Disquieting Aspects of the Recovery Paradigm

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Recovery is the new paradigm for mental health care. In this issue of *Psychiatric Services,* Davidson and colleagues (1) provide an excellent overview of the issues raised by this new paradigm. On the face of it, there is little with which to disagree in the new emphasis on recovery. People are more than their illness symptoms and their diagnoses. Individuals with serious mental illness, like individuals with other severe medical conditions, have an identity and personhood apart from the care that they receive.

As providers, we should adopt an attitude of optimism and strive to facilitate patients' achieving competence, independence, and personal fulfillment. Patients and their providers should work together; unilateral decision making on the part of caregivers is to be avoided. The recovery agenda also emphasizes the use of treatments that are evidence based and thus helps put the care of persons with serious mental illness on a similar footing with treatment for other persistent medical conditions.

So far, so good. However, as noted by Davidson and coauthors, the definition of recovery in the context of mental health care is often elusive, and the implications for services are also uncertain. What exactly should providers do differently in a transformed "recovery-oriented" mental health system? It seems as though recovery is an overarching attitude, a process—part spiritual, part political. As an empirically oriented practitioner, I wonder what the transformed services are that we should be delivering. What are the outcomes that we can measure? How will we know if the recovery movement makes good on its promise? Or will the recovery mantra come to represent another cycle of reform—such as the creation of asylums and the deinstitutionalization movement—that seems to offer the solution but is later evaluated to have been naïve and unscientific?

Davidson and colleagues note that recovery services are not developed parallel to or distinct from existing services and that, in general, they need to be budget neutral. Thus there will be no new funding for these services. Of more concern is the suggestion that the recovery agenda may even help purge the rolls and limit the demand for services. According to Davidson and colleagues, "the more effective our efforts at promoting community inclusion, the less people will need from mental health care, allowing us to reduce caseload sizes. . . ." Is the shift to a recovery orientation a thinly veiled effort to cut back on services and on expenditures?

Speaking of expense, if psychiatric treatment for persons with serious mental illness is becoming more like the rest of medicine in terms of an emphasis on evidenced-based services and on living with disability, shouldn't it be funded like the rest of medicine? What about the inequitable copayments in the Medicare system for psychiatry compared with other medical specialties, and what about Medicaid cuts at the state level for psychiatric rehabilitation programs? Even more disturbing is the very limited implementation of currently available evidence-based psychosocial treatments for persons with serious mental illness. It is an embarrassment that the provision of family education, assertive community treatment, supported employment, and cognitive-behavioral psychotherapy are the exception rather than the standard of care for most patients with schizophrenia, even though we now have extensive evidence-based data indicating their effectiveness. It seems that applying what we already know to be helpful, but are not doing, should be at the top of any recovery agenda.

And then there are the clinical, social, and economic issues faced by many persons with serious mental illness that don't mesh with the enthusiasm accompanying the recovery movement. How can one recover—in any sense of the term—in America in 2006 with a total monthly income of $500, or while homeless, or with no health insurance? It is not clear how the recovery orientation directly helps with these problems. Worse, it may distract us from thorny issues such as these, the solutions to which will require additional resources. And then there are the patients who are tormented by their mental illness symptoms but deny that they are ill and in need of treatment. Can they reach further for self-determination, life satisfaction, and community integration? Maybe so, but I worry that the recovery bandwagon leaves them out and, furthermore, that it may generate unrealistic expectations among patients and their families. Mental illnesses are highly disabling, and, as recent reviews have emphasized, our science has not come even close to being able to cure or prevent them. Learning to live better in the face of mental illness doesn't alter that reality.

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Reference

1. Davidson L, O'Connell M, Tondora J, et al: The top ten concerns about recovery encountered in mental health system transformation. Psychiatric Services 57:640–645, 2006