RECOVERY TO PRACTICE
Resource Center for Mental Health Professionals

Weekly Highlight

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Recovery in Mental Health and Addiction

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As noted in a previous Recovery to Practice Weekly Highlight, a number of common questions keep popping up related to recovery, the nature of recovery-oriented practices, and the ways they may differ from conventional mental health care. We are currently collecting these questions so they can be posted in the "Frequently Asked Questions" (FAQs) section of the RTP Website. We invite readers to suggest their own questions for this growing list.

This Weekly Highlight will be devoted to one of these emerging questions. Again, you, the reader, are invited to comment on and/or submit your own responses to the question raised. You can send your submissions to the Recovery to Practice Resource Center at RecoveryToPractice@dsgonline.com.

This week, we focus on FAQ #6.

Frequently Asked Question #6: ***"How does mental health recovery interface with the addiction recovery movement?"***

Our Response: In the United States, the mental health and addiction fields have different historical roots and traditions. These differences naturally led to there also being two distinct groups of practitioners who had little to do with the other specialty. If a person had both a mental illness and an addiction, it would have been difficult for him or her to receive optimal care. Either the mental health practitioner would not have been trained to identify the signs of substance misuse and/or the addiction practitioner would not have been trained to identify psychiatric symptoms. Even when a practitioner was able to identify both disorders, the best he or she could do was to refer the person for care for the "secondary" condition by a practitioner from the other camp.

Several important developments are changing this picture. First, both fields have come to recognize the high prevalence of what are now called "co-occurring disorders," meaning that many people with mental health conditions also have addictions, just as many people with addictions have mental health conditions. Research has consistently shown that for these individuals to receive effective care, mental health and addiction services must be integrated.

Integration has been difficult, however, for numerous political, fiscal, structural, and attitudinal influences that have been hard to overcome. Previous efforts at integration also have been difficult because they have focused primarily on the etiology or nature of mental illnesses and addictions, or on the types of treatments required by each, failing to establish a common ground that would provide a foundation for integration. As long as the focus has been on the nature of the illness or on the treatments required, historical differences have outweighed commonalities, leaving the fields splintered.

Within the past decade, though, the emergence of a recovery movement in both the mental health and addiction fields has begun to offer a new organizing principle for bringing these two disparate worlds together. As integration has yet to be achieved from focusing on the nature of the disorders or the services required, perhaps concentrating on the processes of recovery, healing, and community inclusion will. As a core principle of both recovery movements suggest, identifying and building on strengths can often accomplish things that attending to deficits and dysfunction have not been able to do. What results is recognition that, while mental illnesses and addictions might be different from each other in important ways—especially when viewed through the lens of a diagnostic manual—processes of recovery may nonetheless be very similar, and at times, even interwoven—especially when viewed from the perspective of the person in recovery. This Highlight will address both the differences and similarities, but will start with the similarities.

The components of an integrated recovery vision begin with the idea that, in both mental illness and addiction, recovery is a personal and individualized process of growth for which there are multiple pathways. People in recovery from either mental illness or addiction have described recovery as a transformational process (sudden, unplanned, permanent) and an incremental process (marked by multiple phases), and recovery narratives are often filled with elements of both types of change. Of central importance within these stories is the fact that within these stories, people in recovery are active agents of change in their own lives—not simply passive recipients of care. These stories are filled with references to new perspectives and insights, important decisions, critical actions taken, and the discovery of previously hidden healing resources within and beyond the self. Recovery narratives often give prominence to the role of diverse religious, spiritual, and secular frameworks in recovery initiation and maintenance. People in recovery also note the role of family and peer support in making a difference in their recovery.

Whether they are living with a mental illness, an addiction, or both, people in recovery need to have hope. They also want to manage or eliminate their symptoms, increase their capacity to participate in valued social roles and relationships, embrace purpose and meaning in their lives, and make worthwhile contributions to their communities. With this shared vision in place, then, differences that have historically existed between the recovery visions of the mental health and addictions systems can now provide opportunities for synergistic growth in both.

In developing recovery-oriented practices and systems that are based on this integrated vision, several guiding principles exist. The first is that both mental illnesses and addictions span a

diversity of population and outcomes. Basically, recovery looks different for different people. Second is the need to adopt a long-term, longitudinal perspective and to use a developmental framework for matching the person's point in the recovery process to appropriate interventions. Also important is the impact of the environment—one must focus on person–environment fit and interactions. Third is the nonlinear nature of recovery and the fact that it is a process and a continuum as opposed to an outcome. Finally, as previously noted, is the importance of family involvement, peer support, and spirituality in supporting the recovery process.

Recovery-oriented care is based on the recognition that each person must be either the agent of and/or the central participant in his or her own recovery journey. All services and supports, therefore, need to be organized to support the developmental stages of this recovery process. It follows from this core value that services also should instill hope; be person and family-centered; offer choice; elicit and honor each person's potential for growth; build on a person's/family's strengths and interests; and attend to the person's overall life, including health and wellness. These values can be the foundation for all services for people in recovery from mental illness and/or addiction, regardless of the service type (e.g., treatment, peer support, family education, etc.). There are many pathways to healing—both inside and outside of the formal health system—that people with mental illnesses and/or addictions can take in their recovery.

That said, what significant differences remain? Apart from the neurophysiology of these disorders, which remains to be determined, one important difference is in the role of behavior change. A useful model of behavioral change that has led to a popular approach to addiction treatment has been the Transtheoretical Model, proposed by DiClemente and Prochaska in 1985. This is the model at the heart of motivational interventions that attempt to facilitate a person's movement along the continuum from pre-contemplative and contemplative to preparation and then action (leading eventually to maintenance). While this model, tailored to the person's stage of change, has been effective in promoting recovery in addiction, its use in relation to mental illness is not as straightforward. This is because the Transtheoretical Model of Change is a model of behavioral change, and the role of behavioral change in mental health is somewhat different from that in addiction. That's because while you can choose not to drink alcohol or use an illicit substance, you cannot choose to stop experiencing the symptoms of a mental illness.

A person can, and does, make many choices when living with and recovering from a mental illness, of course, but these choices are different from the choice to use or not to use. For people in recovery from a mental illness, choices include what they do *in response to* experiencing symptoms (e.g., do what the voices command or try to ignore them); what they do *to prevent or minimize* symptoms (e.g., avoid stressful situations, take medication); and what they do *to manage or overcome* the disorder (e.g., learn self-care skills, reach out to others). But the primary role of behavioral change in addiction may need to be somewhat modulated by the variety of factors that also influence the onset and course of serious mental illnesses, factors that lie outside of the person's own sphere of influence. These include social

conditions, such as poverty, discrimination, and unemployment, as well as interpersonal and biological factors, such as the availability of social support and the responsiveness of symptoms to medications. As we learn more about the neurophysiology and social dimensions of addiction, we may eventually find that this is an area in which the addition field has much to learn from the mental health field. The increasingly important role of recovery support services in addiction care—services, such as case management, that in the past were sometimes viewed as "enabling"—certainly suggests that just such a change is already beginning to take place.

Upcoming SAMHSA Meeting: People in Recovery and Mental Health Consumers in Dialogue

On August 18–19, 2010, SAMHSA will convene a dialogue meeting of people in recovery from addictions and mental health consumers to examine the concept of recovery from an integrated, behavioral health perspective. All invited participants will represent the voices of recovery. The discussion will identify a common working definition for behavioral health recovery, unique factors for each field, and recommendations for ongoing efforts in support of behavioral health integration.

Drawing on the insights and experiences offered by dialogue meeting participants, SAMHSA will produce a report based on both the process and outcomes of the meeting. The report will include a working definition of behavioral health recovery, elements of a recovery-oriented system, and potential measures of recovery from an integrated behavioral health perspective. Unique and/or divergent issues will also be identified, along with implications for behavioral health services and systems. The report will also include specific suggestions and recommendations developed by meeting participants for SAMHSA and others in the field on what recovery means for behavioral health systems.

An announcement will be made via the RTP listserv when the report is completed and available for download and/or ordering from the SAMHSA Health Information Network (http://www.samhsa.gov/shin).

For Further Reading:

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Davidson, Larry, and William White. 2007. "The Concept of Recovery as an Organizing Principle for Integrating Mental Health and Addiction Services." *Journal of Behavioral Health Services and Research* 34:109–120.

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Prochaska, James O., and Carlo C. DiClemente. 1983. “Stages and Processes of Self-Change in Smoking: Toward an Integrative Model of Change.” *Journal of Consulting and Clinical Psychology* 51:390–395.

White, William. 2009. *Peer-Based Addiction Recovery Support: History, Theory, Practice, and Scientific Evaluation*. Great Lakes Addiction Technology Transfer Center and the Philadelphia Department of Behavioral Health and Mental Retardation Services.

White, William. 2005. “Recovery: Its History and Renaissance as an Organizing Construct.” *Alcoholism Treatment Quarterly* 23(1):3–15.

White, William, Michael Boyle, and David Loveland. 2004. “Recovery From Addiction and Recovery From Mental Illness: Shared and Contrasting Lessons.” In Ruth Ralph and Pat Corrigan (eds.). *Recovery and Mentallillness: Consumer Visions and Research Paradigms*. Washington, D.C.: American Psychological Association.

White, William, and Larry Davidson. 2006. “Recovery: The Bridge to Integration? Parts One and Two.” *Behavioral Healthcare* 26(11):22–25 and 26(12):24–26.

Save the Date

The Recovery to Practice Resource Center is pleased to announce the second Webinar of its 2010 series,

"**What Recovery Means for Acute Care**."

It will take place September 16, 2010, from 3:00 p.m. to 4:30 p.m. EDT.

More information on how to register will be forthcoming!

We welcome your views, comments, suggestions and inquiries.

For more information on this topic or any other recovery topics, please contact the *Recovery to Practice* Resource Center at

1-877-584-8535 or email RecoveryToPractice@dsgonline.com