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The Concept of Recovery as an Organizing Principle for Integrating Mental Health and Addiction Services

Larry Davidson, Ph.D., and William White, M.A.
Yale Program for Recovery and Community Health
and Chestnut Health Systems

Abstract

Despite a range of long-standing historical, political, ideological, professional, structural, and practical barriers, there has been, and continues to be, a clear consensus that integration between mental health and addiction services is sorely needed and long overdue. This paper focuses on one dimension of the challenge of integration from among the several—the conceptual—and proposes the construct of recovery as an organizing principle for bridging the divide between the two domains. After reviewing briefly the parallel history of the two traditions and their shared need for transformation to a recovery orientation, the authors offer an integrated model of recovery for persons with co-occurring disorders. They then derive from this model the underlying values, guiding principles, key strategies, and essential ingredients of recovery- oriented systems of care which comprise a common approach across both addictions and mental illness, offering a strengths-based solution to achieving integration where pathology-focused approaches have failed.

> "Treatment in parallel and separate mental health and substance abuse treatment systems . . . is remarkably ineffective" —Drake and colleagues[1, p. 361]

This conclusion was drawn by Drake and colleagues from their recent review[1] of research on the care of individuals with co-occurring psychiatric and addictive disorders. While the conclusion itself is not surprising, it is striking that this conclusion continues to be just as salient today as it was when it was first reached over 25 years ago.[2-4] Since that time, numerous reports, reviews, and research have documented well and extensively the uneasy relationship that exists between mental health services and services for persons with addictions.[5-16] Consistent epidemiological and service utilization data collected during this same period have shown that mental illnesses and addictions co-occur within the same person as frequently as they exist independently of one another. These data further call into question the current bifurcation of the behavioral health field into two distinct and heavily bounded territories.[17-18] While work such as the review by Drake and colleagues cited above has sought to overcome this split in the field by repeatedly highlighting the importance of providing integrated care for persons with co-occurring disorders, systemic efforts continue to lag behind and to encounter numerous obstacles. These obstacles range from historical, political, ideological, professional, and fiscal/structural issues at one end of the spectrum (e.g., separate funding streams, independent state agencies) to practical and logistical issues at the other end. And unfortunately, Ridgley, Goldman, and Willenbring's[14] discussion of these obstacles more than 15 years ago remains as relevant today as when first published. Despite these long-standing and formidable barriers, there has been, and continues to be, a clear consensus in the field that integration is both sorely needed and long overdue.

This paper focuses on one dimension of this challenge from among those mentioned above: the conceptual dimension—and this for several reasons. First, previous efforts that have focused on the etiology or nature of mental illnesses and addictions, or on the types of treatments required by these conditions, have failed to establish a common ground adequate to provide a foundation for integration. Efforts aimed at resolving the political, fiscal, and structural issues that impede integration have had minimal impact thus far, perhaps in part due to their lack of a shared conceptual framework on the basis of which a persuasive argument for integration could be mounted. Second, and more importantly, the recent emergence of a "recovery movement" in both mental health and addiction offers a potential

new organizing principle for bringing these two worlds together. Persons recovering from these disorders may be offering a pathway to service integration that has thus far remained hidden to behavioral health care policy makers, planners, and managers. Integration has yet to be achieved through a focus on the nature of the disorders or the treatments required to address them; perhaps a focus on the processes of recovery, healing, and community inclusion will. As a core principle of the recovery movement suggests, identifying and building on strengths can often accomplish things that attending to deficits and dysfunction alone have not been able to do.

Prior to making the case for recovery as an organizing principle, this paper provides a brief review of those aspects of the history of mental health and addictions which are shared and also argues that there is an equally pressing need for transformation to recovery-oriented care in both systems. A brief conceptual introduction to the notion of recovery currently being developed and promoted by the recovery movement is then offered and followed by a description of some of the areas of overlap between recovery in serious mental illness and recovery in addiction. With this common ground established, the case is then made for a conceptual integration of mental health and addiction services. The discussion focuses on the essential principles and components of recovery-oriented systems of care—approaches that aim to promote the person's resilience and recovery, and foster community inclusion and support, regardless of the nature of the conditions involved.

The parallel histories of addiction and mental illness and shared need for transformation

The fields of mental health and addiction both have a dark past in which people experiencing mental illnesses and/or addictions endured institutions that offered no treatment, ineffective treatment, or well-intentioned treatment that did harm. Each disorder was considered to be intractable and stories of long-term 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 also have been distracted by debates about the causes and nature of the disorders, troubled by wide-spread prejudice and discrimination, and undermined by the criminalization of behaviors associated with these disorders.[19] Even today, addiction and mental illness occupy a common space of disgrace in society, and those suffering from these disorders are over-represented within the nation's prisons.[20-22]

At the present time, neither the mental health nor addiction treatment system is focused on supporting long-term recovery. Both systems have failed to acknowledge and overcome the limitations of their traditional institution-based and/or acute care models of treatment and rehabilitation in order to focus on the longitudinal and community-based processes of lasting recovery. Over the past 30 years of hospital closures and downsizing, the mental health system has shifted its focus to support services in the community, but in failing to acknowledge and facilitate the potential of long-term recovery, has transferred some of the iatrogenic insults of the state hospital (e.g., learned helplessness, hopelessness, and passivity) into community settings. The addiction system, on the other hand, proclaims that addiction is a chronic disorder and that recovery is an enduring process, but continues to deliver an ever-briefer model of acute care with little on-going monitoring, support, or re-intervention services, and with diminishing linkages to indigenous communities of recovery. Both systems share a focus on cyclical episodes of symptom manifestation, clinical stabilization, and (in many mental health programs) an almost exclusive focus on symptom management via medication adherence and cost containment (toward the goal of decreased hospitalizations). Little hope is offered to people when they enter these systems and few people work their way through the pre-determined steps required by the systems for their successful discharge. Many leave treatment prior to graduation or are administratively discharged, recycle through repeated acute care episodes, or, alternatively, establish a foundation for long-term recovery outside of the formal treatment system.[23]

These, and other, shortcomings have given rise over the last decade to increasing calls for substantive reforms of policy and practice—what is referred to as "transformation" by the federal government[24-25]—in both systems of care. This transformation is meant to re-orient the current systems from their focus on acute care, symptom reduction, and maintenance of enduring disability to a focus on promoting long-term recovery and full inclusion of people with mental illnesses and/or addictions in community life. Most readers familiar with the history of addiction treatment will, of course, insist that such a notion of recovery is not a new concept. Being "in recovery" and the vision of full and sustained recovery has long been the guiding vision and goal of peer-based mutual support groups within the addiction community (e.g., Alcoholics Anonymous and its many derivatives). However, this notion has not played as much of a role historically within the addiction service provider community, where concepts of primary treatment and relapse prevention have been more central. Within mental health, the notion of recovery has likewise been around at least since the community support movement of the 1970's, if not before.[26] Only recently with the 1999 *Report on Mental Health* of the U.S. Surgeon General[27] and the 2003 President's New Freedom Commission

Report on *Achieving the Promise: Transforming Mental Health Care in America*[24] has this notion moved from the periphery of the field to center stage. Included in the dialogue is an argument regarding the need to transform *all* mental health services in order to re-orient them to the goal of promoting and sustaining long-term recovery and community inclusion.

Leadership of the new recovery advocacy movement within addictions has come from people in recovery themselves, through their involvement with grassroots recovery advocacy organizations, seeking to remove barriers to recovery and to improve the quality of life for those with alcohol and other drug problems or those recovering from them. These advocates are calling for a reconnection between addiction treatment and the larger and more enduring processes of recovery and a reconnection between addiction treatment agencies and indigenous recovery support structures in local communities.[28] This grassroots movement parallels a similar evolution in mental health, in which people discharged from psychiatric institutions began to congregate in urban areas in the 1970's to advocate for changes in mental health policy and practice. Now having come of age, what has come to be called the Mental Health Consumer/Survivor Movement[29] has been instrumental in lobbying for major legislative advances (e.g., the Americans with Disabilities Act) and for envisioning the possibility of profound and far-reaching changes in the ways in which services are developed and delivered. Both movements have converged in articulating the need for the same paradigm shift. The shift involves moving beyond studying pathology and providing professionally-directed treatments to learning from the lived experiences of processes of recovery and offering people the opportunities and supports they need to be able to self-manage their conditions over time, while in the process of reclaiming and rebuilding their overall lives.

As a result of these efforts, both fields are being challenged to design and implement "recovery-oriented systems of care." Steps that are being taken toward such a vision are evident in the re-conceptualization of the relationship between treatment and recovery, the growing interest in models of peer-based recovery support services, and a re-emphasis on the importance of nesting and anchoring recovery within natural environments, as well as in calls for a national recovery-focused research agenda. In addition to the clear and unequivocal statements of the President's New Freedom Commission *Report*[24] and the resulting *Federal Action Agenda* for mental health,[25] calls for recovery-oriented transformation are attaining a similar level of visibility in the addictions field. This is evident in the growing body of literature on chronic disease and recovery management approaches,[23, 30-32] the Center for Substance Abuse Treatment's Recovery Community Support Program, the White House initiated Access to Recovery program, as well as state (e.g., Connecticut, Arizona) and local (e.g., Philadelphia) efforts at systemic

transformation and innovative pilot projects of private foundations (e.g., Robert Wood Johnson's Paths to Recovery Initiative). The rationale for such a shift is well-defined in a number of recent reports, including the Institute of Medicine's recently released, *Improving the Quality of Health Care for Mental Health and Substance-Use Conditions*.[33]

The integration of mental health and addiction services may be better achieved through the convergence of these two parallel recovery movements in relation to this need for recovery-oriented transformation than it has thus far through previous efforts focused on historical, structural, or disease-related factors. Guided by an alternative vision that focuses on strengths, resilience, and recovery, the mental health and addiction systems could re-organize their services to address the often long-term and complex needs of persons and families living with mental illness and/or addiction and its aftermaths, including people severely disabled by co-occurring disorders. In order to make the case for this approach to integration, a brief introduction to the concept of recovery and its common elements as they have emerged from these two movements follows. Such an introduction is needed because, despite the many reports and policy statements mentioned above, there continues to be considerable ambiguity and lack of clarity about what precisely is meant by recovery. While practitioners and clinical investigators may be assuming that recovery means abstinence, an absence of symptoms, or the amelioration of deficits, advocates and people in recovery themselves may be referring more to having a safe, dignified, and gratifying life in the presence of on-going disability.[34]

Much work thus remains to be done in both mental health and addictions in reconciling these differences and developing a coherent vision of recovery that can prove to be acceptable (as well as useful) to all involved parties. One attempt to achieve such a vision is offered below, albeit in brief. Readers who are interested in learning more about the various views of recovery in more detail are referred to previous publications on this topic.[23, 28, 35-49]

An introduction to recovery and its common elements in mental illness and addiction

Given its multiple and complicated parentage and the diverse constituencies involved, it is not surprising that it has been difficult thus far to reach consensus on any one definition, or on any one list of essential aspects, of the concept of recovery in mental illness or addiction. There appears, however, to be at least one major source of confusion surrounding use of the term *in both* mental health and addiction systems which lends itself to a realistic and ready-made solution. This confusion stems from a lack of clarity about the respective roles of mental health and/or addiction practitioners and those of people with mental illnesses and/or

addictions themselves. For the purposes of this discussion, the following two definitions are offered as having been helpful in distinguishing the process of recovery (in which the person him or herself is engaged) from the provision of recovery-oriented care (in which the practitioner is engaged) within the overall context of behavioral health (i.e., across the mental health/addiction divide).

- *Recovery refers to the ways in which persons with or impacted by a mental illness and/or addiction experience and actively manage the disorders and their residual effects in the process of reclaiming full, meaningful lives in the community.*
- *Recovery-oriented care is what psychiatric and addiction treatment and rehabilitation practitioners offer in support of the person's/family's own long-term recovery efforts.*

Rather than mutually exclusive, these two concepts are intended to be complementary, with the eventual goal of a unified vision that can be promoted equally by people in recovery, their loved ones, behavioral health care practitioners, and the community at large. What is most useful about this distinction is that it places the primary responsibility for recovery clearly with the persons affected most directly by the condition: the person/family themselves. As a direct consequence, the emphasis in transforming systems to become recovery-oriented shifts from what the system, its services, and its practitioners need to do to what people with mental illnesses and/or addictions need to do; with services, systems, and practitioners reworking what they provide to support their recipients of care in entering into and pursuing their own recovery journey. Acknowledging that there are many paths to recovery, and that each individual's journey will be unique, behavioral health providers come to view their primary role as enhancing people's access to a range of opportunities (e.g., to use treatment, gain skills, participate in meaningful activities, pursue their own goals) from which they may choose those most useful to them, and then offering the community-based supports that some people will need (e.g., supported housing, job coaching) in order to take advantage of those opportunities.

Given that this concept of recovery derives from peer support and advocacy communities in both addictions and mental health, it is not surprising that the first definition of recovery refers to what people who have these conditions do to manage their mental illness and/or addiction and their residual effects in order to claim or reclaim their lives in the community. Conventional clinical treatments are not excluded from this definition, but come to take their place alongside of the other non-clinical resources and supports that people need in order to recover, such as love, faith, housing, employment, friendship, and the support of the recovery and broader community. In addition to managing behavioral health conditions, this sense of recovery therefore 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 and unemployment, substandard housing or homelessness, social isolation, 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 discrimination 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(s) and its effects. Overcoming the scars of discrimination requires the development and use of new muscles, often leaving people feeling stronger than prior to the onset of their illnesses (what is discussed below as *transcendent recovery*).

It should be clear from this discussion that recovery involves much more than a removal of symptoms from an otherwise unchanged life. It also should be clear that recovery-oriented care—that is, care that is oriented to promoting and sustaining this sense of recovery—takes on a much broader scope, and involves a much broader repertoire of interventions and supports, than conventional disease-based models of acute treatment followed by so-called "aftercare." The majority of recovery processes, like the majority of the person's life, take place outside of acute care or other treatment settings in the community-based contexts in which people pursue their desires to live, love, learn, work, and play.[24] It is in these processes of recovery, and the ways behavioral health services and community supports are needed to support recovery processes that the basic commonalities between mental illness and addiction are to be found.

Recovery and recovery-oriented care as organizing principles for integration

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 as a transformational process (sudden, unplanned, permanent) and an incremental process (marked retrospectively by multiple stages of recovery), and recovery stories are often filled with elements of both styles of change. Importantly, it also is made clear within these stories that people in recovery are active agents of change in their lives and not passive recipients of care. The stories are filled with references to new perspectives and insights, important decisions, critical actions taken, and discovery of healing resources within and beyond the self. 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 recovery initiation and maintenance. Finally, people in recovery note the role of family and peer support in making a difference in their recovery.

Core aspects of recovery common across the behavioral health spectrum have been distilled from an extensive review of first-person accounts, a review of the existing literature on recovery, and several years of experience in working with recovery communities in both mental health and addiction..[50] These elements are described in Figure 1 below, which depicts dual recovery in a kind of "hopscotch" format, indicating that some aspects coincide or co-exist with other aspects, while some are more easily distinguished on their own. Despite the apparent linearity of this model, recovery itself is not a linear process, as people move freely between and amongst these different elements at different times. Some aspects, however, do appear to precede or be involved in other aspects, as hope seems to involve feeling cared for by others, while incorporating illness seems to require re-defining and accepting self, which appears to be interwoven with discovering or re-inhabiting valued social roles. Where the model in Figure 1 thus falls short of capturing the complex, non-linear, and dynamic interactions involved in processes of recovery, it hopefully makes up for it by offering a few steps forward toward increased clarity with respect to the common elements of these processes.

Insert Figure 1 about here

Examining these common aspects of recovery from addiction and mental illness, it is surprising that the two fields have yet to partner to organize services under a common vision. People living with mental illnesses and/or addictions want to have hope, eliminate or manage 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 the lives of their communities. With this shared foundation in place, differences that have existed historically between the recovery visions of the mental health and addictions systems could then provide opportunities for synergistic growth in both. 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 has, until very recently, lacked a viable concept of full recovery.[23] Both fields, on the other hand, 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.[41] Integrating, among other features, the concepts of full, partial, and transcendent recovery within the

emerging recovery visions of both systems holds promise for promoting a comprehensive, person-centered, approach to behavioral health.

From this common and comprehensive vision of recovery, the most important implications for developing recovery-oriented practices and integrated systems of care can be distilled. At the level of underlying values, recovery-oriented care is based on the recognition that each person must be either the agent of and/or the central participant within his or her own recovery journey, and that all services 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 overall life, including health and wellness, of a person with mental illness and/or addiction. These values can be operational in 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.), recognizing that there are many pathways to healing—both inside and outside of the behavioral health system—that people with mental illnesses and/or addictions can take in their recovery.

In addition to the recognition that there are many paths to recovery, there are several guiding principles in developing recovery-oriented practices and systems. The first of these is that both mental illnesses and addictions demonstrate a broad heterogeneity in both population and outcomes, with the result being that recovery looks different for different people. Second is the need to adopt a long-term, longitudinal perspective and to utilize a developmental framework for matching the person's point in the recovery process to appropriate interventions. Related to this principle is the need to take into account of the impact of the environment on course and outcome, and, as a result, to focus on person-environment fit and interactions. Third is the non-linear nature of recovery and the fact that it is a process and a continuum as opposed to an outcome, and finally are the important roles of family involvement, peer support, and spirituality as supportive of recovery. These values and principles are listed in Table 1 below, along with commonalities between mental health and addiction with respect to historical and societal attitudes, the goals of care, and the role of the person in recovery. Finally, Table 1 begins to describe some of the strategies that can be used to promote recovery and some of the essential ingredients that are to be found in recovery-oriented systems of care.

What becomes clear as one reads down the columns in this list is that when one begins with recovery and then moves into recovery-oriented practices, the areas of commonality far outweigh any salient differences between mental health and addiction. It is not until you reach the very bottom of the table, when the issue

of different treatments and clinical approaches for these conditions emerge, that the table needs to be split along the mental health/addiction boundary. The vast majority of these domains, strategies, and ingredients are common across this historical boundary, and provide ample conceptual common ground for the development of integrated systems of behavioral health care.

Insert Table 1 here

Implications for Behavioral Health Services

While everyone would conceivably gain from such integration, people who are living with co-occurring psychiatric and addiction disorders would be especially well-served in service systems united under this common vision of recovery. Much has been written about the failures of the mental health system and the addiction system to provide people with co-occurring disorders with the long-term services and supports often needed to promote recovery. A shared vision of recovery would compel both systems to provide outreach to engage people in a process of recovery, motivational interventions 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 enhancement supports would be located in communities, in specific environments of need, and be provided by professionals, family members, and people in recovery themselves. With the individual and family becoming the primary focus and locus of care, long-standing divisions between the two fields may be overcome, first conceptually and then, with adequate political will and resources, throughout the other dimensions (e.g., structural, professional) which currently keep them apart. Perhaps in this way the field will be able to take significant steps toward achieving the degree of integration which was first identified as lacking over 25 years ago, and which behavioral health clients so desperately continue to need and deserve.

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Figure 1. A "Hopscotch" Model of the Common Elements of Recovery across Mental Health and Addiction (Davidson, Andres-Hyman, Tondora, Bedregal, Fry & Kirk, 2006)

Figure 1

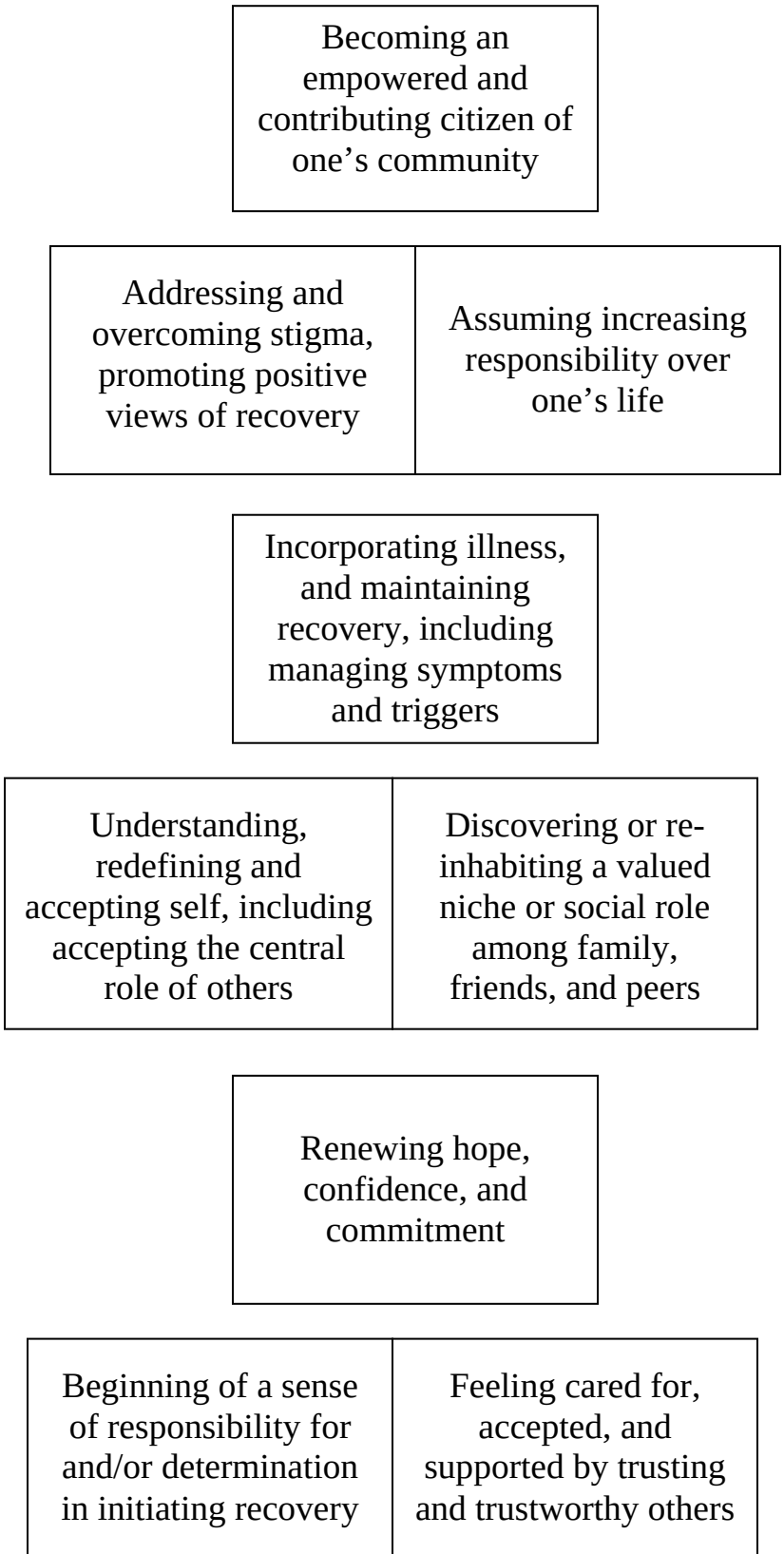

Table 1. Characteristics of Recovery-Oriented Care for Mental Illness and Addiction

Domain	Mental Illness	Addiction
Historical and Societal Attitudes	• Historically, prognosis was often considered hopeless • Debates about cause(s) and nature of illness • Causation theories contributed to harmful interventions, e.g., mandatory sterilization laws • Prejudice and discrimination • Criminalization of illness • Reform movements led by recovering people, families, and visionary professionals	
Goals of Care	• To assist people affected to reduce the interference, impairment, disability, and discrimination associated with the condition(s) and • To support the person's own efforts to manage his or her condition(s) while pursuing a dignified and gratifying life in the community	
Role of the Person with the Condition	• Person must take ownership of his or her own recovery process • Active involvement, including daily decision-making, is necessary for initiating and sustaining recovery • Individual/family involvement, from policy development through service delivery and evaluation	
Underlying Values	• Sustained health care partnership model (versus expert model) • Hope-based • Person- and family-centered • Culturally competent • Trauma informed • Choice philosophy • Promotes growth	

	• Builds on strengths and interests • Focuses on overall life, including wellness, health and spirituality • Recovery-focused outcome measures
Guiding Principles	• There are multiple pathways and styles of recovery • Recovery flourishes in supportive communities • Recovery is enhanced by person-environment fit • Recovery is voluntary • Recovery outcomes vary across heterogeneous population • Recovery is a longitudinal, developmental process and a continuum • Recovery is non-linear. • Family involvement in recovery is helpful • Peer support in recovery may be crucial • Spirituality may be a critical component of recovery
Strategies to Facilitate Recovery	• Identify and engage early • Carry and instill hope, offer role modeling • Increase motivation for change (recovery priming) • Offer information and education about the condition(s), recovery, available resources, and ways to self-manage the condition(s) • Provide treatments and other interventions that are effective in resolving crises, reducing or eliminating symptoms and/or impairments associated with the condition(s), and improving health • Provide opportunities, rehabilitation, and supports for person to gain needed skills for occupying valued roles (e.g., student, spouse) • Assertively connect person to other people in recovery, mutual support, recovery advocacy organizations, and indigenous recovery communities • Provide post-treatment monitoring (recovery checkups) and support, active recovery coaching (stage-appropriate recovery education and advice), and, when necessary, early re-intervention. • Offer community supports to enable person to lead a self-determined and meaningful life in the communities of his or her choice (e.g., supported housing, supported employment, supported education) • Legal advocacy to counter stigma and discrimination,

<table>
<tr><td></td><td colspan="2">ensure the person’s rights, and enable the person to regain the status of being a contributing member of society</td></tr>
<tr><td rowspan="5">Essential Ingredients of Recovery-Oriented Systems</td><td colspan="2">• Motivation-based outreach and engagement interventions
• Basic (material and instrumental) support
• Pre-treatment, in-treatment, and post-treatment recovery coaching/ mentoring
• Assessment processes that are global, continual, and strengths-based
• Respite for people in recovery and families
• Rehabilitation and on-going provision of community supports
• Peer support
• Family education and support
• Legal aid/advocacy
• Intensive clinical services, including crisis prevention and response, pharmacological and psychosocial treatments, and . . .</td></tr>
<tr><td>o Acute inpatient care</td><td>o Detox</td></tr>
<tr><td>o Illness management and recovery</td><td>o Contingency management</td></tr>
<tr><td>o Assertive community treatment</td><td>o Motivational interviewing</td></tr>
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