The 2009 Resolution on APA Endorsement of the Concept of Recovery for People with Serious Mental Illness was completed by the Task Force on Serious Mental Illness and Severe Emotional Disturbance (TFSMI/SED) and approved as APA policy by the APA Council of Representatives on August 5, 2009.

Expiration: These guidelines are scheduled to expire 10 years from August 5, 2009 (the date of their adoption by the APA Council of Representatives). After this date, users are encouraged to contact the APA Practice Directorate to determine whether this document remains in effect.
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Resolution on APA Endorsement Of The Concept Of Recovery For People With Serious Mental Illness

INTRODUCTION: The traditional view of serious mental illness, especially psychotic disorders, is that they have at best a stable course with chronic disability and poorer-than-premorbid functioning, and at worst a chronic deteriorating course. As a result, treatment has typically focused on symptom reduction and relapse prevention, and has been characterized by low expectations with little focus on issues such as living environment, relationships, work, and education. This is now changing. A wealth of data now indicate that the majority of people with serious mental illness eventually improve significantly over time, and can have independent lives that include striving for personal meaning and enhanced quality of life through active efforts in the above domains (e.g, relationships, work), regardless of whether symptoms are present or not. Moreover, research indicates that these areas are important sources of self-esteem for consumers, and are some of their most highly rated goals for treatment. In addition, federal and state agencies are now recommending that the paradigm for treatment of serious mental illness shift away from symptom-oriented care, to this more comprehensive view of how treatment can be envisioned. This new vision for foci of treatment, informed by long-term outcome data suggesting that it is realistic, has been labeled recovery-oriented treatment. It is important to note that the concept of recovery-oriented care does not assume a specific etiology for serious mental illness, nor does it recommend or contraindicate any specific treatments. Rather, it is a vision for a person-based approach to treatment, and a method of treatment delivery that is sensitive to consumer-defined goals and recognizes the need to attend to a range of psychological factors (e.g., identity, self-esteem) as part of an expanded definition of what a positive outcome represents. In the resolution below, a detailed set of points is reviewed to clarify the definition of, and rationale for, the concept of “recovery.” This is followed by recommendations regarding how APA can help to promote this concept and thereby influence both how treatment is provided and the outcomes that are achieved.

Resolution

WHEREAS, as noted in the APA Resolution on Stigma and Discrimination against People with Serious Mental Illness and Severe Emotional Disturbance (1999), the Center for Mental Health Services reports that 5.4 million or 2.7 percent of the adult population has a "severe and persistent" mental illness, such as schizophrenia, bipolar disorder or major depression;

WHEREAS the Center for Mental Health Services (CMHS, 1993), in accordance with PL 102 321 (1992), has defined serious mental illness (SMI) as “a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified by DSM-IV, and that has resulted in functional impairments which substantially interfere with or limit one or more major life activities;”

WHEREAS, as stated in the APA Resolution on Stigma and Discrimination against People with Serious Mental Illness and Severe Emotional Disturbance (1999), the CMHS definition further notes that “functional impairment is defined as difficulties that substantially interfere with or limit role functioning in one or more major life activities including basic daily living skills (e.g., eating, bathing, dressing), instrumental living skills (e.g., managing money, maintaining a household, taking prescribed medication, or functioning in social, family, and vocational/educational contexts) and that adults who would have met

the functional impairment criteria during the year without the benefit of treatment or other support services are considered to have a serious mental illness;"

WHEREAS, APA has previously endorsed a resolution on Stigma and Discrimination against People with Serious Mental Illness and Severe Emotional Disturbance (1999);

WHEREAS, a proficiency which contains language clearly expressing a recovery orientation in the Assessment and Treatment of Serious Mental Illness has been recognized by APA;

WHEREAS the concept of "recovery" is a core theme in the President's New Freedom Commission Report (2003), in which it states that: 1) "the system is not oriented to the single most important goal of the people it serves-the hope of recovery;" 2) "the system should foster recovery, resilience, and independence;" and 3) "Research and personal testimony confirm that "recovery from mental illness is real: there are a range of effective treatments, services, and supports to facilitate recovery;"

WHEREAS recovery has been defined as "A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness" (Anthony, 1993);

WHEREAS the process of recovery includes "that people overcome the effects of being a mental patient - including rejection, poverty, substandard housing, isolation, unemployment, loss of valued social roles and identity, loss of sense of self and purpose in life, and the iatrogenic effects of involuntary hospitalization, medication and other treatments - in order to retain, or resume, some degree of control over their lives" (Davidson, O'Connell, Tondora, Staeheli, & Evans, 2005);

WHEREAS recovery involves "a redefinition of one's illness as only one aspect of a multi-dimensional sense of self capable of identifying, choosing, and pursuing, personally meaningful goals and aspirations despite continuing to suffer the effects and side effects of mental illness" (Davidson, et al., 2005);

WHEREAS the Substance Abuse and Mental Health Services Administration (SAMHSA) issued a National Consensus Statement on Mental Health in which it 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" (SAMHSA, 2005);

WHEREAS the Department of Veterans Affairs is changing its regulations and practice standards to implement recovery-oriented care;

WHEREAS the Department of Justice is promoting recovery-oriented care;

WHEREAS the Joint Commission has incorporated standards that address recovery oriented services for persons with severe mental illness;

WHEREAS the National Association of State Mental Health Program Directors (NASMHPD) issued a report supporting recovery-oriented care in 2004 (NASMHPD/NTAC, 2004);

WHEREAS states, agencies, and other organizations have published guidelines for recovery-oriented care (e.g., Connecticut DMHAS, 2006; Onken, Dumont, Ridgway, Dornan, & Ralph, 2002; Sainsbury Centre for Mental Health, 2004; Young, Forquer, Tran, Starzynski, & Shatkin, 2000);

WHEREAS, as noted in the APA Resolution on Outpatient Civil Commitment (2004), all people have a right to the opportunity for recovery, namely, full participation in society to the best of their ability;

WHEREAS numerous longitudinal research studies indicate that the majority of people with SMI can improve their functional status and move into valued social roles (e.g., spouse, employee, student) over time (e.g., Bleuler, 1978; Ciompi, 1980; DeSisto, Harding, McCormick, Ashikaga, & Brooks, 1995a,b; Harding, Brooks, Ashikaga, Strauss, & Breier, 1987; Harrow et al., 2005; Huber, Gross, & Schuttler, 1975; Huber, Gross, Schuttler, & Linz, 1980; Jablensky, Sartorius, Ernberg, Anker, Korten, Cooper et al., 1992; Ogawa, Miya, Watarai, Nakazawa, Yuasa, & Utena, 1987; Sartorius, Jablensky, & Shapiro, 1977; Tsuang, Woolson, & Fleming, 1979);

WHEREAS these longitudinal data supporting recovery from SMI are consistent with findings that even people diagnosed with schizophrenia who have spent years in state hospitals and are considered treatment-refractory can be discharged to live back in the community after receiving intensive social-learning based inpatient services (Corrigan & Liberman, 1994; Paul & Lentz, 1977; Silverstein, Wong, Wilkniss, Bloch, Smith, Savitz, et al., 2006);

WHEREAS short term outcome data (1-2 years) also support the idea that recovery is possible (Edwards, Maude, McGorry, Harrigan, & Cocks, 1998; Gitlin, Nuechterlein, Subotnik, Ventura, Mintz, Fogelson, et al., 2001; Maslin, 2003; Loebel, Lieberman, Alvir, Mayerhoff, Geisler, & Szymanski, 1992; Whitehorn, Richard, & Kopala, 2004);

WHEREAS converging data on positive long-term outcomes of people with serious mental illness, and on the personal meanings of recovery have come from countries all over the world (Cohen, Patel, Thara, & Gureje, 2008; Jablensky et al. 1992; Ng, Pearson, Lam, Law, Chiu, & Chen, et al. 2008; Sartorius et al. 1977; Warner, 1983).

WHEREAS, despite the general similarities in outcomes and subjective experiences related to recovery in different countries, cultural variation in the expression of serious mental illness and attitudes towards serious mental illness exist, and these must be taken into account in conceptualizing and implementing recovery-oriented care for individual persons;

WHEREAS recovery for some individuals or groups involves religious coping as a way to maintain control of their lives (Yangarber-Hicks, 2004). Research has shown that patterns of religious coping differ between ethnic groups (Bhui et al., 2008);

WHEREAS life challenges associated with recovery are common human experiences that require resilience. Resilience across cultures involves resolving tensions in relationships and cultural adherence (Ungar et al., 2007). Resilience is "...both a characteristic of the individual…and a quality of …environment which provides the resources necessary for positive development despite adverse circumstances" (Ungar et al., 2007);

WHEREAS the "research and clinical literature on resilience has focused largely if not exclusively on individual personality traits and coping styles, and has neglected to explore all possible sources and expressions of resilience in individuals and groups. For many ethnic minorities, traditional notions of resilience, shaped largely by middle class European and North American values, may not capture culturally more familiar modes of positive adaptation to adverse and traumatic experience" (Tummala-Nara, 2007);

WHEREAS, research indicates that recovery is not an inevitable outcome of SMI, but that it is a function of the availability of comprehensive and coordinated psychological interventions (e.g., Harding et al., 1987b);

WHEREAS, despite the existence of evidence-based practices, there are often environmental barriers to accessing potentially beneficial services. Moreover, the research literature suggests that these disparities are more severe for minorities and people of lower socioeconomic status, and that general disparities in health care lead to people with SMI dying, on average, 25 years earlier than expected. In addition, women with schizophrenia are more likely to have experienced severe trauma (e.g., physical or sexual abuse) and to have comorbid post-traumatic stress disorder, and therefore to be at risk for

especially poor outcomes and further comorbidity (e.g., substance abuse) if this is not diagnosed and treated;

WHEREAS, although most people with SMI will experience a significant improvement in functioning over the long term, some people will need long-term intensive treatment and supports and continue to experience significant disability; even in these cases, however, recovery-oriented principles, such as shared decision making, and a focus on multiple dimensions of outcome may improve quality of life;

WHEREAS most discussions of recovery focus on subjective experience as the domain that is most critical for promoting recovery, the extent of recovery is likely to be significantly affected by community and societal values regarding mental illness, and the extent to which people undergoing a process of recovery are accepted as valued members of their communities and the society at large.

WHEREAS, as noted in the APA Resolution on Outpatient Civil Commitment (2004), a key ingredient in recovery from serious mental illness is making choices for oneself and developing skills necessary to make those choices (Anthony & Liberman, 1992);

WHEREAS, as noted in the APA Resolution on Outpatient Civil Commitment (2004), clinical application of psychological methods (including neuropsychological, behavioral, sociocognitive, and functional assessments and interventions) holds substantial promise for enhancing skill development, including skills relevant to recovery from serious mental illness and skills relevant to making competent personal choices (Spaulding, Sullivan, & Poland, 2003);

WHEREAS recovery-oriented interventions such as supported employment, supported housing, and supported education have demonstrated greater effectiveness than traditional interventions for people with SMI (Drake & Bellack, 2005; Mueser, Clark, Haines, Drake, McHugo, Bond, et al., 2004);

WHEREAS the integration of psychological interventions with interventions seen as paradigmatic of recovery can lead to outcomes that are superior than with either intervention alone (e.g., cognitive rehabilitation, when added to supported employment, significantly improves vocational outcomes for people with SMI compared to supported employment alone) (McGurk, Mueser, Feldman, Wolfe, & Pascaris, 2007);

WHEREAS recovery-oriented care is consistent with evidence-based treatment (Bond, Salyers, Rollins, Rapp, & Zipple, 2004; Frese, Stanley, Kress, & Vogel-Scibilia, 2001);

WHEREAS psychologists are well qualified by training and experience, as well as well positioned in both service delivery and policy development roles, to promote such transformation and champion the adoption of recovery-oriented services, including training staff in, and delivery of recovery-oriented interventions in mental health settings;

WHEREAS research conducted by psychologists has identified psychological constructs that are involved in the recovery process (e.g., hope, self-efficacy, self-determination, empowerment, changing personal narratives) (e.g., Lysaker, Lancaster, & Lysaker, 2003; Roe 2001, 2003), and that can form the basis for more effective psychological therapies;

WHEREAS reliable and valid assessment instruments to assess individual staff members on the extent to which they have adopted a recovery orientation, and to assess agencies' growth towards recovery oriented services, are now increasingly used (e.g., Campbell-Orde, Chamberlin, & Leff, 2005; Chinman, Young, Rowe, Forquer, Knight, & Miller, 2003; O'Connell, Tondora, Croog, Evans, & Davidson, 2005; Ridgway & Press, 2004);

WHEREAS recovery is now routinely the subject of books; articles in scientific journals in the fields of psychology, nursing, and psychiatry, articles in consumer-oriented publications such as Schizophrenia Digest, and papers given at local, national, and international conferences;

WHEREAS the American Psychological Association has yet to develop or issue a position on the concept of recovery as it applies to SMI;

THEREFORE BE IT RESOLVED that the American Psychological Association (APA) endorses the concept of recovery as it applies to SMI.

BE IT FURTHER RESOLVED that APA will issue a position statement noting this endorsement, and that this statement will be actively promulgated to the public and appear on the APA website.

BE IT FURTHER RESOLVED that APA will work toward increasing the attention to promoting data-driven views on the realities of long-term outcomes for people with serious mental illness, and to the importance of consumer-defined and community reintegration-centered goals in conceptualizing treatment, in graduate and post-graduate training.

BE IT FURTHER RESOLVED that psychologists be encouraged to continue to promote the development, implementation, and rigorous evaluation of recovery-oriented services.

BE IT FURTHER RESOLVED that, consistent with the principles of recovery, that these efforts involve consumer input and other forms of active collaboration with consumers.

BE IT FURTHER RESOLVED that psychologists be encouraged to support and promote staff training and public education efforts designed to increase awareness of recovery-oriented concepts and treatment.

BE IT FURTHER RESOLVED that psychologists be encouraged to support and promote efforts at stigma reduction, with the understanding that the extent of recovery is partly a function of the degree to which people with SMI are accepted as valued individuals in their communities.

BE IT FURTHER RESOLVED that psychologists be encouraged to conduct further research on the outcomes of recovery-oriented interventions.

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