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Recovery and the Medical Model in Institutional Care

To the Editor: The March issue included an article by Turton and colleagues (1) describing a process that assessed stakeholder views on the most important treatment components in promoting recovery of people receiving institutional care in the European Union. The authors expressed surprise that aspects of care that were ranked as being most important were "therapeutic interventions" and other domains of "a more conventional" medical model. They contrasted these domains to ones that they considered more reflective of a "recovery" orientation—such as "autonomy and self-management, social inclusion, dignity, hope"—and inferred from these findings that the recovery vision might need to be tempered a bit by giving more importance to medical aspects of care and less value to such "broader recovery principles" as autonomy and dignity. Given that the study was limited to asking stakeholders about institutional care and that participants were chosen based on their belief that "the institutional setting [is] an environment that supports people in moving back into the community," the only thing that surprised me was that the authors were surprised by this largely

tautologous finding. Thus I find the conclusions they draw from their findings concerning.

Turton and colleagues readily acknowledge that these findings might be due to the fact that therapeutic interventions and medical care "form the very basis and *raison d'être* of health care." What they perhaps have not taken fully into account is that therapeutic interventions and medical care form the very justification for institutional care in particular. The question they asked participants was, "In your view, what most helps recovery for people with long-term mental health problems in institutional care?" It would be hard to argue that autonomy or social inclusion are the most helpful aspects of care for people in institutions when these are the same aspects of care that are most compromised in institutional settings. In fact, how could institutional care promote autonomy or social inclusion when by its very function it serves to supervise and segregate? A very different answer to this question could have been "What would most help recovery is for these people to be discharged to community-based care in natural settings." It does not seem that this answer was considered as a possibility.

Rather than interpreting these data to suggest that the recovery orientation needs to be counterbalanced by the medical model, I take these findings, along with the focus of the study on institutional care, to indicate the stage at which the participating countries are at this time in history. It is hard to move beyond the authors' acknowledgment that their results "inevitably reflect[ed] the selected orientation and affiliations of our participants." The results would likely have been different had they recruited stakeholders with experiences of systems that no longer use institutional care. It is worth noting, for example, that advocates and service users in Italy, where institutional care has been prohibited since 1978, did not endorse this "medical" domain at all. What the results suggest to me, therefore, is that many stakeholders re-

main tied to a predominantly medical model of care carried out within institutional settings. But this is precisely why a transformation of mental health care is needed to begin with.

Larry Davidson, Ph.D.

Dr. Davidson is affiliated with the Department of Psychiatry, Yale University, New Haven, Connecticut.

Reference

1. Turton P, Wright C, White S, et al: Promoting recovery in long-term institutional mental health care: an international Delphi study. *Psychiatric Services* 61:293–299, 2010

In Reply: We appreciate the opportunity to clarify the goals of our study and to respond to Dr. Davidson's comments. First, we agree that community-based, deinstitutionalized systems of care are preferable, but the reality is that the majority of mental health care in Europe is currently delivered within and from institutions (1). Given this fact, the purpose of our study (and that of the European Commission members who funded it) was to develop a toolkit to assess the quality of care that these facilities deliver, with a particular focus on human rights. We were not asking in this study about alternatives to institutions.

Second, the definition of "institution" in our study included both psychiatric and social care units and was concerned with community-based as well as hospital-based facilities. Indeed, four of the ten countries that took part had no hospital wards providing psychiatric care. Stakeholders with expertise in both of these settings were sought to participate in the Delphi exercise. Thus Davidson's assumption that all participating units had segregated and supervised patients is incorrect.

Third, we do not agree with the belief that institutional care settings necessarily compromise successful rehabilitation of individuals. This view denies hope to people with complex mental health problems whose disabilities are such that they

are unable to return home directly from an acute hospital admission. Promotion of autonomy and social inclusion is key to psychosocial rehabilitation, and our findings demonstrate that recovery principles such as these, together with hope, a strengths-based approach, negotiated treatment choices, and rediscovery of a positive sense of self-identity, are as relevant to institutional care (whether hospital or group home) as they are to other settings. In fact, our study found evidence of the importance of many of the same aspects of care for recovery that Davidson and colleagues (2) have cited as critical in a previous publication: being supported by family, friends, or professionals; taking medications; being involved in meaningful activities; managing symptoms; taking responsibility; and exercising citizenship.

Finally, the purpose of the Delphi

exercise was to provide collated, qualitative evidence of the consensus opinions of four stakeholder groups in ten countries about the most important components of care in promoting recovery for people in facilities that provide long-term care. The four groups comprised service users, advocates, caregivers, and mental health professionals. The countries were chosen by virtue of their different stages of deinstitutionalization. These results were then triangulated with findings from a systematic literature review of effective components of care in use in institutions and with care standards for these types of facilities in the ten countries. We chose this approach specifically to ensure that there was no bias in identifying the components of care most important to recovery through a single evidence source only. Our task was to report our findings accurately—including the fact that the

most highly rated domain across countries was “treatment and interventions.” Nowhere did we suggest that this means that “less value” should be given to such principles as autonomy and dignity; rather, our intent was to emphasize that this important domain should not be neglected in considerations of the recovery approach, which often highlights other aspects of care.

Penelope Turton, Ph.D.
Christine Wright, F.R.C.Psych.
Helen Killaspy, M.R.C.Psych,
Ph.D.

References

1. Muijen M: Mental Health Services in Europe: an overview. *Psychiatric Services* 59:479–482, 2008
2. Davidson L, Sells D, Sangster S, et al: Qualitative studies of recovery: what can we learn from the person?; in *Recovery and Mental Illness: Consumer Visions and Research Paradigms*. Edited by Ralph RO, Corrigan PW. Washington, DC, American Psychological Association, 2005

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