



**RECOVERY TO PRACTICE**

Resource Center for Mental Health Professionals

## **Recovery to Practice**

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# Recovery to Practice

## Overview

The *Recovery to Practice* initiative is the most recent of the federal government's efforts to promote recovery for all Americans affected by mental illness. The *Recovery to Practice* initiative includes two complementary components: 1) creating and disseminating recovery-oriented training materials for each of the major mental health professions, and 2) creating a Recovery Resource Center for mental health professionals complete with Web-based and print materials, training, and technical assistance for professionals engaged in the transformation process.

Through these two major components, the RTP initiative aims to foster a better understanding of recovery, recovery-oriented practices, and the roles of the various professions in promoting recovery.

As part of the RTP project, SAMHSA approved awards to five national behavioral healthcare provider associations to expand awareness, acceptance, and adoption of recovery-based practices in the delivery of mental health services. These national mental health professional organizations will receive funding for 5 years to develop recovery-oriented educational materials and to train psychiatrists, psychologists, psychiatric nurses, social workers, and mental health peer specialists.

Other organizations contributing to the project include the Annapolis Coalition, Mental Health America (MHA), the National Alliance on Mental Illness (NAMI), the National Development and Research Institutes, Inc. (NDRI), and the New York Association of Psychiatric Rehabilitation Services (NYAPRS).

As part of the Recovery to Practice (RTP) initiative, these executive summaries are based on recently completed Situational Analyses conducted by each of the professional disciplines. The RTP Situational Analyses capture the current status of recovery-oriented practice within each discipline, and establish the approach disciplines will use to advance recovery principles and practices within their profession. The Situational Analyses help to determine strengths and identify gaps as each professional organization designs and delivers its curriculum.



## National Association of Peer Specialists

By Steve Harrington, J.D., Executive Director

Peer specialists<sup>1</sup> are persons with a lived history of mental illness and recovery journey who help others on their recovery journeys. Because the peer specialist profession is a relatively new phenomenon in mental health services, it is often unknown or misunderstood by other mental health professionals, medical health professionals, and the general public. Confusion and misunderstandings also exist with regard to the roles peer specialists can or should play in mental health services.

Although peer support can be traced to the beginning of humanity, it emerged as a powerful force in mental health in the early 1980s. At this time, mental health institutions were closing across the United States in favor of community-based treatment, where persons with psychiatric conditions could live and obtain support in the communities in which they lived. Peer support outcomes, the popularity of Alcoholics Anonymous, and the reality of recovery from serious and persistent mental health problems combined to create an atmosphere ripe for the creation of a peer support movement in mental health.

Change agents. Peer providers are now commonplace in some mental health systems. Factors driving this trend included

- The growing recognition of the reality of recovery from even severe and persistent psychiatric conditions
- A political climate that expected cost-effectiveness for public funds
- Positive outcomes associated with peer support
- A ready labor force
- The establishment of formal peer training and certification of peer specialists

In 2001, Georgia became the first State to obtain Medicaid reimbursement for peer support services (Salzer, Schwenk, & Brusilovskiy, 2010). Since then, 13 other States have followed. In addition to providing direct services to their peers, peer specialists were providing services in a variety of ways (one-on-one support, facilitating support groups, community resource connecting, education, and more)—they were acting as change agents. As employees of mental health providers, peer specialists found themselves in positions to influence organizational policies and practices to enhance service effectiveness (Fukul, Davidson, et al., 2010).

In 2004, the National Association of Peer Specialists (NAPS) was formed to promote the use of peer support in mental health settings. NAPS soon became involved in advising policy makers about peer workforce issues. The organization quickly grew from a handful of dedicated peer specialists to more than 1,000 members representing every State, as well as Australia, the United Kingdom, Japan, Guam, Canada, and several other countries. NAPS acts as a peer support information clearinghouse and frequently responds to inquiries from throughout the United States.

Need for national guidelines, certifications. Our Situational Analysis research has found that the number of States creating peer specialist initiatives has grown dramatically in the past 5 years. The number of States with employed peer specialists is somewhat greater than the number receiving Medicaid reimbursement (an estimate of 25 is not unreasonable), but the exact number is often difficult to determine, as programs are sometimes small and/or isolated. At least two States, North Carolina and Texas, are working toward Medicaid reimbursement for peer support and have made much progress in that regard.

One of the main findings we have come across is the lack of national guidelines or certification for the profession. Each State with a formal peer specialist program exercises control over that program as it relates to certification, training, professional discipline, and other operational issues. Until recently, training was generally offered as 1-week courses to satisfy State certification requirements. A common feature among virtually all training programs is heavy reliance on peers as advisors in basic curriculum development and as instructors. Training courses do appear to be increasing in length and the topics covered, but findings have indicated a great desire among peer specialists for greater emphasis or education on cultural competency, the role of trauma in mental health, and ethics issues.

Meanwhile, certification requirements vary across the States. Some States only require training, while others require training, work experience, successful completion of a comprehensive exam, character references, reference from a psychiatrist, an interview, and background investigations. Despite efforts to foster training and certification reciprocity between States, those efforts have generally resulted in rejections to “outside” assistance or suggestions. Although Kansas, Missouri, and Georgia permit a measure of reciprocity, most States do not and, at this time, appear unwilling to consider doing so.

The number of States with formal certification programs is, at least, growing. In August 2007, the Centers for Medicare and Medicaid Services (CMS) issued guidelines to States wishing to use Medicaid funding for peer support services (Smith, 2007). The guidelines addressed supervision, care coordination, and training and certification. But with the issuing of these guidelines and overall growth in the peer specialist workforce, the demand for continuing education opportunities has grown as well. While many States have spent considerable time and effort to develop the basic certification procedure and requirements, many have yet to reach beyond that to develop continuing education programs.

Role of peer specialists. Another finding in our assessment is just how diverse the peer specialist workforce is. This can prove both a challenge and a reward for our field as a whole. Each peer specialist brings a unique skill set to the mental health workplace. And because the profession is relatively new, there is often great flexibility in how and where those skills are used. Peer specialists work in such settings as general hospital emergency rooms, psychiatric hospitals, jails and prisons, and nursing homes. They also work as educators in communities, drop-in centers, clubhouses, and vocational placement agencies.

The diversity of peer specialists is reflected by more than work setting. Tasks are also variable and include—but are not limited to—individual support, facilitating support groups, educating a variety of individuals and groups about recovery and the true nature of mental illnesses, helping people make the transition from hospital to community, housing and educational support, engagement, wellness coaching, resource connecting, advocacy, supervision, administration, teaching of formal recovery courses, and transportation.<sup>2</sup>

In recent years, the Department of Veterans Affairs (VA) has made great strides in the training, certification, and hiring of peer specialists for its healthcare facilities. In some ways, the VA’s efforts have encouraged States that once considered peer support meaningless or marginally meaningful to reconsider their positions and, ultimately, create peer specialist programs. Today, the VA has a significant peer workforce that is well-trained and professional and contributes a wealth of positive outcomes (Salzer, 2011; Salzer, Schwenk, & Brusilovskiy, 2010).

Lack of understanding. That said, there appears to be a great number of mental health provider agencies that misunderstand the valuable roles peer specialists can play. Reports from the field reveal that some peer specialists are relegated to roles in which they are unable to use their recovery experiences and knowledge for the benefit of those they serve (or should be serving). There are reports that some peer specialists are providing parking lot security, medication monitoring, office support, or other duties that do not present meaningful peer-to-peer contact.

This may be because peer specialists are often supervised by non-peers who have no specific training on how to supervise peers in the workforce. In addition, peer specialists may work in an environment where coworkers lack knowledge of the recovery paradigm or feel confused or threatened by the presence of people openly in recovery in the workplace.

Failure to understand the important roles peer specialists can play is detrimental to peer specialists, coworkers, persons served, and mental health systems as a whole (Townsend & Griffin, 2006). Lack of understanding often leads to workplace conflicts.

And, despite the well-proven abilities of peer specialists to create positive outcomes in these many settings (Salzer, 2011; Salzer, Schwenk, & Brusilovskiy, 2010; SAMHSA, 2009; Davidson, Chinman, Kloos, et al., 1999), the profession remains underpaid. In describing our target audience for the NAPS Situational Analysis, we found that working peer specialists often live in poverty—despite being employed. Workers often feel disrespected and operate without a meaningful career ladder, even though they have a high motivation to work and succeed at employment, and to help others on their recovery journeys.

Next steps for future. Based on historical information, however, it seems a certainty that the peer specialist profession

will enjoy considerable (and likely rapid) growth in the next decade. One recent study has shown that peer support can reduce rehospitalization by as much as 72 percent (OptumHealth, 2011).

It is also clear the need for continuing education will grow as a component of State-sanctioned peer specialist programs, in line with the profession's growth, maturity, and CMS guidelines.

It is in this environment that NAPS will develop, and ultimately implement, training on recovery-oriented practices in our field. Our vision is a peer specialist workforce proficient in all aspects of recovery—and an environment in which others in the mental health field understand not only the value of recovery-oriented practice but the value peer specialists bring to recovery-oriented practice.

Work toward this vision will involve, first of all, educating the peer workforce to increase recovery knowledge and increasing recovery knowledge and practices in the long term. NAPS aims to develop a recovery-oriented curriculum that is as participatory and experiential as possible. Among other topics, the curriculum will address cultural competency, trauma-informed practices, and ethics and boundaries. As a field, we should also work to create professional peer specialist standards that can be applied nationally.

Continuing education is also important—not only formal continuing education, but also access to the many useful recovery resources that already exist. Too many of these resources remain unknown or inaccessible to peer specialists. NAPS hopes to forge collaborative relationships with organizations across the country to encourage access to depositories of evaluated and organized recovery materials.

We also suggest collaborating with other mental health professions to foster recovery knowledge and acceptance of recovery practices and policies. Peer specialists often observe practices and are subject to policies that inhibit their ability to move service providers toward a recovery orientation. Without a peer specialist workforce comfortable with expressing opinions and suggestions, and coworkers and supervisors willing to listen and consider them, the recovery paradigm is inhibited. Ensuring acceptance of recovery-oriented practices will mean working closely with the other disciplines on developing and implementing these practices and, where needed, helping to educate those who work alongside peer specialists on the key aspects of recovery. One basic first step we can take in marketing recovery knowledge is to develop a fact sheet that describes why, how, where, and when peer specialists perform their work.

One Indiana State mental health official has already noted our distribution of the Situational Analysis will help him promote the hiring of peer specialists in that State (B. VanDusen, personal communications, Feb. 8, 2011). With hard work, we will achieve a future in which peer specialists, as well as recovery practices as a whole, will be widely respected and adopted.

#### Footnotes:

1Peer specialists may also be referred to as: peer support specialists, peer support technicians, consumer advocates, peer recovery support specialists, recovery specialists, and a myriad of other titles.

2This list is far from exhaustive. Transportation is included here, but it is sometimes debated whether it is a “true” or “valid” peer support task. Transportation of peers can, however, present meaningful opportunities for discussion and relationship-building that supports a individual's recovery.

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# Council on Social Work Education

Social work is concerned with enhancing the well-being of people, groups, and communities by strengthening the opportunities and capacities of individuals, and addressing conditions that limit human potential (Council on Social Work Education (CSWE), 2001, 2008). Social workers are engaged in a variety of settings, operating in direct practice with individuals, families, and groups, as well as practice in management, policy, and community organization. Overall, it is estimated that social workers provide almost half of all mental health services (National Association of Social Workers (NASW), 2011; Manderscheid & Henderson, 2000). Social workers may be the only mental health professionals available—especially in rural areas.

Social work literature accentuates how social work is “uniquely qualified” (Carpenter, 2002, p. 87) to employ the recovery paradigm, listing the profession’s history and contribution to the movement through the strengths perspective and investment in forming and promoting the implementation of recovery (Carpenter, 2002; Scheyett, 2005; Starnino, 2009). Sources posit the profession’s place is noticeable because it contends with environmental and societal oppression, addressing empowerment and social justice in ways other helping professions might not (Scheyett, 2005).

The Situational Analysis found that there are strong theoretical connections between social work and the recovery movement. As it formed, social work built on the existing social sciences, psychology, and biology. The resulting conceptual framework for social work practice pulled together these fields for a holistic view of individuals, termed “person-in-environment.” Social workers are expected to understand and assess the biological, psychological, social, and spiritual aspects of an individual and the environment in which she or he resides. Such a perspective is still a standard of social work practice today. In the 1980s the strengths model for case management was developed. The strengths model tied together the earlier frameworks, introduced hope and equality to the therapeutic relationship, and was consistent with recovery-oriented practice. As explained by Charles Rapp,

*The importance of a strengths approach, however, is that: it is concordant with social work values; it dramatically expands the scope and venues of helping; it gives the client a critical role in the process; it redresses some of the excesses of the expert role; it summons community resources; it fulfills the obligation of the person: environment perspective by drawing upon the energies of body, mind, spirit, and environment in helping; its vocabulary is ordinary and it respects the indigenous psychology of all peoples (their theories); and it can create positive atmospherics in agency and organization (Rapp, 1987, p. 25).*

Social work has made a longstanding commitment to cultural competency and social justice. The NASW Code of Ethics (2008), for example, stresses empowerment, social justice, self-determination, and the person-in-environment framework, and focuses on the individual. The Code of Ethics also identifies six core values of social work that underscore treatment and practice compatible with recovery: service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence.

In spite of many theoretical similarities to recovery, there are areas in which social work practice has fallen prey to the same persistent focus on illness, labeling, and deficits, which dominate the mental health care system and set the consumer apart to be acted on by the practitioner. The theoretical base of the person-in-environment and strengths-based perspectives (which call on social workers to empower consumers) and the Code of Ethics (NASW, 2008; which highlights self-determination and respect) are often found by the practitioner to be at odds with the day-to-day realities of social work practice in the mental health system.

## Target Audience for Curriculum Development

The Situational Analysis has shown how social work is particularly well-suited and prepared for mental health recovery in many ways. Historically, social workers have had a concern for components of recovery cited in the SAMHSA Consensus Statement (2006), especially empowerment, holistic care, the strengths-based perspective, self-direction, and respect. Furthermore, the efforts of social workers to eradicate discrimination and stigma and recognize and engage differences are also consistent with the concerns of recovery. There is evidence that some social work educators and practitioners have already become involved in the recovery movement, and have started to implement it in courses and practice.

The Situational Analysis has also shown that there are some areas in which social work does not entirely embrace the

full meaning of recovery, or where very little evidence exists that anything is being done at all. In particular, the components of peer support and involvement of consumers throughout the process seem to be lacking. Some of the discussions appeared to uncover a true partnership, but others indicated a paternalistic type of practice taking place, in which the consumer was not an equal partner in the process. Some individual faculty members and practitioners stood out as being particularly concerned with including the consumer voice, but these do not appear to be the norm. The other concern is that in many of the areas in which there is theoretical kinship with recovery, there appears to be some cognitive dissonance. For instance, social workers may believe in the strengths-based approach, but in practice are working from a deficits model.

To effect a paradigm shift, change must be as systemic as possible. It is with this mandate in mind that the CSWE team recommends social work practitioners, particularly those serving as field instructors, as the target audience for curriculum development.

Social work practitioners comprise a multifaceted group that intersects with the mental health system at many different points. Practitioners can have an effect on recovery through their direct service to consumers and families, at the organizational and administrative leadership levels, and/or can influence social work students when they serve as field instructors. Even if they are not immediately supervising the students in practicum placements at their agencies, practitioners can have an indelible influence on the culture of those agencies and their embrace of recovery principles, which shapes the experience of the next generation of social workers.

In social work education, all students are required to participate in field education to graduate. Field education, also called the signature pedagogy of social work, is intended to “socialize” students to “perform the role of practitioner” (CSWE, 2008, p. 8). Students must complete at least 400 hours of field education at the baccalaureate level and at least 900 hours at the master’s level (CSWE, 2008). Many programs require completion of more than the mandated minimum hours. Programs can structure the field education as they like, but typically baccalaureate students begin field education their senior year and master’s students begin one field placement in their second semester, with a yearlong placement (in the respective area of concentration) during the second year. Each year there are more than 14,746 baccalaureate and 30,037 master’s students in field placements. Of these, approximately 1,100 (7.6 percent) baccalaureate placements and 6,100 (20.4 percent) master’s placements are in settings identified primarily as mental health or community mental health. Of course, many other settings could also provide opportunities in mental health (e.g., military, family services, child welfare).

Field instructors are practitioners who are working in the field and serve as supervisors to social work students. The 2008 Educational Policy and Accreditation Standards mandate that field instructors must have a degree in social work to supervise students. Programs are also required to provide “orientation, field instruction training, and continuing dialogue with field education settings and field instructors” (CSWE, 2008, p. 10). A single field instructor could supervise more than one student, and the Annual Survey of Social Work Programs collects only data on the number of students in field placements, so it is unknown exactly how many field instructors currently serve as supervisors; however, even assuming that only one third of the placements are unique, it would be a pool of approximately 15,000 practitioners.

For the focus of the curriculum development phase, it is recommended that we use partnerships that already exist between mental health agencies and universities to target practitioners while also affecting students—the future practitioners. CSWE, through the field directors/coordinators at each accredited social work program, could promote and disseminate the training. Within a single year, there would be the potential to reach thousands of practitioners and, through them, even more students.

Thousands of practitioners serve as field instructors every year in social work education. If field education is where students are socialized to the profession, then we should take advantage of this unique existing partnership between classroom and field to infuse mental health recovery throughout social work. Although the specifics have yet to be determined, existing means of communication and structures are in place that will assist with this model.

To read CSWE’s Situational Analysis in its entirety, please visit [www.cswe.org/CentersInitiatives/DataStatistics/42850/51133.aspx](http://www.cswe.org/CentersInitiatives/DataStatistics/42850/51133.aspx). For more information about this Situational Analysis, please contact the Council on Social Work Education’s RTP team at [jholmes@cswe.org](mailto:jholmes@cswe.org).



# American Psychiatric Nurses Association

The State of Psychiatric–Mental Health Nursing in the Recovery to Practice Journey: A Situational Analysis  
SAMHSA has called for the transformation of mental health care in America from an illness-centered paradigm to recovery-oriented systems of care. As part of this initiative, the American Psychiatric Nurses Association (APNA) launched a 5-year project to develop and implement a training curriculum that promotes greater awareness, acceptance, and adoption of mental health recovery principles and practices among psychiatric–mental health care nurses.

This Situational Analysis summarizes the first year’s efforts of the APNA RTP project and recommends a plan for developing the curriculum.

Participants and methods. The RTP project uses Appreciative Inquiry as its framework. This strengths-based model of thinking, seeing, and acting for powerful, purposeful organizational change assumes that what you want more of already exists in the organization. According to this model, the project seeks to engage representatives from all levels of the system through each of five phases: define, discover, dream, design, and deliver. In year 1, the project concentrated on the first two phases, by defining the need for transformational change and through discovery. The result is a Situational Analysis of our nursing specialty’s strengths, needs, and challenges to achieving the desired change.

RTP team members assessed data collected through chapter discussions with a national sample of psychiatric–mental health care–practicing nurses, nursing educators and administrators, and consumers, as well as by interviewing key informants. In facilitated group discussions, the project team aimed to discover the current knowledge and use of recovery principles and practices by psychiatric–mental health care nurses and the skills they need for recovery-oriented practice. Team members also dialogued with the APNA Consumer Advisory Panel about their experiences with psychiatric nurses’ use of a recovery model. Interviews with leaders of mental health systems at the national, State, and local levels—conducted in person and by phone and email—explored recovery-focused policies and resources.

A literature review examined recovery from the nursing perspective in an attempt to identify whether nursing has strengths that relate to SAMHSA’s 10 Fundamental Components of Recovery. These recovery principles are self-direction, individualized and person-centered, empowerment, holistic, nonlinear, strengths based, peer support, respect, responsibility, and hope.

Findings. The nursing literature contains little data on recovery. However, all 10 components of recovery are embedded in nursing theory, research, and practice, particularly in psychiatric–mental health nursing. Nursing also has a strong foundation in cultural competence. In crucial areas that influence recovery, some nurses are actively seeking education, including full partnership with consumers and trauma-informed care (understanding the impact of trauma on people who receive mental health care). The nursing profession can build on these strengths to facilitate change.

Highlights from the facilitated discussions follow.

## Nurses

- Education and professional training in recovery-focused nursing practice has been limited, and nurses need more knowledge, support, and tools in this area.
- Specifically, nurses need to learn and use recovery (e.g., person-centered) language and skills, such as shared decision-making, and to better understand trauma-informed care.
- Psychiatric–mental health nurses must infuse recovery components into daily nursing practice and continue to increase their partnership with consumers.
- Barriers to these efforts include a limited number of nurses who are content experts about recovery, insufficient funding, pressures from insurance providers to lower costs, inconsistent reimbursement for recovery services, and difficulty changing from adherence to a diagnostic and maintenance approach to practice.
- Administrative buy-in is critical to successful implementation of recovery in practice.

## Consumers



- Nurses often do not realize that recovery is possible.
- Nurses and consumers should be more visible champions for recovery.
- Hospital-based nurses are positioned to implement recovery practices.

Thus, the project team identified the following needs: integrated nursing education and training in recovery, peer recovery champions, recovery experts, and consistency in organizational systems and in the mental health care system.

Recommendations and objectives. Within the next 2 years, the RTP nursing curriculum and training manual will be developed, with the continued collaboration of nurses, consumers, and other partners. It will use Web-based technology to be cost effective and highly accessible. Proposed content includes SAMHSA's recovery principles, trauma-informed care, collaborative relationships, cultural competency, and person-centered communication. The target audience will be psychiatric–mental health registered nurses, advanced practice nurses, student nurses, and administrators.

Field testing will involve a pilot group of practicing nurses from selected inpatient settings, beginning in year 3. Full implementation and marketing will occur in the final 2 years.

Desired objectives on completion of pilot training are that psychiatric–mental health nurses

- Begin to apply SAMHSA's 10 mental health recovery components to nursing practice
- Actively use recovery language
- Share decision-making with consumers of mental health care
- Begin to direct consumers to community resources that facilitate recovery

Moreover, the 2012 revision of APNA's Scope & Standards of Psychiatric–Mental Health Nursing Practice is expected to reflect that mental health recovery is fundamental to our practice.

APNA's vision is that behavioral health care will significantly improve by the end of year 5 as a result of psychiatric–mental health nurses integrating recovery-oriented care into their practice.

## American Psychological Association

Psychologists have historically played key roles in the recovery movement, as well as in the community mental health and psychiatric rehabilitation movements that set the stage for it. Studies by psychologists such as Paul and Lentz (1977), Wing and Brown (1970), and Vaughn and Jeff (1976) also helped pave the way for the recovery movement by changing the prevailing idea that there was little hope for improvement in individuals with serious mental illness.

Among the mental health consumer/survivor leaders who ignited and have guided the movement, several have been psychologists (e.g., Bassman, Deegan, Frese). In addition, psychologists have been at the forefront of the research, practice, and policy dimensions of this movement. Their contributions include

- Longitudinal outcome studies that provided the empirical support for—or confirmation of—first-person recovery narratives (e.g., Harding, Harrow)
- Groundbreaking research on promoting functioning (e.g., Bell, Bellack, McGurk, Mueser, Silverstein, Spaulding)
- Contributions to the definition of recovery (e.g., Anthony, Deegan)
- Support of families (e.g., Johnson, Lefley, Marsh)
- Addressing of stigma, discrimination, and resilience (e.g., Corrigan, Russinova, Wahl)
- Addressing of shared decision-making, resilience, and the recovery journey (e.g., Deegan, Harding, Spaniol)
- Development of principles for recovery-oriented practice and competencies (e.g., Anthony, Cook, Davidson, Farkas, Frese, Russinova, Shepherd, Slade)
- Articulation of a vision of recovery-oriented practice that can be used to guide system transformation (e.g., Anthony, Davidson, Farkas)

Anthony's seminal 1993 article, "Recovery from mental illness: The guiding vision of the mental health service system in the 1990s," was not only prescient, for example, but helped to establish the conceptual basis for recovery to become the overarching aim of mental health care as recommended by the U.S. Surgeon General in 1999 (later to be reaffirmed and elaborated in the President's 2003 New Freedom Commission on Mental Health).

While psychologists may have been at the center of the recovery movement, the same cannot be said for recovery being at the heart of the discipline of psychology. Many factors, both historical and sociopolitical, may have contributed to the current state of affairs, but at this time there is a relatively small—if growing—number of psychologists who have embraced and attempted to further the recovery paradigm. Some of these factors include the ascendancy of a neurobiological model of mental illness in the 1980s—establishing psychopharmacological treatment as the apparent approach of choice for these disorders—and the emergence of data at the same time suggesting that psychodynamically oriented psychotherapies lacked efficacy for the population of people suffering from these disorders. By the late 1980s, these developments had already appeared to diminish interest by psychologists in this population, when a group of psychologists dedicated to the care of people with serious and persistent mental illness began to make concerted efforts to revive and expand the broader field's interest in this work (Johnson, 1990; Wohlford, Myers, & Callan, 1993). The relative lack of penetration of the concept of recovery and its implications for transforming mental health practice into the field of psychology can perhaps be read as yet more evidence of the fact that interest in this population has continued to decrease among psychologists.

The involvement of the American Psychological Association (APA) in SAMHSA's RTP Initiative represents a new opportunity to engage in system transformation. In this effort, the discipline of psychology has many strengths on which to build. These include the outstanding work of clinical, community, counseling, school, psychosocial rehabilitation, humanistic, and neuro-cognitive psychologists who have devoted their professional careers to developing and disseminating innovative approaches to care for and promote resilience and recovery.

Strengths also include an increasing number of psychologists who are in recovery and the previous and current membership of APA's Task Force on Serious Mental Illness and Severe Emotional Disturbance (SMI/SED), the body of concerned psychologists that has persistently advocated for the discipline to focus more of its energies and resources on this important cause. Kay Jamison, Elyn Saks, and Wendy Walker Davis are all in recovery from serious mental illness.

They also all are, or were, APA members and served on the APA's Task Force on the SMI/SED. Keris Myrick, the first vice president of the National Alliance on Mental Illness national board of directors, is a person who has been diagnosed with schizophrenia and who has credentials in psychology. The RTP Initiative offers this task force and other like-minded psychologists the opportunity to amplify their voice and to bring the field of psychology into the center of national system transformation efforts.

**Vision.** Through the resulting curriculum, the APA will put forth a framework that trains psychologists in providing recovery-oriented behavioral health care. Recovery-oriented care assists individuals to achieve those optimal functional capabilities chosen by each person to enable him or her in achieving his or her full potential. In addition to being consistent with the values, principles, and knowledge of psychology, the provision of recovery-oriented care incorporates such key APA priorities as healthcare reform and the reduction of health disparities. It also is consistent with the fundamental values of psychology and national trends and expectations, thereby positioning APA and its 154,000 constituent psychologists to be responsive to the rapidly changing healthcare environment and shifting expectations for providers.

**Opportune time.** The RTP Initiative comes at an opportune time for the discipline of psychology. Based in part on the work of generations of psychologists, as well as on the lives and advocacy efforts of people in recovery and their loved ones, the recovery vision has come of age and has been firmly established as the guiding vision for behavioral health care for the foreseeable future. As the APA continues to engage in the important work of healthcare reform and the elimination of health disparities, this vision of recovery will increasingly influence the practice of all psychologists participating in the provision, and study, of health care.

Our field already has many strengths in place, which we can build on as this vision takes root and permeates the broader healthcare arena. The RTP Initiative will need to make effective use of these strengths to expand the circles of psychologists who are embracing and further elaborating on the concepts of both resilience and recovery, overcoming ignorance with education, dispelling stigma and eliminating discrimination toward people with serious mental illnesses, inviting and retaining within the field psychologists with their own firsthand experiences of mental illness and recovery, and bringing the considerable talents, tools, and concepts within the profession together into a coherent and compelling vision of how psychology can enhance and improve the lives of children and youth with serious emotional disturbances and adults with serious mental illnesses.

Key foci for advocacy on behalf of this vision will be to:

- Ensure that Medicaid/Medicare and private insurance cover a range of recovery-oriented psychosocial interventions and community-based supports
- Make effective use of emerging technologies, not only for rural and tribal communities but also for providing ongoing support for people working on establishing and sustaining recovery (e.g., telephonic follow-up support)
- Ensure that all Americans, but especially those with serious mental illnesses, have access to safe and affordable housing and meaningful employment
- Decriminalize mental illness and develop alternatives to incarceration that ensure that people receive effective care rather than ineffective punishment for illness-related behaviors
- Develop and apply behavioral assessment and analysis to the task of enabling people to live self-determined and meaningful lives in the community
- Promote a holistic vision of wellness and well-being, including resilience in the face of adversity, that can be held up as the ultimate goal of health care for all Americans, regardless of trauma history, mental illness, culture, race, ethnicity, sexual orientation, religious affiliation, immigration status, or social class.

For more information about this Situational Analysis, please contact Andrew Austin–Dailey of the American Psychological Association at [aaustin-dailey@apa.org](mailto:aaustin-dailey@apa.org).

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## American Psychiatric Association and American Association of Community Psychiatrists

This Situational Analysis summarizes the information-gathering efforts of the 1st year of a multiyear project to develop and disseminate educational materials on recovery-oriented practices for psychiatrists. 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. It is part of a larger SAMHSA effort to broaden and increase awareness, acceptance, and adoption of recovery principles and practices among mental health care providers.

This 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.

Following are some examples of comments and concerns from participants.

### Clinicians:

- Perception of recovery being associated with substance use disorder and addiction recovery
- Concerns relating to sharing power
- Lack of knowledge and understanding about how to put recovery-based care into practice
- Systems that limit the psychiatrist role in medication management and limit the 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 be viewed as a whole person, not as a diagnosis.”
- The best source of hope is seeing a person in recovery and 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 and 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 the use of interactive and experiential teaching strategies. Finally, in order to reach more people, training materials should be available online and should be available for continuing medical education credit.

For more information about this Situational Analysis, please visit [www.psych.org/Share/OMNA/Recovery-to-Practice\\_1.aspx](http://www.psych.org/Share/OMNA/Recovery-to-Practice_1.aspx) or contact the American Psychiatric Association's RTP team at [abondurant@psych.org](mailto:abondurant@psych.org).