
Whatever Happened to Recovery? Treating Symptoms or a Syndrome

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A. Recovery – Definitions and Attitudes

1. How do you answer a client who asks: “How long do I have to be here?”
2. Does “recovery” mean different things for substance use versus mental health problems?
3. What does treatment completion mean? What does finishing the program and graduation mean?

Recovery in Addiction

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

(White, W. & Kurtz, E. (2005). “The Varieties of Recovery Experience”. Chicago, IL. Great Lakes Addiction Technology Transfer Center. Posted at <http://www.glattc.org>)

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

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

Recovery in Mental Health

“Recovery occurs when people with mental illness discover, or rediscover, their strengths and abilities for pursuing personal goals and develop a sense of identity that allows them to grow beyond their mental illness”

(Pat Deegan, a consumer leader and psychologist with schizophrenic disorder defines recovery from serious mental illness)

Signs and Symptoms

Signs and symptoms are diagnostic “tools” that help the assessor determine the condition of the patient. The Online Medical Dictionary defines them as: “Objective evidence of disease perceptible to the examining physician (sign) and subjective evidence of disease perceived by the patient (symptom).”

In layman's terms, “signs” are those “things” that we can see, and “symptoms” are those “things” that the patient tells us. For example: Pain would be a symptom (you can't see it, but the patient can tell you that he/she has pain). Flinching or “guarding” when touching a painful area would be a sign that the patient is experiencing pain.

(<http://www.emergencymedical.com/Definitions/Signs%20and%20Symptoms.htm>)

Syndrome

A complex of signs and symptoms resulting from a common cause or appearing, in combination, to present a clinical picture of a disease or inherited abnormality.

(Mosby's Pocket Dictionary of Medicine, Nursing and Allied Health, Second Edition, 1994)

B. Recovery – A Conceptual Model

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

Recovery – A Conceptual Model

Internal Conditions

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

Recovery – A Conceptual Model

External Conditions

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

References:

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

Also, check out a commentary on that paper: Peyser H (2001): “What Is Recovery? A Commentary” *Psychiatric Services*. April 2001, Volume 52; No. 4:486-487.

C. Role of Illness Management in Recovery

1. Era of Consumerism (Kizer, KW (2001): “Establishing Health Care Performance Standards in an Era of Consumerism” JAMA 286:1213-1217)
 - US Health care system reengineering itself to address the need for quality improvement
 - It is being actively reshaped by the expectations of consumers
 - All stakeholders demand active collaboration with health care system

2. Self-Management of Chronic Disease (Bodenheimer T, Lorig K, Holman H, Grumbach K (2002): “Patient Self-management of Chronic Disease in Primary Care” JAMA 288:2469-2475)
 - Patients with chronic conditions make day-to-day decisions about their illnesses – self manage is inevitable
 - New chronic disease paradigm: the patient-professional partnership, involving collaborative care and self-management education
 - Programs teaching self-management skills are more effective than information only patient education in improving clinical outcomes
 - Self-management education for chronic illness may soon become an integral part of high-quality primary care

3. Illness Management and Recovery (Mueser KT, Corrigan PW, Hilton DW et al (2002): “Illness Management and Recovery: A Review of the Research” Psychiatric Services 53:1272-1284; Drake RE, Essock SM, Shaner A et al (2001): “Implementing Dual Diagnosis Services for Clients with Severe Mental Illness” Psychiatric Services 52:469-476; Carey KB, Carey MP, Maisto SA, Purnine DM (2002): “The Feasibility of Enhancing Psychiatric Outpatients’ Readiness to Change Their Substance Use” Psychiatric Services 53: 602-608)
 - “Illness management is a broad set of strategies designed to help individuals with serious mental illness collaborate with professional, reduce their susceptibility to the illness, and cope effectively with their symptoms”
 - Involves psychoeducation to improve people’s knowledge of mental illness; behavioral tailoring to help people take medication as prescribed; relapse prevention to reduce symptom relapses and re-hospitalizations; coping skills training to reduce severity and distress of persistent symptoms
 - Comprehensive, long-term, staged approach to recovery; assertive outreach; motivational interventions; help clients acquire skills and supports to manage both illnesses and pursue functional goals; cultural sensitivity and competence
 - Empowerment corrects a lack of control, sense of helplessness, and dependency; aim is to have consumers assume increasing responsibility for themselves in making choices and taking risks; full empowerment requires that consumers live with consequences of their choices (Mueser, Corrigan et al., 2002; Drake, Essock et al., 2001; Carey, Carey et al., 2002; Jacobson & Greenley, 2001).

4. Evidence-Based Practices and Quality Improvement: Guidelines for the redesign of health care were published in “Crossing the Quality Chasm: A New Health System for the 21st Century” (2001) and “Improving the Quality of Health Care for Mental and Substance-Use Conditions” (2005) – both reports from the Institute of Medicine. Of the 10 rules originally published to guide the redesign of the health care system, at least 5 involve “patient-centered care”:
 - The system of care should be designed to meet the most common types of needs, but have the capability to respond to individual patient choices and preferences.
 - Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over health care decisions that affect them. The health system should be able to accommodate differences in patient preferences and encourage shared decision making.
 - Patients should have unfettered access to their own medical information and to clinical knowledge. Clinicians and patients should communicate effectively and share information

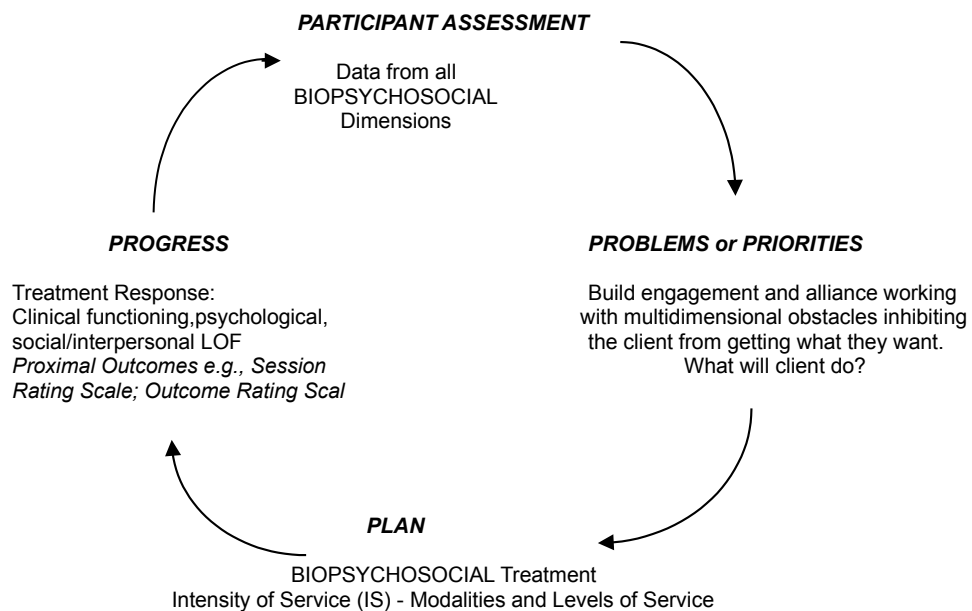
- The health care system should make information available to patients and their families that allows them to make informed decisions when selecting a health plan, hospital, or clinical practice, or choosing among alternative treatments. This should include information describing the system’s performance on safety, evidence-based practice, and patient satisfaction.
- The health system should anticipate patient needs, rather than simply reacting to events.

D. Recovery and the Relationship to the Care of Symptoms

Addiction illness is often a chronic, potentially relapsing illnesses needing on-going process of prevention, treatment, rehabilitation and recovery, with brief episodes of acute care and stabilization.

1. Client-Directed, Outcome Informed Treatment

A diagnosis is a necessary, but not sufficient determinant of treatment. A client is matched to services based on multidimensional needs and the focus of treatment, not placed in a set program based only on having met diagnostic criteria.



2. Multidimensional Assessment - ASAM Assessment Dimensions

The six assessment dimensions identify areas for prevention; treatment obstacles/assets to help client get what they want; identify what client is willing to do in the context of an alliance and focus of treatment.

1. Acute intoxication and/or withdrawal potential
2. Biomedical conditions and complications
3. Emotional/behavioral/cognitive conditions and complications
4. Readiness to Change
5. Relapse/Continued Use/Continued Problem potential
6. Recovery environment

E. Inconsistencies in Attitudes and Practice

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

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

F. Terminology and its Effect on Practice – Do you really believe in recovery and illness management?

1. “Negative consequences” – In addiction treatment clinicians often say that if a person uses while in treatment there needs to be “negative consequences”. But if a person gets depressed again and cuts herself; or manic and spends a lot of money; or psychotic because of not taking medication, do we say there need to be “negative consequences”?
2. “Graduation” – Clients and counselors talk of “graduation” from the program. But when does a person graduate from diabetes treatment? Or from Bipolar Disorder treatment? Or from hypertension or asthma treatment?
3. “Complete the program” – Similarly, when does a person complete the depression program; or complete the Schizophrenic Disorder program? On what basis is the decision to discharge or transfer a person from successful treatment made? Is it based on a set time and/or number of sessions? Or do you focus on the level of function and the quality of the person’s recovery?
4. “How long is your program?” or “How long do I have to stay?” – The same issue is raised here. Do we really believe we are managing long-term illnesses; or do we act more like there is a set of program expectations and monitoring compliance with rules and expectations.
5. “More willing to follow rules and compliant with treatment activities”; “Compliant participation in group” – These are examples of Progress Notes that focus on a client’s doing time, not doing treatment. They do not speak of harnessing a client’s positive efforts and energy. It promotes passive behavior to please others or to jump through certain hoops.
6. “Serious and persistent” – This phrase has no counterpart in general medicine care, which describes general illnesses with similar consequences as “severe” and “chronic” as opposed to “mild” and “acute.” It is not common for example, to talk about “serious” cancers. The term “persistent” could connote a lack of belief in the ability to improve and recover. There is a less pejorative and clinically useful way to categorize individuals with mental illnesses that have chronic functional limitations. It might be to refer to them as having mild, moderate, or severe disability associated with a mental illness symptom or diagnosis, rather than to refer to them as the “seriously” mentally ill. (“Improving the Quality of Health Care for Mental and Substance-Use Conditions” pp. 86-87 Institute of Medicine. The National Academies Press, Washington, D.C. 2005)

LITERATURE REFERENCES AND RESOURCES

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