The International Journal of Psychosocial Rehabilitation
Volume 18, Number 2
July 2013– June 2014

The Rehabilitation of a Hospital: The Transformation of a State Psychiatric Hospital

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Citation:
Martz E & Newbill W (2014) The Rehabilitation of a Hospital: The Transformation of a State Psychiatric Hospital. International Journal of Psychosocial Rehabilitation. Vol 18(2) 89-100

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Abstract

Several decades of research have indicated that many individuals with a range of psychiatric disorders regain functioning and return to community life. The consumer-driven recovery movement and professional community of researchers and service providers have collaborated to clarify definitions and processes related to recovery from psychiatric disorders, but many questions remain about the implementation of the recovery philosophy in service systems. The present article focuses on experiences of one state psychiatric hospital in its movement toward implementing the recovery model. The following research questions will be the focus of this article: How can psychiatric hospitals sustain a recovery philosophy when individuals have restricted movement and limited choices for the purpose of protecting themselves or others from harm? What have been the successes and the problems experienced by one state psychiatric hospital in its drive to systemically implement a recovery perspective?

Key words: recovery, psychiatric rehabilitation, treatment mall, systemic change, self-management of chronic illness

Introduction

Longitudinal research has indicated that a majority of individuals with severe mental illnesses (SMI) experience recovery by returning to the community and by functioning in many different roles in community settings (for a summary, see Silverstein & Bellack, 2008). Anthony's (1993) often-cited definition of recovery defined it as "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles…Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness" (p. 527). Jacobson and Greenley (2001) proposed that recovery included both internal conditions (i.e., one's own attitudes, hope, empowerment, and healing processes) and external conditions (i.e., policies, services, and conditions that assist recovery). Slade, Amering, and Oades (2008) advocated for a distinction between clinical recovery (e.g., reduction of symptoms and functional impairment) and personal recovery (e.g., an individual's growth

experience). Numerous teams of researchers (Davidson, O'Connell, Tondora, Lawless, & Evans, 2005; Onken, Craig, Ridgway, Ralph, & Cook, 2007; Schrank & Slade, 2007) described recovery from a holistic perspective that involved components related to the person and to the environment in which they lived. They depicted person-centered elements of recovery as including the components of hope, sense of agency, self-determination, meaning and purpose, the awareness of the possibility and potentiality of change, symptom management, and a redefining of the self.

In the past few decades, there also has been international interest in defining what the "recovery perspective" means for individuals with SMI (Davidson, Borg, Marin, Topor, Mezzina, & Sells, 2005; Harrison, Hopper, Craig, Laska, Siegel, Wanderling, et al., 2001; Slade, Amering, & Oades, 2008). Without a doubt, a multidimensional definition of recovery will continue to evolve as knowledge increases about what facilitates restoration and rehabilitation among individuals with SMI. A focus also is needed on defining what works and what does not work when implementing and integrating recovery services into psychiatric institutions, in order to better understand how to facilitate recovery of individuals while they are receiving care from an in-patient psychiatric institution. As Davidson, O'Connell, Tondora, Styron, and Kangas (2006) noted, "the issue is not what role recovery plays in treatment, but what role treatment plays in recovery" (p. 643).

It is important to discuss some of the challenges experienced when implementing recovery concepts into a psychiatric hospital for the possible learning and benefit of other hospitals that try to make similar changes. The present article will explore the issues experienced by one state psychiatric hospital, Oregon State Hospital (OSH), during the implementation of the recovery model into its practice. The present article also will contain quotes from an interview with the superintendent of OSH (Greg Roberts), in order to provide a more detailed understanding of one psychiatric hospital's process of change.

Do We Really Need State Psychiatric Hospitals?

"The transformation of systems from a paternalistic, illness oriented perspective to collaborative, autonomy enhancing approaches represents a major cultural shift in service delivery." Sowers (2005, p. 760)

Clifford Beers (1908) depicted his own mistreatment in psychiatric hospitals in his articulate book, A Mind that Found Itself. His poignant story and his resultant advocacy for change helped to start the "Mental Hygiene" movement to improve conditions for individuals in psychiatric hospitals in the U.S. Some of Beers' experiences reflected the prevailing treatment philosophy of many psychiatric hospitals, which consisted of a mixture of a 'medical model' approach that targeted treatment and medication to reduce symptomatology and a 'custodial approach' of providing basic care and protection. In contrast to the medical or custodial models of treatment, the recovery model is multidimensional and includes not only treatment of symptoms and providing physical and environmental safety, but it also addresses the psychosocial needs of individuals and helps them to learn skills that permit them to become more independent and return to the community.

Over many decades, humane psychiatric institutions have provided numerous benefits to patients with SMI. In many cases, a psychiatric institution offers an improvement in living conditions for patients and acts as a sanctuary from stressful or dangerous conditions (e.g., jails, homelessness, or an abusive environment) (Pratt, Gill, Barrett, & Roberts, 2007). Smith (1998) described that "Before 1991, the treatment philosophy emphasized 'individualized care' in which staff took care of the patients and tended not to teach skills required for their successful reintegration into the community. The major treatment emphasis was medication" (p. 593). Another benefit of a psychiatric institution, according to Pratt and colleagues, is that it can provide centralized, coordinated care for an individual with SMI when the available psychiatric services in the community are fragmented and are poorly coordinated.

Many societies view psychiatric institutions as essential for providing them protection from individuals who have been a danger to themselves or others in the community. Some view this segregated care as a necessity to protect society. Running any large institution and providing hundreds of individuals with food, shelter, and appropriate

medical and psychological care require complex planning. Tailoring services to individual needs can easily be overwhelmed by the responsibility of having to take care of a large quantity and range of patient needs. Goffman (1961) used the term "total institution" to describe the psychosocial dynamic that may result from psychiatric institutions being responsible for scheduling every moment of a patient's day. He proposed that this condition creates a power differential between provider and the one being 'serviced.'

The core difference between a total institution that attempts to physically care for and medically treat the symptoms of its residents and a modern, recovery-oriented institution can be found in the treatment philosophy. If an individual has threatened harm to themselves or others, then most citizens would agree that a limited separation from society is justifiable and necessary, just like communities have the right to ask for protection when an individual has committed a crime. Because individuals typically become in-patients in a psychiatric institution when their behaviors physically threaten or harm others or their own selves, individuals forfeit some of their freedom of movement during their stay in a psychiatric institution. This need to physically confine individuals for their own and/or others' safety seems to conflict with some of the core philosophical principles of recovery, such as choice and self-empowerment. However, a recovery-oriented model in a psychiatric institution would center on promoting and teaching patients not only about physical safety, but also about psychological safety, which Bloom (1997, p. 115) defines as "the ability to be safe with oneself, to rely on one's own ability to self-protect against any destructive impulse." The concept of promoting psychological safety reflects that psychiatric institutions can be both agents of healing for patients and protectors of both the individual and society.

No member of our society is endowed with unlimited choice or autonomy. When a person violates elements of the social contract, as codified into law, that individual, regardless of whether or not they have been assigned a psychiatric diagnosis, is expected to undergo some experience that limits the harm they can generate. A person's stay at a recovery-oriented psychiatric hospital ideally can provide some transformative influence as captured in the aspirational notion of recovery, while temporarily restricting the freedom of movement of individuals in that institution.

While it can be argued that psychiatric institutions have both possible benefits and drawbacks, "cost of illness" research studies, which focus on the economic consequences of the presence of psychiatric disorders, make it clear that the financial impact of SMI is profound on both the personal and social levels. For example, Kessler, Heeringa, Lakoma, Petukhova, Rupp, Schoenbaum, et al. (2008) investigated the individual-level and societal-level effects of mental disorders by examining national data from the U.S. They concluded that having SMI significantly predicted decreased earnings, and that the societal-level impact of this reduction due to SMI totaled $193.2 billion. They concluded that "the impaired functioning associated with mental disorders carries an enormous societal burden" (p. 7). Hu (2006) conducted an international review of the cost estimates of mental illness, analyzing studies published between 1990-2003 and concluded that "Empirical results from the reviewed studies indicate that the negative economic consequences of mental illness far exceed the direct cost of treatment, thus making it important to treat mental illness" (p. 6). These studies reflect that is imperative to treat individuals with SMI; the question for the remainder to this paper is how to implement recovery-oriented care that promotes empowerment while individuals live in the restricted environment of a psychiatric institution.

Reasons for Systemic Change in a Psychiatric Hospital

The Oregon State Hospital (OSH) opened in 1883 as a general psychiatric institution. OSH's Forensic Psychiatric Program was created by the Oregon Legislature in 1966 (Governor's Commission on Psychiatric Inpatient Services, 1988) to help individuals who were found guilty except for insanity. This 1988 Governor's Commission report described OSH programs as "an integral part of the comprehensive spectrum of services from inpatient to outpatient care which permit the tailoring of treatment programs to individual needs" (p. 9, emphasis added). This report also mentioned some of the deficiencies at OSH that included overpopulation, understaffing, lack of staff training, aged and unsafe physical facilities, and insufficient community resources during that time. Besides declaring the urgent

need for more hospital funding, the report mapped out the way forward for OSH by clarifying its mission, establishing standards of care, sufficient staffing, and implementing more treatment, such as drug and alcohol treatment, medical and dental treatment, and psychosocial and vocational rehabilitation. Sixteen years later, the Governor's Mental Health Task Force (2004) in Oregon added the recovery perspective into its standards, stating that "Recovery is possible and is the goal of all mental health services. Recovery means that individuals with mental illness have control over their own lives and are able to have a meaningful role in their families and communities" (2004, p. 11).

The U.S. Department of Justice (DOJ) visited OSH in 2006. Two years later, the DOJ (2008) produced a publicly-available report, which detailed five main areas in which OSH needed to improve or change (e.g., adequately protecting patients from harm; providing appropriate psychiatric, psychological, and nursing care; using seclusion and restraint according to professional standards). Since that time, OSH has worked to address the specific issues raised by DOJ by hiring multiple consultants to determine how best to move the organization forward and to facilitate systemic change (e.g., Kaufman Global, 2011). The phrase, "Hope, Safety, and Recovery" was created in 2011 to reflect the vision of OSH. A new hospital facility was built and patients gradually populated the new facilities during 2011-2012. The use of electronic health records was implemented during that time period. In addition, OSH successfully obtained reaccreditation in 2012 from the Joint Commission.

The current superintendent of OSH, Greg Roberts, has worked in the field of mental health for 40 years. In an interview with the authors of this article, Roberts stated that he believes that the mission not only of OSH, but of state psychiatric hospitals across the U.S., has changed entirely. Roberts noted that there has been a radical shift in the treatment philosophy at psychiatric institutions, changing from a focus of providing medical and custodial care to providing time-limited, active treatment to promote individuals' return to the community. He stated that (emphasis added):

[We are amidst a] national culture change…In the 21st century, state hospitals provide active treatment related to that change in mission. That really is a paradigm shift. We don't take care of people for the rest of their lives. We really, really believe that every person here today can live successfully in community. That's the roadmap to get where we want to go.

Mr. Roberts emphasized that the custodial model of psychiatric care is no longer an appropriate treatment philosophy, noting that "The state psychiatric hospital should never be regarded as somebody's home." He asserted on the perspective that psychiatric hospitals should be viewed as temporary stay, stating that "The hospital, as an element in the spectrum of mental health services, has a specific role to play, which is to receive people from the community when they need to be here and to successfully return them back to the community when they are ready to leave." Mr. Roberts compared OSH's mission, emphasizing time-limited services, to services of a general hospital that treats physical illness, describing that:

If you are physically ill, your doctor is not going to send you to the hospital unless you are so ill that you cannot be treated in the community. The same is true for someone with mental illness. You are not going to the state hospital unless you are so severely ill and dangerous that you must go to the state hospital. Otherwise, you should be treated in community.

But if you are so physically ill that you do have to go to the hospital, they will run tests to start answering the questions 'What's wrong with you? What do we need to do? What treatment do we need to give you so you can recover and leave? What treatment do you think is most helpful?' The same is true for state psychiatric hospitals. If you are too ill and too dangerous by reason of your mental illness to be treated in the community, you come to the state hospital, we conduct a multitude of assessments and use the findings of those assessments to formulate a treatment plan that is aimed at getting you out of the hospital. This is the same thing [as general hospitals], but it is very different mission from the historical mission of the state hospitals.

This quote reflects the view that the purpose of hospitals is to help individuals heal from acute phases of their disorders, whether these are mental or physical conditions. If a psychiatric hospital maintains a 'medical model' treatment philosophy, then it will focus on pathology and on fixing acute disorders. With the medical model perspective, hospitals provide stabilization of psychiatric illnesses, but they will not necessarily be a place of psychosocial recovery and will not directly focus on building skills that will facilitate living in a community setting. In an interview, William Anthony noted the difference in treatment philosophies several decades ago:

It is not so much that there are deficits in the medical model, but the lack of recognition by the proponents of the medical model that they need a rehabilitation model to complement it. We are talking about a total helping approach that should have the capability not only reducing symptoms, but also helping people cope better with their environment….[the medical model] has a heavy emphasis on symptoms and symptom improvement, so that we need a rehabilitation approach with its focus on building skills and developing community supports to complement the medical model (Livneh, 1984, p. 87).

Shifting to a Recovery Perspective

Mr. Roberts was asked to describe when and how the decision was made to implement a recovery perspective at OSH. He responded that:

The hospital never had an option not to [implement the recovery philosophy]. Laws require it, the philosophy in the field required it, advocacy requires it, patients have a right to it….It has been an incremental change as a whole culture, the idea of the rights of the mentally ill, the right not to live in an institution if you could be living in the community…there are many factors: the expansion of community mental health programs, the development of more effective medications. Taken together, these factors enabled people to live in the community and not in the state hospital.

The authors inquired about what were some changes made in practice as a result of implementing a recovery perspective. Mr. Roberts described that historically treatment teams would meet, have a discussion, and then invite the patient into the room and tell the patient the results of the meeting. But nowadays, patients are encouraged to collaborate with interdisciplinary treatment teams, such that "the patient is the driver of the treatment team."

How to Support and Facilitate Patient Change

Mr. Roberts noted that one precondition for individuals' change at a psychiatric institution involves hope by both the individual with SMI and the hospital staff: "The bedrock principle of recovery is [the belief that] people with serious mental illness can recover." If an individual with SMI does not believe that recovery is possible, staff at the psychiatric hospital should "hold hope" (Diamond, 2006) until the individual is able to believe in their own ability to recover. Anthony (1993) noted that "People who are recovering talk about the people who believed in them when they did not even believe in themselves, who encouraged their recovery but did not force it, who tried to listen and understand when nothing seemed to be making sense…" (p. 531).

Mr. Roberts emphasized the importance of staff believing in recovery. He remarked that the psychiatric literature states that "recovery is more than likely for people with serious mental illness…it is not just a possibility that it might happen, it is more than likely. Our job [as a psychiatric hospital] is to believe that and to act on that belief." Mr. Roberts remarked (emphasis added) that "hope is the essential ingredient of recovery…If you are a patient or if you are an organization, and you don't believe in the first place that your life can be better….then you cannot move toward recovery."

Changing Attitudes of Staff from a Control Perspective

Starkey and Leadholm (1997) wrote about staff attitudes in a public psychiatric hospital, noting that:

[The] use of the word 'empowerment' caused consternation among some staff who believed this gave patients license to make rules and run the wards as they chose…many staff…perceived patients as needing to be controlled

rigidly in order to maintain safety…Staff learned slowly that patient participation was indeed a form of treatment and education…[and staff began to] realize their own critical role in facilitating patients' development into higher functioning individuals (p. 505).

Under a 'control' or 'custodial model' of treatment, some staff reflected cynical and negative attitudes toward patients, viewing them as untreatable. Like other psychiatric hospitals that are in the middle of a transition from a medical model, custodial care model, or control model of treatment to a recovery model, OSH faces many challenges, especially in the area of staff attitudes and practices. Mr. Roberts gave one example of the 'control model' of treatment that he had observed: some staff would say to certain patients that "You have to lay in your bed all day. If you get up, there is going to be a problem."

When OSH moved into the new hospital facility during 2011-2012, Mr. Roberts noted that some staff had difficulty adjusting to the physical surroundings of the new hospital. Whereas the old OSH had long hallways, bars, and "jail doors," the new OSH had improved surroundings, such as brightly lit corridors and less obtrusive security features. Patients had their own bathroom and shower. Some staff at OSH believed that this new environment was less safe. Longo, Marsh-Williams, and Tate (2002) observed a similar resistance to environmental changes in psychiatric hospitals because "a prevalent fear was that the proposed change to the least restrictive environment would trigger massive elopements and place both patients and the public and risk" (p. 209) and "if the consumers were given control over their environment, then chaos, increased aggression, and elopement would quickly escalate" (p. 212).

Mr. Roberts asserted that "The emphasis on control is at the opposite end of the spectrum of recovery." While parts of the control and custodial models of treatment may have arisen from staff's desire to protect and care for a patient, staff attitudes may not have simultaneously reflected a belief in the person's ability to recover enough to be able to live in the community, as is typically expected in an acute-care medical hospital:

Early on in my career and for a while [after that], I can clearly, easily remember staff who would be upset, really upset, if you were discharging a patient. 'We love them, we are their family, we are their home, this is their home'—they would actually say that 'Look, this person is going to be here the rest of their life…and who is going to love them out there?'

Mr. Roberts noted that as OSH attempted to systemically integrate the recovery model, there was a range of staff attitudes about the change in treatment philosophy. He described how "some staff were very receptive to the principles of recovery and would respond with 'I've been ready for this for 10 years.' Other staff still maintained views that more derived from a culture of control…When the conditions come along that allow [for the former group] to implement changes that facilitate a recovery model, they were already there; they believed in it, but hadn't been able to do anything about it." Roberts noted that the latter group had to be convinced that recovery was possible and that assaults would not increase when OSH shifted away from control and custodial care to a recovery treatment model. He commented that:

We've gone quite far on that spectrum...away from control and custodial care to provision of active treatment, but we are not fully there. Some units within the hospital are far along with that, but others are not. It's growth, it's belief, it's training, it's modeling….and at its very essence, it's person-centered. You can't do person-centered treatment planning if you are not a person-centered person. If you don't believe in the first place that a person with serious mental illness can recover and live in the community, you are not going to value the answer to the question when you say [to a patient], 'Where do you see your life going?'

Providing Active Treatment

In Harding, Brooks, Ashikaga, Strauss, and Breier's (1987) longitudinal study on the outcomes of individuals with SMI, their results indicated that a majority of the sample (N= 118) exhibited considerable improvement over five to ten years. It is noteworthy that the entire sample had received comprehensive rehabilitation services, which supports

the concept that patients with SMI improve with treatment that is more holistic and that is not primarily focused on providing medications and therapy that target symptom reduction. Harding and Zahniser (1994) asserted that rehabilitation of patients with SMI should begin on day one and involve rehabilitative treatment strategies, such as "skill building (e.g., how to manage one's symptoms, managing one's medication, learning how to manage a budget, acquiring a job skill, conducting social conversation) [which a]ll raise a patient's self-esteem and lower symptoms" (p. 142).

Geller (2000) provided an extensive overview of the federal legislation and the evolving perspectives of psychiatric practitioners for a half a century. He noted that the 1974 court case of Donaldson v. O'Connor resulted in the ruling that individuals who are in a psychiatric institution have a constitutional right to treatment. Geller also commented that "psychosocial rehabilitation was an active enterprise at state hospitals in the 1950s, and it was seen even then as a bridge to community life for persons with serious mental illnesses" (p. 57). Yet, the treatment focus changed over the following decades and resulted in a decreased emphasis on psychosocial rehabilitation. The decreased use of psychosocial rehabilitation in state hospitals may be due to the deinstitutionalization movement in the 1970's, which shifted psychosocial treatment more toward providing rehabilitation in outpatient settings.

The concept of providing centralized treatment in a psychiatric institution is not a new idea. The "treatment mall" concept was first proposed by Bopp, Ribble, Cassidy, and Markoff (1996). They defined a treatment mall as a centralized location where a range of therapeutic activities is offered to patients, consisting of "a series of rehabilitative, skill-building modules…[that] provide consumers with a basis for developing the skills and habits they will need for community living" (p. 698). One important feature of the treatment mall is that it is held away from the units, such that "the ward is reserved for sleeping and self-care functions; that is, [the unit] becomes more like a residence" (Bopp et al., 1996, p. 698). Riley (2009) described the Oregon State Hospital's use of the treatment mall as providing three components to patients: a house area (where the patient lives), the neighborhood area (i.e., treatment mall), and a downtown area (i.e., gym, hair salon, art therapy).

The treatment mall concept reinforces several key principles, such as encouraging normalization and socialization into groups and giving individuals a choice over which kinds of treatments, therapies, and classes in which they will participate. Choice over one's treatment mall groups supports a recovery philosophy of patient-centered treatment. McLoughlin, Webb, Myers, Skinner, and Adams (2010) noted that by providing "centralized psychosocial rehabilitation" by means of the treatment mall, many positive changes were noted, including a reduction in the use of seclusion and restraints.

Dr. Geller consulted with OSH from 2007 to 2011 and advised that all patients should be on the treatment mall during treatment mall hours. Geller's treatment mall concept originally required that every unit should be empty except for the housekeepers, but was later altered by OSH to provide exceptions for individuals who were medically or psychiatrically too fragile to participate at a specific time. Mr. Roberts noted that "The whole treatment mall implementation and, I think, the first serious discussion about the implementation of recovery principles and understanding of recovery principles began" after Dr. Geller visited OSH. OSH currently holds treatment mall fairs that allow patients to sign-up for groups and seeks input from patients about what kinds of groups work for and are interesting to them. Mr. Roberts summarized its impact by stating that "The establishment of treatment malls [and] the provision of active treatment are the means to the end. And the end is very different than the end used to be."

What Do Recovery Principles Look Like in an In-Patient Psychiatric Setting?

Recovery principles involve giving control over recovery to the individual. Mr. Roberts noted that "We must ask the patient, 'What do you think we need to do to help you recover and leave the hospital?'" Roberts provided examples of how to encourage patients to think about their future and what they need to get there:

'Where do you see your life headed? What do you want to do when you leave the hospital? What do you want to be?...What are your dreams?...In response, staff should say, 'This is where you are now. This is where we want to help you go, based on your input. The line that connects those two dots is your treatment plan. That's what a

treatment plan is--a simple answer to the question: What do we need to do to help you get out of this hospital?' And that demonstrates the implementation of psychiatric rehabilitation principles, based on their own recovery process.

Another component of the recovery model is self-empowerment. An example of this is the 'advanced psychiatric directive' that patients can create, which allows them to state, ahead of time, what actions would best help them when they are amid a psychiatric crisis. Mr. Roberts described that at OSH:
We need to ask: 'In the event that you become agitated, what's the best thing for us to do? What works for you?'… as opposed to 'Listen, when we see you getting agitated, we are going to grab you and put you into seclusion.'…The basis of that is [that] patient information has value; I should listen to you. And again, it's what we want. If you or I are in the general hospital for some physical illness, and the doctor and nursing staff walk into the room all the time and tell you all the time what they are going to do, you're not going to like it that much if nobody asked you! Our patients have the same rights. We should want to know, 'What works for you? What should we do? What shouldn't we do? What's the worst thing I could do'...Otherwise there is no point. If I am not going to really listen to what you say, I shouldn't be asking.

Given the shift of expectations that psychiatric institutions should provide time-limited, not life-long, care to its patients, it makes sense that individuals should be empowered to deal with their own psychiatric disorders. An emerging perspective in the medical profession is promoting 'self-management' among individuals who have a range of chronic illnesses (e.g., diabetes, arthritis). Self-management reflects not only knowledge about one's chronic condition, but also the self-empowerment to make choices related to handling one's chronic illness. Bodenheimer, Lorig, Holman, and Grumbach (2002) described self-management as consisting not only of patient education and a collaborative relationship between doctor and patient, but also providing patients with problem-solving skills. This concept is highly applicable to helping individuals in psychiatric hospital return to and remain in the community, given many psychiatric illnesses are disorders that can be expected to fluctuate over time and to be exacerbated under certain stressful conditions or triggers (Schrank, Bird, Rudnick, & Slade, 2012).

Teaching and promoting self-management of chronic illnesses supports the recovery philosophy of self-empowerment. When staff helps patients realize that they can deal with their own psychiatric disorders, patients may begin to see evidence that they can be successful in their own self-management. Thus, empowering patients by giving them additional knowledge and tools about their conditions and verbal messages that they have the ability to cope with their conditions can encourage them to be hopeful about their own recovery. Psychiatric staff and professionals can help individuals to learn how to manage their own chronic physical and/or mental health issues by providing them, as much as possible, the education, self-empowerment, and choice over their own treatment so that they can self-manage their own mental disorders, which a skill that will be invaluable when individuals return to community settings.

Changing Organizational Attitudes

Altering the way that a mental-health system operates is a huge challenge and is a developmental process that can take years (Anthony, Cohen, Farkas, & Gagne, 2002). Most organizational change requires a huge amount of energy and often will be met by resistance by certain groups within the organization. Mr. Roberts described the assumptions of some staff that change at OSH would be easy and effortless:
The construction of the new hospital [building] helped, but it was certainly possible to bring a bad, old hospital across the street into a new building. Before the move, …[while talking about] things that were problematic with the hospital, I would hear people actually say that 'we won't have that problem when we are the in the new facility.'… So, I started to ask, 'Beautiful hospital, beautiful facility, how much did the magic cost?' Some people did not understand what I was saying…But my point was that simply moving across the street into the new facility would not automatically, magically solve the problem…People would say 'this won't be a problem in the new facility,' and I would say 'yes, it will. Why wouldn't it be?'…At that point, people realized that that we had to fix the problems now, while we were still in the old hospital.

Major hospital changes, such as a shift toward a recovery-oriented treatment philosophy require a "cultural change" within an organization. Mr. Roberts noted that the OSH's cultural identity had to be altered:
Culture shifts…are never easy. They take time…Most people don't like change. Some people, at least at the beginning and maybe for some time, did not believe that this [shift to the recovery model] was going to work, that this was the right change for us to be making. For some people, it had to be demonstrated, and now they get it, they buy it. Some people don't get it and don't buy it, but I expect that, over time, they will. Sadly, some people never will.

Mr. Roberts noted that it was essential for staff to believe that change was possible, because if they did not believe in the possibility of positive change, they would not even try to affect change. He remarked that:
If you are a hospital… and everybody thinks that these problems have lasted so long, and they are so severe, they can't be fixed, then you cannot make progress forward. If you believe that they can be fixed, the next question is the more important question, 'What would it take to fix them?' People won't answer that question if they don't even believe in the first place that you can fix them.…You have to believe in the first place that the problem can be fixed. Otherwise you'll never come up with a solution…If people begin to believe it can be fixed, then all you are really talking about is what's going to be our methodology.

Leadership in Change

When the authors asked Mr. Roberts what has helped to support the paradigm shift to the recovery model, Mr. Roberts replied by citing a phrase that a social work professor said to him, back in the early 1970's. His professor, Dr. Bernie Indik, declared that when there are roadblocks to change, "the root cause is one of only three things: leadership, leadership, or leadership." Mr. Roberts explained that:
If the leadership says, 'We don't really believe in the recovery principles,' the staff won't either. And even if they do, they won't bother if they don't have the support of the leaders. So leadership always drives equation. It all starts there. The collaboration of leadership in the clinical side of the hospital and in the administrative side certainly is one of the most important factors in supporting the move forward.

When the authors asked Mr. Roberts whether there were mixed messages given by leadership about implementing recover, he responded:
OSH leadership understands that our job is to facilitate patients' recovery. The issue is only how to accomplish that. Frankly, if the leaders don't have a sense of where we are going, how are the followers, the workers [the employees], going to understand where we are going? As leaders, we are painting a picture and asking, 'What are we going to look like when we are done?'

Mr. Roberts explained his view on the importance of clarity of vision by OSH leaders by citing the William Butler Yeats' quote: "Too long a sacrifice makes a stone of the heart." His interpretation was that:
If things are so bad, for so long, people can become hopeless. You can't see daylight. You can't even envision the possibility that things can be better. You begin to live day to day. You say to yourself, 'My goal is to survive today. And I'll come back tomorrow and hope for the best.' And that happened at OSH, in the past, on the leadership level. You have to get people out of that. An important role of leaders in such a situation is to be a cheerleader. You have to say, 'Get your heads up. Let's go! We can fix this! Come on!' One step at a time, and after two years at OSH, we look back and say 'Things are getting better.' But don't fool yourself.…There is always more…As a superintendent, you can only be satisfied to know that if you look back from where you started to where you are…Is it better? If it is, you did your job. But you must also ask, 'Is it as good as it is going to be?' And the answer is always, 'No we have more to do.' Each generation is expected to make incremental positive changes over time, and then turn things over to the next generation to do the same. As stated, it takes time, and consistent effort.

Mr. Roberts noted that one instrument of change at OSH has been the use of a LEAN team (Teich & Faddoul, 2013). By using LEAN processes that include staff in reworking processes within the hospital, Mr. Roberts (emphasis

added) said that "We are changing the belief, in the first place, that things can't be fixed. We are telling people not only that problems can be fixed, but by the way, you can fix it."

When Mr. Roberts was asked about his vision for OSH, he replied:
My vision for the future of the hospital is that everyone who works here would honestly be able to say that they'd be very happy to have their relatives treated at OSH… That would be a true measure of success…[My hope is] that we become truly a recovery-focused organization…As stated, we are relatively better than we used to be, we are not objectively as good as we need to be. We need to focus more on evidence-based practices, we need to be meeting external expectations of a real, quality, 21-st century state hospital. I think we are on the right path, but we need to continue that until we know that we are objectively, measurably a hospital instituting recovery… Yes, we are better than we used to be, yes, things are different, but we have more to do. I can't say that often enough.

The Recovery of Institutions

During the interview, the authors and Mr. Roberts discussed the parallels between individual and organizational change. Hospitals also have to experience a type of 'recovery' in that they need to believe in the possibility of change and that the futures of individuals with SMI can have positive outcomes. There are many parallels of the organizational changes with the changes that individuals with SMI face in the process of their recovery. Mr. Roberts noted that:
Just as hope is the basis for a person's recovery, hope is the basis for an organization's recovery. If you can't see [the goal], you can't achieve it. If you can't hope, if you can't believe that positive change is possible, you cannot achieve positive change....If the organization does not have hope that it can recover, if you don't believe that the problems can be fixed, these problems won't be fixed.

Facilitating hospitals to become a recovery-oriented environment includes helping staff not only understand that recovery from SMI is possible, if not probable with appropriate treatment, but also helping staff integrate recovery attitudes into their practices.

Longo, Marsh-Williams, and Tate (2002) discussed the steps taken and challenges faced by one public psychiatric hospital when they implemented psychosocial rehabilitation with the purpose of "transform[ing] a custodial model of care to a highly interactive educational and skills building program" (p. 205). Longo and colleagues listed the four main steps as involving the following components: 1) providing administrative support by training staff on psychosocial principles; 2) building hospital-wide, multi-disciplinary treatment models, assessments, and behavioral procedures that provide different ways of intervening than ones based on restrictive care (e.g., seclusion and restraint); 3) providing environmental support that includes patients and trains staff on psychosocial rehabilitation, and 4) evaluating the program by collecting data on significant outcomes and satisfaction with services.

Conclusion

Hospitals, like people, may need education, assistance, and encouragement to change. Many psychiatric hospitals need to acknowledge that a culture change is necessary in order to move toward a more holistic, healing environment. Believing in the ability to change and in the importance for hope of positive outcomes is essential in helping to guide the organization toward an integration of a treatment philosophy that facilitates choice, self-empowerment, hope, and self-management of chronic illness among individuals with SMI. Just as person-centered planning helps promote recovery for individuals, informed leadership with a unified vision and techniques like the LEAN processes can help move a hospital system forward in its implementation of the recovery model as the primary treatment model for assisting individuals with SMI to return to the community.

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