Recovery-Oriented Practice in Psychiatry

American Psychiatric Association and
American Association of Community Psychiatrists

Project Background

The project is a collaborative effort of the American Psychiatric Association and the American Association of Community Psychiatrists with assistance from an advisory group of psychiatrists, other mental health professionals, and consumers. The project is part of a larger Substance Abuse and Mental Health Services Administration (SAMHSA) effort to broaden and increase awareness, acceptance, and adoption of recovery principles and practices among mental health care providers.

The first-year report, *Psychiatry and Recovery-Oriented Practice: A Situational Analysis*, summarizes the information-gathering efforts of the first year of a multiyear project to develop and disseminate educational materials for psychiatrists to help further the use of recovery-oriented practices. The report looks at current knowledge and application of recovery-oriented practices among psychiatrists across the United States. It summarizes information from a variety of sources, including a review of existing literature and in-person dialogues and telephone conference calls involving psychiatrists, other mental health care providers, consumers, and family members.

Building on previous research and drawing from information provided by psychiatrists, consumers, and others, the report identifies barriers to recovery-oriented practice, including lack of practical knowledge and tools needed to put concepts into practice, perceptions/misperceptions about recovery and recovery-oriented practice, and systems-related issues such as restrictions and limitations that largely result from scarcity of resources. An increasingly diverse population also poses challenges to providers and calls for understanding of cultural influences on perceptions and approaches to mental illness and recovery.

Examples of comments from participants

Clinicians

- Perception of recovery being associated with substance use disorder and addiction recovery
- Concerns relating to sharing power
- Lack of knowledge, understanding about *how* to put recovery based care into practice. “
- Systems that limit psychiatrist role to medication management and limit potential time spent with individual consumers
- Institutional/system pressure to treat as many individuals as possible.
- Separation of substance use disorder and mental health programs/treatment

Consumers/family members

- “The most powerful thing anyone said to me was ‘I have so much hope for you.’”
- “Doctors need to speak in a language we can understand”
- “I want to viewed as a whole person, not as a diagnosis”
- The best source of hope is seeing a person in recovery, learning from their experience
- Family members can be an important resource and often bear much of the responsibility – but often feel left out of communication and not part of the team

A number of recommendations for content and format of training emerged. The training materials should:
- connect to participants’ prior knowledge and experiences,
- demonstrate recovery-oriented practices that address common clinical challenges,
- focus on how to use recovery principles in real situations (e.g., within time/resource limitations),
- involve consumers as trainers, provide personal recovery stories.

In addition, given the time constraints experienced by most psychiatrists and the many topics competing for their attention, the information should be accessible and brief and should extend beyond written or lecture formats to include use of interactive and experiential teaching strategies. In order to reach more people, training materials should be available online and should be available for continuing medical education credit.

**Introduction**

The American Psychiatric Association (APA), in partnership with the American Association of Community Psychiatrists (AACP), is one of five national mental health professional organizations working under the Recovery to Practice Initiative to develop training material on recovery-oriented practice and to conduct trainings with their respective members (others include psychology, psychiatric nursing, social workers, and peer specialists).

The Recovery to Practice Initiative (RTP) is a five-year project of the Substance Abuse and Mental Health Services Administration (SAMHSA) to broaden and increase awareness, acceptance, and adoption of recovery principles and practices among mental health providers.

Almost since its inception as a medical specialty, psychiatry has experienced several shifts in its identity. Even before the advent of the medication era, there was a tension between the desire to be viewed as a mainstream scientifically based medical specialty and an alternate identity as a more humanistic and spiritually based discipline. In recent times, psychoanalytic or psycho-dynamically oriented practice which dominated the mid twentieth century, has given way to predominantly biologic perspectives that have placed pharmacotherapy at the center of treatment approaches. During this period significant changes were underway in the manner in which people with severe mental illness were treated. A variety of social and economic forces coalesced at that time, resulting in the transition from state hospital care to community based care. Although the advent of pharmacologic treatments is often credited for contributing to this deinstitutionalization, it remains unclear how significant a role it played. Nonetheless, daunting challenges remained for these individuals as they were released from the hospital, due in part to inadequate resources in the community mental health system. Treatment with medication alone, without other supports or living skills often resulted in repeated crises; revolving door hospitalizations, incarceration, homelessness, substance use disorders and increased vulnerability to physical illness.

The principles and practices of psychiatric rehabilitation were gradually developed as a means to address these deficits in services and to foster independence, but knowledge and availability of these services was quite limited for many years. Psychiatric rehabilitation offered programs designed to develop skills for daily living, interpersonal interactions, education, and employment to enhance people’s ability to live in the community successfully and to reach their full potential. Other types of community support were also progressively added to the toolbox of psychiatric and behavioral health services. These included supported housing, family supports, case management and assertive community treatment, and crisis and respite care, all of which helped reduce the likelihood that persons with mental health and substance use disorders would end up in highly restrictive or otherwise punitive settings. There has been growing awareness that integrated treatment of co-occurring physical, addictive and developmental disorders is needed to adequately address and optimize outcomes for persons with multiple challenges.

Despite advances in both biologic and psychosocial interventions for persons with behavioral health disorders, not all of them have been broadly disseminated and practiced, or incorporated into psychiatric training programs. The relationships between psychiatrists and their clients have too often been paternalistic and
even custodial. Relatively few psychiatrists encouraged the pursuit of goals and dreams for people with disabling behavioral health problems, and the majority often painted a pessimistic picture of what those people could expect from their lives. The actual practice of psychiatry has been increasingly constricted toward biological aspects of treatment in recent years due to financial pressures and training deficits.

The recovery concept has been present throughout the history of mental health care in various forms, but until recently it has been most closely associated with the process of overcoming addictions. For mental health, recovery has roots from within psychiatry (Abraham Lowe and Recovery, Inc) and from outside it (consumer/survivor movement). Today the recovery community is diverse and includes many different ideas about what recovery is and how it is accomplished. For many it represents the last frontier for civil rights and human dignity, for others it is a quest for personal growth and harmony. Despite these differences, ideas of “recovery” also have many elements in common. These common elements include autonomy, hope, responsibility, effort, affiliation, adaptability, productivity, purpose, faith and respect for one’s self and others. These elements are reflected in the SAMHSA Consensus Statement on Recovery as well as the AACP Guidelines for Recovery Oriented Services.

While these elements provide some ways of thinking about what recovery is composed of, they tell us little about how it is accomplished. While there may be many paths to recovery, for most people it is not a solitary enterprise, and it requires the help of others. Engagement with peers who have overcome similar challenges is one source of help in the recovery process. Many people with behavioral health issues also engage with service providers, but traditional services have not commonly nurtured the qualities mentioned above. With the exception of psychiatric rehabilitation programs and organizations such as the American Association of Community Psychiatrists (AACP), which embraced the recovery movement and its principles early on, until now, psychiatry has largely been unaware of the potential of recovery principals to transform lives or the role that they might play in facilitating that process. Too often psychiatry has been dismissive and self-righteous when confronted by the new assertiveness, activism and sometimes, the understandable anger of people with mental illness.

In this light, the recognition and implementation of practices that promote and facilitate recovery by psychiatrists and other clinicians is critical to optimizing the resources available to people who seek recovery. There are significant obstacles that have prevented the adoption of these practices, which have roots in our systems of care. So it is not only psychiatry that must change. Systems transformation must occur and psychiatry must be part of that transformation movement. It is particularly important that these changes occur in the context of fiscal constraints, because ultimately, recovery offers not only more satisfactory results, but a more economic context for service delivery. Psychiatry must resist pressures to reduce its role to prescribing medications in brief and infrequent visits. Rather than surrender and acquiescence, activism and advocacy are hallmarks of recovery not only for service users, but for service providers as well. The frustration that many psychiatrists have experienced in recent years will not change if they simply lament their misfortune. Change requires optimism and effort.

The Recovery to Practice project offers an opportunity to realize a vision of psychiatry and behavioral healthcare in which a thriving, nurturing and fully integrated recovery community blossoms. In it, psychiatry resumes a prominent place in the leadership of behavioral health service delivery and in facilitating the recovery of people who suffer. Psychiatrists will understand and embrace recovery principles and recovery oriented practices and use them as a basis for empathy and engagement. They will recognize and emphasize what they have in common with those who seek assistance rather than those things which set them apart. The incorporation of recovery oriented practices will allow the relationship between psychiatrists and their clients to flourish and allow these people seeking assistance to find motivation, hope, support, strength and determination to resume fulfilling and meaningful lives in spite of whatever disability they are limited by. This collaborative effort of the American Psychiatric Association and the AACP will equip psychiatrists with the tools they need to provide recovery-oriented psychiatric care no matter where they practice or under what conditions. This initiative has the potential to catalyze the transformation of the field of psychiatry into one in
which psychiatrists enter into partnership with consumers, place the consumer at the center of care planning and keep the goals and dreams of the consumer in the forefront as a guiding light of hope, wellness and quality of life.

**Target Audiences for APA Recovery-Oriented Practices Curriculum/Educational Materials**

Overall, we are seeking to develop materials that have broad applicability to all psychiatrists who may have an interest in learning about recovery-oriented practices. Many of the basic principles are the same regardless of where or in what circumstances psychiatrists are practicing or where they are in their professional career (residency, early career, established practice).

Much of the materials developed under the project will be designed to be relevant to wide audiences, with modest modification/instructions. Rather than a single curriculum, the materials will include a series of modules addressing specific aspects of recovery-oriented practice that could be used independently.

Target audiences can be divided into two primary groups: receivers of the training and trainers who are teaching or supervising psychiatrists.

1) Receivers of training. The curriculum and educational materials will be designed for use by the following groups:
   - Psychiatry residents, medical students, and fellows;
   - Very early career psychiatrists;
   - Public/community psychiatrists (including National Health Service Corps and VA);
   - Inpatient psychiatrists and emergency psychiatrists (acute care settings).

Raising awareness and increasing knowledge and understanding among those in the first two groups in the list above will be key to making broader system changes in the future. Psychiatrists in the second two groups are those most likely to be working with individuals with serious mental illness, often in complex and difficult circumstances.

2) Trainers/supervisors. The curriculum and educational materials will be designed to be efficiently used by the following presenters:
   - Residency program supervisors and lecturers; medical student educators;
   - Case conference and grand rounds organizers; and
   - “Early adaptor” local training organizers and training providers (i.e., people who are already providing training or would like to) who could use the materials to supplement other resources.

Given the limited resources of the project, the curriculum will focus on the practical and on “making it real” and will thus be most appropriate for audiences who are already somewhat exposed to recovery concepts but want to move from inspiration to action. These audiences would include psychiatrists who know a little about recovery and are interested in learning more or those who are on board with the concepts but are unsure how to apply them in their particular circumstances.