

Behavioral Health Recovery Management

[Home](#) [Updates](#) [Project Summary](#) [Staff](#) [Papers & Publications](#) [Clinical Guidelines](#) [Recovery Support](#)

Behavioral Health Recovery Management: A Statement of Principles

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Behavioral Health Recovery Management is a model of intervention for severe mental illness and severe substance use disorders that shifts the focus of care from professional-centered episodes of acute symptom stabilization toward client-directed management of long-term recovery. The following 11 principles distinguish the Behavioral Health Recovery Management (BHRM) model.

1. Recovery Focus: Full and partial recoveries from severe behavioral health disorders are living realities evidenced in the lives of hundreds of thousands of individuals in communities throughout the world. Where complete and sustained remission is not attainable, individuals can actively manage these conditions in ways that transcend the limitations of these disorders and allow a fulfilled and contributing life. The BHRM model emphasizes recovery processes over disease processes by affirming the hope of such full and partial recoveries and by emphasizing client strengths and resiliencies rather than client deficits. Recovery re-introduces the notion that any and all life goals are possible for people with severe behavioral health disorders.

2. Client empowerment: The client, rather than the professional, is at the center of the BHRM model. The goal is the assumption of responsibility by each client for the management of his or her long-term recovery process and the achievement of a self-determined and self-fulfilling life. Client empowerment involves not just self-direction of one's own recovery, but opportunities for involvement in the design, delivery and evaluation of services provided by behavioral health organizations and involvement in shaping public attitudes and public policies regarding behavioral health disorders.

[Back to top](#)

3. The Destigmatization of Experience: The BHRM model seeks to "normalize" or otherwise respect a person's experiences with behavioral health disorders and subsequent services. In this way, the person escapes attacks on self-esteem and self-efficacy that often accompany the stigma of mental illness. Moreover, the public begins to endorse positive images of behavioral health that undermine the prejudice and discrimination that frequently accompanies services.

4. Evidence-based Interventions: The BHRM model emphasizes the application of "evidence-based" interventions at all stages of the disease stabilization and recovery process. The "evidence" undergirding such interventions includes scientific studies (randomized clinical trials, clinical field experiments) and inter-disciplinary professional consensus regarding promising approaches, but the ultimate evidence is the fit between the intervention and the client at a particular point in time as judged by the experience and response of the client.

5. Development of Clinical Algorithms: As knowledge and application of evidence based

practices advance, the challenge becomes knowing what treatment approaches to use with specific individuals as they progress through the stages of change and stages of treatment. Medication algorithms have been developed that specify preferred first line prescriptions for specific diagnoses, dosing and time frames for evaluating the effects. Similar practice support algorithms are needed for clinicians utilizing psychosocial treatments.

[Back to top](#)

6. Application of Technology: The rapid advances in technology must be applied to recovery from serious mental illness and addictions. Technology being utilized in other fields may be adopted or adapted to addressing behavioral health issues. While web based services and supports are currently being explored, what other technologies could be made available for treatment and recovery support? Is there an application for GPS, nanotechnology or other developing scientific advances? Many technologies could be applied today while we await the miracles that will arise from the human genome project through fields such as genetic engineering and bioinformatics.

7. Service Integration: Based on the recognition that severe disorders heighten vulnerability for other disorders and problems, the BHRM model seeks to coordinate categorically segregated services into an integrated response focused on the person rather than territorial ownership of the person's problems. The goal is to mesh these historically isolated services into an integrated, recovery-oriented system of care. The BHRM model advocates multi-agency, multidisciplinary service models that can provide less fragmented and more holistic care.

8. Recovery Partnership: In the BHRM model, the traditional professional role of "expert" and "treater" progressively shifts to a recovery management partnership with the client. Within this partnership, the professional serves primarily as a "recovery consultant." The service relationship within the BHRM model is marked by continuity of contact in a primary service relationship (with a recovery consultant) over time--a relationship analogous to that between a physician and patient managing any health care problem characterized by chronicity and episodic acuity.

[Back to top](#)

9. The Ecology of Recovery: The family (as defined by the client) and community constitute a reservoir of support for long-term recovery from behavioral health disorders. The BHRM model seeks to enhance the availability and the support capacities of family, intimate social networks and indigenous institutions (e.g., mutual aid groups, churches) to persons recovering from behavioral health disorders. The BHRM model also extends the locus of service delivery from the professional environment to the natural environment of the client. One of the major goals of the BHRM model is to create the physical, psychological and social space within which recoveries can flourish in local communities.

10. Monitoring and Support Emphasis: The BHRM model emphasizes the need for on-going monitoring, feedback and encouragement, linkage to indigenous supports and, when necessary re-engagement and early re-intervention. This model of sustained monitoring and recovery support services contrasts with models that provide repeated episodes characterized by "assess, admit, treat, and discharge," as is traditional in the treatment of substance use disorders. It also contrasts with mental health programs that focus on stabilization and maintenance of symptom suppression rather than on recovery and personal growth.

11. Continual Evaluation: Service and support interventions must be matched not only to the

unique needs of each client but to the stage-specific needs of each client as these needs evolve through the stages of recovery. In the BHRM model, both assessment and evaluation become continual activities rather than activities that mark the beginning and conclusion of a service episode. There is also a shift from evaluating single episodes of care to evaluating the effect of particular combinations and sequences of interventions on the course of behavioral health disorders and on recovery careers.

[Back to top](#)



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