Strategies for Promoting Recovery to Mental Health Professionals

(2009)

The recovery movement has progressed to the point where it has become imperative to influence mental health professionals to change their actual practices. This is a complex and demanding task because recovery has largely been ignored by mainstream professionals and because it is not obvious to many professionals, even when they are exposed to recovery, that it is something they want to or should adopt. As our transformation efforts have intensified the recovery movement has become increasingly sophisticated and diverse in our strategies to promote recovery based changes to professionals. Here is a sampling of the strategies I feel most likely to be effective:

1) The recovery movement is a true revolution in mental health working to fundamentally alter the treatment models and culture being used, the existing power structure, and the expectations, goals, and outcomes of services. The professional organizations represent the existing establishment. To this point recovery has generally relied on a confrontative approach and has successfully attracted a number of innovative and individualistic professionals, but not the mainstream professionals. We do not intend to rely on confrontation. Unlike other revolutionary movements recovery does not have to rely on overturning the prevailing models by force because all of the mental health professions have recovery values and practices within their roots and traditions even though much has been lost. The major task at this point does not have to be to win a battle with the establishment. It can be to help the professions recover their own roots and traditions. We will attempt to facilitate the recognition and celebration of underlying recovery practices of professionals. If given a chance to embrace recovery most professionals will experience recovery as a return to what they were meant to do and why their heart got them into the field in the first place. One of the main challenges of this approach is to truly meet professionals where they are at which is why “insider” collaboration is essential. When the Village has done trainings for mental health professors we help them identify what role models and practices they are using in class that can be built upon to teach recovery.

2) Recovery does require many real changes. The motivation of the professionals to change is crucial for success. We will be looking to create materials to approach professionals at various stages of change motivation. Some professionals will need help in contemplating recovery changes, some in planning changes, some in taking action, some in sustaining changes. We intend to create training materials at 5 levels: 1) building exposure and enthusiasm, 2) Building believability and motivation, 3) taking action, 4) building expertise, and 5) building sustainability.

3) Part of motivating professionals is helping them to understand the environment around them and the changing incentives. Unfortunately a large number of professionals view the administration of the larger public mental health system very negatively and cope primarily by distancing themselves from it and creating a bubble for themselves and their clients, disengaged

from the system. Many others leave the public sector entirely. This disengagement makes it very difficult for recovery promoting changes on the system level to impact professionals. Our materials would therefore need to begin not with how the system is changing, but with re-engaging with the system. Then we can describe the real changes in our system.

4) We live in a time where many professionals feel like their professionalism rests upon "keeping up with the literature," knowing "what the research shows," and using "evidence based practices." Unfortunately, a strong research basis is not the recovery model's strongest area. This is probably due more to the nature of research methodology than to any lack of effectiveness: Research is better suited to reductionistic models than holistic ones, to objective factors than subjective ones, to symptom outcomes more than quality of life, to observing practices more than relationships, values, and cultures, to commonality more than individuality, to linear processes more than variable processes. Nonetheless, there is some research backing for recovery, but even the best work, like Courtney Harding's longitudinal studies are virtually unknown and untaught to professionals. This is not because the methodology is suspect, but because recovery simply isn't something we teach about. Our presentations of research materials therefore need to begin with the "validity" of recovery itself. Virtually all professionals do not use any "evidence based practices" in their pure, researched form. There is a process of applying the research and evidence to the reality of our practices. Much of the time, these adaptations, that are needed to apply the practice, invalidate the evidence. The recovery research, therefore, should be presented as useful concepts and lessons from the research rather than "proven practices." A recovery based culture can also be promoted as the culture in which a number of evidence based practices can be adapted and integrated into a successful team and program.

5) I am old enough to remember when doctors were expected to learn from our patients; when the mark of an experienced clinician was the wisdom they had learned from their practice, not the number of studies they could cite. I believe that despite the efforts to make mental health scientific and objective, most professionals still value practice based learning above all else. This is recovery's strongest area, both because the model has been built upon listening to people with mental illnesses and because recovery is shockingly effective in actual practice. Recovery can be taught to professionals through clinical learning. The areas we would focus on include: How do you reduce drop outs? How do you help people who lack insight into their illness? How do you help people who are noncompliant with following treatment orders? How do you help people who are resistant to taking medications? How do you help people who abuse drugs and alcohol? How do you help people who become passive and detached when they are taken care of? How do you help people who are overwhelmed by their illnesses, and have lost hope, and feel powerless? How do you help people who are unmotivated to change? How do you help people move on from services? How do you help people who don't show up for appointments? How do you help people from other cultures with different expectations, roles, and explanatory models? How do you help people incorporate spirituality into their healing? How do you create and sustain a "therapeutic milieu" in your program? How do you talk with overwhelmed,

frightened families? Each of these questions is important to almost all professionals and for each of them recovery has a superior approach to the traditional medical model which too often describes people as "inappropriate for treatment" and leaves it at that. I believe that, at bottom, most professionals want most to help as many people as much as they can and that is our greatest chance to promote recovery.

6) Staff burnout is a major problem in public mental health today. Increasing emphasis on cost control and cutting, efficiency, production, billing quotas, documenting effectiveness, auditor based accountability, etc. have dehumanized what arguably what should be the most emotionally intense, satisfying social service. Recovery brings back emotional connectedness and healing by returning the mission to helping people instead of just treating illnesses. It encourages staff to remember why their hearts got them into this work, the sources of their compassion, their ability to empathize with and relieve suffering, the joy of a life of caring for others, and the magic of this work. Many experienced staff experience recovery as validating of things they do, but were afraid to admit – like hugging people. Successful recovery based training "made me think of myself in a way that I had long forgotten" according to one 20 year veteran. One of our approaches will be promoting recovery as an antidote to staff burnout.

7) Recovery practice fundamentally rethinks the professional – client relationship. To do so safely and ethically requires more attention to safety and ethics, not less. Most of our professional "rules" were created to guide individual practitioners seeing people in private, isolated offices – quite possible the single most dangerous and ethically difficult way to work. We need to promote materials that give clear, helpful guidelines for recovery based practice that do not destroy our ability to connect with people and help them, while keeping each of us as safe and ethical as possible. This is one of the most controversial areas of the recovery movement and the one that usually creates the most "resistance" stopping the process. Therefore, materials must be created that are appropriate for both exposing people to recovery and building expertise.

8) There are three general approaches by which trainings can influence people: 1) Development – people can learn a new skill to add to their present practice – for example collaborative medication or motivational interviewing or supported employment. 2) Transition – people can look at where they are, their strengths and weaknesses, and where they'd like to be, and develop a plan to move from here to there – for example they may want to move from being an appointment based practitioner to doing street outreach, or learn how to adapt their present highly structured CBT practice to work with poorly self coordinating clients. 3) Transformation – people can experience an internal shift in their thinking, values, or feelings, that leads to them approaching things differently than they would have before. – for example a psychiatrist can go to a patient's funeral at a local clubhouse they've never been in before, feel the enormous warmth and caring people have for their patient, and realize there is a whole world there that they had been dismissing. Training materials should be developed that use all three of these approaches.