The A.C.T. Model

"The greatest challenge we face as leaders is leading ourselves"
– John C. Maxwell

Apply for me **C**hange in me **T**each others

We often wonder what to do with all of the information, learning and ideas that are discussed and suggested in a workshop? How will you take what you've learned and use it to grow yourself **and** to add value to others (staff, team members, clients, family and communities)?

This tool is for your use and thinking throughout the session. It is intended to "jump start" your follow up and adoption actions. A suggested strategy is below. Keep in mind that the tool is not proscriptive and can be revised to fit your unique needs and ways in which you work:

1st: Use the codes A C T in the margins as you take notes

2nd: Following the session compile a list of each code (3 separate lists)

3rd: Prioritize each list

4th: Using your priorities, take say the first one or two items and work on them for 2-4 weeks until it becomes a habit or instituted change or process

5th: Continue working through your lists

6th: This tool might also serve as a process for your team, steering committee, managing entity, hospitals, patients/clients, families, recovery community, etc.

Source: Lonnetta Albright, Forward Movement, Inc. Adapted from a presentation by John C Maxwell.

A.C.T. Worksheet

Use a separate Worksheet for each Code

ACTION ITEM A, C OR T	WHAT WILL YOU DO?	WITH WHOM?	HOW WILL YOU KNOW IT IS MAKING A DIFFERENCE?

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Minnesota Department of **Human Services**

Co-occurrences

Newsletter of the Minnesota Co-Occurring State Incentive Grant Project

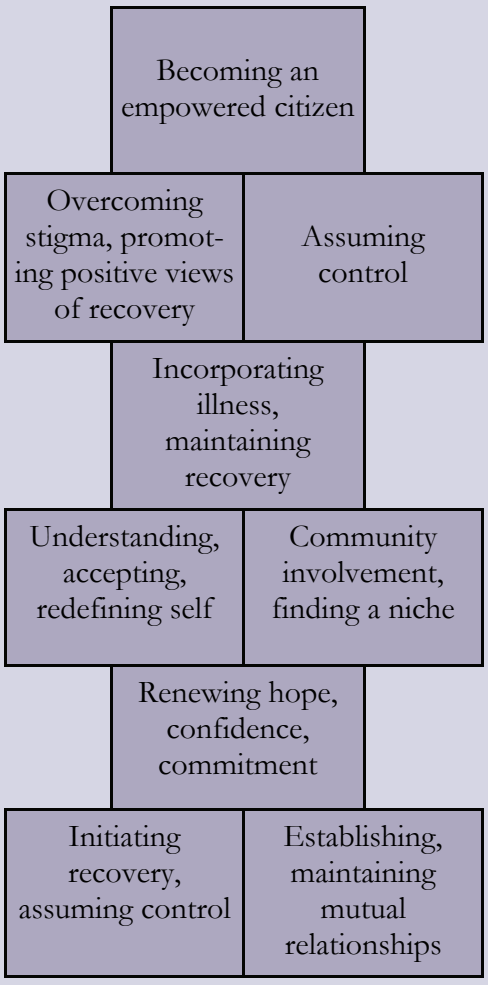
January 2009
Volume 2, Issue 7

Recovery concept finds common ground in mental health and addiction

Much like the fields of mental and chemical health in general, the recovery concept within each field grew from different roots, followed different growth patterns, and had different histories and advocates. In the past decade, however, practitioners from both fields have joined forces to find overlap in their respective recovery concepts, both as a way for individuals with co-occurring disorders to describe their recovery experiences and as a potential integrating mechanism for these traditionally divided fields.

As an example of an integrated model, Larry Davidson and colleagues developed what they called a "hopscotch" model of dual recovery. First developing separate models of recovery from reviews of first-person recovery literature in each field, then revising them based on feedback from recovery advocates, they found remarkable similarity of recovery phases and language in each model. Their dual model combines these common elements, showing where in some phases there seems to be a single recovery goal, and in others dual goals to be tackled simultaneously with "both feet". Unlike hopscotch, the phases may be nonlinear and of flexible order.

Source: Davidson, L., et al. 2008. From "Double Trouble" to "Dual Recovery": Integrating models of recovery in addiction and mental health. *Journal of Dual Diagnosis, 4(3):* 273-290.



"….the phases of recovery from serious mental illness and recovery from addiction have many parallels. In fact, the manner in which participants in different forms of recovery independently used the same or similar language to name and describe their own processes of recovery was striking." —Davidson, et al., 2008, p. 235

Resources on co-occurring disorders

A version of Dr. Davidson's "hopscotch" model is shown in a brief PowerPoint presentation, "Recovery as an organizing principle for integrating mental health and addiction services" at: **<http://coce.samhsa.gov/products/cod_presentations.aspx>**

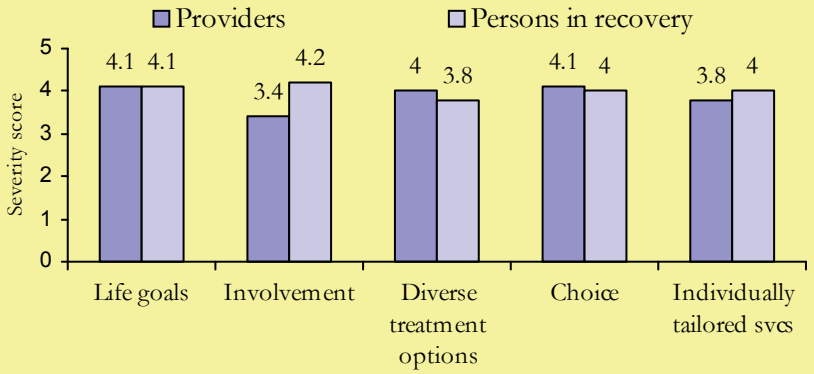
The two-part essay "Recovery: The bridge to integration?" by William White and Larry Davidson argues that the recovery concept may be the key to integrating the addiction and mental health treatment fields. Click on the "Archives" link and the November and December 2006 issues of *BehavioralHealthcare* at: **<http://www.behavioral.net/ME2/Default.asp>**

"Recovery from addiction and from mental illness: Shared and contrasting lessons" by William White, Michael Boyle & David Loveland describes shifts in the recovery movement and the history of mutual aid groups. Click on the chapter title at: **<http://www.oregon.gov/DHS/addiction/recovery.shtml>**

Multiple domains and measures of recovery

O'Connell and colleagues asked 974 individuals to complete the Recovery Self-Assessment measure, and from the data identified five recovery domains. The scores at right are from mental health and addiction providers and persons in recovery on these domains.

In later work, the researchers refined four versions of the Recovery Self-Assessment, one each for Person in recovery, Family member/advocate, Provider, and CEO/ Director (**<http://www.yale.edu/PRCH/tools/rec_selfassessment.html>**).



Source: O'Connell, et al. 2005. From rhetoric to routine: Assessing perceptions of recovery-oriented practices in a state mental health and addiction system. *Psychiatric Rehabilitation Journal, 28(4)*, 378-386.

What is recovery from co-occurring disorders?

Davidson and colleagues reviewed first-person accounts of recovery from addictions and mental illness and asked members of advocacy networks in both fields for feedback on their summaries. They arrived at this simple conclusion:"In an age of evidence-based practice, this research suggests that recovery, be it from the hardships of addiction or problems of mental illness, rests on the same principles of human development as do other spheres of psychological and social functioning. **Just like everybody else, people living with these problems require hope, a sense of self-efficacy and control, affiliation and connections with others, a sense of meaning and purpose, and the quiet integrity of leading a dignified life**." [emphasis added; Davidson, et al., 2008, p. 288]

Five video clips in which people talk about their experiences of living with co-occurring disorders can be viewed on the website of the Co-Occurring Collaborative Serving Maine. In his clip, Michael explains that what a person in recovery needs is similar to what everyone wants from life. **<http://www.ccsmetraining.org/movies/index.asp>**

Co-occurring glossary

- **Recovery:** "Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness and quality of life." (Center for Substance Abuse Treatment: **<http://pfr.samhsa.gov/rosc.html>**)
- **Recovery:** "Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential." (Center for Mental Health Services: **<http://mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/>**)
- **Recovery:** "Recovery refers to the ways in which persons with or affected by a mental illness and/or addiction tap resources within and beyond the self to move beyond experiencing these disorders to actively managing them and their residual effects to build full, meaningful lives in the community. Recovery is more than the elimination of symptoms from an otherwise unchanged life. It is about regaining wholeness, connection to community, and a purpose-filled life." (Recovery: The bridge to integration, part one. See resources, p. 1.)

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RECOVERY TO PRACTICE
Resource Center for Mental Health Professionals

Weekly Highlight

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
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Recovery in Mental Health and Addiction

Larry Davidson, Ph.D., and William L. White, M.A.

As noted in a previous Recovery to Practice Weekly Highlight, a number of common questions keep popping up related to recovery, the nature of recovery-oriented practices, and the ways they may differ from conventional mental health care. We are currently collecting these questions so they can be posted in the "Frequently Asked Questions" (FAQs) section of the RTP Website. We invite readers to suggest their own questions for this growing list.

This Weekly Highlight will be devoted to one of these emerging questions.

This week, we focus on FAQ #6.

Frequently Asked Question #6: ***"How does mental health recovery interface with the addiction recovery movement?"***

Our Response: In the United States, the mental health and addiction fields have different historical roots and traditions. These differences naturally led to there also being two distinct groups of practitioners who had little to do with the other specialty. If a person had both a mental illness and an addiction, it would have been difficult for him or her to receive optimal care. Either the mental health practitioner would not have been trained to identify the signs of substance misuse and/or the addiction practitioner would not have been trained to identify psychiatric symptoms. Even when a practitioner was able to identify both disorders, the best he or she could do was to refer the person for care for the "secondary" condition by a practitioner from the other camp.

Several important developments are changing this picture. First, both fields have come to recognize the high prevalence of what are now called "co-occurring disorders," meaning that many people with mental health conditions also have addictions, just as many people with addictions have mental health conditions. Research has consistently shown that for these individuals to receive effective care, mental health and addiction services must be integrated.

Integration has been difficult, however, for numerous political, fiscal, structural, and attitudinal influences that have been hard to overcome. Previous efforts at integration also have been difficult because they have focused primarily on the etiology or nature of mental illnesses and addictions, or on the types of treatments required by each, failing to establish a common ground that would provide a foundation for integration. As long as the focus has been on the nature of the illness or on the treatments required, historical differences have outweighed commonalities, leaving the fields splintered.

Within the past decade, though, the emergence of a recovery movement in both the mental health and addiction fields has begun to offer a new organizing principle for bringing these two disparate worlds together. As integration has yet to be achieved from focusing on the nature of the disorders or the services required, perhaps concentrating on the processes of recovery, healing, and community inclusion will. As a core principle of both recovery movements suggest, identifying and building on strengths can often accomplish things that attending to deficits and dysfunction have not been able to do. What results is recognition that, while mental illnesses and addictions might be different from each other in important ways—especially when viewed through the lens of a diagnostic manual—processes of recovery may nonetheless be very similar, and at times, even interwoven—especially when viewed from the perspective of the person in recovery. This Highlight will address both the differences and similarities, but will start with the similarities.

The components of an integrated recovery vision begin with the idea that, in both mental illness and addiction, recovery is a personal and individualized process of growth for which there are multiple pathways. People in recovery from either mental illness or addiction have described recovery as a transformational process (sudden, unplanned, permanent) and an incremental process (marked by multiple phases), and recovery narratives are often filled with elements of both types of change. Of central importance within these stories is the fact that within these stories, people in recovery are active agents of change in their own lives—not simply passive recipients of care. These stories are filled with references to new perspectives and insights, important decisions, critical actions taken, and the discovery of previously hidden healing resources within and beyond the self. Recovery narratives often give prominence to the role of diverse religious, spiritual, and secular frameworks in recovery initiation and maintenance. People in recovery also note the role of family and peer support in making a difference in their recovery.

Whether they are living with a mental illness, an addiction, or both, people in recovery need to have hope. They also want to manage or eliminate their symptoms, increase their capacity to participate in valued social roles and relationships, embrace purpose and meaning in their lives, and make worthwhile contributions to their communities. With this shared vision in place, then, differences that have historically existed between the recovery visions of the mental health and addictions systems can now provide opportunities for synergistic growth in both.

In developing recovery-oriented practices and systems that are based on this integrated vision, several guiding principles exist. The first is that both mental illnesses and addictions span a

diversity of population and outcomes. Basically, recovery looks different for different people. Second is the need to adopt a long-term, longitudinal perspective and to use a developmental framework for matching the person's point in the recovery process to appropriate interventions. Also important is the impact of the environment—one must focus on person–environment fit and interactions. Third is the nonlinear nature of recovery and the fact that it is a process and a continuum as opposed to an outcome. Finally, as previously noted, is the importance of family involvement, peer support, and spirituality in supporting the recovery process.

Recovery-oriented care is based on the recognition that each person must be either the agent of and/or the central participant in his or her own recovery journey. All services and supports, therefore, need to be organized to support the developmental stages of this recovery process. It follows from this core value that services also should instill hope; be person and family-centered; offer choice; elicit and honor each person's potential for growth; build on a person's/family's strengths and interests; and attend to the person's overall life, including health and wellness. These values can be the foundation for all services for people in recovery from mental illness and/or addiction, regardless of the service type (e.g., treatment, peer support, family education, etc.). There are many pathways to healing—both inside and outside of the formal health system—that people with mental illnesses and/or addictions can take in their recovery.

That said, what significant differences remain? Apart from the neurophysiology of these disorders, which remains to be determined, one important difference is in the role of behavior change. A useful model of behavioral change that has led to a popular approach to addiction treatment has been the Transtheoretical Model, proposed by DiClemente and Prochaska in 1985. This is the model at the heart of motivational interventions that attempt to facilitate a person's movement along the continuum from pre-contemplative and contemplative to preparation and then action (leading eventually to maintenance). While this model, tailored to the person's stage of change, has been effective in promoting recovery in addiction, its use in relation to mental illness is not as straightforward. This is because the Transtheoretical Model of Change is a model of behavioral change, and the role of behavioral change in mental health is somewhat different from that in addiction. That's because while you can choose not to drink alcohol or use an illicit substance, you cannot choose to stop experiencing the symptoms of a mental illness.

A person can, and does, make many choices when living with and recovering from a mental illness, of course, but these choices are different from the choice to use or not to use. For people in recovery from a mental illness, choices include what they do *in response to* experiencing symptoms (e.g., do what the voices command or try to ignore them); what they do *to prevent or minimize* symptoms (e.g., avoid stressful situations, take medication); and what they do *to manage or overcome* the disorder (e.g., learn self-care skills, reach out to others). But the primary role of behavioral change in addiction may need to be somewhat modulated by the variety of factors that also influence the onset and course of serious mental illnesses, factors that lie outside of the person's own sphere of influence. These include social

conditions, such as poverty, discrimination, and unemployment, as well as interpersonal and biological factors, such as the availability of social support and the responsiveness of symptoms to medications. As we learn more about the neurophysiology and social dimensions of addiction, we may eventually find that this is an area in which the addition field has much to learn from the mental health field. The increasingly important role of recovery support services in addiction care—services, such as case management, that in the past were sometimes viewed as "enabling"—certainly suggests that just such a change is already beginning to take place.

For Further Reading:

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Recovery Oriented Systems of Care (ROSC) - Change Agents

The purpose of this cohort of individuals is to build the capacity of regional ROSC subject matter experts; to serve effectively in the role of Change Agent. The overarching goal for the ROSC Change Agent is to have the knowledge and ability to link the needs and desires of individuals, families, and community's formal and informal institutions; through strategic and critical problem-solving solutions. The intention of the change agent's role is to assist their regional stakeholders in achieving positive outcomes that reflect recovery-oriented values; and build collaborative partnerships to improve the quality of life for individuals, families and communities.

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