

Recovery Model

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November 19, 2022

RECOMMENDED CITATION

mohammad looti (2022). *Recovery Model*. PSYCHOLOGICAL SCALES. Retrieved from <https://scales.arabpsychology.com/?p=39238>

The Recovery Model as it applies to mental health is an approach to mental disorder or substance dependence (and/or from being labeled in those terms) that emphasizes and supports each individual's potential for recovery. Recovery is seen within the model as a personal journey, that may involve developing hope, a secure base and sense of self, supportive relationships, empowerment, social inclusion, coping skills, and meaning. Originating from the 12-Step Program of Alcoholics Anonymous and the Civil Rights Movement, the use of the concept in mental health emerged as deinstitutionalization resulted in more individuals living in the community. It gained impetus due to a perceived failure by services or wider society to adequately support social inclusion, and by studies demonstrating that many can recover. The Recovery Model has now been explicitly adopted as the guiding principle of the mental health systems of a number of countries and states. In many cases practical steps are being taken to base services on the recovery model, although there are a variety of obstacles and concerns raised. A number of standardized measures have been developed to assess aspects of recovery, although there is some variation between professionalized models and those originating in the Consumer/Survivor/Ex-Patient Movement.

History

In general medicine and psychiatry, recovery has long been used to refer to the end of a particular experience or episode of illness. The broader concept of "recovery" as a general philosophy and model was first popularized in regard to recovery from substance abuse/drug addiction, for example within twelve-step programs.

Application of recovery model concepts to psychiatric disorders is comparatively recent. By consensus the main impetus for the development came from the Consumer/Survivor/Ex-Patient Movement, a grassroots self-help and advocacy initiative, particularly within the United States during the late 1980s and early 1990s. The professional literature, starting with the psychiatric rehabilitation movement in particular, began to incorporate the concept from the early 1990s in the United States, followed by New Zealand and more recently across nearly all countries within the "First World". Similar approaches developed around the same time, without necessarily using the term recovery, in Italy, the Netherlands and the UK. Developments were fueled by a number of long term outcome studies of people with "major mental illnesses" in populations from virtually every continent, including landmark crossnational studies by the World Health Organization from the 1970s and 1990s, showing unexpectedly high rates of complete or partial recovery, with exact statistics varying by region and the criteria used. The cumulative impact of personal stories or testimony of recovery has also been a powerful force behind the development of recovery approaches and policies. A key issue became how service consumers could maintain the ownership and authenticity of recovery concepts while also supporting them in professional policy and practice.

Increasingly, recovery became both a subject of mental health services research and a term emblematic of many of the goals of the Consumer/Survivor/Ex-Patient Movement. The concept of recovery was often defined and applied differently by consumers/survivors and professionals. Specific policy and clinical strategies were developed to implement recovery principles although key questions remained.

Concepts of recovery

Variation

There is some variation in how recovery is conceptualized within models. Professionalized clinical approaches tend to focus on improvement, in particular symptoms and functions, and on the role of treatments; consumer/survivor models tend to put more emphasis on peer support, empowerment and real-world personal experience. Recovery can be seen in terms of a social model of disability rather than a medical model of disability, and there may be differences in the degree of acceptance of diagnostic "labels" and treatments. In psychiatric rehabilitation, the concept of recovery may be used to refer primarily to managing symptoms, reducing psychosocial disability, and improving role performance. A review of the psychiatric literature suggested authors are rarely explicit about which concept they are employing; the reviewers called "rehabilitation" perspectives those which focused on life and meaning within the context of supposedly enduring disability, and "clinical" those which focused on observable remission of symptoms and restoration of functioning.

A consensus statement on mental health recovery from US agencies, that involved some consumer input, defined recovery as a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential. Ten fundamental components were elucidated, all assuming that the person continues to be a "consumer" or to have a "mental disability". Conferences have been held on the importance of the "elusive" concept from the perspectives of consumers and psychiatrists.

From the perspective of psychiatric rehabilitation services, a number of qualities of recovery have been suggested: recovery can occur without professional intervention; recovery requires people who believe in and stand by the person in recovery; a recovery vision is not a function of theories about the cause of psychiatric conditions; recovery can occur even if symptoms reoccur; recovery changes the frequency and duration of symptoms; recovery from the consequences of a psychiatric condition are often far more difficult than from the symptoms; recovery is not linear; recovery takes place as a series of small steps; recovery does not mean the person was never really psychiatrically disabled; recovery focuses on wellness not illness; recovery should focus on consumer choice.

An approach to recovery known as the Tidal Model focuses on the continuous process of change inherent in all people, conveying the meaning of the experiences through water metaphors. Crisis is seen as involving opportunity, creativity is valued, and different domains are explored such as a person's sense of security, their personal narrative and their relationships. Initially developed by mental health nurses along with service users, Tidal is one of the few recovery models to have been researched rigorously. The Tidal Model is based on a discrete set of values (the Ten Commitments) and emphasizes the importance of each person's own voice, resourcefulness and wisdom. Since 1999, projects based on the Tidal Model have been established in the USA, Canada, Japan, New Zealand, Australia, Republic of Ireland, Scotland, Wales and England, where Tidal was originally developed. The Tidal Model has been used with a wide range of populations and is, arguably, the most widely used model of recovery.

For many, "recovery" has a political as well as personal implication--where to recover is to find meaning, to challenge prejudice (including diagnostic "labels" in some cases), perhaps to be a "bad" non-compliant patient and refuse to accept the indoctrination of the system, to reclaim a chosen life and place within society, and to validate the self. Recovery can thus be viewed as one manifestation of empowerment. An empowerment model of recovery may emphasize that conditions are not necessarily permanent, that other people have recovered who can be role models and share experiences, and "symptoms" can be understood as expressions of distress related to emotions and other people. One such model from the US National Empowerment Center proposes a number of principles of how people recover and identifies the characteristics of people in recovery.

Recovery may be seen as more of a philosophy or attitude than a specific model, requiring that "we regain personal power and a valued place in our communities. Sometimes we need services to support us to get there".

Concerns

Some concerns have been raised about recovery models, including that recovery is an old concept, that a focus on recovery adds to the burden of already stretched providers, that recovery must involve cure, that recovery happens to very few people, that recovery represents an irresponsible fad, that recovery happens only after and as a result of active treatment, that recovery-oriented care can only be implemented through the addition of new resources, that recovery-oriented care is neither reimbursable nor evidence based, that recovery-oriented care devalues the role of professional intervention, and that recovery-oriented care increases providers' exposure to risk and liability. There have also been tensions between recovery models and particular "evidence-based practice" models in the transformation of US mental health services based on the recommendations of the New Freedom Commission on Mental Health.

The New Freedom Commission's emphasis on the recovery model has been interpreted by some critics as saying that everyone can fully recover through sheer will power, and therefore as giving false hope to those judged unable to recover and implicitly blaming those people judged unable to recover. However, the critics have themselves been charged with undermining consumer rights and failing to recognize that the model is intended to support a person in their personal journey rather than expecting a given outcome, and that it relates to social and political support and empowerment as well as the individual. Other criticisms include that the recovery model can be manipulated by officials to serve various political and financial interests including withdrawing services and pushing people out before they're ready; that it is becoming a new orthodoxy or bandwagon that neglects the empowerment aspects and structural problems of societies and primarily represents a middle class experience; that it hides the continued dominance of a medical model; and that it potentially increases social exclusion and marginalizes those who don't fit into a recovery narrative.

Various stages of resistance to recovery approaches have been identified amongst staff in traditional services, starting with "Our people are much sicker than yours. They won't be able to recover" and ending in "Our doctors will never agree to this"--but ways to harness the energy of resistance and use it to move forward have been proposed. Staff training materials have been developed, for example by the National Empowerment Center.

Assessments

The data-collection systems and terminology used by services and funders are typically incompatible with recovery frameworks, so methods of adapting IT resources or paper forms have been developed. It has also been pointed out that the Diagnostic and Statistical Manual of Mental Disorders (and to some extent any system of categorical classification of mental disorders) uses criteria, definitions and terminology that are inconsistent with a recovery model, and therefore does not promote a culture in which people can improve and recover. It has been suggested that the DSM-V requires greater sensitivity to cultural issues and gender; needs to recognize the need for others to change as well as just those singled out for a diagnosis of disorder; and that it needs to adopt a dimensional approach to assessment that better captures individuality and does not erroneously imply excess psychopathology or chronicity.

A number of standardized questionnaires and assessments have been developed to try to assess aspects of the recovery journey. These include the Milestones of Recovery (MOR) Scale, Recovery Enhancing Environment (REE) measure, the Recovery Measurement Tool (RMT) and the Recovery Oriented System Indicators (ROSI) Measure, the Stages of Recovery Instrument (STORI), and numerous related instruments.

Elements of recovery

It has been emphasized that each individual's journey to recovery is a deeply personal process, as well as being related to an individual's community and society. A number of features have been proposed as often being core elements, however:

Hope

Finding and nurturing hope has been described as a key to recovery. It is said to include not just optimism but a sustainable belief in oneself and a willingness to persevere through uncertainty and setbacks. Hope may start at a certain turning point, or emerge gradually as a small and fragile feeling, and may fluctuate with despair. It is said to involve trusting, and risking disappointment, failure and further hurt.

Secure base

Appropriate housing, a sufficient income, freedom from violence, and adequate access to health care have also been proposed. It has been suggested that home is where recovery may begin but that housing services and the "continuum of care concept" have failed to flexibly involve people and build on their personal visions and strengths, instead "placing" and "reinstitutionalizing" them.

Self

Recovery of a durable sense of self (if it had been lost or taken away) has been proposed as an important element. A research review suggested that people sometimes achieve this by "positive withdrawal"--regulating social involvement and negotiating public space in order to only move towards others in a way that feels safe yet meaningful; and nurturing personal psychological space that allows room for developing understanding and a broad sense of self, interests, spirituality, etc. It was suggested that the process is usually greatly facilitated by experiences of interpersonal acceptance, mutuality, and a sense of social belonging; and is often challenging in the face of the typical barrage of overt and covert negative messages that come from the broader social context.

Supportive relationships

A common aspect of recovery is said to be the presence of others who believe in the person's potential to recover, and who stand by them. While mental health professionals can offer a particular limited kind of relationship and help foster hope, relationships with friends, family and the community are said to often be of wider and longer-term importance. Others who have experienced similar difficulties, who may be on a journey of recovery, can be of particular

importance. Those who share the same values and outlooks more generally (not just in the area of mental health) may also be particularly important. It is said that one-way relationships based on being helped can actually be devaluing, and that reciprocal relationships and mutual support networks can be of more value to self-esteem and recovery.

Empowerment and Inclusion

Empowerment and self-determination are said to be important to recovery, including having self control. This can mean developing the confidence for independent assertive decision making and help-seeking. Achieving social inclusion may require support and may require challenging stigma and prejudice about mental distress/disorder/difference. It may also require recovering unpracticed social skills or making up for gaps in work history.

Coping strategies

The development of personal coping strategies (including self-management or self-help) is said to be an important element. This can involve making use of medication or psychotherapy if the consumer is fully informed and listened to, including about adverse effects and about which methods fit with the consumer's life and their journey of recovery. Developing coping and problem solving skills to manage individual traits and problem issues (which may or may not be seen as symptoms of mental disorder) may require a person becoming their own expert, in order to identify key stress points and possible crisis points, and to understand and develop personal ways of responding and coping.

Being able to move on can mean having to cope with feelings of loss, which may include despair and anger. When an individual is ready, this can mean a process of grieving. It may require accepting past suffering and lost opportunities or lost time.

Meaning

Developing a sense of meaning and overall purpose is said to be important for sustaining the recovery process. This may involve recovering or developing a social or work role. It may also involve renewing, finding or developing a guiding philosophy, religion, politics or culture. From a postmodern perspective, this can be seen as developing a narrative.

National policies and implementation

United States and Canada

The New Freedom Commission on Mental Health has proposed to transform the mental health

system in the US by shifting the paradigm of care from traditional medical psychiatric treatment toward the concept of recovery, and the American Psychiatric Association has endorsed a recovery model from a psychiatric services perspective.

The US Department of Health and Human Services reports developing national and state initiatives to empower consumers and support recovery, with specific committees planning to launch nationwide pro-recovery, anti-stigma education campaigns; develop and synthesize recovery policies; train consumers in carrying out evaluations of mental health systems; and help further the development of peer-run services. Mental Health service directors and planners are providing guidance to help state services implement recovery approaches.

Some US states, such as California (see the California Mental Health Services Act), Wisconsin and Ohio, already report redesigning their mental health systems to stress recovery model values like hope, healing, empowerment, social connectedness, human rights, and recovery-oriented services.

At least some parts of the Canadian Mental Health Association, such as the Ontario region, have adopted recovery as a guiding principle for reforming and developing the mental health system.

New Zealand and Australia

Since 1998, all mental health services in New Zealand have been required by government policy to use a recovery approach and mental health professionals are expected to demonstrate competence in the recovery model. Australia's National Mental Health Plan 2003-2008 states that services should adopt a recovery orientation although there is variation between Australian states and territories in the level of knowledge, commitment and implementation.

UK and Ireland

In 2005, the National Institute for Mental Health in England (NIMHE) endorsed a recovery model as a possible guiding principle of mental health service provision and public education. The National Health Service is implementing a recovery approach in at least some regions, and has developed a new professional role of Support Time and Recovery Worker. A leading independent charity issued a 2008 policy paper proposing that the recovery approach is an idea "whose time has come". The Scottish Executive has included the promotion and support of recovery as one of its four key mental health aims and funded a Scottish Recovery Network to facilitate this. A 2006 review of nursing in Scotland recommended a recovery approach as the model for mental health nursing care and intervention. The Mental Health Commission of Ireland reports that its guiding documents place the service user at the core and emphasize an individual's personal journey towards recovery.