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Recovery:
A Common Vision for the Fields of Mental Health and Addictions.

ABSTRACT

The vision of recovery is reshaping the fields of mental health and addiction services. This paper reviews how this broad vision is shaping common goals, principles, values and strategies across the two fields. We further examine how a common vision of recovery can positively impact the treatment of co-occurring disorders and speculate on how this vision can bridge the seeming differences between these two fields and reshape a mutual understanding of the essentials of recovery from severe mental illness and addiction.

Concept of Recovery in Mental Health: Current Perspective

In the field of mental health the recovery vision was introduced and most often discussed in the writings of people with psychiatric disabilities (e.g., Anonymous, 1989; Deegan 1988; McDermott, 1990; Ralph, 2000, 2004; Unzicker, 1989). Empirical support for the promulgation of the recovery vision in mental health has been by means of the synthesis and dissemination of numerous long-term outcome studies (Harding & Zahniser, 1994; Harding, in press), which suggested that a significant percentage of people with severe mental illnesses were dramatically improving over time. Currently, there are 10 national and international longitudinal studies of 20 to 30 years demonstrating that recovery is possible for at least one-half of people with schizophrenia and other severe mental illnesses (Bleuler, 1972; Ciompi & Muller, 1976; Desisto, Harding et al., 1995 a and b; Harding, Brooks et al., 1987, a, b; Hinterhuber, 1973; Huber, Gross & Schuttler, 1979; Kreditor, 1977; Marinow, 1974; Ogawa et al., 1987; Tsuang, Woolson & Fleming, 1979). Furthermore, a review of systems-level literature and mental health policy statements suggests that even though heretofore there has been no explicit consensus about the meaning of the term recovery, the vision of recovery is now guiding policies and practice in many state mental

health systems (see for example, Onken, et al., 2002; Jacobson & Curtis, 2000; Legislative Summer Study Committee of the Vermont Division of Mental Health, 1996; State of Nebraska Recovery Work Team, 1997; State of Wisconsin Blue Ribbon Commission on Mental Health, 1997), as well as in entire countries like New Zealand (Lapsley et al., 2002) and the U.S. (Presidents' New Freedom Commission on Mental Health, 2003).

Concept of Recovery in Addictions: Current Perspective

In the addictions field, the use of the concept of recovery as an organizing construct for transformative change pre-dates the rise of formal addiction treatment (White, 1998). The field's conceptual center has subsequently evolved through a focus on pathology (the study of AOD problems as medical diseases) to treatment (medical, psychiatric, and psychological interventions into AOD problems) to a re-emerging focus on recovery (prospects and processes for long-term resolution of AOD problems) (White, 2004a; White, in press). There is growing interest in the multiple pathways and styles of long-term recovery and in the international diversification and growth of addiction recovery mutual aid societies (Humphreys, 2004; White, 2004b). A new addiction recovery advocacy movement (see www.facesandvoicesofrecovery.org) led by recovering people and their families is calling for a reconnection of addiction treatment to the larger and more enduring process of personal and family recovery (Elsie, 1999; White, 2000). Frontier issues within this re-emerging recovery focus include struggles to define recovery and its conceptual and linguistic boundaries (White 2002), efforts to measure the prevalence of addiction recovery in America (Road to Recovery, 1998), calls for a recovery research agenda (White, 2000), a shift from the current acute models of problem intervention to models of sustained recovery management (McLellan, et al, 2000; White, et al., 2003) and the growth in peer-based models of recovery support services (Jason, et al, 2001; White, 2004c). This renewed recovery focus is evident in the White House initiated Access to Recovery program, the Center for Substance Abuse Treatment's Recovery Community Support Program, and in state efforts to develop more recovery-oriented systems of care (see http://www.dmhas.state.ct.us/policies/policy83.htm).

Common Characteristics between the Two Fields

The fields of mental health and addiction share a dark past in which people experiencing the psychiatric and/or addiction disorders endured institutions that offered ineffective, if any, treatment. Each disorder was considered to be intractable and stories of recovery were rare. 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 the

disorders. Even today, addiction and mental illness occupy a common space of disgrace in society.

Examining the characteristics influencing recovery from addiction and recovery from mental illness, it is astonishing that the two fields have not collaborated to organize services under a common vision of recovery. (See Table A). People living with psychiatric and/or addiction disorders want to eliminate or manage their symptoms, increase their capacity to participate in valued roles, and embrace purpose and meaning in their lives, in other words, experience recovery. People in recovery from mental illness and/or addiction disorders are leading the call to change the current service systems of care to become recovery-oriented.

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 and that there are multiple pathways to recovery. First person accounts of people in recovery from addiction or mental illness have described recovery 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 reveal the individualized nature of recovery processes. Also made clear within these stories is that people in recovery are active agents of change in their lives and not passive recipients of services. People in recovery from mental illness and/or addition disorders also often note the role of family and peer support in making the difference in their recovery.

The values of recovery-oriented mental health and addiction systems are based on the recognition that each person is the agent of his/her own recovery and all services can be organized to support recovery. 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 have a place in a recovery-oriented system. These values can be operational 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 synergistic 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 has, until recently, lacked a viable concept of full recovery (Fisher & Ahern, 1999; White, Boyle & Loveland, 2004).

Integrating the concepts of full and partial recovery within the emerging recovery visions of both fields holds great promise.

Reshaping the Future of both fields under a Recovery Vision

Presently neither the mental health nor addiction treatment system is designed to assist people in their recovery from mental illness and/or addiction. Both fields have had to acknowledge the limitations of the institutionally based "acute model" of treatment to bring about lasting recovery. Over the past 30 years, mental health system has reorganized to offer support services in the community, while the addiction field continues to deliver primarily a model of acute care with little on-going community support. Guided by a vision of recovery, the mental health and addiction fields could organize their services to address the often long-term and complex needs of people living with mental illness and/or addiction, including people severely disabled by co-occurring disorders. People who are living with co-occurring psychiatric and addiction disorders could be well served in service systems united under a 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 (Drake et al., 2001, Minkoff, 1989, Mueser et al., 1998). The 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 treatment and/or rehabilitation, and provision of on-going recovery support services to assist people to reach their recovery goals. Recovery support services would be located in communities, in specific environments of need, and be provided by professionals, family members, and peers.

A unified recovery vision communicates realistic hope, emphasizes the role and responsibility of the person in recovery, and recognizes the many pathways to healing and wholeness that people with mental illness and/or addiction take in their recovery. The recovery vision might influence the research agenda to shifts its focus from acute pathology to the prevalence and processes (stages and styles) of long-term recovery from mental illness and addiction. The vision of recovery will require the mental health and addiction systems to work together with people in recovery as individuals and communities to develop effective services, strategies, and supports. Finally the recovery vision encourages the development of a culture of recovery and recovery communities to assist all people who are affected by mental illness and/or addiction, in other words, most of us.

Table A: 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 is agent of recovery. Active involvement 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 • Family involvement is helpful • Peer support is crucial • Spirituality may be critical component of recovery • Multiple pathways to 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
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	• Treatment i.e.: post-treatment monitoring, early re-intervention, medication, therapy • Community support

	• Skills for valued roles • On-going, flexible recovery-enhancing services • Advocacy	• 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

Anonymous. (1989). How I've managed chronic mental illness. *Schizophrenia Bulletin, 15*, 635-640.

Bleuler, M. (1972). Die schizophrenen Geistesstorungen im Lichte langjahriger Kranken und Familiengeschichten. In.Stuttgart: Georg Thieme. Translated by S.M. Clemens as The Schizophrenic Disorders: Long-term Patient and Family Studies New Haven, CT: Yale University Press, 1972.

Ciompi, L., & Muller, C. (1976). *Lebensweg und Alter der Schizophrenen: Eine katamnestische Longzeitstudie bis ins senium*.Berlin: Springer-Verlag.

Deegan, P. E. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal, 11*(4), 11-19.

DeSisto, M. J., Harding, C. M., Ashikaga, T., McCormick, R. V., & Brooks, G. W. (1995a). The Maine and Vermont three-decade studies of serious mental illness: Matched comparison of cross-sectional outcome. *British Journal of Psychiatry, 167*, 338-342.

DeSisto, M. J., Harding, C. M., Ashikaga, T., McCormick, R. V., & Brooks, G. W. (1995b). The Maine and Vermont three-decade studies of serious mental illness II. Longitudinal course comparisons. *British Journal of Psychiatry, 167*, 338-342.

Drake, R.E., Essock, S.M., Shaner, A., Carey, K., Minkoff, K., Kola, L., Lynde, D., Osher, F.E., Clark, R., & Richards, L., (2001). Implementing dual diagnosis services for clients with severe mental illness. *Psychiatric Services*, *52*(4), 469-476.

Else, D. (1999). Recovery recovery. *Journal of Ministry in Addiction and Recovery, 6*(2), 11-23.

Fisher, D., & Ahern, L. (1999). People can recover from mental illness. *National Empowerment Center Newsletter*, 8-9.

Harding, C. M. (In press). Overcoming the persistent resistance of professionals within the helping professions ideas of recovery in serious mental illness. In P. Ridgeway & P. E. Deegan (Eds.), *Deepening the mental health recovery paradigm: Defining implications for practice*.

Harding, C. M., Brooks, G. W., Ashikaga, T., Strauss, J. S., & Breier, A. (1987a). The Vermont longitudinal study of persons with severe mental illness: I. Methodology, study, sample, and overall status 32 years later. *American Journal of Psychiatry, 144*(6), 718-726.

Harding, C. M., Brooks, G. W., Ashikaga, T., Strauss, J. S., & Breier, A. (1987b). The Vermont longitudinal study: II. Long-term outcome of subjects who retrospectively met the criteria for DSM-III schizophrenia. *American Journal of Psychiatry, 144*(6), 727-735.

Harding, C. M., & Zahniser, J. H. (1994). Empirical correction of seven myths about schizophrenia with implications for treatment. *Acta Psychiatrica Scandinavica Supplementum, 90*(384, Suppl), 140-146.

Hart, P. D. (1998). *The road to recovery: A landmark national study on the public perceptions of alcoholism and barriers to treatment*. San Francisco, CA: The Recovery Institute.

Hinterhuber, H. (1973). Zur Katamnese der Schizophrenien. *Fortschritte der Neurologie Psychiatrie, 41*, 527-588.

Huber, G., Gross, G., & Schuttler, R. (1979). *Schizophrenie: Verlaufs und sozialpsychiatrische Langzeit unter suchugen an den 1945 bis 1959 in Bonn hospitalisierten schizophrenen Kranken*.Monographien aus dem Gesamtgebiete der Psychiatrie Bd. 21 Berlin: Springer-Verlag.

Humphreys, K. (2004). *Circles of recovery: Self-help organizations for addictions*. Cambridge, UK: Cambridge University Press.

Jacobson, N., & Curtis, L. (2000). Recovery as policy in mental health services: Strategies emerging from the states. *Psychiatric Rehabilitation Journal, 23*(4), 333-341.

Jason, L. A., Davis, M. I., Ferrari, J. R., & Bishop, P. D. (2001). Oxford House: A review of research and implications for substance abuse recovery and community research. *Journal of Drug Education, 31*(1), 1-27.

Kreditor, D. K. (1977). Late catamnesis of recurrent schizophrenia with prolonged remissions (according to an unselected study). *Zh Nevropatol Psikiatr Im S.S. Korsakova, 77*(1), 110-113.

Lapsley, H., Nikora, L. W., & Black, R. (2002). *"Kia Mauri Tau!" Narratives of recovery from disabling mental health problems*: Wellington: Mental Health Commission.

Legislative Summer Study Committee of the State of Vermont Division of Mental Health. (1996). *A position paper on recovery and psychiatric disability*. Waterbury, VT: Vermont Development Disability & Mental Health Services.

Marinow, A. (1974). Klinisch-statische und katamnestische Untersuchungen und chronisch Schizophrenen 1951-1960 und 1961-1970. *Archiv fur Psychiatrie und Nervenkrankheiten, 218*, 115-124.

McDermott, B. (1990). Transforming depression. *The Journal, 1*(4), 13-14.

McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association, 284*(13), 1689-1695.

Minkoff, K., (1989). An integrated treatment model for dual diagnosis of psychosis and addiction. *Hospital and Community Psychiatry*, *40*, 1031-1036.

Mueser, K.T., Drake, R.E., & Noordsy, D.L., (1998). Integrated mental health and substance abuse treatment for severe psychiatric disorders. *Journal of Practical Psychiatry and Behavioral Health, 4*, 129-139.

New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America. Final report.* DHHS Pub. No. SMA-03-3832 Rockville, MD.

Ogawa, K., Miya, M., Watarai, A., Nakazawa, M., Yuasa, S., & Utena, H. (1987). A long-term follow-up study of schizophrenia in Japan - with special reference to the course of social adjustment. *British Journal of Psychiatry, 151*, 758-765.

Onken, S. J., Dumont, J., Ridgway, P., Dornan, D., & Ralph, R. (2002). *Mental health recovery: What helps and what hinders? A National Research Project For The Development Of Recovery Facilitating System Performance Indicators. Draft briefing paper*, from http://www/nasmphd.org/ntac/reports/index.html

Ralph, R. (2000). Recovery. *Psychiatric Rehabilitation Skills, 4*, 480-517.

State of Nebraska. (1997). *Recovery: A guiding vision for consumers and providers of mental health services in Nebraska*. Omaha, NE: Recovery Work Team.

State of Wisconsin. (1997). *Final report*. Madison, WI: Department of Health and family Services, Blue Ribbon Commission on Mental Health.

Tsuang, M. T., Woolson, R. F., & Fleming, J. A. (1979). Long-term outcome of major psychoses. 1. Schizophrenia and affective disorders compared with psychiatrically symptom free surgical conditions. *Arch. Gen. Psychiatry, 36*, 1295-1131.

Unzicker, R. (1989). On my own: A personal journey through madness & re-emergence. *Psychosocial Rehabilitation Journal, 13*(1), 71-77.

White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.

White, W. (2000, April 3-5.). *Toward a new recovery movement: Historical reflections on recovery, treatment and advocacy.* Paper presented at the Recovery Community Support Program (RCSP) Conference, Arlington, VA. Posted at www.bhrm.org and www.facesandvoicesofrecovery.org.

White, W. (2002). *An addiction recovery glossary: The languages of American communities of recovery*, from www.facesandvoicesofrecovery.org

White, W. (2004a). Recovery: The next frontier. *Counselor, 5*(1), 18-21.

White, W. (2004b). Recovery mutual aid: An enduring international phenomenon. *Addiction, 99*, 532-538.

White, W. (2004c, March 22-23). *The history and future of peer-based addiction recovery support services.* Paper presented at the SAMHSA Consumer and Family Direction Initiative 2004 Summit, Washington, DC. Posted at www.bhrm.org and www.facesandvoicesofrecovery.org.

White, W. (in press). Recovery: Its history and renaissance as an organizing construct. *Alcoholism Treatment Quarterly*.

White, W., Boyle, M., & Loveland, D. (2002). Addiction as chronic disease: From rhetoric to clinical application. *Alcoholism Treatment Quarterly, 3/4*, 107-130.

White, W., Boyle, M., & Loveland, D. (2004). Recovery from addiction and recovery from mental illness: Shared and contrasting lessons. In R. Ralph & P. Corrigan (Eds.), *Recovery and mental illness: Consumer visions and research paradigms* (pp. 233-258). Washington, DC: American Psychological Association.