An Integrated Model of Recovery-Oriented Behavioral Health Care

Department of Behavioral Health and Mental Retardation Services

City of Philadelphia

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Introduction

Over the last two years, the City of Philadelphia has been taking increasing advantage of unprecedented opportunities for reforming behavioral health policy and practice to improve the lives of its citizens facing the challenges of addictions and serious mental illnesses, their loved ones, and their communities. These opportunities have been created by the joining of several distinct, yet related, streams that have been winding separately toward a common destination over several years to decades.

Within mental health the notion and expectation of "recovery" has been around at least since the community support movement of the 1970's, if not before. This vision has come fully of age with the 1999 *Report on Mental Health* of the U.S. Surgeon General and the 2003 President's New Freedom Commission Report on *Achieving the Promise: Transforming Mental Health Care in America*; both of which identify the need to transform mental health services to reorient them toward promoting recovery.

At the same time, a new recovery advocacy movement has been taking shape in the addiction field. This movement has the two-fold aim of removing barriers to recovery and improved quality of life for people suffering from alcohol and other drug problems. As in mental health, this movement has been led by people in recovery who envision far-reaching changes in the ways services are developed and delivered. The goal is to shift from a professionally driven model focused primarily on stabilization to a disease- and recovery-management model in which professional treatment is one aspect among many that supports people in managing their own conditions over time and in building their own resources for recovery.

Simultaneous with both of these developments has been the accumulation of consistent and convincing data which shows that mental illnesses and addictions just as often co-occur in the same person as exist independently. These findings call into question the current division of the field into two distinct and heavily bounded territories and the often adversarial relationship between these "systems".

It suggested in the following pages that there be opportunities to respond to each of these three streams separately, and that the City of Philadelphia has a unique opportunity to seize upon a shared vision of recovery to address these issues collectively. The structure of the Department of Behavioral Health with Mental Health, Addiction Services, Managed Care and Mental Retardation services all under one umbrella, supports the development of a system in which there is truly no "wrong door" for entry, where people can be met where they are at the beginning of their contact with the system.

Mental illnesses and addictions converge with each other and with current services primarily at the interface of each individual person, family and community. An integrated system is in a unique position to respond to these blended needs. Transformation to a recovery orientation in both addictions and mental health becomes possible through focusing on the central role of individuals and families in responding to, managing, and overcoming these serious, potentially lethal illnesses—and using this focus as an organizing point for the entire system.

This paper provides a brief review of the shared, and tragic, history of addiction and mental illness. The need to transform both systems is also presented along with the varied recovery experiences of persons with behavioral health needs. The conclusion presents the essential elements of recovery-oriented practices and systems that are being shaped by an understanding of first-person experiences of recovery. Appendices are also attached that offer a glossary of recovery-oriented language and examples of how current deficit-based approaches can be transformed to service strategies based on the assets and “recovery capital” that people bring to the recovery process.

The concepts in this paper are applied in practice in the DBH system in the System Transformation Blueprint Document and in the Strategic Plan for Addiction Services.

The shared history of addiction and mental illness

The mental health and addiction fields share a dark past in which people experiencing mental illnesses and/or addictions endured institutions that offered no treatment, ineffective treatment and/or well-intentioned treatment that did great harm. Each disorder was considered intractable; stories of recovery rarely reached professional or public consciousness. People living with either disorder were expected to end up in the least favorable places in society: the gutter, prisons, asylums, or morgues.

Throughout history, both systems of care have been distracted by debates about the causes and nature of the disorders, troubled by widespread prejudice and discrimination, and undermined by the criminalization of behaviors associated with these disorders. Even today, addiction and mental illness occupy a common space of disgrace in society and those suffering from these disorders are inordinately over-represented within the nation’s prisons.

Examining the characteristics influencing recovery from addiction and recovery from mental illness, it is astonishing that the two fields have yet to partner to organize services under a common vision of recovery. People living with mental illnesses and/or addictions want to eliminate or manage their symptoms, increase their capacity to participate in valued relationships and roles, and embrace purpose and meaning in their lives—in other words, experience recovery. People in recovery from mental illness and/or addictions and their family members are leading the call to change the current service systems of care toward a more focused goal of long-term recovery.

The principles of a common recovery vision begin with the notion that for both disorders, recovery is a personal and individualized process of growth that unfolds along a continuum, with multiple pathways leading to recovery. First-person accounts of people in recovery from mental illness or addiction have described recovery both as a transformational process and an incremental process, and recovery stories are often filled with elements of both styles of change.

First-person narratives of recovery from addiction and mental illness also reveal the individualized nature of recovery processes, and the existence of diverse religious, spiritual and secular frameworks of what starts and sustains the recovery process (recovery initiation and maintenance). Importantly, these stories make clear that people in recovery are active agents of change in their lives and not passive recipients of services. Finally, people in recovery note the contribution to their recovery that family and peer support make.

The values of recovery-oriented mental health and addiction systems are based on the recognition that each person must either lead or be the central participant in his or her own recovery. All services need to be organized to support the developmental stages of this recovery process. Person-centered services that offer choice, honor each person's potential for growth, focus on a person's strengths, and attend to the overall health and wellness of a person with mental illness and/or addiction play a central role in a recovery-oriented system. These values can operate in all services for people in recovery from mental illness and/or addiction, regardless of the service type (i.e. treatment, peer support, family education etc.).

Differences that have existed in the recovery visions of the mental health and addictions fields could provide opportunities for mutually reinforcing growth in both fields. For example, the addictions field has had a well-developed concept of full recovery but has lacked a legitimized concept of partial recovery, while the mental health field has long-promoted the goal of partial recovery but until recently has lacked a viable concept of full recovery (Fisher & Ahern, 1999; White, Boyle & Loveland, 2004). Both fields have lacked the concept 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). Integrating, among other features, the concepts of full, partial and transcendent recovery within the emerging recovery visions of both fields holds great promise for promoting a comprehensive, person-centered approach to recovery in behavioral health.

The shared need for transformation to recovery in addiction and mental health systems

Presently neither the mental health nor addiction treatment systems focus on supporting long-term recovery from mental illness and/or addiction. Neither field has acknowledged or overcome the limitations of traditional institution-based acute care models of treatment and rehabilitation to focus on the processes of lasting recovery.

Over the past 30 years the two fields have been moving in different directions. The mental health system has been reorganized to offer support services in the community. These services have focused almost exclusively on symptom management (via medication compliance) and cost management (toward the goal of decreased hospitalization). During the same period of time the addiction field was delivering an ever-briefer model of acute care with little on-going monitoring, support and early re-intervention services and diminishing linkages to naturally occurring communities of recovery.

Guided by an alternative vision of recovery, the mental health and addiction fields could organize their services to address the often long-term and complex needs of individuals and families living with mental illness and/or addiction, including people severely disabled by co-occurring disorders. Much has been written about failures of the mental health and addiction systems to provide people with co-occurring disorders with the long-term services and supports often needed for recovery. People living with co-occurring psychiatric and addiction disorders could be well served in service systems united under a common vision of recovery.

A shared vision of recovery would compel both systems to provide outreach to engage people in a process of recovery; motivational services to help people develop readiness for change, treatment, and/or rehabilitation; and provision of on-going recovery support services to assist people to reach their recovery and broader life goals. These pre-recovery engagement, recovery initiation and recovery maintenance support services would be located in specific environments of need in communities and be provided by professionals, family members, and peers.

A unified recovery vision communicates the reality and hope of recovery, emphasizes the role responsibilities of the person in recovery and their family members, and recognizes the many pathways to healing that people with mental illnesses and/or addictions take in their recovery. This vision of recovery requires that the mental health and addiction systems work together with people in recovery as individuals and communities to develop effective services, strategies, and supports. Finally this recovery vision encourages the development of a culture of recovery that embraces multiple communities of recovery that support all people who are affected by mental illnesses and/or addiction; in other words, most of us.

A conceptual introduction to recovery

The notion of recovery has become the focus of a considerable amount of dialogue and debate between and among various constituencies within the mental health and addiction communities. Before we talk about how to bring this vision to reality within the DBH system we thought it important to clarify these confusions, some of which are due to the fact that the notion of recovery is in transition, moving gradually from a well-established vision among people with addictions or mental illnesses to exerting more influence on behavioral health care providers' service practices.

Being “in recovery” has long been the guiding vision and goal of self-help within the addiction community. Primarily a force within self-help, this notion has not played as much of a role historically within the addiction service provider community, where concepts of treatment and relapse prevention have been more central. Having a fifty-year history of peaceful, if benign, co-existence, these two complementary approaches have recently entered a period of partnership. This partnership offers the potential to promote a unified vision of recovery among people with addictions that incorporates the contributions of both natural and formal supports.

On the other hand, the notion of “recovery” has emerged as a dominant force within mental health just within the last decade. Most recently, it has taken center stage through its prominent role in both the Surgeon General’s *Report on Mental Health* and the President’s New Freedom Commission on Mental Health. In its influential *Final Report*, the Commission strongly recommended “fundamentally reforming” all of mental health care to be based on the goal of recovery.

In both of these reports, however—as well as in clinical and rehabilitative practice—there is considerable ambiguity and lack of clarity about what is meant by recovery in mental health. As in addiction, much work remains to be done in mental health in developing a coherent vision of recovery that can be acceptable (as well as useful) to all involved parties.

Given its multiple and complicated parentage and the diverse groups involved, it is not surprising that it has been difficult to reach consensus on any one definition, or even on any one list of essential aspects, of the concept of recovery in behavioral health. For the sake of clarity—as well as to facilitate future discussions—we propose the following distinction to guide the development, monitoring, and evaluation of clinical and rehabilitative services and supports offered within a recovery-oriented system of behavioral health care. These two concepts are intended to be somewhat overlapping and complementary. The eventual goal is to join them into a unified vision that can be promoted equally by people in recovery, their loved ones, behavioral health care providers, and the community at large.

One major source of the confusion surrounding use of the term "in recovery" in behavioral health derives from a lack of clarity about the respective roles of behavioral health practitioners and those of people with behavioral health disorders. For purposes of this document, we offer the following two definitions which we have found helpful in distinguishing the process of recovery (in which the person him or herself is engaged) and the provision of recovery-oriented care (in which the practitioner is engaged).

- ***Recovery*** *refers to the process by which persons with or impacted by a mental illness and/or addiction* ***experience*** *and* ***actively manage this disorder and*** *reclaim their lives in the community.*
- *Recovery-oriented care* ***is what psychiatric and addiction treatment and rehabilitation practitioners*** *offer* ***in support of the individual/family's own recovery efforts.***

Given that the notion of recovery derives from self-help and self-advocacy communities in both addictions and mental health, the first definition of recovery refers to *what people who have these conditions do to manage their mental illness and/or addiction and to claim or reclaim their lives in the community*.

In addition to managing the condition, this sense of recovery also involves *what people do to overcome the effects of being perceived as an addict or a mental patient*—including rejection from society, alienation from one's loved ones, poverty, substandard housing or homelessness, social isolation, unemployment, loss of valued social roles and identity, and loss of sense of self and purpose in life—in order to regain some degree of control over their own lives.

As experiences of being discriminated against are viewed as traumatic and irreversible, advocates also argue that a return to a pre-existing state of health (as another alternative definition of recovery) is not only impossible for many people, but also would diminish the gains the person has had to make to overcome the disorder and its effects. Overcoming the scars of stigma requires the development and use of new muscles, often leaving people feeling stronger than prior to the onset of their illness (discussed further below as *transcendent recovery*). It is clear from this discussion that recovery is much more than the removal of symptoms from an otherwise unchanged life.

The varieties of recovery experience

Recovery is, in its essence, a highly individualized, lived experience of moving through and beyond the limitations of one's disorder. Given the uniqueness of each person's recovery journey, the translation of knowledge about processes of recovery into principles for recovery-oriented practices and systems is neither straightforward nor direct. Before taking up the complex challenge of beginning to identify and elaborate on the implications of a recovery orientation for practice, we review some of the lessons which have been learned to date about the varieties of recovery experiences in the lives of people with addictions and/or mental illnesses.

Recovery is the process of healing the effects of a) one's illness and its consequences, b) the social stigma attached to the illness, and c) the sometimes painful effects of well intended treatment interventions. Recovery implies a process of regaining what was lost due to one's illness and its treatment and a process of discovery and moving beyond the illness and its limitations into previously unexplored potential.

There are many pathways to and varieties of recovery experience. The course and outcome of both mental illnesses and addictions vary across transient and persistent patterns. Transient patterns respond to self-resolution or brief professional intervention, while persistent patterns often require sustained professional- and peer-based supports. Those with a more prolonged course often differ in the presence of greater personal vulnerability (e.g., family history, lower age of onset, traumatic victimization), greater problem severity, interlocked co-occurring problems, and low family and social supports. Recovery styles span natural recovery (without the aid of professional or peer support), peer-assisted recovery (mutual aid involvement), and professionally-assisted recovery (professional treatment).

Treatment and recovery are not the same. Treatment encompasses the way professionals intervene to stabilize or alter the course of an illness; recovery is the personal experience of the individual as he or she moves out of illness into health and wholeness. Recovery is the experiential shift from despair to hope, alienation to purpose, isolation to relationship, withdrawal to involvement, and from passive adjustment to active coping.

Recovery can occur within or outside the context of professionally-directed treatment. Where treatment is involved, treatment may, depending on its orientation and methods, play a helpful, neutral or hurtful role in recovery. Recovery can be claimed only by the person in recovery, and that ownership includes the right to take risks, make mistakes, and learn from one's experiences.

Recovery exists on a continuum of improved health and functioning. The mental health field has long affirmed the concept of partial recovery (some residual disability with reduced social costs and improved health and functioning) but, until recently, has lacked a vision of full recovery from serious mental illness (minimal residual disability and resumption of pre-illness levels of health and functioning). In contrast, the addiction treatment field has had an unequivocal goal of full recovery (sustained abstinence and increased health) but has lacked an operational concept of partial recovery (reduced frequency and intensity of alcohol and other drug use and related problems and increased quality of life). The complementarity between these two forms of recovery may benefit both fields.

In addition, it may be time for both fields to recognize within the growing body of recovery narratives the existence of what might be called <u>transcendent recovery</u> (minimal residual disability and the achievement of health, functioning and quality of life superior to that which existed before the onset of illness). Transcendent recovery acknowledges the existence of people who, following the experience of addiction and/or mental illness, get "better than well," not despite the illness but because of the insights, experiences, and often untapped strengths that emerged within the recovery process. It is within this experience of transcendent recovery that some people reframe their illness from a curse to a condition that has brought them unexpected gifts.

The potential for recovery and the quality of recovery are determined by the synergy between *recovery debits (personal and environmental factors that inhibit and limit recovery) and recovery capital (internal and external resources that serve to initiate, sustain and expand recovery).* Recovery facilitating and inhibiting factors identified through the experiences of individuals in recovery exist at multiple, interacting levels:

- characteristics of the individual (e.g., the presence or lack of hope, resourcefulness, self-reliance, recovery self-management skills);
- characteristics of the environment (e.g., the presence or lack of safety-enhancing material resources—housing, transportation, health care, and a means of communication); and
- characteristics of the interaction between the individual and the environment (e.g., the presence or lack of meaningful relationships and activities, choices, empowering and hopeful service and peer relationships).

There are variations in recovery styles based on the extent to which one's disorder becomes a central part of one's identity and one's degree of affiliation with a larger community of recovering people. There are

- acultural styles of recovery (no affiliation with other recovering people);
- bicultural styles of recovery (affiliation with recovering people and people without recovery backgrounds);, and
- culturally enmeshed styles of recovery (emersion in a culture of recovery).

People in recovery display highly variable styles of relationship to professionally-directed treatment, peer-driven support services, and mutual aid societies. The behavioral health field is slowly (and painfully) learning to work within this variability of styles rather than attempting to program all recovery experiences through a narrow, single-pathway vision of how recovery is achieved and sustained. .

The role of the person in recovery is essential to understanding the recovery process; the self, not the service professional, is the "agent of recovery." Recovering people are more than passive recipients of care or cure. While they may draw on the clinical technologies of professional helpers and the experience, strength, and hope of others in recovery, each recovering person <u>must ultimately</u> take ownership of his or her own recovery even when the centerpiece of that recovery lies in resources and relationships beyond the self.

Recovery involves:

- a reconstruction of personal identity;
- a reformulation of the relationship between self and illness; and
- a reconstruction of one's relationship with the world.

These dimensions are often evident in the three-part story style of people in recovery: 1) the way it was (depiction of the onset and course of the illness), 2) what happened (the experience of recovery initiation), and 3) what it is like now (depiction of life in recovery).

The initiation of recovery may be marked by processes of transformational or incremental change. The former, which has been christened “quantum change,” involves sudden recovery-inducing experiences that are dramatic, unplanned, positive, and enduring. The latter depicts a process of recovery initiation with the following components (these are not necessarily sequential events but build on each other):

- hope and resolution for change;
- first steps toward self-management;
- a process of stabilization (ownership and active management of one’s own recovery);
- a mastery of rituals of daily living (increased comfort and confidence, self-monitoring and active efforts to prevent relapse, deepened insight about self in relationship to illness); and
- a sustained movement toward health and community integration (increased quality of life via greater independence, self-acceptance, a safe and pleasant living environment, satisfying relationships, and meaningful activities)..

Within such incremental models, factors required to initiate recovery are often quite different than the factors that later serve to maintain and enrich recovery. As a result, interventions helpful at one stage of recovery may be ineffective or even harmful at other stages. For example, continuing to provide care taker functions within an assertive community treatment model could have negative effects upon individuals who are developmentally ready to take ownership of their own recovery.

There are critical points (developmental opportunities) that arise within the prolonged course of a disorder that constitute doorways of entry into recovery or opportunities to move from one stage of recovery to another. These milestones can mark a shift either toward greater problem severity or the initiation or qualitative strengthening of recovery. When such transitional experiences initiate or deepen recovery, they are nearly always characterized by a synergy of pain and hope.

The awakening of hope that is such a central theme in recovery narratives almost always occurs in the context of relationships and resources beyond the self, and often occurs through encounters with the experience, strength, and hope of others in recovery. Historically, the addiction field believed that recovery initiation was grounded in the experience of pain (“hitting bottom”), but there is growing recognition that the deepest despair incites recovery only in the presence of hope. In the addiction field, this is sparking a transition from pain-based interventions to hope-based interventions (e.g., the replacement of confrontation with motivational enhancement techniques).

Spirituality is a potentially important but little-understood ingredient of the recovery process. The role of spirituality to provide hope, neutralize stigma and shame, and bolster strength and courage is frequently noted in recovery narratives. The addictions field has a long history of emphasizing the role of spirituality in the recovery process—so much so that purely secular frameworks of recovery are lauded as innovations. Mental health professionals, on the other hand, are just beginning to explore the role of spirituality in recovery and to recognize its critical role in the recovery narratives of many people.

What the addictions field is slowly learning is that, like many aspects of recovery, spirituality is a highly personal experience and a choice, not something to be codified within a "program." Where spirituality is a centerpiece in many recovery narratives, there is also an increased interest in the varieties of secular (without religious or spiritual dimensions) recovery experiences.

People recovering from two or more co-occurring problems may address these interacting processes simultaneously (dual recovery) or sequentially (serial recovery). People may be at different stages or levels of motivation for addressing various problems that they are experiencing. The same person can experience differential rates of recovery from multiple disorders/experiences, e.g., mental illness, addiction, traumatic victimization, and loss.

The relationship between medication and recovery is a complex and potentially stage-dependent one. The addiction and mental health fields have histories that underscore the value as well as the potential side effects of medications on the recovery process. The mental health field has had, especially in recent years, a bias towards medication, including medications with severe and debilitating side effects. The addictions field has had a bias against medication, even when those medications have had overwhelming research support for their safety and efficacy, e.g., methadone.

Medication-assisted recovery is a legitimate (personally and scientifically defensible) style of recovery in spite of its continued stigmatization by the public, by some service professionals and within particular communities of recovery. The narratives of recovering people emphasize that medication can facilitate or hinder recovery and that symptom elimination or minimization via medication, in and of itself, does not constitute recovery. The future promises more effective medications and a widening menu of alternatives and adjuncts to medication.

Both illness and recovery require substantial energy of one's family and social network in adapting to the difficulties of the illness and the challenges of recovery. The responses of family members to illness and disability and to stages of recovery represent normal rather than pathological reactions. Family recovery is the process of finding the best ways to adapt to the presence and then the absence of illness as an organizing motif within the family system. There may be developmental stages of family recovery that parallel the stages of personal recovery. Family members make these changes in their own style and at their own pace. Recovery-oriented systems of care must by definition become family-oriented systems of care.

Recovery involves transcending the stigma that has been attached to addiction and/or mental illness. Stigma within the larger culture creates conceptual (how one sees oneself) and concrete (discrimination resulting from how one is seen by others) barriers to recovery. Stigma-shaped practices within treatment systems have also served to depersonalize and dehumanize. Confronting and exorcising stigma within oneself (self-healing) and within one's environment (political advocacy) are frequent dimensions of the recovery process.

Language is important to personal recovery. Words are the conceptual building blocks of recovery. The ability of recovering people to coin or select words that accurately and respectfully portray their experiences and aspirations is a crucial dimension of the personal recovery experience. Words have long been used to objectify and demonize people experiencing mental illnesses and addictions. In recovery, alternative words and metaphors become instruments of personal and collective liberation. Crafting recovery language is about personal and social change, not political correctness.

Common Elements of Recovery

The two tables below describe those elements of recovery identified by people with first- person experience of addiction recovery and mental health recovery. Following the tables, we identify the common elements of a unified framework for recovery in behavioral health, remaining mindful that individuals can be at various stages of recovery.

Table 1. Core Components of Addiction Recovery

Component	**Person In Recovery:** *To me, recovery means…*
Initiating recovery	• a pivotal transforming moment, a breakthrough of self-perception, a wake up call • admitting and accepting that I have a problem • changing the way I live, my perceptions • overcoming my environment • responsibility and accountability for my actions • learning to take feedback • honesty, open-mindedness, willingness • self-knowledge which allows me to not repeat old behaviors
Hope, confidence and commitment	• spiritual awakening • willingness to go through difficult times without self medicating • breaking down the intensity of shame • being loved by others until I learn to love myself • a commitment to change • inner strength • getting hope back • having confidence in myself • self-esteem • seeing someone else that is an inspiration • guidance from others • learning by example that recovery is possible • faith • making an honest assessment of oneself • the willingness to continue to ask for help in any area of my life
Understanding and accepting self	• education about addiction • finding myself • setting boundaries • finding balance • rebirth • becoming a whole person physically, mentally, emotionally and spiritually • understanding I am not perfect

	• managing my emotions • caring about myself • getting over feelings of guilt • learning to be patient • having humility • making peace with the past • the realization that I am not a bad person • finding happiness, feeling joyous and free
Relationships with family, friends, and supportive others	• learning who to trust • asking for help • taking a risk in engaging in a relationship • learning how to trust others and myself • friends • not letting my kids down • separation from those that use • being involved in 12-step groups and other supports • helping others • having education and ongoing supports for families
Maintaining recovery	• knowledge of recovery process • learning how to live again, pay bills, life skills • a dynamic, ongoing process • learning recovery promoting skills like how to self-soothe • daily behaviors that support recovery • morals, teachings, structure • healing my body, mind and spirit • education • employment • development of new coping mechanisms (support network, prayer, etc.) • helping others, sponsorship • having access to safe, sober housing • conscious contact with a power greater than myself • spirituality
Community supports	• getting a job • owning my own home • having a family • running my own business • trying to be a helpful person in society • social activities, church, fellowship • integrity and honesty • sober sports, bowling leagues, dance clubs, and meeting places • mentoring
Promoting positive views of recovery	• being able to get a job • being able to buy a house • opportunities to be visible in the community as a person in recovery • opportunities for recovery while in the criminal justice system and options to support that recovery upon leaving the criminal justice system • participating in recovery advocacy activities

Becoming an empowered citizen	• helping others, giving back • being a productive member of society • greater involvement in community and awareness of others • acts of community service

Table 2. Core Components of Mental Health Recovery

Component	**Person In Recovery:** *To me, recovery means…*
Being supported by others	• having people I can count on. • being loved and accepted as I am. • having people in my life who believe in me even when I don't believe in myself. • having something to give back. • feeling like a worthwhile human being. • being able to help others when they need me.
Renewing hope and commitment	• having a reason to get out of bed. • having a sense my life can get better. • being able to tackle every day. • realizing that there is more to life than mental illness. • feeling good about the future. • being determined to live well and take care of myself. • believing I can manage my life and reach my goals. • having dreams again. • having people I can count on.
Finding your niche in the community	• getting involved in stuff I enjoy, e.g., attending church, volunteering, dating, taking classes, playing sports, visiting friends, attending support groups. • having nice places to hang out with my friends. • having a routine I enjoy. • making new friends. • catching up with old friends. • filling my day with stuff I like.
Redefining self	• person with strengths and resources. • knowing my illness is only a small part of who I am. • not allowing "label" or a diagnosis to take control my life. • exploring life outside the mental health system. • learning what I have to offer. • proving wrong the people who said I'd never do anything with my life
Incorporating illness	• knowing when I need to ask for help. • not feeling defeated. • dealing with setbacks. • avoiding the things that make me feel bad. • knowing how to take care of myself in good times and in bad. • accepting that there are some things that I can't do yet. • being proud of the things I can do. • taking one day at a time.
Overcoming stigma	• feeling good about myself. • learning ways to overcome the negative attitudes of others. • finding places in the community where I feel at home.

	• not feeling ashamed about having a mental illness. • being proud of myself. • having role models. • not letting people put limits on me. • knowing when I am being discriminated against. • standing up for myself when I have been mistreated. • not buying into the stereotypes of mental illness. • realizing that other people have problems too. • knowing when I deserve better and demanding it. • being willing to share my story and not hide my recovery
Assuming control	• knowing when, and how, to voice my opinion. • having control over my life and treatment. • taking risks and trying new things. • accepting the consequences and learning from my mistakes when things don't work out as planned. • being able to appreciate some else's view and reach a compromise. • telling people what I want and need from them. • meeting commitments and being proud of it • not taking "no" for an answer!
Managing symptoms	• learning how my illness affects me. • asking questions when I don't understand something. • having ways to cope and be good to myself. • controlling my symptoms so that they don't get in the way of my life. • understanding what medication can, and can not, do for me. • finding other tools to help me in my recovery. • knowing when to ask for help. • taking time to relax. • giving myself some slack. • giving myself and others permission to be human.
Becoming an empowered citizen	• feeling like I have choices. • choosing where I live and how I spend my time. • voicing my opinion. • giving back and sharing my experiences with other people working toward recovery. • being a responsible citizen, e.g., by voting, volunteering, working, paying taxes, managing my own money, keeping up with my bills, etc. • having other people respect me. • being a responsible parent, a caring friend, or a good neighbor. • making a difference in my community. • taking responsibility for my recovery.

Integrating the descriptions from each of these tables yields the following model of common elements of behavioral health recovery. These elements are not necessarily achieved in sequence but may represent a circular process. How these elements can be promoted by a recovery-oriented service system is then taken up in the section that follows:

- *Feeling cared for, accepted, and supported by trusting and trustworthy others.*
- *Renewing hope, confidence, and commitment.*

- *Beginning of a sense of responsibility for and/or determination in initiating recovery.*

- *Discovering or re-inhabiting a valued niche or social role among family, friends, and peers.*

- *Understanding, redefining and accepting self, including accepting the central role of others.*

- *Incorporating illness, and maintaining recovery, including managing symptoms and triggers.*

- *Assuming increasing control over daily recovery decisions..*

- *Addressing and overcoming stigma, promoting positive views of recovery.*

- *Becoming an empowered and contributing citizen of one's community.*

Recovery-oriented practices and essential components of recovery-oriented systems

A recovery-oriented system of behavioral healthcare will offer the city's citizens an array of *accessible* services and supports from which they will be able to choose those which are most *effective* and *responsive* in addressing their particular behavioral health condition or combination of conditions. These services and supports will be *culturally appropriate, build on individual, family, and community strengths,* and have as their primary and explicit aim *promotion of the person/family's resilience, recovery, and inclusion in community life.*

Services and supports will be provided in an *integrated* and *coordinated* fashion within the context of a *locally-managed* system of care developed *in collaboration* with the surrounding community—thereby ensuring *continuity of care* both over time (e.g., across episodes) and across agency boundaries, and maximizing the person's opportunities for establishing, or reestablishing, a safe, dignified, and meaningful life in the communities of his or her choice.

The following proposal attempts to outline the various components of such a system of care. Prior to describing the different components of the system, it is important to mention first the roots of recovery-oriented system transformation in the Civil Rights Movement. Rather than referring to advances in the effectiveness of psychiatric medications or an accumulating body of research on clinical improvements or positive outcomes in serious mental illness or addictions, it has been through the advocacy efforts of people with behavioral health disorders that recovery has been pushed to the forefront of behavioral health policy and practice in the U.S. and elsewhere.

More than innovations in clinical practice, recovery refers to affording people with behavioral health conditions the right to "live, work, learn, and participate fully in the community." Based most recently on the Olmstead decision, but grounded in 30 years of consistent federal law preceding it, this right cannot be made contingent on improvements in the person's clinical or functional status, nor can it be indefinitely delayed based on a system's lack of available resources to support community tenure.

Citizens of Philadelphia with behavioral health conditions have a right to live in the community alongside of their peers, to participate in treatment and rehabilitative interventions, and to make use of the community supports needed for recovery and the pursuit of their life goals.

The challenge for a recovery-oriented system of care is to carry out this work in the most efficient and effective, and least coercive and restrictive, manner possible, both respecting the dignity and autonomy of its clients while ensuring the safety and well-being of the community.

Based on the stages of change model first introduced into treatment of addictions, the overarching principle for design of this system and its various components is that a person should be able to access effective and responsive services and supports regardless of where he or she is in the process of recovery from addiction, psychiatric disorder, or both. Realizing that addictions and psychiatric disorders co-occur at least as frequently as they occur independently, this model further allows for a person to be in different stages with respect to each of the conditions he or she may have.

Most importantly, being unaware of, or choosing not to accept having, a behavioral health condition is to be viewed as a point of departure for treatment, rehabilitation, and support efforts as opposed to being viewed as cause for discharge from care. Based also on the input of people who are in recovery from addiction and/or psychiatric disorder, this model places central emphasis on the role of peer-delivered services and supports at each point along the continuum of care.

We thus begin with this last component, while offering a depiction of this overall model in Figure 1 attached.

1. <u>Recovery Support Services</u>: It is clear that within a recovery-oriented system of care, all services and supports must be supportive of recovery. The term "recovery support services" has come to refer specifically to a subgroup of interventions. Particularly in view are those that focus on enhancing a person's ability and resources to manage his or her own behavioral health condition(s) and/or increase his or her participation in the community activities of his or her choice. These services and supports are often provided by people who are in recovery themselves, but do not need to be exclusively so.

As seen in Figure 1, these services and supports also can be used during various stages of recovery. Relative to outreach and engagement services, however, recovery support services are typically offered to people who are engaged in care. Examples include:

- <u>Wellness Recovery Action Plan</u> (WRAP): Copeland's manualized approach to self-care and recovery for people living with serious mental illness (with or without co-morbidity) (see also Borkman's distinction between "recovery plans" and treatment plans within the social model of addiction treatment in California.)

- <u>Pathways to Recovery</u>: Manualized approach to recovery and self-care developed by Ridgway et al. for people living with serious mental illness (with or without co-morbidity).

- Asset-Based Community Development (ABCD): Knight's manualized approach to identifying, mapping, and incorporating existing community resources in an individual's recovery, including the collaborative development of community resources that do not yet exist.

- Peer &/or Mutual Support: The provision of support—including instilling hope, role modeling self-care and recovery, and mentoring—between people who have personal experiences of addiction and/or psychiatric disorder. This can take a variety of forms, ranging from one-on-one relationships in which one person is a paid employee of a provider agency (e.g., peer engagement specialist, certified peer support specialist) to group formats in which the provision of support is reciprocal and voluntary (i.e., no one is paid, as in 12-step groups and Schizophrenia Anonymous). This approach also provides the foundation for peer-run programs such as Recovery Community Centers in the addiction field.

- Being a Tenant/Homeowner: A structured approach to supporting people in learning how to live independently, either as a responsible tenant or as a first-time homeowner. First developed for people who were homeless or unstably housed, this intervention has the potential to increase residential tenure among a broader population, and may be combined with legal advocacy.

- Affirmative Businesses: Also called micro-enterprises, social cooperatives & peer-run businesses, these are not-for-profit organizations staffed at least in part by people in recovery that offer retail goods or services to the broader community. Examples include sober housing, renovation, transportation, catering, landscaping, or any other income-generating activity. In Italy, for instance, this includes hotels, jewelry and furniture manufacturing, and dining facilities.

2. Recovery Coach/Guides: The functions of a recovery guide or coach could be conceptualized as an ongoing recovery support service as well as a vehicle through which outreach and engagement services can be provided (see below). Given its centrality in a recovery-oriented system of care, however, we consider the role of the recovery coach or guide to deserve its own separate discussion. The model of the guide or coach is proposed as a recovery-oriented alternative to case management, with or without a clinical component.

This guide helps identify and remove obstacles to recovery, connects the person to community life, and serves as a mentor in the management of the person's condition and his or her life. This role also may involve supporting the person's efforts to participate in the naturally occurring community activities of his or her choice, at first perhaps accompanying the person, with a longer term goal of enabling the person to decrease his or her reliance on care providers through the development of positive relationships with community members.

3. Outreach and Engagement: Especially needed, and valuable, during the pre-contemplation and contemplation stages of change, these services are offered in community settings such as on the street or under bridges, in shelters or soup kitchens, in prospective clients' homes, or in any other settings in which people with behavioral health conditions who are not yet engaged in care can be found. Incorporating motivation-enhancing interventions, and addressing prospective clients' basic needs and expressed goals, these services aim to "jump start" or "prime" people for recovery who otherwise are in an active addiction or are unaware of having, or choose not to

accept having, a disabling psychiatric disorder.

4. Intensive Outpatient Services: As some people become engaged in care, their clinical status and/ or the severity of their condition(s) require a higher level of care than can be provided in the one or two hours offered by conventional ambulatory services. When possible, it is preferable for these services to be offered through intensive outpatient care as an alternative to extracting people from their natural community settings.

There is a wide range of outpatient services with varying degrees of intensity, from cognitive-behavioral treatments offered in two to four hours per week (a low level of intensity) to assertive community treatment teams accessible to clients 24 hours per day seven days per week (high intensity). Other examples include contingency management in active treatment of addiction and skills training offered in psychiatric rehabilitation.

5. Acute Care: When intensive outpatient services are not adequate to ensure safety and/or enable people to regain independent functioning, access to acute care settings is needed. Conventionally offered through inpatient psychiatric and detox units, alternatives have emerged in recent years that may be more conducive to recovery for certain people at certain times or under certain circumstances. These include bringing paid staff into a person's own home (e.g., "specialing") or offering respite care in home-like settings staffed 24 hours a day. Staff in these programs are often peers (people in recovery), but do not necessarily need to be. For the foreseeable future, ready access to facility-based acute care options also will continue to be required by persons whose needs cannot be adequately addressed in less intensive or less medically-oriented settings.

6. Supported Community Living: This concept serves as an umbrella term for a variety of strategies for providing in vivo supports to increase and enhance a person's participation in naturally occurring activities and assumption of normative social roles. Examples include supported housing, supported employment, supported education, and supported socialization. Particularly noteworthy is the rapid growth of peer-run recovery homes and work co-ops within the addiction field.

Some of these supports in the mental health field have been offered as part of a psychosocial clubhouse model. However, the aim is to match a person's interests and aspirations with opportunities in natural community settings, providing the supports needed for people to be successful in taking advantage of these opportunities. Within this context, some people will prefer to go bowling with other members of their social club; others will prefer to join a bowling league in their neighborhood.

The issue here, as so often in recovery-oriented systems of care, is offering people a range of options from which they then can make meaningful choices based on their individual and cultural values, preferences, and interests.

7. Medication Assessment, Administration & Monitoring: Many people with behavioral health conditions will need to, and/or benefit from, taking medications for extended periods of time; some for the remainder of their lives. There thus is ongoing need for access to qualified and experienced healthcare professionals who can assess the need for, administer, and monitor a person's responses to safe and effective medications.

Early in recovery, this is likely to be a behavioral healthcare professional, such as a psychiatrist or advanced practice nurse, who specializes in the treatment of addictions and/or psychiatric disorders. Later in recovery, people who have achieved sustained recovery and/or significant improvement in their condition may prefer to have these medications, as well as their overall health status, managed by primary care providers in a so-called “shared care” arrangement. It is important that these primary care providers understand the recovery process.

Annual recovery check-ups, similar to annual physicals, are recommended for people in sustained recovery; more frequent visits (e.g., twice a year, once a quarter, monthly) may be more appropriate for individuals earlier in recovery. Allowing for personal choice, it is preferable for behavioral healthcare to be provided in normative or natural settings, such as primary care offices or clinics, as well as in specialty care settings.

8. Risk Assessment & Management (including the need for extended residential or inpatient care): Essential, if at times overlooked, components of care, competent risk assessment and management are crucial to ensuring the success of all other components of a recovery-oriented system. Untreated addictions and psychiatric disorders, particularly in combination, increase a person’s risk for harm, both to him/herself and to others. At the same time, stigma remains the number one barrier to recovery. Rare but tragic instances in which someone with a behavioral health disorder takes his or her own life or violates others perpetuate or even magnify the stigma associated with these conditions. As a result, for recovery-oriented care to promote community inclusion the risk associated with addiction and/or psychiatric disorder needs to be assessed and managed in a timely and responsive manner.

At times, management of risk will require placement in a secure and supervised setting, such as extended residential treatment or inpatient care. In a recovery-oriented system, these more restrictive (and costly) settings should only be used in such cases when the risk a person poses, either to self or others, outweighs his or her rights to participation in community life. Likely the number of people requiring this level of care at any given time will be a much smaller number than the number of individuals living with, and managing, behavioral health conditions in the community.

Table 3: Common characteristics under a Recovery Vision

	Mental Illness	**Addiction**
Goals	To assist people affected by mental illnesses reduce the impairment and disability, and improve quality of life	To assist people affected by addiction disorders reduce the impairment and disability, and improve quality of life
Role of person with disability	Person is agent of recovery. Active involvement is necessary for recovery	Person must take ownership of his/her recovery. Active involvement (daily recovery decision-making) is necessary for recovery.
Principles	• Broad heterogeneity of population and outcomes • Focus on person and environment • Long-term perspective • Recovery is a process and a continuum • Non linear process of recovery	• Broad heterogeneity of population and outcomes • Focus on person and environment • Long-term perspective • Recovery is a process and a continuum • Non linear process of recovery

	• Family involvement is helpful • Peer support is crucial • Spirituality may be critical component of recovery • Multiple pathways to recovery	• Family involvement is helpful • Peer support can be crucial • Spirituality may be critical component of recovery • Multiple pathways to recovery
Values	• Person-centered • Partnership (person involvement) • Growth • Choice • Strengths perspective • Focus on wellness and health	• Person-centered • Partnership (person involvement) • Growth • Choice • Strengths perspective • Focus on wellness and health
Strategies to Facilitate Recovery	• Treatment i.e.: Crisis intervention, medication, therapy, illness management education • Community support (connection to peer-support and recovery organizations) • Skills for valued roles • On-going, flexible recovery-enhancing services • Advocacy	• Treatment i.e.: post-treatment monitoring, early re-intervention, medication, therapy • Community support (assertive linkages to communities of recovery) • Skills for valued roles • On-going, flexible recovery-enhancing services • Advocacy
Essential ingredients of Recovery-oriented System	• Treatment • Rehabilitation • Peer support • Community Support • Legal Aid • Enrichment • Basic Support • Family education and support	• Treatment • Rehabilitation • Peer support • Community Support • Legal Aid • Enrichment • Basic Support • Family education and support
Societal Attitudes	• Historically, prognosis was considered hopeless • Debates about cause(s) and nature of illness • Criminalization of illness • Prejudice and discrimination	• Historically, prognosis was considered hopeless • Debates about cause(s) and nature of illness • Criminalization of illness • Prejudice and discrimination

Glossary of Recovery-Oriented Language

Creation of a recovery-oriented system of care requires behavioral health care practitioners to change how they look at mental illness and addiction, their own roles in facilitating recovery from these conditions, and the language they use in referring to the people they serve. The following glossary and associated tables are intended as tools for providers to use as they go about making these changes in practice. Not meant to be exhaustive, this material will be further enhanced in the process of implementing recovery-oriented practices across the state.

Given its central role in the remaining definitions, we will start with the term “recovery” itself, followed by a list, in alphabetical order, of other key terms.

Recovery: there are several different definitions and uses of this term in behavioral health. In the addiction recovery community, for example, this term refers to the achievement and maintenance of abstinence from alcohol, illicit drugs, and other substances (e.g., tobacco) or activities (e.g., gambling) to which the person has become addicted, vigilance and resolve in the face of an ongoing vulnerability to relapse, and pursuit of a clean and sober lifestyle.

Persons with less severe AOD problems also speak of moderated recovery—the sustained reduction of AOD use and related consequences to a point that such use no longer interferes with personal and interpersonal functioning. (See expanded discussion in definition of moderated recovery below.)

In mental health there are several other forms of recovery. For those fortunate people, for example, who have only one episode of mental illness and then return to their previous functioning with little, if any, residual impairment, the usual sense of recovery used in primary care is probably the most relevant. That is, such people recover from an episode of psychosis or depression in ways that are more similar to, rather than different from, recovery from other acute conditions.

Persons who recover from an episode of major affective disorder or psychosis, but who continue to view themselves as vulnerable to future episodes, may instead consider themselves to be “in recovery” in ways that are more similar to, than different from, being in recovery from a heart attack or chronic medical condition. Many others will recover from serious mental illness over a longer period of time, after perhaps 15 or more years of disability, constituting an additional sense of recovery found in some other medical conditions such as asthma.

More extended periods of disability are often associated with concerns about the effects and side effects of having been labeled with a mental illness as well as with the illness itself, leading some people to consider themselves to be in recovery also from the trauma of having been treated as mental patients.

Finally, those people who view taking control of their illness and minimizing its disruptive impact on their lives as the major focus of their efforts might find the sense of recovery used in the addiction self-help community to be most compatible with their own experiences. Such a sense of recovery has been embraced, for instance, among some people who suffer from co-occurring psychiatric and addictive disorders who consider themselves to be in "dual recovery."

The Philadelphia Department of Behavioral Health has adopted the following single definition to capture the common elements of these various forms of recovery:

> "Recovery is the process of pursuing a fulfilling and contributing life regardless of difficulties one has faced. It involves not only the restoration but also continued enhancement of a positive identity as well as personally meaningful connections and roles in one's community. It is facilitated by relationships and environments that provide hope, empowerment, choices and opportunities that promote people reaching their full potential as individuals and community members."
> -- Philadelphia Recovery Advisory Committee 2006

Other Key Terms

Abstinence-Based Recovery: is the resolution of alcohol- and other drug-related problems through the strategy of complete and enduring cessation of the non-medical use of alcohol and other drugs. The achievement of this strategy remains the most common definition of recovery in addiction, but the necessity to include it in this glossary signals new conceptualizations of recovery that are pushing the boundaries of this definition (see partial recovery, moderated recovery, and serial recovery).

Affirmative Business: see Social Cooperative/Entrepreneurialism

Asset-Based Community Development: a technology for identifying and charting the pathways and destinations in the local community most likely to be welcoming and supportive of the person's efforts at community inclusion. A first step is the development of local resource maps (see below). A strategy of community preparation is then used to address gaps identified in the resource maps through educational and other community building activities aimed at decreasing stigma and creating a more welcoming environment in partnership with local communities.

Asset Mapping: part of asset-based community development (above) referring to the process of identifying opportunities in local communities for people in recovery to take up and occupy valued social roles in educational, vocational, social, recreational, and affiliational (e.g., civic, spiritual) life. Although not a literal "map" (i.e., as in contained on a piece of paper), asset mapping involves developing and utilizing virtual or mental landscapes of community life that highlight resources, assets, and opportunities that already exist in the person's local community.

Choice: a key concept in recovery-oriented care, choice refers to the central role people with psychiatric disabilities and/or addictions play in their own treatment, rehabilitation, recovery, and life. Within the behavioral health system, people in recovery need to be able to select services and supports from among an array of meaningful options (see menu below) based on what they will find most responsive to their condition and effective in promoting their recovery.

Both inside and outside of the behavioral health system, people in recovery have the right and responsibility for self-determination and making their own decisions, except for those rare circumstances in which the impact of the illness or addition contributes to their posing imminent risks to others or to themselves.

Citizenship: a strong connection to the rights, resources, roles, and responsibilities that society offers people through public institutions and associational life.

Community Supports: material and instrumental resources (including other people), and various forms of prostheses that enable people to compensate for enduring disabilities in the process of pursuing and being actively involved in naturally-occurring community activities of their choice.

Consumer: literally means someone who purchases services or goods from others. Historically has been used in mental health advocacy to offer a more active and empowered status to people who otherwise were being described as “clients” or “mental patients.” Given that people in recovery have not really viewed themselves as consumers in the traditional sense (ala Ralph Nader), this term has never really generated or been met with wide-spread use.

Continuity of Care/Contact: is a phrase used to underscore the importance of sustained, consistent support over the course of recovery. Such support can come from living within a community of shared experience and hope, but also can refer to the reliable and enduring relationship between the individual in recovery and his or her recovery coach. Such sustained continuity is in marked contrast to the transience of relationships experienced by those who have moved through multiple levels of care or undergone multiple treatment relationships.

Disparities in Healthcare: differences in access, quality, and/or outcomes of health care based on such issues as race, ethnicity, culture, gender, sexual or religious orientation, social class, or geographic region.

Empowerment: is the experience of acquiring power and control over one’s own life decisions and destiny. Within the addiction recovery context, there are two different relationships to power. Among the culturally empowered (those to whom value is ascribed as a birthright), addiction-related erosion of competence is often countered by a preoccupation with power and control. It is not surprising then that the transformative breakthrough of recovery is marked by a deep experience of surrender and an acceptance of powerlessness.

In contrast, the culturally disempowered (those from whom value has been systematically withheld) are often attracted to psychoactive drugs in their desire for power, only to discover over time that their power has been further diminished. Under these conditions, the initiation of recovery is often marked by the assumption of power and control rather than an abdication or surrender of power.

Within the mental health context, empowerment typically refers to a person first taking back control of his or her own health care decisions prior to regaining control of his or her major life decisions and destiny. As such, “empowerment” has been used most by advocacy groups in their lobbying efforts to make mental healthcare more responsive and person-centered.

In either community, empowerment is meant to be inspiring, horizon-raising, energizing, and galvanizing. The concept of empowerment applies to communities as well as individuals. It posits that the only solution to the problems of addiction and/or mental health in disempowered communities lies within those very communities. It is important to note that, by definition, one person cannot “empower” another, as to do so undermines the very premise of the term, which attributes power over the person’s decisions, recovery journey, and life to the person him or herself.

Evidence-Based Practices: are clinical, rehabilitative, and supportive practices that have scientific support for their efficacy (under ideal conditions) and effectiveness (in real world settings). Advocacy of evidence-based practice is a commitment to use those approaches that have the best scientific support, and, in areas where research is lacking, a commitment to measure and use outcomes to elevate those practices that have the greatest impact on the quality of life of individuals, families and communities.

Faith-Based Recovery: is the resolution of alcohol and other drug problems within the framework of religious experience, beliefs, and rituals and/or within the mutual support of a faith community. Faith-based recovery frameworks may serve as adjuncts to traditional recovery support programs or serve as alternatives to them.

Harm Reduction (as a stage of recovery): is most often viewed as an alternative to, and even antagonistic to, recovery, but can also be viewed as a strategy of initiating or enhancing early recovery. The mechanisms through which this can occur include preventing the further depletion of recovery capital, increasing recovery capital when it does not exist, and enhancing the person’s readiness for recovery via the change-encouraging relationships through which harm reduction approaches are delivered.

Inclusion: refers to a person’s right to be afforded access to, and to participate in, naturally occurring community activities of his or her choice.

Illness Self-management: is the mastery of knowledge about one’s own illness and assumption of primary responsibility for alleviating or managing the symptoms and limitations that result from it. Such self-education and self-management shifts the focal point in disease management from the expert caregiver to the person with the illness.

Individualized Care: see Person-Centered Care.

Indigenous Healers and Institutions: are people and organizations in the natural environment of the recovering person who offer words, ideas, rituals, relationships, and other resources that help initiate and/or sustain the recovery process. They are distinguished from professional healers and institutions not only by training and purpose, but through relationships that are culturally-grounded, enduring, and often reciprocal and/or non-commercialized.

Initiating Factors: are those factors that spark a commitment to recovery and an entry into the personal experience of recovery. Factors which serve this recovery priming function are often quite different than factors that later serve to sustain recovery. Recovery-initiating factors can exist within the person and/or within the person's family and social environment as well as in the behavioral health system. These factors can include pain-based experiences, e.g., anguish, exhaustion, and boredom with addictive lifestyle; death of someone close; external pressure to stop using; experiences of feeling humiliated; increased health problems; failures or rejections; or suicidal thoughts.

Less well-recognized, however, are the hope- and pleasure-based experiences: pursuing interests and experiencing enjoyment and success; exposure to recovery role models; new intimate relationships; marriage, parenthood, or other major positive life change; a religious experience; or new opportunities.

Jump Starts: see Initiating Factors.

Menu (of services and/or supports): an array of options from which people can then choose to utilize those services and/or supports they expect will be most effective in assisting them to achieve their goals and most responsive to their individual, familial, and socio-cultural values, needs, and preferences.

Micro Enterprise: see Social Cooperative/Entrepreneurialism.

Moderated Recovery: is the resolution of alcohol or other drug problems through reduction of alcohol or other drug consumption to a sub-clinical level (shifting the frequency, dosage, method of administration, and contexts of drug use) that no longer produces harm to the individual or society. The concept takes on added utility within the understanding that alcohol and other drug problems exist on a wide continuum of severity and widely varying patterns of acceleration and deceleration.

The prospects of achieving moderated recovery diminish in the presence of lower age of onset, heightened problem severity, the presence of co-occurring psychiatric illness, and low social support. The most common example of moderated resolution can be found in studies of people who develop alcohol and other drug-related problems during their transition from youth to adulthood. Most of these individuals do not go on to develop enduring substance-related problems, but instead moderate their use through the process of maturation.

Motivational Interventions: is a non-confrontational approach to eliciting recovery-seeking behaviors that was developed by Miller and Rollnick. This approach emphasizes relationship-building (expressions of empathy), heightening discrepancy between an individual's personal goals and present circumstances, avoiding argumentation (activation of problem-sustaining defense structure), rolling with resistance (emphasizing respect for the person experiencing the problem and his or her sense of necessity and confidence to solve the problem), and supporting self-efficacy (expressing confidence in the individual's ability to recovery and expressing confidence that they will recovery). As a technique of preparing people to change, motivational interviewing is an alternative to waiting for an individual to “hit bottom” and an alternative to confrontation-oriented intervention strategies.

Multiple Pathways of Recovery: reflects the diversity of how people enter into and pursue their recovery journey. Multiple pathway models contend that there are multiple pathways into psychiatric disorder and addiction that unfold in highly variable patterns, courses and outcomes; that respond to quite different treatment approaches; and that are resolved through a wide variety of recovery styles and support structures. This is particularly true among ethnic minority and religious communities, but diversity is to be found wherever there are people of different backgrounds.

Mutual Support/Aid Groups: are groups of individuals who share their own life experiences, strengths, strategies for coping and hope about recovery. Often called “self-help” groups, they more technically involve an admission that efforts at self-help have failed and that the help and support of others is needed. Mutual aid groups are based on relationships that are personal rather than professional, reciprocal rather than fiduciary, free rather than fee-based, and enduring rather than transient (see also Indigenous Healers and Institutions).

Natural Recovery: is a term used to describe those who have initiated and sustained recovery from a behavioral health disorder without professional intervention or involvement in a formal mutual aid group. Since people in this form of recovery neither access nor utilize behavioral health services, it is difficult to establish the prevalence or nature of this process, but it is believed to be common.

New Recovery Advocacy Movement: depicts the collective efforts of grassroots recovery advocacy organizations whose goals are to: 1) provide an unequivocal message of hope about the potential of long term recovery from behavioral health disorders, and 2) to advocate for public policies and programs that help initiate and sustain such recoveries. The core strategies of the New Recovery Advocacy Movement are: 1) recovery representation, 2) recovery needs assessment, 3) recovery education, 4) recovery resource development, 5) policy (rights) advocacy, 6) recovery celebration, and 7) recovery research.

Natural Support: technical term used to refer to people in a variety of roles who are engaged in supportive relationships with people in recovery outside of behavioral health settings. Examples of natural supports include family, friends, and other loved ones, landlords, employers, neighbors, or any other person who plays a positive, but non-professional, role in someone’s recovery.

Partial Recovery: is 1) the failure to achieve full symptom remission, but the achievement of a reduced frequency, duration, and intensity of symptoms and a reduction in personal and social costs associated with one’s disorder, or 2) the elimination of symptoms (e.g., achievement of complete abstinence from alcohol and other drugs) but a failure to achieve parallel gains in physical, emotional, relational, and spiritual health. Partial recovery may precede full recovery or constitute a sustained outcome.

Peer: within behavioral health, this term is used to refer to someone else who has experienced first-hand, and is now in recovery from, a mental illness and/or addiction.

Peer-Delivered Services: any behavioral health services or supports provided by a person in recovery from a mental illness and/or addiction. This includes, but is not limited to, the activities of peer specialists or peer support providers (see below), encompassing also any conventional behavioral health intervention which a person in recovery is qualified to provide.

Examples of these activities range from medication assessment and administration by psychiatrists and nurses who disclose that they are in recovery to illness management and recovery education by peers trained in providing this evidence-based psychosocial intervention. An underlying assumption here is that there is "value added" to any service or support provided by someone who discloses his or her own recovery journey, as such disclosure serves to combat stigma and inspire hope.

Peer-Operated or Peer-Run Programs: a behavioral health program that is developed, staffed, and/or managed by people in recovery. In contrast to peer-run businesses (described below) which are self-sustaining and able to generate profits, peer-run programs are typically private-non-profit and oriented to providing behavioral health services and supports such as respite care, transportation to and from healthcare appointments, recovery education, and advocacy.

Peer-Run Businesses: see Social Cooperative/Entrepreneurialism

Peer Specialist: a peer (see above) who has been trained and employed to offer peer support to people with behavioral health conditions in any of a variety of settings. These settings may range from assertive or homeless outreach in shelters, soup kitchens, or on the streets, to part of a multi-disciplinary inpatient, intensive outpatient, or ambulatory team, to roles within peer-run or peer-operated programs (see below).

Peer Support: while falling along a theoretical continuum, peer support differs both from traditional mutual support groups as well as from consumer-run drop-in centers or businesses. In both mutual support groups and consumer-run programs, the relationships peers have with each other are thought to be reciprocal in nature; even though some peers may be viewed as more skilled or experienced than others, all participants are expected to benefit. Peer support, in contrast, is conceptualized as *involving one or more persons who have a history of significant improvement in either a mental illness and/or addiction and who offers services and/or supports to other people with mental illnesses or addictions that are considered to be not as far along in their own recovery process*.

Person-Centered Care: behavioral health care that is based on the person's and/or family's self-identified hopes, aspirations, and goals, which build on the person's and/or family's own assets, interests, and strengths, and which is carried out collaboratively with a broadly-defined recovery management team that includes formal care providers as well as others who support the person's or family's own recovery efforts and processes, such as employers, landlords, teachers, and neighbors.

Person in Recovery: a person who has experienced a mental illness and/or addiction and who has made progress in learning about and managing his or her behavioral health condition and in developing a life outside of, or in addition to, this condition.

Recovery Capital: is the quantity and quality of internal and external resources that one can bring to bear on the initiation and maintenance of recovery from a life-changing disorder. In contrast to those achieving natural recovery, most people with psychiatric or addictive disorders entering treatment have never had much recovery capital or have dramatically depleted such capital by the time they seek help.

Recovery Celebration: is an event in which recovered and recovering people assemble to honor the achievement of recovery. Such celebrations serve both healing and mutual support functions but also (to the extent that such celebrations are public) serve to combat social stigma attached to addiction or mental illness by putting a human face on behavioral health disorders and by conveying living proof of the possibility and enduring nature of recovery from these disorders.

Recovery Coach/Guide (Recovery Support Specialist): is a person who helps remove personal and environmental obstacles to recovery, links the newly recovering person to the recovery community and his or her broader local community, and, where not available in the natural community, serves as a personal guide and mentor in the management of personal and family recovery.

Recovery Community (Communities of Recovery): is a term used to convey the sense of shared identity and mutual support of those persons who are part of the social world of recovering people. The recovery community includes individuals in recovery, their family and friends, and a larger circle of "friends of recovery" that include both practitioners working in the behavioral health fields as well as recovery supporters within the wider community. Recovery management is based on the assumption that there is a well-spring of untapped hospitality and service within this community that can be mobilized to aid those seeking recovery for themselves and their families.

"Communities of recovery" is a phrase coined by Kurtz to convey the notion that there are multiple recovery communities and that people in recovery may need to be introduced into those communities where the individual and the group will experience a goodness of "fit." The growth of these divergent communities reflects the growing varieties of recovery experiences.

Recovery Management: is the provision of engagement, education, monitoring, mentoring, support, and intervention technologies to maximize the health, quality of life, and level of productivity of persons with severe behavioral health disorders. Within the framework of recovery management, the "management" of the disorder is the responsibility of the person with the disorder. The primary role of the professional is that of the recovery consultant, guide, or coach.

Recovery-Oriented Practice: a practice oriented toward promoting and sustaining a person's recovery from a behavioral health condition. DMHAS policy defines recovery-oriented practice as one that "*identifies and builds upon each individual's assets, strengths, and areas of health* *and competence to support the person in managing his or her condition while regaining a meaningful, constructive, sense of membership in the broader community."*

Recovery-Oriented Systems of Care: are systems of health and human services that affirm hope for recovery, exemplify a strengths-based orientation, and offer a wide spectrum of services and supports aimed at promoting resilience and long term recovery from behavioral health disorders.

Recovery Planning and Recovery Plans: in contrast to a treatment or service plan, is developed, implemented, revised, and regularly evaluated by the client. Consisting of a master recovery plan and regular implementation/action plans, the recovery plan covers life domains in addition to behavioral health issues (e.g., physical, employment, finances, legal, family, social life, personal, education, and spiritual). In mental health settings, recovery planning follows the principles described above under person-centered care.

Recovery Priming: see Initiating Factors.

Recovery Support Services: are designed to 1) remove personal and environmental obstacles to recovery, 2) enhance identification and participation in the recovery community, and 3) enhance the quality of life of the person in recovery. Such services include outreach, engagement and intervention services; recovery guiding or coaching, post-treatment monitoring and support; sober or supported housing; transportation; child care; legal services; educational/vocational supports; and linkage to leisure activities.

Serial Recovery: is the process through which individuals with multiple concurrent or sequential problems resolve these problems and move toward optimum level of functioning and quality of life. Serial recovery refers to the process of sequentially shedding two or more drugs, or to the overlapping processes involved in recovering from addiction and co-occurring psychiatric or other physical disorders.

Social Cooperative/Entrepreneurialism: the development and operation of small businesses ("micro enterprises") by people in recovery based on their talents and interests and in partnership with their local community. The resulting businesses offer goods and services to the general public and may be either for profit or not for profit, but should be at least financially self-sustaining, although perhaps subsidized through tax breaks or other government means.

Spirituality: refers to a system of religious beliefs and/or a heightened sense of perception, awareness, performance, or being that informs, heals, connects, or liberates. For people in recovery, it is a connection with hidden resources within and outside of the self. There is a spirituality that derives from pain, a spirituality that springs from joy or pleasure, and a spirituality that can flow from the simplicity of daily life. For many people, the spiritual has the power to sustain them through adversity and inspire them to make efforts toward recovery. For some, this is part of belonging to a faith community, while for others is may be the spirituality of fully experiencing the subtlety and depth of the ordinary as depicted in such terms as harmony, balance, centeredness, or serenity. All of these can be part of the many facets of recovery.

Triggering Mechanisms: see Initiating Factors.

User/Service Recipient: a person who receives or uses behavioral health services and/or supports, preferred by some people as an alternative to "consumer" or "person in recovery."

Valued-Based Practice: a practice which has not yet accrued a base of evidence demonstrating its effectiveness in promoting recovery, but for which there are other persuasive reasons to view it as having been a helpful resource, and as being a helpful resource in the future, for people with behavioral health conditions. Examples of value-based practices include peer-based services that offer hope, role modeling, and mentoring and culturally-specific programs oriented toward cultural subgroups.

WRAP (Wellness Recovery Action Planning): a self-help approach to illness management and wellness promotion developed by Mary Ellen Copeland.

Moving from a Deficit-Based to a Strengths-Based Approach to Care

The following are examples of how language, thinking, and practice shift in the evolution of a recovery-oriented system of care

Presenting Situation	**Deficit-based Perspective**		**Recovery-oriented, Asset-based Perspective**	
	Perceived Deficit	**Intervention**	**Perceived Asset**	**Intervention**
Person re-experiences symptoms	Decompensation, exacerbation or relapse	Involuntary hospital-ization; warning or moralizing about "high risk" behavior (e.g., substance use or "non-compliance")	Re-experiencing symptoms as a normal part of the recovery journey; an opportunity to develop, implement, and/or apply coping skills and to draw meaning from managing an adverse event; symptoms are a way the self speaks to the self—a call for change; goal is not to eliminate but to listen.	Express empathy and help person avoid sense of demoralization; highlight how long it may have been since symptoms had reappeared; provide feedback about the length of time it takes to achieve sustained change; offer advice on strategies to cope; reinforce sense of self-efficacy; exposure to "living proof" of potential for sustained recovery
Person demonstrates potential for self-harm	Increased risk of suicide	Potentially intrusive efforts to "prevent suicide"	Indicators of potential for self-harm are important signals to respond differently. The person is likely to have a weakened sense of efficacy and feel demoralized, and thus may require additional support. On the other hand, the person has already survived tragic circumstances and extremely difficult ordeals, and should be praised for his or her prior resilience and perseverance.	Rather than reducing risk, the focus is on promoting safety. Supportive, ongoing efforts are oriented to "promote life," e.g., enabling people to write their own safety/ prevention plans and advance directives. Express empathy; reinforce efficacy and autonomy; enhance desire to live by eliciting positive reasons and motivations, with the person, not the provider, being the source of this information. Help promote a life that is incongruent with self-injury.
Person takes medication irregularly	Person lacks insight regarding his or her need for meds; is in denial of illness; is non-compliant with treatment; and needs monitoring to take meds as prescribed.	Medication may be administered, or at least monitored, by staff; staff may use cigarettes, money, or access to resources as incentives to take meds; person is told to take the meds or else he or she will be at risk of relapse or decompensation, and therefore may need to be hospitalized.	Prefers alternative coping strategies (e.g., exercise, structures time, spends time with family) to reduce reliance on medication; has a crisis plan for when meds should be used. Alternatively, behavior may reflect ambivalence regarding medication use which is understandable and normal, as appro-ximately half of people with any chronic health condition (e.g., diabetes, asthma) will not take their medication as prescribed.	Individual is educated about the risks and benefits of medication; offered options based on symptom profile and side effects; and is encouraged to consider using meds as one tool in the recovery process. In style and tone, individual autonomy is respected and decisions are ultimately the person and his or her loves one's to make. Explore person's own perspective on symptoms, illness, and medication and invite him or her to consider other perspectives. Person is resource for important ideas and insights into the problem and is invited to take an active role in problem solving process.

Presenting Situation	Deficit-based Perspective		Recovery-oriented, Asset-based Perspective	
	Perceived Deficit	**Intervention**	**Perceived Asset**	**Intervention**
Person makes poor decisions	Person's judgment is impaired by illness or addiction; is non-compliant with directives of staff; is unable to learn from experience	Potentially invasive and controlling efforts to "minimize risk" and to protect the person from failure, rejection, or the other negative consequences of his or her decisions	Person has the right and capacity for self-direction (i.e., Deegan's "dignity of risk" and the "right to fail"), and is capable of learning from his or her own mistakes. Decisions and taking risks are viewed as essential to the recovery process, as is making mistakes and experiencing disappointments and set backs. People are not abandoned to the negative consequences of their own actions, however, as staff stand ready to assist the person in picking up the pieces and trying again.	Discuss with the person the pros, cons, and potential consequences of taking risks in the attempt to maximize his or her opportunities for further growth and development. This dialogue respects the fact that all people exercise poor judgment at times, and that making mistakes is a normal part of the process of pursuing a gratifying and meaningful life. Positive risk taking and working through adversity are valued as means of learning and development. Identify discrepancies between person's goals and decisions. Avoid arguing or coercion, as decisions made for others against their will potentially increase their learned helplessness and dependence on professionals.
Person stays inside most of the day	Person is withdrawing and becoming isolative; probably a sign of the illness; can only tolerate low social demands and needs help to socialize	Present the benefits of spending time outside of the house; offer the person additional services to get the person out of the house to a clubhouse, drop-in center, day program, etc.	Person prefers to stay at home; is very computer savvy; and has developed skills in designing web pages; frequently trades e-mails with a good network of NET friends; plays postal chess or belongs to collectors clubs; is a movie buff or enjoys religious programs on television. Person's reasons for staying home are seen as valid.	Explore benefits and drawbacks of staying home, person's motivation to change, and his or her degree of confidence. If staying home is discordant with the person's goals, begin to motivate for change by developing discrepancies. If leaving the house is important but the person lacks confidence, support self-efficacy, provide empathy, offer information/advice, respond to confidence talk, explore hypothetical change, and offer to accompany him or her to initial activities.
Person denies that he or she has a mental illness and/or addiction	Person lacks insight or is unable to accept illness	Educate and help the person accept diagnoses of mental illness and/or addiction; facilitate grieving loss of previous self	Acceptance of a diagnostic label is not necessary and is not always helpful. Reluctance to acknowledge stigmatizing designations is normal. It is more useful to explore the person's understanding of his or her predicament and recognize and explore areas for potential growth.	In addition to exploring person's own understanding of his or her predicament, explore symptoms and ways of reducing, coping with, or eliminating distress while eliciting ways to live a more productive, satisfying life. Providing normative information about AOD consumption & its consequences; eliciting client's own criteria of when AOD use would be defined as a problem.

Presenting Situation	Deficit-based Perspective		Recovery-oriented, Asset-based Perspective	
	Perceived Deficit	**Intervention**	**Perceived Asset**	**Intervention**
Person sleeps during the day	Person's sleep cycle is reversed, probably due to illness; needs help to readjust sleep pattern, to get out during the day and sleep at night.	Educate the person about the importance of sleep hygiene and the sleep cycle; offer advice, encourage-ment, and inter-ventions to reverse sleep cycle	Person likes watching late-night TV; is used to sleeping during the day because he or she has always worked the night shift; has friends who work the night shift so prefers to stay awake so she or he can meet them after their shift for breakfast. Person's reasons for sleeping through the day are viewed as valid.	Explore benefits and drawbacks of sleeping through the day, the person's motivation to change, the importance of the issue and his or her degree of confidence. If sleeping through the day is discordant with the person's goals, begin to motivate change by developing discrepancy, as above.
Person will not engage in treatment	Person is non-compliant, lacks insight, or is in denial	Subtle or overt coercion to make person take his or her medications, attend 12-step or other groups, and partici-pate in other treat-ments; alternatively, discharge person from care for non-compliance	Consider range of possible reasons why person may not be finding available treatments useful or worthy of his or her time. It is possible that he or she has ambivalence about treatment, has not found treatment useful in the past, did not find treatment responsive to his or her needs, goals, or cultural values and preferences. Also consider factors out-side of treatment, like transportation, child care, etc. Finally, appreciate the person's assertiveness about his or her preferences and choices of alternative coping and survival strategies	Compliance, and even positive behaviors that result from compliance, do not equate, or lead directly, to recovery. Attempts are made to understand and support differences in opinion so long as they cause no critical harm to the person or others. Providers value the "spirit of noncompliance" and see it as sign of the person's lingering energy and vitality. In other words, he or she has not yet given up. Demonstrate the ways in which treatment could be useful to the person in achieving his or her own goals, beginning with addressing basic needs or person's expressed needs and desires; earn trust. Exposure to recovery role models whose personal stories and energy make recovery contagious.
Person reports hearing voices	Person needs to take medication to reduce voices; if person takes meds, he or she needs to identify and avoid sources of stress that exacerbate symptoms	Schedule appoint-ment with nurse or psychiatrist for med evaluation; make sure person is taking meds as prescribed; help person identify and avoid stressors	Person says voices have always been there and views them as a source of company, and is not afraid of them; looks to voices for guidance. Alterna-tively, voices are critical and disruptive, but person has been able to reduce their impact by listening to walkman, giving them stern orders to leave him or her alone, or confines them to certain parts of the day then they pose least inter-ference. Recognize that many people hear voices that are not distressing.	Explore with person the content, tone, and function of his or her voices. If the voices are disruptive or distressing, educate person about possible strategies for reducing or containing voices, including but not limited to medication. Ask person what has helped him or her to manage voices in the past. Identify the events or factors that make the voices worse and those that seem to make the voices better or less distressing. Plan with the person to maximize the time he or she is able to manage or contain the voices.

Presenting Situation	Deficit-Based Perspective		Recovery-oriented, Asset-based Perspective	
	Perceived Deficit	**Intervention**	**Perceived Asset**	**Intervention**
Family will not engage in treatment activities	Family is non-supportive, uncaring or bridges are "burned" and so relationship is permanently lost.	After one or two attempts actively engaging the family is not attempted.	Staff recognizes that the family has had a long journey of which they know very little and are coping with possible stress, grief and loss in the best way they know. They are respected for what they have been able to give in the past.	Staff actively engage family in relating to them by phone or in person. They listen carefully to what has been successful and difficult in family relationships in the past. They explore with the family and the person about what kind of relationship might work for them at this point. They work with helping to identify possible ways of relating that keep an old connection or establish a new connection step by step.

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