Recovery and Person-Centered Care: Empowerment, Collaboration, and Integration

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Introduction

The concept of recovery is not a new one in behavioral health, but it has experienced resurgence since the release of the President's New Freedom Commission report in 2003 (Hogan 2003). The belief that persons with mental illness or substance use disorders can lead productive and satisfying lives has been part of the philosophic core of community psychiatry for many years and was practiced most notably in psychiatric rehabilitation paradigms through the latter part of the twentieth century. While variations on the theme of recovery have been noted since the nineteenth century and perhaps even earlier, they were established more formally in the 1930s with the establishment of the Alcoholics Anonymous and Recovery, Inc. (Sowers 2003).

Brief Historical Perspective

The idea of recovery has been a mainstay of the addiction community for many years. It has its roots in the 12-step movement that began in the 1930s (White 1998). It became clear to the founders of Alcoholics Anonymous that overcoming the disease of addiction was much more than establishing abstinence. They recognized that addictive disorders create thought processes and conditioned responses that are far more powerful than the physiological manifestations of dependence. They offered an alternative to professional offerings that appeared to be more effective (Laudet et al. 2000). The 12 steps and the various slogans related to thought processes common in persons with addictions are all related to current concepts about recovery.

Although recovery has had a less prominent role in the mental health community in the past, it has been part of the scene for nearly as long as it has been part of the addiction field. Abraham Low, MD, a psychiatrist, began developing recovery-enhancing techniques in 1937, and by 1952, Recovery, Inc was established (Lowe 1950; Sachs 1997). Recovery, Inc. is an organization run by Mental Health consumers that employs many of the ideas developed by Dr. Low. It offers a peer-assisted healing program that focuses on changing thought processes, developing autonomy, and regaining productive and satisfying lives. Like the 12-step approach, it attempts to empower people to take responsibility for managing their illness or disability. In contrast to 12-step programs, Recovery, Inc. has incorporated the value of developing a partnership with helping professionals and has attempted to support this relationship (Sowers 2003).

An anti-psychiatry movement, originated within the profession in the later part of the twentieth century, questioning the controlling and judgmental nature of common practices. The legitimacy of

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diagnosis was also questioned, in light of the lack of biologic or etiologic explanation for them as in other branches of medicine. Who should define "normal" experience? These threads were expanded by "survivors" of treatment who also saw psychiatry as being controlling and oppressive, and psychiatrists were generally vilified in some circles such as Scientology. RD Laing and Thomas Szasz were psychiatrists who were among the original critics of the profession and social constructs of mental illness, but they were not critical of treatment per se, so long as people were interested in receiving it. However, as the movement evolved, it began to ostracize those who sought and participated in treatment, depicting them as brainwashed. These controversies continue today as diagnostic systems evolve (Rissmiller and Rissmiller 2006).

There are many people with mental illness or substance use disorders who have felt that they have been mistreated by the system and they have become more organized and more vocal in recent years regarding their rights as individuals, their conviction that they must control their own destiny, and that they should not be oppressed by authorities whose primary interests are control and public safety. The "Recovery Movement" has emerged from these convictions, and while it is not necessarily a unified movement, it has become a significant political force impacting policy and practice in the administration of behavioral health services. Persons in "recovery" have asserted that systems of care and professional attitudes must change if they are hoping to engage with them. Only then will they find meaningful assistance in their struggle to attain autonomy and meaning in their lives (Borkin 2000).

System transformation has emerged as a major priority in federal and state behavioral health services administrations since the issue of the President's New Freedom Commission Report and the Surgeon General's report on mental health issues (SAMHSA 2003; U.S. Department of Health and Human Services 1999). Penetration to policy makers and administrators has been fairly broad, but much work remains to be done with regard to training and actual practice (Jacobson and Curtis 2000). The movements mentioned above have been progenitors of the current emphasis on "social inclusion" and securing the civil rights of persons with behavioral health disorders and have significant impact on the evolution of services today. This "transformation" aims to replace a system that has been described as prescriptive and paternalistic with one that is collaborative, empowering, and recognizes the potential for growth and change in the individuals that it serves. While there are few that oppose this transformation in principle, there are many who feel the obstacles to achieving the ideal are too formidable to overcome and that is not applicable to everyone who suffers these maladies.

This chapter will consider the nature of recovery and resiliency and their usefulness as organizing concepts in the evolution of our systems of care. It will examine the principles and practices which may be most helpful in moving people toward recovery and the value of incorporating them into the way that services are delivered.

The Elements of Recovery

The concept of recovery has a long history as noted earlier, but it is not a monolithic one, and there have been many variations in how persons or groups have defined it. If recovery is an individual experience as most contend, then each person who has experienced it may define it somewhat differently. Even though recovery has individual meanings and is a dynamic concept, there are certain elements that can be identified that are commonly included in the definitions and that remain fairly stable through changing circumstances (Whitley and Drake 2010). This section will attempt to identify some of those common elements and consider their significance (SAMHSA 2005).

The term "recovery" implies that a person, who has been disabled for some period of time, returns to their previous level of function, but it has come to take on a much broader significance with regard to persons with behavioral health disorders. There are many who feel that the term is inadequate because in many cases people have not ever developed good capability and are working toward establishing it for the first time. This is especially true for children with emotional disturbances. Another objection is the implication that there is an end point, or cure. This point

remains controversial, and there are many who claim that recovery, even from severe mental illness, may be complete, while others contend that it is an ongoing process, which, for most people, is lifelong.

Whichever position is adopted, being "in" recovery, as opposed to being "recovered" describes a process. As various aspects of this process are considered, it may be of interest to consider how they mirror other theories of development, mature coping strategies, and self-actualization. Even though the idea of recovery has been applied most commonly to situations in which a person is struggling to overcome an identifiable (or diagnosable) condition, in its most basic sense, recovery is about a growth and maturation process, not distinct from what all people must negotiate at some time in their lives (Erikson 1950; Vogel-Scibilia et al. 2009). As such, it can be considered a developmental process leading to a "mature" state of being (Mead and Copeland 2000).

By contrast, people who do not engage in a recovery process often appear to be "stuck" in a cycle of making the same decisions over and over, despite the fact that they are not happy with the results. Most of us experience this state at some time in our lives or in some aspect of our living and find that we are afraid of uncertainty and the possibility that we could be even unhappier if we choose to do something unfamiliar. This state will be referred to as "Stagnation" for the purposes of our discussion.

The Aims of a Recovery Process

Change

A person enters a recovery process as an attempt to break patterns of behavior that have been detrimental to their well-being. There are almost always choices that can be made about how to think and act regardless of what type of limitations or disabilities with which one is confronted. Change must often be radical in order to escape the rigidity of past patterns of behavior, and "reinventing oneself" is a challenging and daunting prospect.

Growth

Change leads to growth, to an expanding sense of self and of the world. A growth or maturation process begins when one is able to embrace change and continues in an incremental fashion as new experiences and behaviors are added to an individual's palette. A state of stagnation implies a closed world of repetition circumscribed around sets of stereotyped behaviors. Recovery, in contrast, implies expanding world, new possibilities, and customized responses to the significant challenges presented by a changing environment (Deegan 1988).

Autonomy and Resilience

Growth and the development of a broader array of behaviors allow people to adapt to a wide variety of circumstances. Adaptability and the capacity to influence the environment lead to a greater sense of personal effectiveness. The way that one understands their reality changes from one in which they believe that they have no control over or responsibility for what happens to them, to one in which they believe that the choices that they make and things they do are the most important determinants of their experience and circumstance. As the process of recovery progresses, there is a growing capacity to act independently and to make responsible decisions (Mead et al. 2001).

Purpose and Meaning

Ultimately, satisfaction in life must be derived from the ideas and activities that give it meaning. We derive meaning from a number of sources: spiritual connections, work, relationships, social structures, education, recreation, and artistic endeavors (King 2004; Green et al. 1997). As growth progresses and we see ourselves as the agents that shape our world, we begin to create a set of beliefs to replace a nihilistic void that characterizes a stagnant life.

Development of Enabling Qualities

In order to initiate and sustain a recovery process, a person must develop several qualities to enable it. These may be described in various ways, but however they are conceived; there is an evolution in the thinking process as people progress toward the changes they wish to make. Many of these qualities are included in various formulations of stages of change. The most common of these elements will be presented here as a progression, but in reality, they do not always appear in a linear or predictable chronologic order.

Acceptance and Responsibility

Before a desire to change can take hold, a person must recognize their limitations and/or disabilities. While there is often tremendous tenacity in resistance to admitting vulnerability, and to giving up the belief that factors outside one's self are responsible for one's trouble, once it is surmounted, there is a possibility for change. With acceptance comes responsibility, the recognition that we must depend on ourselves to do what is required to make changes.

Desire and Determination

In order for change to occur, people must move beyond ambivalence and even willingness, and develop a genuine desire to live differently and a determination to do whatever is needed to do so.

Hope and Faith

When people are stuck and stagnant, they are often unable to see that things can be any different and feel helpless to change their circumstances. When a person decides to enter a recovery process they are embracing the possibility of change and they must develop the belief that they are capable of it.

Courage, Diligence, and Tolerance

Change requires intense and consistent effort and causes a great deal of discomfort and pain. A person must find the courage to face/experience this challenge and the tenacity to persevere under physical and emotional stress.

Integrity, Honesty, and Trust

A person engaging in a recovery process is most successful when able to consistently pursue and represent the truth and judicious values and avoid misrepresentation and deception. Achieving this, it is possible to gain respect and trust in oneself and from others. These qualities make it possible to join a community and find meaning beyond immediate self-interests.

Tolerance, Humility, and Forgiveness

To be human is to make mistakes; sometimes they may be egregious mistakes that cause a great deal of suffering. In order to progress in a recovery process, a person must develop some capacity to accept the weaknesses of others and to recognize their own. Freedom and equanimity come with the capacity to forgive both oneself and others.

Characteristics of a Mature Recovery

The development of the foregoing virtues is obviously an extended process which is likely to proceed in fits and starts and it may take many years to achieve great consistency. For most people, it is a lifelong struggle to stay on track. This process, when successfully negotiated, leads ultimately to a certain balance and satisfaction in life in which a person is also a reliable and trusted member of a community. As these qualities become more and more consistent, confidence grows, as does the ability to adapt to

and make changes. People find new ways to manage their lives and relationships, drawing on growing resources and a willingness to accept some of the risk that comes with self-disclosure and emotional investment. Openness to new ideas, self-observation and assessment, a capacity for kindness and empathy, thoughtfulness, and flexibility, and the realization that one need not denigrate others to value one's self would all be aspects of maturity in recovery, whether in mental health or with substance use disorders.

Resiliency and Recovery

As someone progresses with recovery, they become more resilient, or better able to cope with adversity (Unger 2011). These two concepts share many common elements, and they both imply an ability to thrive. They are generally used in different contexts. "Resiliency" is most often used by clinicians and other stakeholders when referring to the characteristics of children and adolescents. The negative implications of recovery, described earlier, are more significant for this age group. "Recovery," on the other hand, is more often used when referring to adult development but it is not easily separated from the resiliency concept. Many have commented on the inadequacy of the terminology, but it has not been easy to find broadly acceptable alternatives. While the two terms are similar, there are some qualities that distinguish them:

- Resiliency describes a *characteristic* or *state* that allows positive adaptation within the context of significant adversity. Each person has his or her own unique level of resilience.
- Recovery describes a *process* that allows restoration or renewal following personal setbacks related to disabling circumstances. Individuals may or may not engage in a recovery process.
- Resiliency is partly determined by one's genetic makeup, and partly developed through experience and environmental influences (i.e., nurturing vs. neglectful).
- Recovery is independent of biological determinants and is largely characterized by attitudes and values rather than abilities.
- Developing resiliency is an essential aspect of a successful recovery process.
- Resiliency may occur in the absence of a recovery process.

Universal Aspects of Recovery

Over the years, the definitions of recovery and what it represents have been variable, and different groups may conceive of it in different ways. This raises the question of whether recovery is the same for everyone, regardless of their affliction, or is it distinct for people recovering from a particular type of disability? Recovery may be defined narrowly or broadly. For example, recovery from an addiction might be conceived of as attaining abstinence or it may be defined more broadly as life satisfaction and growth. Likewise in mental health, recovery may be seen as the absence of symptoms and a reduction in the use of services, or alternatively as the ability to live autonomously and make healthy choices.

While there has been some controversy around who "owns" recovery and how it should be formulated, there is a growing consensus on the main elements that constitute a recovery process. This is fortunate, because it makes obvious sense to have a unified understanding of recovery, especially as we struggle to better integrate services for persons with behavioral health issues.

These elements of recovery provide a blueprint for change, regardless of individual circumstances. Whether someone has a mental illness, a substance use disorder, a physical disability, had a traumatic experience, or is simply struggling against patterns of behavior that make managing their daily lives difficult, the recipe for change is more or less the same. Although the degree of disability and the difficulty of engaging in a recovery process may vary considerably, recognizing that everyone must follow a common pathway to accomplish change has significant implications for clinical processes, service delivery, and social stigma.

The Value of the Recovery Paradigm

Recovery creates a framework for change that can be applied in a variety of circumstances and settings, so it provides a common language which all clinicians and service users can understand and use to promote health and wellness. As such, it can be the basis for integration of an often diverse array of providers that may be involved in a person's care (Mueser et al. 2002). In clinical settings, it can be the foundation for empathy and collaboration through its formulation of shared human emotions, experience, and ambition. In the broader community, its universal aspects form a strong weapon to wield against stigma. As the community comes to recognize the common experiences of all its constituents, it becomes the basis for acceptance and inclusion and the protection of every individual's human rights. Many observers have noted that the recovery movement is ultimately a civil rights struggle.

Developing Person-Centered, Recovery-Oriented Services

Having considered what constitutes a recovery process, we can now turn our attention to how psychiatrists and other clinicians can promote and facilitate recovery and how we can create services that support it. The development of Recovery-Oriented Services (ROS) begins with the recognition that services must be constructed to meet the needs of individuals and that individuals should not be expected to benefit from programs or treatments designed for stereotypic patients with preconceived needs (Anthony 2000). Person-Centered Care is sometimes used interchangeably with Recovery-Oriented Services, but may also be seen as an aspect of these services that particularly emphasize the key concept described above. The following principles provide further description of ROS:

- *Hopeful-optimistic*: The clinician's role is to inspire hope and create an atmosphere that assertively recognizes the possibility for change in every individual (Borkin 2000).
- *Respectful-strength based*: The attitude of service providers must be respectful and focused on the positive attributes that define an individual. They must be sensitive to and avoid the subtle condescension that has generally characterized paternalistic approaches of the past (Kaufmann et al. 1989).
- *Empowering*: ROS encourage service users to take control of their lives, accept responsibility for change, and use shared information to make informed choices (Fisher 1994).
- *Collaborative*: Treatment is conceived of as a partnership between the person seeking assistance and those offering care. Discarding the traditional roles of a controlling provider and a passive consumer, in this paradigm the two work as a team to accomplish the consumer's goals (Noordsy et al. 2000).
- *Supportive-nurturing*: Disabilities are destructive to self-esteem and confidence. Recovery is a progressive process and requires gradual fortification of these qualities through support, encouragement, recognition of achievements, and trust (Mead et al. 2001).
- *Capacitating*: Growth implies an expanding ability to live, learn, work, create, and interact. ROS should help every individual to define and reach their potential with regard to these activities (Carlson et al. 2001).
- *Inclusive*: ROS should offer and encourage inclusion of disabled individuals in all administrative processes that govern the operation of services. They will also encourage involvement in the larger community (Townsend et al. 2000).
- *Comprehensive*: People should have access to a complete array of clinical and supportive services to meet their basic needs as well as their emotional and spiritual needs. In the planning process, these services should be tailored to fit individual issues.
- *Outcome informed*: To make informed health choices, people must have access to information related to the likely results associated with available treatments. There should be opportunities for them to learn about outcomes and evidence, and how to evaluate them (Roberts 2002).
- *Culturally sensitive*: Individuals may have multiple cultural influences in their lives, including

spiritual concerns (Huguelet et al. 2011). ROS should celebrate diversity, explore cultural experience, and value the unique contributions that it makes to how one operates in the world and how people understand and experience a disability.

- *Integrated*: It may require several different providers to meet the needs of a particular person. ROS recognize the need to coordinate and, if possible, consolidate the services provided into a coherent and interactive plan with the consumer at its center.
- *Voluntary*: The use of seclusion, restraint, and coercion are not consistent with ROS and are only used if there are clearly no other alternatives. ROS recognize that individuals may have periods of incapacity and encourage the formulation of appropriate plans for these circumstances (Davis 2002).

A significant aspect of Person-Centered Care is its focus on *information sharing* and offering choices that are informed by that knowledge. It encourages individuals to formulate a personal vision for their lives and to create plans that will give them an opportunity to fulfill those ideals. The central role of the relationship in healing processes is also a critical aspect of Person-Centered Care and ROS. The *relationship-building* process is ultimately the source of trust that is essential for a clinical partnership. This partnership is what allows engagement in a collaborative planning process, which is the best guarantor of investment in the product of that process (Manfred-Gilham et al. 2002).

A focus on *health and wellness* as opposed to illness and disability is another hallmark of ROS. The prevention or the mitigation of relapse to active illness is accomplished by developing skills that facilitate making healthy choices and exercising effective health management. In this regard, it mirrors the *chronic care and disease management models* promulgated in physical health care. Recognition of the interaction of mental and physical processes as an important determinant of overall well-being leads to an *integrated or holistic approach to service delivery* which fits with recent concepts of medical/mental health homes, or centralized, coordinated care models (Beardslee et al. 2011). The great disparity in health status and life expectancy, between those with behavioral health issues and the general population, makes this aspect of recovery-oriented care ever more critical. Health cannot be subdivided into its components, as all aspects are interdependent. ROS recognize that people can be healthy, even with an active illness, just as they maybe unhealthy without identifiable disease.

Concerns are often raised about the applicability of ROS to persons with very severe mental illnesses who have periods of cognitive deficits rendering them unable to make prudent choices. They may consistently make choices that place them at risk of harm (Davidson et al. 2006). It is important to recall in these instances that recovery is a *developmental process*, and it is not always a linear one. We might think of "stages" of recovery as analogous to the stages of change often referred to in the addiction literature. Just as we would not offer a young child complete freedom to do as they please, we would not offer this to someone who has uncontrolled and severe symptoms of mental illness. The operating principle in cases where a person has diminished capacity is to gradually extend their capacity to make wise and responsible choices. Gradually increasing degrees of freedom and choice are required to accomplish this. In the most severe cases of mental illness and intellectual disability this may be a very slow process. The intention of ROS is to consistently attempt to extend an individual's capacity for self-management and self-agency. When this is not possible, the use of *advanced directives* can be a very valuable tool to allow individuals to exercise some control even when they are most debilitated (Srebnik et al. 2005; Henderson et al. 2008).

Finally, ROS must find ways to challenge individuals to recognize their own possibilities and to pursue their vision without creating overwhelming stress. Much of this work will be accomplished through motivational techniques, allowing individuals to gradually define their own needs, desires, and solutions. Rather than striving for compliance or adherence, ROS hope to create *investment* in a shared plan for change. Change is disruptive and frightening, calling many beliefs and practices into question. ROS

must be comfortable in helping people to confront and find answers to spiritual/existential questions; and it must help them to find ways to become part of a community and develop satisfying relationships with others.

Implementation and System Transformation

The characteristics described above provide a basic idea of the nature of services provided by organizations that wish to promote recovery. The American Association of Community Psychiatrists developed the *Guidelines for Recovery Oriented Services*. This document provides further elaborated description of ROS by delineating 17 separate characteristics, and dividing them into three categories: Administrative, treatment, and support. For each characteristic, a set of measurable indicators follows a descriptive paragraph. This document provides a "blueprint" for organizations that would like to develop this model. Its companion *Recovery Oriented Services Evaluation* (*ROSE*) is a self-assessment tool, which translates the indicators of the Guidelines into anchors in its rating process. While not validated, the use of this tool creates capacity to enable organizations to measure their progress in developing ROS over time. There have been several other tools that have become available recently, which provide similar guidance.

Several other issues will be encountered by organizations wishing to implement ROS in place of traditional practices. The existing behavioral health workforce has, for the most part, not been well trained to work in a collaborative, egalitarian manner with the people that they serve. As noted above, change is very difficult to embrace, and it is commonly experienced as a threat. Clinicians can often be resistant to change that is not self-initiated, or they may minimize differences between these proposed practices and those currently in place. Full implementation of ROS usually constitutes a cultural change, and it is very difficult to uproot established practices and attitudes.

In this context, it requires visionary or transformational leadership to move organizations toward person-centered, recovery-focused care (Corrigan and Garman 1999). Leaders and teachers will be most successful by taking a motivational approach, helping their staff to find incentives for and value in making changes to their practice. To do so, there must be a significant investment of time and energy to allow not only adequate information transfer but opportunities to process the information and its implications. Significant change occurs most readily when people see that it will further their own interests, so it will be important to help staff define what those interests are.

Leadership, in moving the organization toward ROS, has an opportunity to model facilitative and collaborative practices rather than directive, authoritarian methods. Transparency, informality, flexibility, and suggestibility all contribute to the empowerment of staff, and eventually contribute to their ability to treat their clients reciprocally. Solicitation of input and participation in administrative activities and program design and development also allow staff to feel invested in the organization and to take pride in its success. As one might expect, this idea of participation is one that facilitates clients' investment in a treatment planning process and adherence to the collaborative plan developed from it. Having this experience in the workplace begins to create a different culture and will make a translation to clinical processes much easier.

Nontraditional approaches to training may also help to overcome some of the resistance to change. One method that has been well received and successful is the promotion of dialogues between consumers and providers outside their usual roles in the clinical context. Fears about the consequences of honesty can be minimized if participants feel that they have no real life relationship with their counterparts. This arrangement allows a genuine sharing of experience both from the consumer and the Behavioral Health professional and is inevitably appreciated by the participants. It promotes empathy and trust, and helps participants to understand that they are less different from one another than they have imagined.

Creating a competent workforce for ROS is a long-term process, but can be expedited with

organizational commitment and consistency in applying the principles of ROS at all levels of the organization. Even with these conditions in place, there may be some individuals in the organization who do not feel comfortable with this new paradigm, and will want to leave. In most cases it is wise to facilitate these wishes, and accept the idea that not everyone is ready for change or well suited to work in this way.

Changing the content of professional training to incorporate the principles of ROS in both didactic and practical aspects of training will ensure that a new generation of clinicians becomes available to replace those leaving the workforce (Peebles et al. 2009). Although it may seem daunting to insert this new content into the already overcrowded curricula commonly encountered in psychiatric training programs, this is an overarching attitudinal shift that will not necessarily replace other topics, but instead should enhance them all. It will require commitment from academic institutions to implement these necessary changes in curricula and incentives are needed to facilitate have movement in this direction.

Evidence, Quality, and Recovery-Oriented Services

As discussed above, one of the important elements of ROS is to provide information to consumers and allow them to choose among available options based on what they have learned (Farkas et al. 2005). A full discussion of evidence-based practices is discussed elsewhere in this book, but it is important to state that the strength of evidence for the effectiveness of each available clinical option is an essential part of ROS.

But what is the evidence for the effectiveness of ROS? There is not yet a clear answer to that question. Many people believe that, intuitively, if people have more control over their care, they will be more invested and more likely to adhere to the plans that they have made to progress in their recovery. A variation of that theme is that ROS is not a "treatment," but provides a *context* and an *attitude* for the delivery of services. If ROS promote equality and justice for persons with behavioral health disorders, then the issue of "evidence" needs not be relevant.

Others note that ROS are complex and multifaceted and as a result, it would be extremely difficult to generate evidence for its effectiveness using standard approaches. Furthermore, if "recovery" is the desired outcome, then traditional measures of successful treatment may no longer be appropriate. This would apply equally to quality improvement processes. Indicators of success would be more closely aligned with consumer satisfaction and quality of life, rather than service needs and utilization (Drake et al. 2003). While evidence-informed interventions are an important element of ROS, the nature of "valid" evidence must be scrutinized, and perhaps broadened, to accurately reflect the benefits of these approaches (Torrey et al. 2005).

Recovery and ROS are recurrent themes throughout this text and the concepts presented here provide a foundation for thinking about the many implications these perspectives will have on the typical activities of the community psychiatrist. They inform our relationships with clients, our approach to service design and delivery, and the scope of our involvement in the community. As noted earlier, a recovery perspective has long been an aspect of good community psychiatry, and indeed, it is hard to imagine how it could be otherwise.

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