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Will Hospitals Recover?: The Implications of a Recovery-Orientation

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Recovery has emerged as a dynamic and effective model for community services for people with serious mental illness. As the efficacy of the model is demonstrated and the reality of recovery is experienced by many consumers, some state hospital systems are expressing an interest in how a recovery model might influence prevailing institutional practices. The challenge in the hospitals may be to recognize at what point in the treatment process the recovery model informs the medical model. Issues to be considered in implementation of the recovery model in state hospitals include the relative dominance of symptom-focused treatment models, hierarchical institutional structures and employee attitudes that tend to resist change, and the effects of chronic institutionalization on patient and staff attitudes toward recovery and autonomy. State hospitals may need to focus on consumer-identified themes such as hope, self-identity, responsibility, and meaning as they attempt to incorporate the recovery model into the hospital culture. These themes are not incongruent with exemplary medical practice. Practical application of the model should consider these dimensions with respect to the key hospital domains of treatment team function, patient role, hospital environment, administrative leadership, and intervention strategies.

Keywords: Custodial care; Medical model; Recovery; State psychiatric hospital

State psychiatric hospitals continue to treat people with methodologies that predate the emergence of the recovery model. As a
conceptual model, recovery has greatly influenced community program policies and has enhanced expectations for many consumers of mental health services. The pervasive influence of the model has begun to generate interest in state psychiatric hospital settings. Administrators and practitioners in these institutions have begun to think of ways to implement programming that utilizes this new vision for services while maintaining high standards of medical care. It is understandable, due to lack of exposure to recovery-based principles, that some hospital staff are naïve as to the potential of the “patients” with whom they work. For many of these professionals the statement that “they’re too sick to recover” is perceived as obvious and inevitable. This article will consider several topics germane to the current practices in state hospitals before a more in-depth look at how recovery principles could inform a transformation of hospital services.

FOUR COMPONENTS OF RECOVERY FROM A HOSPITAL PERSPECTIVE

The concept of recovery and its application as a practical strategy was greatly enhanced when the consumer movement began questioning the notion that schizophrenia necessarily has a long-term, deteriorating course. This pessimistic view of schizophrenia had been sustained by diagnostic classifications that changed if the person improved and by clinicians that lacked feedback from people who improved and no longer needed services (Andresen, Oades, Caputi, 2003). The personal stories of significant and sustained recovery and landmark longitudinal studies (e.g., Harding, Brooks, Ashikaga, Strauss, Breier, 1987) demonstrated that a significant number of people can experience improvements in important aspects of their lives. Recovery as a vision for mental health gained momentum in the 1990s (Anthony, 1993) and is now endorsed on the federal level in the President’s New Freedom Commission Report (DHHS, 2003) as well as in Mental Health: A Report of the Surgeon General (DHHS, 1999).

A recent review of published experiential accounts was conducted to further refine a definition of recovery and to identify key processes (Andresen et al., 2003). The authors of this study propose an emerging model that they identify as “psychological recovery.” The model “falls between the rehabilitative model and the empowerment model
and is most compatible with consumer beliefs’’ (Andresen et al., 2003, p. 588). They further state that:

“Psychological recovery refers to the establishment of a fulfilling, meaningful life and a positive sense of identity founded on hopefulness and self-determination. The person recovers from the psychological catastrophe of the illness” (Andresen et al., 2003, p. 588).

Four components of recovery are discussed in the present article. Each has relevance to a discussion of recovery and its efficacy as a model in state hospitals.

Hope

Hope can be seen as the belief that one can attain significant personal goals. Patricia Deegan describes the role that hope played in her recovery from schizophrenia and in her goal to earn a doctoral degree in psychology (Deegan, 1988). In contrast, how can hospital programming based on compliance with group interventions provide the necessary individual support and relationship building necessary to take the preliminary step to achieve this sense of hope? The experiential literature is replete with accounts of a single individual being identified as inspiring someone towards hope (Deegan, 1996). Unnecessarily long hospital stays contribute further to hopelessness. In a recent review of current data at a state hospital in the Northeast approximately half of the more than 500 people there no longer met the requirements for commitment but had their commitment extended pending placement (CEPP). This condition has resulted in a successful lawsuit against the state of New Jersey based on the L.C. vs. Olmstead decision. Consider the impact of “extended commitment” on such individuals. How can a spirit of hopefulness prevail?

Self Identity

Many consumers express the view that the roles that they have taken on in life and that they find uniquely valuable are jeopardized by a serious psychiatric disorder and the system designed to treat it. Pat Deegan (1997, p. 15) describes her feelings: “My teenage world in which I aspired to dreams of being a valued person in valued roles...I felt these parts of me being stripped away from me.” In a hospital setting those threads of self-identity can be even more difficult to maintain. The role of ‘‘patient’’ is generally
a passive role where others are expected to help or cure them. Adopting roles that are focused on strengths, where illness is just a part of a person, appears to be important for recovery. There is evidence that people in the hospital who were making progress in their recovery, and who took on the role of supporting others to recover, experience additional positive outcomes (Patrick, Smith, Schleifer, Morris, & McLennon, 2005).

Meaning in Life

People experiencing mental illness often report the feeling that previous goals no longer seem possible for them. This sometimes involves finding other ways of expressing those core values. Victor Frankl (1973, p. xi) said “a goal can only be a goal of life if it has meaning.” In hospital settings the treatment planning process and “patient” goals are often more influenced by existing programs than by a genuine attempt to determine meaningful goals. It can be argued that this system adequately ensures the basic medical and general needs of each individual and this is understandably important given the nature of large institutions. However, if a hospital is interested in establishing recovery and wellness as an expanded vision of what hospitals can be, the current model needs to be reassessed.

Responsibility

Preliminary findings from the experiential literature support recovery as a stage based process (Andresen et al., 2003). Responsibility for oneself or an increased sense of “agency” is reported by consumers to be an important stage leading to an increased sense of autonomy. For many people in hospitals the desire to assume responsibility is thwarted by the overall dictum that “until you leave, you are our responsibility.” Central to responsibility is the self-management of medications, wellness promotion behaviors, as well as the opportunity to take informed risks and learn from those experiences.

THE INFLUENCE OF THE MEDICAL/HOSPITAL MODEL

The medical model is generally seen as an expert model that offers “patients” the best available evidence regarding the treatment of
conditions and diseases in an effort to eliminate suffering. This is done by diagnosing the condition or disease, prescribing an evidence-based treatment and providing or referring people for the treatment. This “medicalization” of care for people diagnosed with mental illness has the unfortunate reputation of being delivered in a way that excludes the individual’s input.

As treatment of the insane was medicalized, the classic (and hegemonic) shape of medical service delivery was maintained… the physician in the role of agent (literally one who acts on the external environment and the ill person in the role of patient (literally, one who primarily is acted upon by the external environment rather than acting upon it). For the successful completion of this sequence the “patient” must be passive. In modern medical service delivery the person needing medical services exchanges his or her agency (and often, dignity) for the receiving of services, which are delivered in a one-way direction. The basic social organization of high tech medicine is “hold still while I give you the treatment.” (Erickson & Straceski, 2004, p. 113)

Most individuals have voluntarily sat in paper gowns during a doctor’s visit waiting for someone to do something to them in order for them to improve or get well. This experience is common in medical practice and in many ways makes even more sense when thought of in relation to individuals whose judgment may be impaired due to psychiatric illness. For this reason the “hospital model” is the medical model delivered in an even more passive, more custodial form. The hospital model tends to start with a highly controlled custodial environment where staff use their clinical expertise to diagnose problems and prescribe treatments. This is followed by attempts to move the “patient” toward an understanding of the value of the treatments and eventual compliance. Table 1 looks at some of the fundamental features of the hospital model. Some consumers find the custodial and prescriptive aspects of the hospital model so dissatisfying they seek to avoid the delivery system altogether.

The medical model of psychiatric care has been criticized in some circles as representing much that is wrong with traditional treatment. It is accused of being disconnected from the comprehensive needs of people with severe and persistent mental illness and inflexible in the face of client centered approaches. The model, however, is not tied to a given theory and is thought of and practiced in a variety of ways.
Iatrogenic Cycle

Consumer advocates have asserted that the best chance that people have to recover from a severe mental illness is to never enter “the mental health system” in the first place (White, 2005). This sentiment has particular resonance for individuals in state hospitals for prolonged periods of time. Custodial care remains commonplace in today’s psychiatric hospitals and can cause an atrophy of self-care, motivation, and social skills (Wirt, 1999). There is a self-perpetuating cycle in which control of a person’s life is “borrowed” until he or she improves enough to assume this responsibility. Generally the cycle starts with a finding that a person is in “clear and imminent danger” due to the impact of mental illness. Few would argue that, when an individual affected with mental illness is a danger to themselves or others, someone, often a mental health worker, needs to intervene. This intervention sometimes results in the removal of a person’s freedom through involuntary hospitalization. Currently the hospital model has a central role during this acute phase of mental illness. Once a “patient’s” condition has improved, the hospital model’s utility diminishes rapidly and the recovery model’s utility increases.

Each individual’s capacity for autonomy must be respected, eventually to the point where all decisions about treatment are in

<table>
<thead>
<tr>
<th>Table 1. Hospital model</th>
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<tbody>
<tr>
<td><strong>Treatment Team’s Role</strong></td>
</tr>
<tr>
<td>• Diagnose the condition, disease, or skill deficit</td>
</tr>
<tr>
<td>• Design interventions to treat the condition, disease, or skill deficit</td>
</tr>
<tr>
<td>• Provide the intervention(s).</td>
</tr>
<tr>
<td><strong>Patient Role</strong></td>
</tr>
<tr>
<td>• Attend programs in order to address deficits identified by the treatment team.</td>
</tr>
<tr>
<td>• Follow hospital rules in order to maintain or increase level of privilege.</td>
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<tr>
<td><strong>Environment</strong></td>
</tr>
<tr>
<td>• Meets the basic needs for nutrition and habitation in a safe, cost-effective manner.</td>
</tr>
<tr>
<td><strong>Hospital Administrative Role</strong></td>
</tr>
<tr>
<td>• Develop and monitor policies and procedures across the hospital to assure safe and ethical practices.</td>
</tr>
<tr>
<td>• Assure adequate supervision/staffing/hiring.</td>
</tr>
<tr>
<td><strong>Treatment Interventions/Programs</strong></td>
</tr>
<tr>
<td>• Interventions are designed to remediate patient deficits.</td>
</tr>
<tr>
<td>• Treatment interventions are voluntary unless absolutely necessary to maintain safety.</td>
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</tbody>
</table>
the hands of the person. (Frese, Stanley, Kress, & Vogel-Scibilia, 2001). Unfortunately, people in the hospital may find their personal agency difficult to regain even after signs of overt dangerousness or incapacity has passed. Often at some point in the hospitalization process the “bar is raised” to include skills or behaviors that are deemed to be lacking and seen as necessary for discharge. These deficits are often delineated in treatment plans with little input from the person themselves. (Deegan, 1996). The process can pit the individual against the treatment team in a battle of wills. Resentment or ambivalence to the process is seen as evidence of the necessity of continued hospitalization. Even in instances where the plan is otherwise adequate, the person’s collaboration is crucial for success (Deegan, 2004). This is not to say that the hospital model causes all problems or that some aspects of the hospital model are not crucial to recovery. Instead, it does suggest that some iatrogenic effects of this model can be reduced or eliminated.

The need for caretaking and prescriptive treatment in an individual’s acute phase of illness may be unavoidable, but it should be weighed against the eventual need for meaningful collaboration with the patient in the future. The blending of this aspect of the hospital model and the recovery model involves the concept of progressive empowerment. Other vestiges of the hospital model such as aspects of the hierarchical administrative structures and the normal-abnormal divide are fundamentally inconsistent with the recovery model.

Progressive Empowerment

As a person in the hospital progresses from the need for acute treatment, the restrictive nature of the care given recedes and the amount of autonomy increases. This can be seen as a progressive and incremental process of empowerment. The recovery model has the client in a central, active role in the progression. However the current hospital model is not organized from a client-centered perspective and the client’s role is generally passive. The hospital model has not historically provided staff that were trained or acculturated with the mindset of client-centered empowerment. This is not to say that empowerment does not happen, but that the model itself makes it less likely. What the hospital model offers as a substitute for a client-centered relationship is social control in the form of rules. The focus on rules is functional up to a point but as the need for
client self-determination increases, the hospital model with no effective mechanism to accommodate this change, resorts to “compliance” as the barometer of psychiatric stability. This mindset can lead to confusion regarding clinical stability and lead to the over use of medications and unnecessarily prolonged hospitalization.

Hierarchical Structures

Although recovery is an individual journey and may happen outside of the mental health system (Anthony, 1993), a person within the confines of a state hospital system is inevitably dependent on the hospital staff. The organizational structure of state psychiatric hospitals is characterized by disciplines with rigid guidelines and little lateral authority. This “stovepipe” system attempts to define responsibilities discretely through job descriptions. This rigidity is not conducive to the kind of communication and relationship building that is integral to the recovery process (Deegan, 2004). In contrast, consider the Clubhouse principle that all staff function as generalists and do whatever needs doing (International Center for Clubhouse Development, 2005). By contrast, the narrowly defined demarcation of responsibilities in hospitals often leads to a diffusion of responsibility. This perception that staff are like interchangeable cogs is inconsistent with the notion that ongoing supportive, trusting relationships are pivotal to recovery (Deegan, 2005).

The Normal-Abnormal Divide

Historically, mental health services have spent considerable effort trying to get people in the “abnormal world” to adapt or fit into the “normal world” (Deegan, 1988). This creates a divide or separation that may enforce the illusion that staff are not wounded in any way and not in need of the spirit of recovery. From this perspective “patients” are fundamentally different. This sense of separateness or otherness is constantly reinforced. Most of the buildings or units are locked. All staff have keys. Bathrooms, dining facilities, parties, and celebrations are designated for either staff-only or patient-only. Other examples of the divide are subtler. Staff are regularly reminded to maintain a professional distance and to “treat all patients the same.” This results in staff not developing the kind
of person-to-person working relationships that consumers often identify as being integral to the recovery process (Deegan, 2005).

THE RECOVERY MODEL IN A STATE HOSPITAL

The radical premise of the recovery movement is that the focus of treatment moves from the professional to the client’s perspective. Historically, the power to define and prescribe has been in the hand of clinicians (Walker, 2006). The question we ask is: “What role treatment has in recovery and how would a hospital adapt in response to this shift in perspective?” To support each individual’s personal and idiosyncratic path to recovery, hospital staff need to manage elements of both the hospital model and the recovery model. This is dependant on hospital staff recognizing the value of a client-centered process and not just the outcome of maintaining safety and control. This also requires the acceptance that consumers rely on a wide range of methods to evaluate information that may help them get better (Roe & Yanos, 2006). “The negotiation process by which a person learns, rejects, collects, forgets and attributes meaning may be an important part of the recovery process” (Roe & Yanos, 2006, p. 55). Environments that support recovery often have a particular subjective quality or feeling for both professionals and clients. In an ethnographic study of the Village, a community mental health center in California, this subjective feeling was called “quality of the heart” and was used to define the pervasive values that influenced this highly successful program (Erickson & Straceski, 2004). This feeling is a product of the “person-first” egalitarian philosophy that attempts to remove barriers between staff and clients. This helps elevate the client’s role to one of “person” of equal value and near equal power to staff. The relationships established between participants and professionals and the respect, empathy, and hope engendered by these relationships are fundamental to the recovery model’s success. These relationships ideally come about naturally from the evolution of an institutions recovery oriented vision. Carling (Carling, 1995) puts it well when he says “...how difficult it must be to embark on the path of their own recovery, when their most trusted service providers ...believe such a path to be impossible.”

Fundamental assumptions of a hospital/recovery model are described in Table 2 and if necessary can be used progressively
and sequentially with the hospital model as presented in Table 1. This is followed by a more detailed description of what programmatic aspects of the hospital would look like when using the recovery model.

**Treatment Team’s Role**
The treatment team has the potential to be a significant factor in each person’s hospital experience. Where treatment teams are sometimes lacking is in formulating a plan that is truly responsive to each individual client’s personal needs or goals. The sad joke that goes around the hospital is that “we’re treating the chart.” Add to this a tendency toward a “diffusion of responsibility” that sometimes leads to few if any of the team members establishing effective therapeutic relationships with clients. The treatment planning process and the team meetings themselves could be a place that conveys hope, is characterized by dialogue and compromise, and is respectful of stage based change that is personal and idiosyncratic. Staff must resist the urge to simply make the “right” decision.

**Table 2. Recovery model in the hospital**

<table>
<thead>
<tr>
<th>Treatment Team’s Role</th>
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<tbody>
<tr>
<td>• Practitioners use a partnership that honors the client’s expertise and perspectives.</td>
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<tr>
<td>• The practitioner uses relationships instead of rules and strives to collaborate</td>
</tr>
<tr>
<td>rather than coerce.</td>
</tr>
<tr>
<td>Patient Role</td>
</tr>
<tr>
<td>• The patient’s role is to collaborate and negotiate with professionals as an expert</td>
</tr>
<tr>
<td>on their needs, strengths, and deficits.</td>
</tr>
<tr>
<td>• This may mean focusing more on their goals and on what makes them well, not</td>
</tr>
<tr>
<td>on what makes them sick.</td>
</tr>
<tr>
<td>Environment</td>
</tr>
<tr>
<td>• The environment is designed to communicate respect.</td>
</tr>
<tr>
<td>• There is a focus on a need for privacy, safety, and comfort.</td>
</tr>
<tr>
<td>• Patients actively participate in making decisions about all aspects of the</td>
</tr>
<tr>
<td>environment.</td>
</tr>
<tr>
<td>Hospital Administrative Role</td>
</tr>
<tr>
<td>• Develop a shared vision of recovery programming.</td>
</tr>
<tr>
<td>• Hire staff with a passion for working with people.</td>
</tr>
<tr>
<td>• Expect staff to provide services with empathy and hope.</td>
</tr>
<tr>
<td>• Provide supportive clinical supervision that requires accountability to these</td>
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<tr>
<td>recovery principles.</td>
</tr>
<tr>
<td>Treatment Interventions Programs</td>
</tr>
<tr>
<td>• Interventions and medications are seen as tools for use by patients to manage</td>
</tr>
<tr>
<td>their illness and their lives.</td>
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</tbody>
</table>

**Practitioners use a partnership that honors the client’s expertise and perspectives.**

**The practitioner uses relationships instead of rules and strives to collaborate rather than coerce.**

**The patient’s role is to collaborate and negotiate with professionals as an expert on their needs, strengths, and deficits.**

**This may mean focusing more on their goals and on what makes them well, not on what makes them sick.**

**The environment is designed to communicate respect.**

**There is a focus on a need for privacy, safety, and comfort.**

**Patients actively participate in making decisions about all aspects of the environment.**

**Develop a shared vision of recovery programming.**

**Hire staff with a passion for working with people.**

**Expect staff to provide services with empathy and hope.**

**Provide supportive clinical supervision that requires accountability to these recovery principles.**

**Interventions and medications are seen as tools for use by patients to manage their illness and their lives.**
for the person. Recovery from mental illness cannot be done to someone.

**Patient Role**
The person is encouraged and expected to lead the process of his or her own recovery. Clubhouse staff used to quip that “I’m going to empower you whether you like it or not.” People may not desire to be “empowered” and to lead their own recovery plan. Generally when people have the option of making real choices where the risk and benefits are discussed, and the choices are regarding things that are meaningful to them, they will respond positively. An example of this is a “patient” in a hospital setting who is offered the choice of one of three groups or activities that are offered at a particular time. The groups last for six weeks each and the syllabus for each group is reviewed. A fourth option in this scenario is to pursue independent studies and there is a staff assigned to assist a smaller number of participants pursuing this. The large number of programs available in the centralized programming of large psychiatric hospitals makes this complicated but feasible.

Severe and persistent mental illness can have a devastating impact on a person’s sense of identity and on their role in communities in which they reside. It is for this reason that there must exist opportunities for the adoption of healthy roles for people to assume other than that of patient. Ideally, this is done through discharge. At the same time, useful roles must exist within the hospital setting for the time the person spends there. These roles must be voluntary, meaningful, and productive. When staff are periodically reliant on “patients,” a sense of reciprocity can develop that can have a powerful curative affect. Non-patient roles can allow people an opportunity to experience self-efficacy and feelings of increased self worth.

**Environment**
Research has found that individuals who maintain high levels of wellness have consistent characteristics in their environments and in their lives. Recovery environments need to provide the opportunity for people to achieve these states of high-level wellness. The environment needs to provide opportunities for privacy when and if a person desires it. Staff should be expected to knock before entering someone’s personal space. There needs to be the ability to
have contact with nature and have opportunities for physical exercise. Intellectual stimulation is equally important as well as activities that people find meaningful (Cannon, 2005). Due to its idiosyncratic nature, it is unclear exactly what the necessary and sufficient conditions are for supporting an individual’s recovery. It appears that what is sufficient is different for everyone and that each person likely has a critical mass of unique ingredients that, when present, allow that individual to begin to recover. What is clear is that certain factors inhibit recovery for virtually everyone. Environments that are loud, violent, noisy, overcrowded, or unsafe are unlikely to promote recovery regardless of the model of treatment used.

Hospital Administrative Role
State hospital administration needs to hire direct care staff based on their current or future ability to be hopeful and provide recovery-based services. This means having patience, empathy, and the belief in the possibility of recovery. Community mental health systems have been successful in recruiting workers with these somewhat amorphous qualities and state hospital systems could follow their example.

The administrations largest hurdle in including the recovery model will be dealing with the legacy of attitudes and beliefs left over from the custodial version of the hospital model. The new vision of recovery must be clearly expressed and the new expectations expressed. Staff must be held accountable for meeting these expectations. Ironically, the strategies used in state institutions with hierarchical management structures often disenfranchise the staff at the bottom of the organizational chart. Direct service staff often believe that they have been just as mistreated and just as “institutionalized” as the “patients” with whom they work (Bogden, Taylor, DeGrandpre, & Haynes, 1974). Staff cannot be influenced to promote a vision of egalitarian interactions with “patients” without feeling they receive the same treatment themselves. An organization intent on implementing the recovery model needs to adopt a management stance acknowledging the perspectives from all levels of the organization based on a shared recovery vision. Administrators must accept that there are necessary risks in utilizing the recovery model and that recovery is not a process where tight control from a top down management will serve the needs of the practitioners or “patients.”
Treatment Interventions/Programs

There are a large and growing number of evidence-based practices that have been shown to produce outcomes meaningful to consumers (Mueser, Torrey, Lynde, Singer, & Drake, 2003). Despite extensive evidence consistently showing that they improve client outcomes, state hospitals have largely not adopted these practices (Drake, Goldman, Leff, Lehman, Dixon, Mueser, & Torrey, 2001). Evidence-based practices can be compatible with the recovery model when consumers are able to have input into the services that they receive (Frese et al., 2001). Large institutions often prescribed groups for people because the group exists and not because anyone necessarily needs or wants them. Program outcomes should focus on what people get out of the service or group and not on the number of groups attended. Generic programs must be augmented by specific individual approaches (Dhillon & Dollieslager, 2000). Interventions need to be reinforced and supported during incidental contacts in morning meetings, lunch, and leisure time. An example of this is a state hospital that has expanded programming to include identifying specific interventions by paraprofessionals staff that include relationship building and are designed to assist each individual to take steps toward discharge.

CONCLUSION

The recovery model continues to gain wide acceptance in community-based programming and has received endorsements from the federal level as the fundamental transformation required across the service delivery system (DHHS, 2003). A responsive mental health system will understand that recovery as a value and expectation needs to be embraced by all service providers. Although the recovery model may challenge some of the prevailing perspectives within state hospitals, the medical/hospital model is not incompatible with the ideals of hope, self-identity, responsibility, and finding meaning in life. For hospital administrators and practitioners who are ready to move in the direction of the recovery model a new set of priorities could include a consideration of how interventions could progressively empower someone through the dependent stages of their initial hospitalization to their eventual self-determination.
The largest issue may be the legacy of custodial aspects of many hospitals and their underlying attitudes. These attitudes can form an institutional identity that is not easily changed even in the face of great pressure (Bogden et al., 1974). Clinicians may feel a loss of status or uncomfortable with relinquishing control to their “patients.” Questions that remain to be answered involve determining the most efficient way to change existing institutional cultures to adapt to the recovery model. Future research needs to focus on institutional environments in order to understand why and how they resist change in general and recovery based changes specifically. The ethnographic method used to study The Village in California (Erickson & Straceski, 2004) presents a methodology that offers the possibility of understanding an organizational culture in a more complete way. Borrowing from anthropology, the Village was studied by a researcher who was embedded in the program. They interviewed and observed the staff and members over a period of one year. Eventually this method uncovered the real values in operation in the Village.

Many psychiatric institutions have mission statements and policy and procedures manuals with the rhetoric of recovery but with practices rooted squarely on custodial, controlling practices. The need to examine what actually happens in these organizations as opposed to what staff say, and even believe, happens is of critical importance.

The power of the recovery model is transforming the lives of many people with severe and persistent mental illness. Mental health systems are adopting these practices because they work and it’s what consumers say that they want. State psychiatric hospitals have the additional challenge of providing treatment to acutely ill individuals as well as promoting their recovery. We believe that the recovery model is a necessary addition to the hospital model.

REFERENCES


