White, W. & Davidson, L. (2006). System Transformation. Recovery: The bridge to integration? (Part 1) *Behavioral Healthcare,* 26(11), 22-25.

White, W. & Davidson, L. (2006). System transformation (Part 2) Recovery: The bridge to integration? *Behavioral Healthcare Tomorrow*, 26(12), 24-26.

Recovery:
A Conceptual Bridge Between the Mental Health and Addictions Fields

By William White, MA and Larry Davidson, PhD

During the late nineteenth century, conflict flourished between leaders of the Association of Medical Superintendents for American Institutions for the Insane (AMSAII) and leaders of the American Association for the Study and Cure of Inebriety (AASCI). Members of both groups represented institutions and practitioners plagued by the confluence of addiction and mental illness. Chicken or egg arguments on the relationship between the two disorders abounded, as did debates about cultural/ professional ownership of the most intractable clients and their appropriate diagnosis and treatment (Deutsch, 1937; White, 1998). From this inauspicious beginning, an uneasy relationship between the addictions and mental health fields has evolved, marred by sustained conflict, competition, mutual antipathy, and failed service integration efforts followed by re-segregation of the fields. Pockets of successful behavioral health service integration at the local level within this history have been obscured by the overall bifurcation of behavioral health into separate addictions and mental health fields.

A recovery revolution is now occurring within and across the addictions and mental illness problem arenas that challenge practices within both of these fields as well as their historical segregation. This paradigmatic shift will fuel debate over whether this recovery revolution is a long-awaited and desperately needed opportunity to revitalize, or a cataclysm that will de-professionalize and then destroy, both fields. The purpose of this brief essay is to explore whether the concept of recovery could serve as a conceptual bridge through which the treatment of addiction and mental illness could be integrated within one recovery-oriented system of care. The authors speak as long-tenured insiders within these respective fields whose writings and presentations advocate embracing this revolution in thinking and practice (e.g., White, Boyle & Loveland, 2004; White, 2005; White, 2006; Davidson,

O'Connell, Tondora, Staeheli & Evans, 2005; Davidson, O'Connell, Tondora, Styron & Kangas, 2006; Davidson, Stayner, Nickou, Stryon, Rowe & Chinman, 2001; Davidson & Strauss, 1992, 1995).

Service Integration: Inhibiting and Promoting Forces

A review of the histories of the addictions and mental health fields provides three clues on why past service integration efforts may have failed. First, efforts to integrate the treatments of addiction and mental illness have failed when they focused on discussions of the etiology or nature of these disorders or on treatment philosophies and techniques. Historically, common ground for behavioral health integration does not lie in these arenas, although advances in neurobiology may yet establish such common ground. Second, practitioners from both the addictions and mental health fields have been unprepared and often unwilling to treat clients from their sister field. The relationships between addiction treatment providers and clients with severe mental illness and the relationships between mental health service providers and those with severe alcohol and other drug problems both have been characterized by institutionalized counter-transference (e.g., lack of empathy, disrespect, contempt, exclusion, and extrusion). Service integration efforts have often failed to address these attitudinal barriers. Third, the historical conflict that has pervaded the relationship between theses two fields is imbedded in prolonged competition for scarce resources, fears regarding the loss of institutional and professional legitimacy and integrity, and structural issues at the national level that drive segregated policies, funding streams, and regulatory oversight. Without a strong and shared conceptual foundation, the processes involved in service integration experiments have occurred largely by administration fiat and were often experienced at the front lines as one field attempting to colonize the resources of the other.

What is surprising in light of this history is the continued discussion regarding the potential advantages of an integrated behavioral health system. The forces pushing integration appear to be just as significant as those inhibiting it. People experiencing addictions and those with severe mental illness have often been considered hopeless and been the target of intense social stigma manifested in their sequestration in almshouses, decaying asylums, jails, and prisons, or abandoned on the nation's streets. There is in this shared history a sense that the fate of individuals and families impacted by mental illness and addiction may be somehow linked, and that joint efforts might lead to more progress than isolated efforts.

Adding to the weight of this history is the growing confluence of these problems. Epidemiological and service utilization data reveal that these problems are as likely to co-occur in the same individuals and families as to exist independently of one another. Over the past two decades, an extensive body of literature has illuminated the poor quality of care individuals and families with multiple problems receive within the current system of categorically segregated services. That body of research is confirming the superior outcomes achieved within integrated models of care. All of these factors add momentum to service integration initiatives, but we suspect the primary spark for such integration will come from another source. The individuals and families experiencing these problems and the lived solutions they are discovering suggest new rationales and strategies for service integration that have hitherto escaped policy makers, managers, and practitioners.

The Recovery Revolution

There is a shift within the broad arena of behavioral health from pathology and treatment paradigms to one of recovery (White, 2005). This shift is indicated by:

- The growth and diversification of recovery mutual aid structures (support groups, clubhouses, recovery support centers, recovery housing, recovery educational programs, recovery job co-ops)
- The growth in grassroots recovery advocacy organizations in both fields that are addressing the problem of co-occurring disorders at both clinical and organizational levels,
- Major policy reports, including the President's New Freedom Commission Report on *Achieving the Promise (2003)*, SAMHSA's *Transforming Mental Health Care in America* (2005), and the National Institute of Medicine's *Improving the Quality of Health Care for Mental and Substance-use Conditions (2006)*.
- New pilot initiatives at the Federal level (CSAT's Recovery Community Support Program and Access To Recovery), and state- and city-initiatives (e.g., CT, Philadelphia) to integrate behavioral health care within a recovery-focused system transformation, and
- Significant increases in number and quality of scientific studies on the pathways and processes of long-term recovery from addiction and from mental illness.

"Recovery-oriented system transformation" is becoming an umbrella concept for integrating behavioral health care and creating systems of care that are culturally competent, trauma-informed, evidence-based, inclusive of families, based on strengths, and connected to communities (as indigenous sources of recovery support). Leading the call for such system transformation are new recovery advocacy movements in both the addictions and mental health fields. These movements, led by people in recovery, their families and visionary professionals, are demanding that care be focused on the processes of long-term recovery and anchored within natural supports and local communities.

Core Ideas

Recovery refers to the ways in which persons with or impacted by a mental illness and/or addiction tap resources within and beyond the self to move beyond experiencing these disorders to actively managing the disorders, managing their residual effects and building full, meaningful lives in the community. Recovery is more than the elimination of symptoms from an otherwise unchanged life; it is about regaining wholeness, connection to community, and a purpose-filled life. There are a number of over-arching ideas that are at the core of these new recovery advocacy movements.

1. Recovery is a reality in the lives of millions of individuals and families.
2. There are many pathways and styles of recovery.
3. Recovery is a voluntary process.
4. Recovery flourishes in supportive communities.
5. Recovery gives back (to individuals, families, and communities) what addiction and mental illness have taken away.
6. Behavioral health care must move beyond emergency and palliative care to care that is oriented to promoting long-term recovery.

Recovery-oriented care is what psychiatric and addiction treatment and rehabilitation practitioners offer in long-term support of the person's/family's own recovery efforts. Recovery-oriented care shifts the design of the addiction treatment system from an acute care model focused on serial episodes of biopsychosocial stabilization to a model of sustained recovery management. That same recovery orientation in the mental health field shifts the service design beyond cyclical crisis intervention and "sustaining care" aimed at symptom suppression and reduced

hospitalizations to one of recovery enhancement. Recovery-oriented care focuses on the acquisition and maintenance of recovery capital (internal and external assets required for recovery initiation and self-maintenance), global health (physical, emotional, relational, and spiritual) and community integration (meaningful roles, relationships, and activities).

Understanding that system change, like recovery, must be led by people with lived experiences of recovery, the Connecticut Department of Mental Health and Addiction Services consulted with statewide recovery advocacy organizations to develop a set of core recovery values (e.g., self-sufficiency, dignity, respect) and principles to drive their system transformation process. These principles included the following admonitions: 1) f*ocus on people rather than services,* 2) m*onitor outcomes rather than procedural performance,* 3) e*mphasize strengths rather than deficits or dysfunction,* 4) e*ducate the public to combat stigma,* 5) *foster collaboration as an alternative to coercion, and 6*) p*romote autonomy and decrease reliance on professionals* (Recovery Resource Guide, 2002).

Transforming Practices

As we have watched and helped facilitate these experiments in system transformation in states like Connecticut and cities like Philadelphia, we have been struck by the broad changes in practices in both mental health and addiction agencies that unfold as an outcome of recovery-focused system change. Some of the most profound of these changes occur in the following areas (White, Boyle & Loveland, 2002):

- Roles of clients, families, and recovery advocates: Shifts from viewing people with mental illnesses or addictions as the problems a system has to deal with to viewing people in recovery as valuable assets and partners, with their involvement at all levels of service organization and across major functions (policy development, planning, service delivery, service evaluation) in advisory, volunteer, and paid roles; decision-making viewed as crucial to long-term recovery; and a philosophy of choice guides all levels of care and nuanced across developmental stages of recovery.
- Identification, engagement, and retention: Assertive outreach programs, shift from pain-based to hope-based intervention strategies, lowered thresholds of admission, increased use of case management to resolve obstacles to participation, and use

- Assessment: Shifts from assessment protocols that are categorical (specialized), pathology-based, individual-focused, and an intake function to assessment protocols that are global, strengths-based, family-centered, and continual.
- Service Goals: Symptom reduction/remission shifts from a goal to a strategy; goals focus on quality of life, achievement of personal aspirations, meaningful participation in and service to the community.
- Service planning and service team: Rapid transition from professionally-directed treatment plans to client-driven recovery plans; move to multi-agency, interdisciplinary service models; inclusion of family and indigenous healers (clergy, folk healers, recovery peers, e.g., sponsor) in treatment and recovery planning process.
- Role of the Community: Emphasis on local recovery education and policy advocacy; shift from viewing community as context for or precipitant of relapse to reservoir of resources, hospitality, and support; focus on collaboration with existing recovery support resources and community development strategies to expand the scope and quality of such resources.
- Service Timing: Shifts from crisis-based contact to long-term support focused on critical windows of peak functioning (to acknowledge and celebrate recovery) and critical windows of vulnerability (to provide support through situations that pose risk of relapse); use of regular recovery checkups.
- Locus of Service Delivery: Shifts from institutional environments to client's natural environment; considerable focus on the "ecology of recovery" (helping clients create a recovery-conducive physical and social environment).
- Service Relationship: Shifts from an expert model of diagnosis and treatment to a sustained heath care partnership; shifts from relationship that is hierarchical, transient, and highly commercialized to one that is less hierarchical, sustained, and natural; increased use of peer-based models of recovery support.

- Service Evaluation: Significantly involves clients, family members, and community elders in the evaluation process; emphasis shifts from pathology measures to key recovery indicators; shift from evaluating discrete service episodes to evaluating impact of service combinations and sequences on person's overall life over time.

Toward a Recovery-Oriented, Integrated System of Care

A move toward a more recovery-oriented system of care can occur concurrently and independently with the addictions and mental health fields or it can be used as an opportunity to move towards an integrated system of behavioral health care. We have been frankly surprised at the amount of common ground that is being discovered as recovery advocates from both fields have come to know each other and share their respective stories and concerns. In working with those systems that are attempting behavioral health integration, we have been similarly struck by the discovery that the greatest obstacles to integration are coming at structural levels (the segregation of policy development, service planning, funding, documentation requirements, and regulatory monitoring) and not at the front-line service levels. It is tragically ironic that the infrastructures put in place separately within both fields with a vision of enhancing quality of care now constitute obstacles in achieving that goal.

The structural obstacles to behavioral health care integration are substantial, and only sustained advocacy and new organizing constructs are likely to overcome these obstacles. The collaboration and growing influence of grassroots mental illness and addiction recovery advocacy groups and their progressive elaboration of the recovery concept may well provide the momentum for service integration and the conceptual bridge between the addictions and mental health fields. There is much potential synergy if this continues to unfold. To cite just one example, the addictions field has had a well-developed concept of full recovery for more than 200 years, but has lacked a legitimized concept of partial recovery, while the mental health field has long-promoted the goal of partial recovery but has, until very recently, lacked a viable concept of full recovery from severe mental illness. Neither field have had an understanding of "transcendent" recovery—a heightened level of personal and interpersonal functioning achieved as a result of having survived and transcended the limitations imposed by such severe and complex disorders (White & Kurtz, 2005). Both fields have much to gain from a dynamic interplay between these various views of recovery,

expanding the range of possibilities available to people living with these conditions.

The mental health and addictions fields have focused their collective energies on the study of pathology based on the assumption that discovering the etiological roots, natures, and courses of these disorders would generate effective treatments. Both fields are making substantial progress in the scientific evaluation of interventions designed to treat these disorders. But both fields are just beginning to build foundational knowledge on the prevalence, pathways, styles, and stages of long-term recovery. We envision a future in which behavioral health care will be designed based on intimate familiarity with and knowledge of the lived solutions to these problems. In that vision, two fields will have become one, and its primary message to the community will be one of hope for recovery from addiction and from mental illness.

Acknowledgment: Work on this article was supported in part by the Philadelphia Department of Behavioral Health and Mental Retardation Services.

About the Authors: William White, MA, (bwhite@chestnut.org) is a Senior Research Consultant at Chestnut Health Systems. Larry Davidson, PhD, (Larry.Davidson@Yale.edu) is Director of the Program for Recovery and Community Health, Department of Psychiatry, Yale University School of Medicine.

References

Anthony, W., Gagne, C. & White, W. (submitted for publication) Recovery: A common vision for the fields of mental health and addictions.

Davidson, L., O'Connell, M., Tondora, J., Staeheli, M.R. & Evans, A.C. (2005). Recovery in serious mental illness: A new wine or just a new bottle? *Professional Psychology: Research and Practice,* 36(5): 480-487.

Davidson, L., O'Connell, M.J., Tondora, J., Styron, T. & Kangas, K. (2006). The top ten concerns about recovery encountered in mental health system transformation. *Psychiatric Services,* 57(5): 640-645.

Davidson, L., Stayner, D.A., Nickou, C., Stryon, T.H., Rowe, M. & Chinman, M.J. (2001). "Simply to be let in": Inclusion as a basis for recovery from mental illness. *Psychiatric Rehabilitation Journal*, 24: 375-388.

Davidson, L. & Strauss, J.S. (1992). Sense of self in recovery from severe

mental illness. *British Journal of Medical Psychology*, 65: 131-145.
Davidson, L. & Strauss, J.S. (1995). Beyond the biopsychosocial model: Integrating disorder, health and recovery. *Psychiatry: Interpersonal and Biological Processes*, 58: 44-55.
Deutsch, A. (1937). *The Mentally Ill in America: A History of Their Care and Treatment from Colonial Times.* NY: Columbia University Press.
Recovery Resource Guide (2002). Hartford, CT: State of Connecticut Department of Mental Health and Addiction Services. http://www.dmhas.state.ct.us/recovery/resourceguide.doc
White, W. (2006). *Let's Go Make Some History: Chronicles of the New Addiction Recovery Advocacy Movement (Papers of William L. White)*. Washington, D.C.: Johnson Institute and Faces and Voices of Recovery.
White, W. (2005) Recovery: Its history and renaissance as an organizing construct. *Alcoholism Treatment Quarterly*, 23(1), 3-15.
White, W. (1998). *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Bloomington, IL: Chestnut Health Systems.
White, W., Boyle, M. & Loveland, D. (2003). Addiction as chronic disease: From rhetoric to clinical application. *Alcoholism Treatment Quarterly*, 3/4:107-130.
White, W., Boyle, M. & Loveland, D. (2004) Recovery from addiction and recovery from mental illness: Shared and contrasting lessons. In Ruth Ralph and Pat Corrigan, Eds. *Recovery and Mental Illness: Consumer Visions and Research Paradigms*. Washington DC: American Psychological Association, pp 233-258.
White, W. & Kurtz, E. (2005). *The Varieties of Recovery Experience*. Chicago, IL: Great Lakes Addiction Technology Transfer Center. (In press, *International Journal of Self Help and Self Care*).