What's Really Different About Recovery? A Case Study

(2011)

Mental Health staff in programs all over the country are being told they need to be providing recovery based services. When they ask what that means they're supposed to be doing differently, they're usually given either a set of recovery based values - like client-driven, person-centered, goal-driven, empowering, and strengths-based - or a new set of paperwork requirements to add to what they're doing. Neither approach meets them where they're at; providing direct services to challenging people trying to help them with their mental illnesses. They don't usually understand what they're "doing wrong" and why they need to change. This article describes a single case in detail to try to concretely describe what's different about recovery based services from what we usually provide.

> *Robert served in the army in Korea, but long after the fighting was done. He mainly remembered using drugs sold to him by his sergeant. When he left the military, he was lost, confused, isolated, using drugs, and increasingly wrapped up in a religious guilt feeling that God was punishing him. He wandered the country and became suicidal. He went to a midwestern VA hospital for help, but was locked in a barren ward, deprived of any means to hurt himself. After two weeks, he promised not to kill himself, so they let him out. He hated the experience and never returned to the VA for any services or benefits.*
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> *He spent the next decade travelling around, doing odd jobs and learning some construction skills. Occasionally homeless, he often lived in hotels or shelters as he moved about. He never held a steady job or an apartment of his own, and had no long-term relationships or connections with his family.*
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> *Then a terrifying thing happened. He fell asleep on a bus and two undercover military agents sat behind him and implanted a receptor in his head so they could transmit satellite messages to him. These messages were very disturbing and crazy making, telling him to kill himself or hurt other people, especially black people. When he saw a newspaper report that his old sergeant had been made a general, it all made sense to him. He was being discredited so he could never testify against his old sergeant.*
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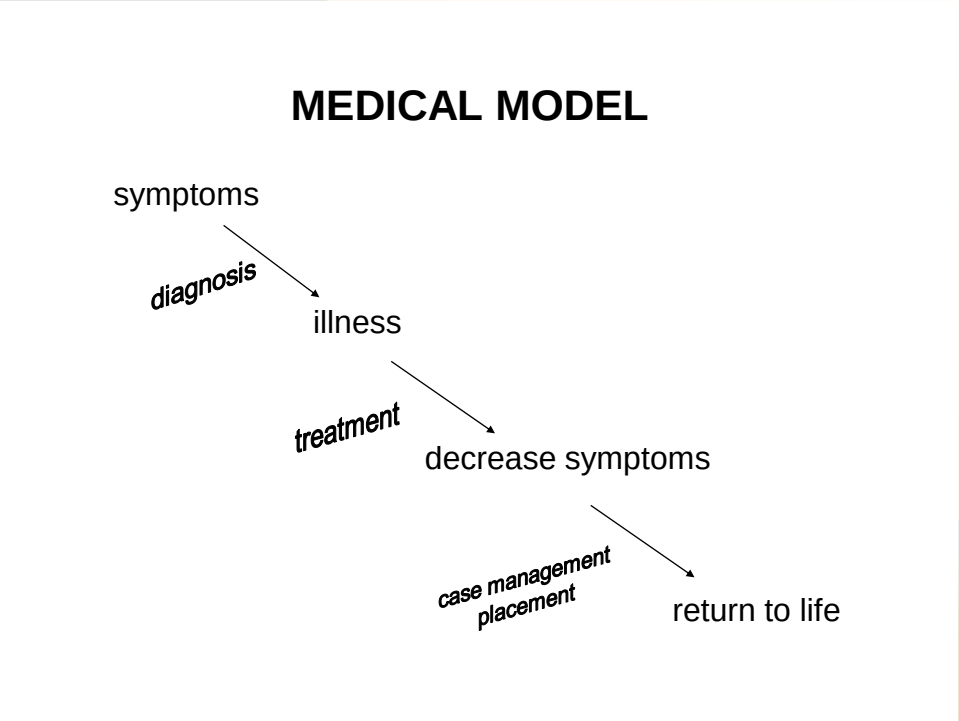
> *He went to hospitals to get x-rays to find the implant and remove it, but instead was told he was crazy. He was given meds that confused him. He felt unable to fight the machine. He struggled mightily against these messages, but sometimes did attack people. He developed headaches, severe anxiety, and insomnia. He learned that alcohol calmed him and helped him sleep, but dulled his mind and reduced his vigilance. Speed seemed to work better, because it helped him think fast enough to outsmart the machine, but then the headaches, insomnia and anxiety returned. He isolated himself, to avoid hurting anyone, and ended up living under a bridge.*

Our discussion begins by comparing and contrasting the two most common mental health treatment models, the medical model and the rehabilitation model, with the recovery model.



The Medical Model is predicated on the notion of diagnosing psychiatric illnesses, treating their symptoms, and helping persons with these conditions return to health and more productive and meaningful lives. However, it is a paradigm that fails to address some concerns for persons with mental illnesses. Many people with mental illnesses don't agree that they have an illness, at least not in the way it is defined by the medical model and are often difficult to engage in treatment. Even with excellent treatment, many do not experience sufficient symptom relief from treatment alone to feel healthy enough to return to life. After most symptoms are relieved, many continue to have substantial disabilities from other factors (e.g., trauma and loss, personality issues, low intelligence, poor relationship skills, poverty, lack of education, social ostracism), not to mention the immediate and longer term impacts of involuntary and coerced treatment interventions. This leads many to seek additional, often equally insufficient, medical treatments and/or to give up on the mental health system entirely.

> ***Robert's Medical Model scenario:*** *Robert was hospitalized and was diagnosed with a co-occurring mental illness and addiction disorder. The hospital staff explained to him in a compassionate, psychoeducational manner that there wasn't any machine. They explained that he had a chemical imbalance in his brain, probably exacerbated by substance use. The brain disorder was causing his mind to misperceive reality, that the "machine" was a delusion. The good news was that medications could restore his brain's chemical imbalance so he wouldn't be delusional anymore.*
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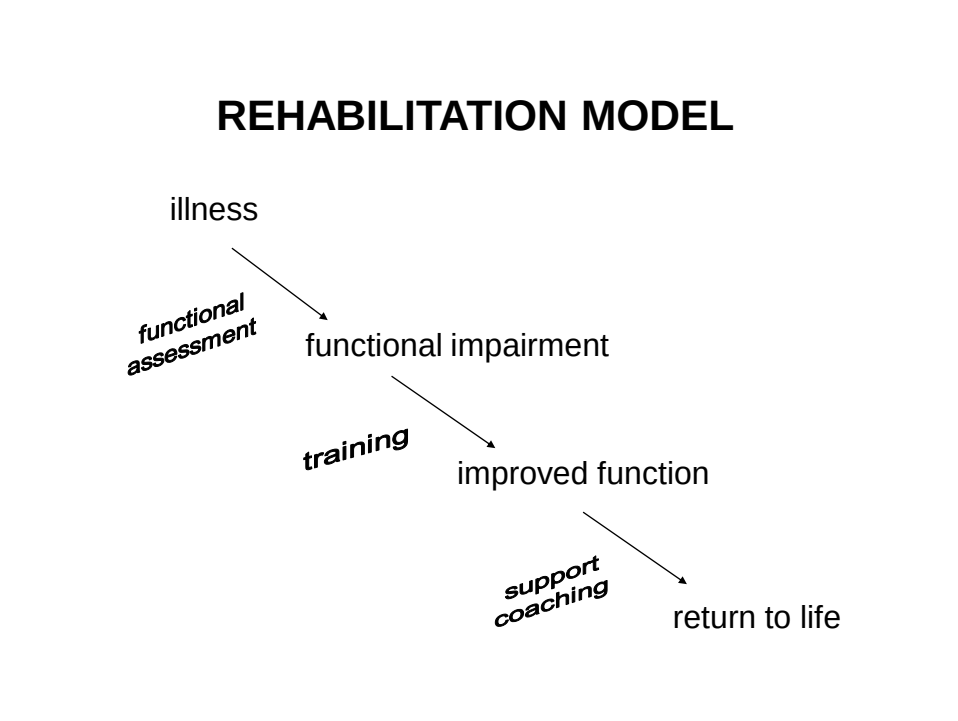
> *Unfortunately, Robert refused to believe this explanatory model, even though the staff were kind and compassionate. He refused the medications and never returned to the outpatient clinic to which he was referred. Since Robert lacked insight and was struggling to meet his basic needs, he was repeatedly hospitalized on an involuntarily basis and forcibly medicated. When not hospitalized*

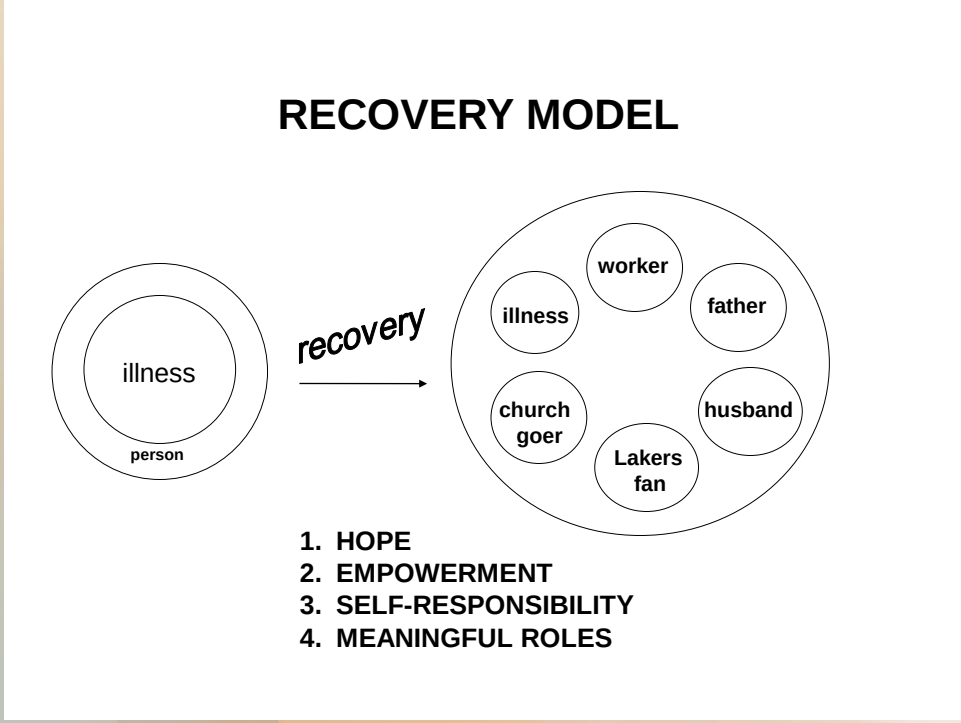
and removed from society for his protection and public safety, he would often return to a life of alienation, homelessness, loneliness, and little hope of returning to a productive life.



The Rehabilitation Model focuses more on functioning than on symptoms. A functional assessment leads to training to reduce deficits and build strengths. When persons are sufficiently supported and perceived as likely to succeed, they are assisted in using their new and restored skills to return to life. This model also fails for a significant number of people. It is almost always used sequentially with the medical model, based on the presumption that symptoms must be treated and stabilized before skills training and support efforts would be effective. If symptoms aren't able to be controlled, such people are often deemed not ready for rehabilitation. This vulnerability is being actively addressed with various supportive rehabilitation techniques (e.g. supported employment, housing, education). The need for symptom control is not necessarily a prerequisite for effective functioning, but our system often reflects social stigma and rejection by not giving people with overt symptoms a chance to build functioning. The Rehabilitation model depends on sufficient opportunity: that if someone has job skills, there is a job available or if someone is able to live independently, there is an affordable apartment available. To be effective, rehabilitation has to be supplemented by community development to build such opportunities.

Robert's Rehabilitation scenario: *After being discharged from the hospital, the outpatient rehab program staff told Robert that they would help him with supportive housing and employment after he was stabilized. When he became compliant with medications (by taking medications) and maintained sobriety (by completing a drug treatment program), he would be ready for*

rehabilitation . Alternatively, if he felt that such an approach was too difficult, they would help him get on Social Security disability. They would then offer him housing and services in a residential program where he would receive the treatment, structure, and supervision that he needed until he could again function safely and independently. When offered these choices, he refused all services and eventually wandered off and out of contact with the treatment program.



The recovery model emphasizes changes that persons make in and for themselves. When people first come for services they often feel their illness has swallowed them up. They have struggled to overcome it on their own for quite a while, but with little success. They have experienced substantial loss, destruction, and rejection, as well as self doubt. They often feel crippled by the illness and that life is a constant all-consuming struggle. Recovery engages the part of the person that is struggling, that may still have hopes and dreams, and aligns with that part. The recovery approach helps by decreasing the impact of the illness and by restoring or expanding the rest of the person's life. Recovery requires building meaningful roles in life.

Robert's Recovery scenario. *The staff guided Robert towards recovery step by step. They helped him rebuild hope by having him work with an outreach worker who used to be homeless and hopeless himself. "If I could make it so can you." They helped him create an image of a better future dealing with the "implant" and other frightening thoughts and to get back to work.*

They helped to empower him and build up his belief in himself. They gave him self-help coping tools, including meds he could manage and administer himself. They insisted on him taking responsibility for not hurting anyone, no matter what the "satellite" or other entities would tell him. They invited him to contribute to their program in meaningful ways, making lunches for homeless people and earning money to pay rent. As he struggled to rebuild, they stuck with him to find ways to overcome the barriers that emerged.

Recovery is both a destination and a journey Meaningful goals mark progress along the way:

1. Functions may be recovered - the ability to read, to sleep restfully, to work, to have coherent conversations, to make love, to raise children, to drive a car, etc.
2. External things may be recovered - an apartment, a job, friends, playing in a band, a spouse, a car, family relationships, TV, educational programs, etc.
3. Internal states can be recovered - feeling good about oneself, satisfaction, self confidence, spiritual peace, self-responsibility, a sense of identity other than as a mentally ill person, etc.

A homeless outreach worker, himself a veteran with a history of mental illness and alcoholism, began stopping by Robert's encampment, bringing him sack lunches, sharing stories, and listening quietly. After several months, Robert agreed to come into a drop-in center to shower and get some clean clothes.

After another week Robert was introduced to the team psychiatrist, to "see if our doctor can help you." As he listened to his story, the doctor didn't ask many diagnostic questions. He asked Robert about the story of his life instead of the history of his illness. He learned that Robert was a very moral man, that he missed working, and was getting sick and tired of living on the streets. When the psychiatrist shared pictures of his family, Robert said that he still hoped he could marry and have a family some day. Rather than providing corrective insights that the machine wasn't real and that he had a psychotic disorder that would likely respond to medication, the doctor met him where he was. He said he knew nothing about military satellite technology, but a lot about strengthening brains and dealing with overwhelming stressors. He was interested in Robert's efforts to strengthen his brain with alcohol and speed and thought he could offer a better alternative. He offered him a drug that "combines the effects of alcohol and speed that might calm you and focus your thinking". Would you be willing to try it instead of alcohol and speed to see if that helped you fight the machine better?" He agreed.

Put simply, the goal of recovery is not to treat mental illnesses, but to help people with mental illnesses to have better lives. Recovery based services are built on consumer strengths leading to resilience, rather than the clinical mastery of the professional treating the consumer's deficits.

The psychiatrist told Robert that he was more vulnerable to the machine by staying alone under the bridge than in a hotel room, and that he'd probably cope better if he was doing something positive instead of sitting worrying about this all day long. To take advantage of his work ethic, he was offered "work for a day – house for a day." He could work 2 hours a day in the program's café /

lunchroom making hamburgers and sandwiches to earn a nightly hotel voucher. He was assured there would be people there who could help if he felt overwhelmed or violent and who wouldn't lock him up. They began working together on his goal of fighting off the machine and rejoining society. They invited him to become a member of the community program (The Village).

Over the next few months he improved. The machine quieted down enough so he could relax and sleep ; the headaches went away. When he worked, the machine didn't affect him at all. He began driving the van on catering jobs. The program staff were encouraged and offered him a permanent job and help getting a subsidized apartment.

Strengths aren't people's skills or talents or things we like about them. They are the resources they will use to overcome their illnesses. Strengths can be internal qualities like determination, hopefulness, self awareness, self responsibility, pride, a strong work ethic, family values, and spiritual faith. Strengths can be external resources like money, family, community, stable and safe housing, mentors and friends. Strengths can be discovered (or rediscovered) or newly developed. When someone has enough strength to overcome the next symptom increase, drug relapse, relationship breakup, job loss, family disappointment, or even tragic loss without falling apart, without becoming homeless or jailed or hospitalized, without losing everything they've worked so hard for, then they have resilience. Our goal is not to protect them from tragedies but to help them build enough resilience to handle the inevitable crises when they come.

Robert disappeared back under the bridge. The treatment team suspected that either he'd relapsed on speed or stopped taking his medication and was more psychotic. The peer outreach worker looked for him and found that neither of those things had happened. Robert was just scared and thought they were pushing him too fast. He agreed to return to "work for a day – house for a day".

Six months later he chose to move on to permanent work and an apartment. By the time the team celebrated his achievement with a housewarming party, he'd gained so much confidence dealing with the machine that he stopped his medications. The psychiatrist continued to see him and, although his old religious guilt returned, the machine remained very quiet. He worked on his shame and guilt without meds. He began volunteering by providing homeless outreach with his old worker as a way to give back to others.

Robert felt proud of himself and the emotional closeness he had developed with the community of staff and program members who reminded him of his lost family. The program helped him find his sister on the internet and to visit her in a distant city. She welcomed her long lost brother. Six months later he decided to move to be with his sister, realizing that he was strong enough to make it without the treatment program.

Robert never got insight. He never really complied with treatment or medications very well. His illness was never stabilized and certainly it wasn't cured. Yet he recovered… and we played an important role in his recovery.