovery Coaching practice to counteract the hopelessness often felt at the outset of care.

- Help teams use creative approaches in deploying CPSs to attract and engage people to the service.

- Create a culture where peers, who have achieved their goals and left Recovery Coaching services, are encouraged to "give back" to the service and its participants through storytelling, mentorship, and sponsoring.

- Support ongoing review and communication of available community resources and events – e.g., bulletin board, peer-led community meetings – and encourage peer initiated participation in opportunities that may prove meaningful to a participants' recovery.

- Help teams to overcome challenges to support participants to attend recovery conferences and other educational opportunities.

- Support the expansion of CPSs who are trained to facilitate Wellness Recovery Action Plan (WRAP) groups, both at the agency and in the community.

- Create roles for peers within your team/service that help reach out to new participants; welcome committee, Recovery Coaching buddies.

- Create roles for peers within your team/service that help reach out to others, such as sunshine club that sends get-well and birthday greetings, or team telephone support.

## *SUPPORTING EMPLOYEES WITH LIVED EXPERIENCE*

Individuals with lived experience of mental health challenges prove every day that they possess a powerful ability to engage, persuade, and teach individuals receiving services that living a full, rich, connected life in the community is not only possible but desirable. Whether acting within multidisciplinary Recovery Coaching teams, or other connections, peer staff and leaders bring wisdom not acquirable through traditional professional preparation. **Directors and Team Leaders recognize that lived experience is an asset to the role of a Recovery Coach. Certified Peer Specialists (CPSs) and individuals who self-identify as having lived experience are actively recruited to the service.**

Some strategies for incorporating and or collaborating with staff who utilize their lived experience in their work are:

**If the staff is a CPS:**

- Encourage them to educate the team about CPS values and competencies.

- Promote the skills they gained in CPS training in supervision (individual and group).
    - Consider listing some of the skills for non-CPS staff.

- Find ways to support peer identity.
    - Professional development and networking meetings, peer skill development trainings, etc.

- Encourage the development of a workplace Wellness Recovery Action Plan (WRAP).
- Encourage their careful and considerate self-disclosure aimed at meeting the needs of the participant.

**If the staff is not a CPS, but a person with lived experience:**

- Encourage their careful and considerate self-disclosure aimed at meeting the needs of the participant.

- Support mutuality and learning from one another in staff meetings
    - Create a culture where individuals can share their experiences and/or look to their own life experiences for lessons learned to use in their work.

- In supervision, keep a focus on using lived experience as an important skill set.

- Support learning about recovery by encouraging peers and Recovery Coaches to attend recovery related trainings together.

- Hold the hope and excitement for recovery by giving space for success stories of staff and participants.

- Teach recovery in a recovery manner.
    - Recovery-oriented systems of care support person-centered and self-directed approaches which build on the strengths and resilience of the person.

- Embrace the skills sets developed through CPS training and encourage eligible staff to explore the advantages of CPS training.

## RECOVERY COACHING SUSTAINABILITY & EVALUATION

Agency Recovery Coaching Departments have all developed sustainability plans for the service, with targets and action steps related to the ongoing assessment of strengths and challenges in delivering the service. Recovery Coaching Departments are expected to evaluate their own performance on an annual basis and share these self-evaluations with both the County and Magellan.

Self-evaluations include:

- Reviewing developmental goals for the previous year.
- Summarizing program accomplishments that have been measured, explaining how they have been measured, and including supporting data.
- Identifying areas needing improvement.
- Establishing developmental goals for the following year, specifying indicators that will be used to measure achievement of each goal.

Self-evaluation is aimed at advancing the agency's goals. In addition, Magellan and the County will review basic Recovery Coaching expectations, including rapid access to service, engagement and enrollment of individuals with high needs, hospitalization, intensity of service related to tier levels, and transitions out of service.

## *QUALITY IMPROVEMENT & OUTCOMES*

Recovery Coaching is dedicated to helping individuals achieve a fulfilling life in the community. Recovery Coaches, immersed in the demanding day-to-day work of supporting participants, cannot easily know or demonstrate the outcomes of their efforts. **Quality Improvement, using a "Plan, Do, Study, Act" cycle, provides a systematic process of making changes to improve services and outcomes. NIATx Rapid Cycle Process Improvement is another option that provides faster way to test interventions and incorporate successful strategies into Recovery Coaching practice.**

Some strategies for using Quality Improvement and measuring outcomes are to use Rapid Cycle Process Improvement, incorporating the "Plan, Do, Study, Act" cycle, to test the effectiveness of targeted strategies, evaluating meaningful outcomes – that improve people's lives.

- Start with a **PLAN:**
  - Target a significant service issue needing improvement related to the primary goal of Recovery Coaching, for example:
    - Reduce time between referral to service and meeting with a Recovery Coach.
    - Decrease the number of 30-day readmissions to inpatient service.
    - Increase the number of individuals with safe and affordable housing.
    - Increase the number of individuals employed or enrolled in education/training activities.
  - Develop a clear goal, e.g., 90% of individuals will meet with a Recovery Coach within 10 days of receipt of referral.
  - Select simple basic measures and methods to collect baseline data.
  - Determine the time period for collecting baseline data, e.g., a few weeks.
  - Select an intervention based on a theory of what the intervention will accomplish.

- Implement **(DO)** the plan and collect data for a short time period, e.g., 4-6 weeks, to measure progress

- **STUDY** the results – what did the intervention accomplish?

- **ACT** on findings – abandon, adapt, or adopt:
  - If there was no improvement, abandon the intervention.
  - If there was some improvement, but the goal was not reached, adapt the intervention – tweak what was done, again using a theoretical rationale for what you expect to accomplish.
  - If the goal was met, adopt the intervention into agency Recovery Coaching practice.

- Repeat the process, always focusing on an important issue that is related to the main goal of Recovery Coaching – to help individuals set and attain goals so they live fulfilling lives in the community.

- Support Recovery Coaches to use the same rapid cycle approach to try out new interventions with participants, teaching them the process and helping to develop results-based learning. This facilitates new behavior and new learning for participants. Taking risks by "trying out" new behavior is part of the recovery process.

- Celebrate accomplishments and tell everyone via posters, newsletters, parties, etc.

# APPENDIX

## BOUNDARIES

*Shared by St. Luke's Penn Foundation*

### BOUNDARIES

**What is a boundary?** A line on a map; a mark dividing two areas/a dividing line; an edge or limit of something; the limit of what someone considers to be acceptable behavior, limits on time/energy/resources, limits regarding what is acceptable or not acceptable within a specific relationship.

- **Types of boundaries:**
  - **Physical:** personal space, who can touch you, how, where and when they can touch you, sexual boundaries, limits on time, limits on who can touch oruse your belongings
  - **Mental/Emotional:** Your thoughts, values, opinions, feelings, right to make your own choices, what people can say to you, who you will and will not engage with/have a relationship with, your energy.
  - **Professional:** limits around the nature of the relationship between a professional helper and a person being helped through a formal service. Limits will look different than that of a friend/family member. Protects both the helper and the person being helped. Sets the expectation of what will and will not occur within the helping relationship.

- **What makes boundaries tricky:**
  - Can differ from person to person (different comfort levels), relationship to relationship. May vary depending on the type of relationship (e.g. your spouse vs. a stranger on the street)
  - The water can look muddy! For example, real-life situations can be complex and it may not always be clear where/when to set a boundary. It just won't always be clear where the boundary should be set
  - Expectations – our own and others. Fear of others reactions to our boundary setting can be fear of client reaction, or fear of how our supervisor, client's family, insurance/county oversight body, etc. may react.
  - The **slippery slope:** boundary violations do NOT typically start with big violations, but rather start with relatively small boundary infractions that begin to occur more frequently and become larger and larger over time or as the relationship continues
    - Examples: "Okay, I will take you/help you/do this for you just this once," concessions, giving extra time to a specific client, sharing personal information of a minor nature/seemingly minor nature, using a term of endearment, making excuses for problematic behavior, etc.
    - MUCH more likely to occur when there is countertransference response occurring. For example, the client looks just like your grandmother whom you

love dearly, or the grumpy client that reminds you of your father, the client who always compliments you or tells you how helpful you are, etc.

- **Professional boundaries:**
  - Being a professional helper is NOT the same as being a friend, a kind stranger, family member etc.!
  - The professional helping relationship is a ONE WAY street: the professional does the helping, the client receives the help. The client's needs are the main focus of the relationship.
  - There is typically a financial exchange aspect to this type of relationship, meaning either the client, their insurance, or a third party is funding the provision of the help being offered.
  - The help is being provided as part of the helping professional's job, not a part of their free time, and is therefore governed by the rules of that job/position.
  - The relationship will likely be a temporary situation as part of the service the client is receiving.
  - Power differential: there is inherent in this type of relationship an imbalance of power. Where the professional holds a greater level of power or responsibility for the outcome of the help/service that is being provided to the client

- **How do I know when my boundaries are being crossed?**
  - "Gut" feeling
  - Feeling uncomfortable with a situation/person
  - Anger/irritation/frustration
  - Feeling used
  - Something you stated as a boundary was ignored
  - Giving more than originally intended
  - Feeling manipulated o Knowing my own limits-
  - What am I comfortable with? What do I need?
  - Will doing this create other problems for me?
  - If Ido it will I feel resentful afterwards?
  - Is this part of the service I am delivering or not?
  - If I do this, how will it affect my client? How willit affect me?
  - Who am I doing this for?
  - Do I want to do this?
  - Am I only doing this because I am afraid of what will happen or what the other person will think ofme/consequences of not doing it?
  - If I spend my time on this, will it take my time away from something else that is important to me?

- **Good questions to ask when deciding where to draw a line:**
  - Who am I doing this for? Is it for me or for the client?
  - Why am I doing this? How will doing this behelpful?
    - Consider both short-term AND long-term implications

        - Consider the client's recovery plan. Does this support the client's goals? Will it possibly harm progress on any of those goals?

- **Self-management vs. dependency:**
    - A general goal of professional helping relationships is to facilitate greater self-management in the people whom we are helping. This creates a sense of empowerment, greater sense of pride in one's self, feelings of control over one's life, and improves self-esteem and feelings of self-efficacy. All of these things can help clients to be more successful in reaching their life goals, even beyond just the ones they are currently addressing.
    - Need to ask ourselves, will doing this help my client to be more empowered? To be more independent?
    - Will doing this for my client create dependency? Will they be dependent on me to continue to do this? For how long?
    - If I do this for my client, how will they get it done when I am not around/unavailable/no longer working with them? Is there a better solution available?
    - Does the client really need me to do this for them? What evidence do I have to support the need, or is it instead contrary to the need?
    - Does doing this meet any of MY needs?
        - Need to be helpful/be the helper
        - Will this benefit the work in the long run?
        - Billing/productivity requirements
    - If YES to any of these, you need to consider more carefully whether or not you are doing it truly for the client's benefit or for your own. These may not be mutually exclusive! Sometimes doing something may not only be of benefit to the client but may also benefit us, BUT we must be very clear and honest with ourselves about why we are really doing it first.

## PERSONAL ASSESSMENT

*Shared by Resources for Human Development – Lower Merion Counseling & Mobile Services*

# PERSONAL ASSESSMENT

### Section 1: Team Member Information

Staff Member Name: _____

Supervisor Name: _____

Hire Date: _____ Date completed: _____

### Section 2: Assessment

Please attach additional sheets if necessary when answering the following questions:

1. What qualities do you most appreciate in a supervisor/employee?

2. What is a professional goal that your supervisor can help you with?

3. How would your supervisor know that you are overwhelmed/stressed and what can they do to help you?

4. Are there additional skills or knowledge that would help you more effectively perform your present job or enhance your skill opportunities? If yes, please list.

5. What goals (specific measurable results) do you expect to accomplish during the next 90 days and how can your supervisor help you reach those goals?

List the subjects you would like to discuss during your supervisions:

1.

2.

3.

### Section 3: Signatures

Team Member: _____ Date: _____

Supervisor: _____ Date: _____

## CELEBRATING STRENGTHS

*Shared by St. Luke's Penn Foundation*

**Celebrate Strengths and Successes**

Choose a person you are currently working with where you think your work together *is going well, that is, progressing in a meaningful and productive way* (work that you are proud of!). Briefly describe the person – age, gender, reason for referral, goals – just some details to provide a "picture" of the person. Reflect on the following questions to share with the group.

What made you choose this person?

Describe the qualities of your relationship with this person that contributed to progress?

What were this person's strengths?

What needs of the person were met?

Were there challenges to overcome in your relationship? In your work together? In resources? How did you overcome them?

Anything else to add that makes your work with this person special or stands out? For example, collaborations? Natural supports? Resilience? Personality? Perseverance? You? Them?