Recovery and Treatment Courts: What Do You Really Mean and Walking the Talk about Recovery

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A. Recovery and Recovery Management – Definitions and Attitudes

(a) How do you answer a client who asks: "How long do I have to be here?"
(b) Does "recovery" mean different things for substance use versus mental health problems?
(c) What does treatment completion mean? What does finishing the program and graduation mean?

Recovery in Addiction

- "Recovery is the process through which severe alcohol and other drug problems (here defined as those problems meeting DSM-5* criteria for *substance use disorder*) are resolved in tandem with the development of physical, emotional, ontological (spirituality, life meaning), relational and occupational health."

(White, W. & Kurtz, E. (2005). "The Varieties of Recovery Experience". Chicago, IL. Great Lakes Addiction Technology Transfer Center. Posted at http//:www.glattc.org) (* Updated to reflect DSM-5)

- The immediate goal of reducing alcohol and drug use is necessary but rarely sufficient for the achievement of the longer-term goals of improved personal health and social function and reduced threats to public health and safety."

(McLellan A.T., McKay J.R., Forman R., Cacciola J., Kemp J. (2005) Reconsidering the evaluation of addiction treatment: from retrospective follow-up to concurrent recovery monitoring. Page 448 *Addiction* 100:447-458.)

Recovery in Mental Health

"Recovery occurs when people with mental illness discover, or rediscover, their strengths and abilities for pursuing personal goals and develop a sense of identity that allows them to grow beyond their mental illness"
(Pat Deegan, a consumer leader and psychologist with schizophrenic disorder defines recovery from serious mental illness)

Recovery Management

Behavioral Health Recovery Management (BHRM) is the stewardship of personal, family and community resources to achieve the highest level of global health and functioning of individuals and families impacted by severe behavioral health disorders. It is a time-sustained, recovery- focused collaboration between service consumers and traditional and non-traditional service providers toward the goal of stabilizing, and then actively managing the ebb and flow of severe behavioral health disorders until full remission and recovery has been achieved, or until they can be effectively self-managed by the individual and his or her family. BHRM draws its principles from the biopsychosocial model of treatment, the health care consumer movement, and the strengths-based model of service delivery.

(White, WL, Boyle, MG et al: "What is Behavioral Health Recovery Management? A Brief Primer")

- A 2001 paper in *Psychiatric Services* summarized a conceptual model on recovery and referred to both internal conditions ("the attitudes, experiences and processes of change of individuals who are recovering") and external conditions ("the circumstances, events, policies and practices that may facilitate recovery").

Recovery – A Conceptual Model
Internal Conditions

- Hope – belief that recovery is possible; it lays the groundwork for healing to begin
- Healing – recovery is not synonymous with cure; active participation in self-help activities; locus of control is with consumer
- Empowerment – corrects a lack of control, sense of helplessness, and dependency; aim is to have consumers assume increasing responsibility for themselves in making choices and taking risks; full empowerment requires that consumers live with consequences of their choices
- Connection – recovery is a social process; a way of being in the company of others; to find a role to play in the world

Recovery – A Conceptual Model
External Conditions

- Human rights – reducing and eliminating stigma, discrimination against psychiatric disabilities; equal opportunities in education, employment, housing; access to needed resources
- Positive Culture of Healing – a culture of inclusion, caring, cooperation, dreaming, humility, empowerment, hope
- Recovery-oriented services – best practices of clinical care, peer and family support, work, community involvement to be implemented by consumers, clinicians, and community; services that facilitate individual recovery and personal outcomes; collaborative services; consumers for consumers

References:
Jacobson N, Greenley D (2001): "What Is Recovery? A Conceptual Model and Explication" Psychiatric Services. April 2001, Volume 52; No. 4:482-485. You can go to Google, type in Psychiatric Services journal and get to the April 2001 edition and download the paper.

B. **Why the Interest in Recovery and Recovery Management**

1. Era of Consumerism (Kizer, KW (2001): "Establishing Health Care Performance Standards in an Era of Consumerism" JAMA 286:1213-1217)

- US Health care system reengineering itself to address the need for quality improvement
- It is being actively reshaped by the expectations of consumers
- All stakeholders demand active collaboration with health care system

2. Self-Management of Chronic Disease (Bodenheimer T, Lorig K, Holman H, Grumbach K (2002): "Patient Self-management of Chronic Disease in Primary Care" JAMA 288:2469-2475)

- New chronic disease paradigm: the patient-professional partnership, involving collaborative care and self-management education
- Programs teaching self-management skills are more effective than information only patient education in improving clinical outcomes
- Self-management education for chronic illness soon an integral part of high-quality primary care

3. Illness Management and Recovery (Mueser KT, Corrigan PW, Hilton DW et al (2002): "Illness Management and Recovery: A Review of the Research" Psychiatric Services 53:1272-1284; Drake RE, Essock SM, Shaner A et al (2001): "Implementing Dual Diagnosis Services for Clients with Severe Mental Illness" Psychiatric Services 52:469-476; Carey KB, Carey MP, Maisto SA, Purnine DM (2002): "The Feasibility of Enhancing Psychiatric Outpatients' Readiness to Change Their Substance Use" Psychiatric Services 53: 602-608)

- "Illness management is a broad set of strategies designed to help individuals with serious mental illness collaborate with professional, reduce their susceptibility to the illness, and cope effectively with their symptoms"

- Involves psychoeducation to improve people's knowledge of mental illness; behavioral tailoring to help people take medication as prescribed; relapse prevention to reduce symptom relapses and rehospitalizations; coping skills training to reduce severity and distress of persistent symptoms
- Empowerment corrects a lack of control, sense of helplessness, and dependency; aim is to have consumers assume increasing responsibility for themselves in making choices and taking risks; full empowerment requires that consumers live with consequences of their choices (Mueser, Corrigan et al., 2002; Drake, Essock et al., 2001; Carey, Carey et al., 2002; Jacobson & Greenley, 2001).

4. Evidence-Based Practices and Quality Improvement: Guidelines for the redesign of health care were published in "Crossing the Quality Chasm: A New Health System for the 21st Century" (2001) and "Improving the Quality of Health Care for Mental and Substance-Use Conditions" (2005) – both reports from the Institute of Medicine. Of the 10 rules originally published to guide the redesign of the health care system, at least 5 involve "patient-centered care":

- The system of care should be designed to meet the most common types of needs, but have the capability to respond to individual patient choices and preferences.
- Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over health care decisions that affect them. The health system should be able to accommodate differences in patient preferences and encourage shared decision making.
- Patients should have unfettered access to their own medical information and to clinical knowledge. Clinicians and patients should communicate effectively and share information
- The health care system should make information available to patients and their families that allows them to make informed decisions when selecting a health plan, hospital, or clinical practice, or choosing among alternative treatments. This should include information describing the system's performance on safety, evidence-based practice, and patient satisfaction.
- The health system should anticipate patient needs, rather than simply reacting to events.

C. **Terminology and its Effect on Practice** – Do you really believe in recovery?

- "Negative consequences" – In addiction treatment clinicians often say that if a person uses while in treatment there needs to be "negative consequences". But if a person gets depressed again and cuts herself; or manic and spends a lot of money; or psychotic because of not taking medication, do we say there need to be "negative consequences"?

- "Graduation" – Clients and counselors talk of "graduation" from the program. But when does a person graduate from diabetes treatment? Or from Bipolar Disorder treatment? Or from hypertension or asthma treatment?

- "Complete the program" – Similarly, when does a person complete the depression program; or complete the Schizophrenic Disorder program? On what basis is the decision to discharge or transfer a person from successful treatment made? Is it based on a set time and/or number of sessions? Or do you focus on the level of function and the quality of the person's recovery?

- "How long is your program?" or "How long do I have to stay?" – The same issue is raised here. Do we really believe we are managing long-term illnesses; or do we act more like there is a set of program expectations and monitoring compliance with rules and expectations.

D. **SAMHSA's Definition of Recovery**

The Substance Abuse and Mental Health Services Administration (SAMHSA) announced a new working definition of recovery from mental disorders and substance use disorders on December 22, 2011. They recognized that "there are many different pathways to recovery and each individual determines his or her own way."

The new working definition of recovery from mental and substance use disorders is as follows:

> ***A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.***

SAMHSA has delineated four major dimensions that support a life in recovery:

- Health: **overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way;**
- Home: **a stable and safe place to live;**
- Purpose: **meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and**
- Community: **relationships and social networks that provide support, friendship, love, and hope.**

Specific steps this recovery definition and dimensions highlight:

1. Clinicians and providers need to be focused on facilitating a *process of change.*

2. The goal of treatment and recovery services is to *improve health and wellness*, not just stabilize signs and symptoms. Thus the focus is not just on pathology and sickness, but also on strengths, skills and resources for wellness.

3. Patients, clients, consumers, and participants are actively involved to *live a self-directed life*, not a passive recipient of a treatment plan with which they must comply.

4. The ultimate outcome of our partnership with participants is to have them *reach their full potential* involved in *meaningful daily activities* that provide a sense of *purpose* in the safety of their *home* and *community* of friends and loved ones.

(Substance Abuse and Mental Health Services (SAMHSA) Definition of Recovery. For further detailed information about the new working recovery definition or the guiding principles of recovery, visit: http://www.samhsa.gov/newsroom/advisories/1112223420.aspx)

E. **Inconsistencies in Attitudes and Practice**

Person's Attitudes and Behavior	Recovery Process in 12 Step Programs and other Recovery Groups	Traditional Addiction Treatment Attitudes and Practice
1. Ambivalent about abstinence and recovery	1. "Keep coming back" – do the research; you don't have to get the program; it will get you; stages of change and cognitive behavioral approach (SMART Recovery)	1. Client must agree to abstinence as a precondition of admission into treatment; or "come back when you are ready"
2. Reluctant to attend recovery meetings and groups	2. Outreach with 12-Step calls; offer to be a sponsor; assist with transportation; welcoming and "attraction not promotion"	2. Access to care is difficult; long waiting lists; recorded messages and complicated intake procedures
3. Shows up to a meeting after a few drinks	3. "Keep coming back" – "There but for the grace of God go I"; a good "remember when"	3. Leave and come back when you are sober. Sign a contract that you will not come to treatment if you have used
4. Feels will power will fix addiction and trouble accepting suggestions	4. "Powerlessness" and helping people understand the paradox of surrender and power; unmanageability and making amends	4. Counselors act as if powerful and able to confront and coerce recovery; work harder for recovery than client
5. Involves family and significant others in a web of pain and loss	5. "Detachment" – Al-Anon, Alateen; Naranon; help the family develop serenity and their personal recovery	5. Act as if we will stop addiction; work as hard as the family did to stop addiction; compassion fatigue and staff burnout

Person's Attitudes and Behavior	Physical and Mental Health Recovery Approach	Addiction Treatment Recovery Approach
1. Relapse or re-occurrence of signs and symptoms of disorder	1. Viewed as a poor outcome or crisis requiring a timely response; assessment and treatment plan change	1. Viewed as willful misconduct with exclusion from treatment that day and possible discharge from treatment. "Punitively discharge clients for becoming symptomatic" (W.White, 2005)
2. Psychosocial crisis; treatment adherence problems; acute exacerbation of the disorder	2. Discussed as lack of progress and a poor outcome requiring a change in treatment strategies e.g., individual, group, family therapy, pharmacotherapy, case management	2. Discussed as the need for "consequences", sanctions and possible discharge or transfer to another treatment team and setting
3. Persistent treatment adherence problems	3. Variety of proactive strategies – Assertive Community Treatment (ACT teams); Intensive Case Management (ICM); supported housing and employment; variety of "wet", "damp" and "dry" shelters; mental health crisis teams to enhance natural and community supports	3. Blacklist client from readmission to the facility; discharge and send notice of case closed; refer to extended residential and inpatient care away from the person's community with poor continuing care and reintegration into the community; invoke legal sanctions and remove from treatment
4. Severe and chronic illness	4. Utilize levels of care including acute hospitalization; day treatment; outpatient and community-based services; group and independent housing options. No fixed length of stay. Illness, disease and recovery management model.	4. Utilize predominantly fixed length of stay residential programs for those who can pay. Utilize predominantly low intensity outpatient services in the public sector. "Serial episodes of self-contained, unlinked interventions….Relegate post-treatment continuing care services to an afterthought" (W.White, 2005) Repeated episodes of acute care for detox; stabilization; discrete fixed program stay; "treatment completion"; "graduation"
5. Poor outcomes	5. Viewed as the need for more intensive case and care management and community outreach	5. Blame the client for denial and "stinking thinking"; non-compliance; stubbornness to take suggestions

F. Rename the Graduation or Treatment Completion Ceremony

Perhaps you could call it the RCA - the *Reflection, Celebration and Anticipation* ceremony or event.

- ***Reflection*** on what the client and family have learned, seen, gotten in touch with, changed since entering treatment. It can also be a reflection not just of positive things, but in all honesty (this is an honest program), reflection about things still not resolved or still not accepted. This is to model that this is about Progress not Perfection; about beginnings in recovery, not an end or completion of treatment; about reflecting on what might not yet be working, not just putting on a brave front to say everything is rosy

- ***Celebration*** of any accomplishments in this piece of recovery work done at this time in this program. Celebrating what has worked and what the program community has given the person; a time to be thankful for the challenging work the person has done so far in their recovery that is just beginning, not ending. Celebrating the hope that can be there for the client and family when there was only despair and hopelessness.

- ***Anticipation*** of what lies ahead in their recovery – plans on how to continue gains that have been made; but also how to keep working on doubts or ambivalences or challenges that still may be there or are even likely to be there. Anticipation of what needs to be done to keep progressing and if not "perfect" and there is a slip or relapse, what is plan B to get back on track – not with shame or a sense of failure, but with determination and commitment to keep moving forward – a day at a time with serenity.

LITERATURE REFERENCES AND RESOURCES

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