Acad Psychiatry (2016) 40:461–467
DOI 10.1007/s40596-015-0445-3

IN DEPTH ARTICLE: COMMENTARY

Transforming Psychiatry: A Curriculum on Recovery-Oriented Care

Wesley Sowers[1] · Annelle Primm[2] · Deborah Cohen[3] · Jacquelyn Pettis[4] · Ken Thompson[5]

Received: 6 February 2015 / Accepted: 13 October 2015 / Published online: 19 November 2015
© Academic Psychiatry 2015

The concept of recovery in substance use disorders care is well known in the medical world and psychiatric community. The recovery-oriented approach to mental health care has more recently become prominent. It emphasizes a strong therapeutic relationship between the mental health professional and the person seeking care and focuses on hope, strengths, shared decision-making, and personalized plans for goal achievement. It is based on the notion that all people with psychiatric challenges have abilities and capacities that other treatment approaches have not always recognized [1, 2]. People in recovery have become leaders in the mental health advocacy community and have been on the vanguard of integrating a recovery focus in helping people with mental illness.

In 2009, the Substance Abuse and Mental Health Services Administration (SAMHSA) established an initiative on recovery-oriented mental health care as a transformative effort in mental health professional disciplines. The Recovery to Practice initiative involved a 5-year project to develop and implement curricula in six discipline areas, including psychiatric nursing, addiction counseling, psychology, social work, peer support, and psychiatry. An advisory group formed to guide this process was comprised of a diverse group of thought leaders including mental health professionals and people with lived experience of mental illness and substance use.

This paper chronicles the development of the Recovery-Oriented Care in Psychiatry curriculum and its meaning for the field. But first we take a brief look back at some of the history of the field of psychiatry.

The psychoanalytic or psychodynamically oriented practice that dominated the mid-twentieth century has now given way to predominantly biologic approaches with pharmacotherapy at the center of treatment. Starting in the 1950s, a variety of social and economic forces coalesced resulting in deinstitutionalization—an abrupt transition from primarily state hospital care to community-based care. As individuals with mental illness were released from hospitals, they faced daunting challenges due in large part to inadequate funding, lack of community support, and a poorly developed community mental health system. Limited treatment, without related supports and living skills, often resulted in repeated crises, revolving door hospitalizations, incarceration, homelessness, substance use disorders, and increased vulnerability to physical illness [3].

It was during this time that former hospital "patients" took the initiative and began meeting in their communities to provide each other with support and advocate for more control over decisions about their mental health treatment [4]. Advocacy organizations have been persistent in their demands for system change including a larger role in determining the kind of care people with mental illness receive. Over the years since, there has been an expansion of community resources in most areas and the principles and practices of psychiatric rehabilitation gradually developed to meet these demands. Psychiatric rehabilitation helps individuals learn skills for daily living, interpersonal interactions, education, and employment to enhance their ability to live in the community successfully [3].

✉ Deborah Cohen
dcohen@psych.org

1 Western Psychiatric Institute and Clinic, Pittsburgh, PA, USA
2 Urban Behavioral Associates, Baltimore, MD, USA
3 American Psychiatric Association, Arlington, VA, USA
4 ValueOptions® Maryland, Linthicum Heights, MD, USA
5 Pennsylvania Psychiatric Leadership Council, Philadelphia, PA, USA

Despite advances in both biologic and psychosocial interventions for persons with behavioral health disorders, the practice of psychiatry has been increasingly focused on biological aspects of treatment in recent years. Even with substantial evidence of recovery for people with mental illness and substance use disorders [5], psychiatrists often painted a pessimistic picture of what people with these disorders could expect from their lives.

The Recovery Approach

Today, the recovery community is diverse and includes many different ideas about what recovery is and how it is accomplished [6]. For many, it represents a movement for civil rights and human dignity; for others, it is a quest for personal growth and harmony. Despite differences, ideas of "recovery" have many elements in common, such as autonomy, hope, responsibility, adaptability, productivity, purpose, faith, and respect for one's self and others. These elements are reflected in the SAMHSA's Working Definition of Recovery as well as the American Association of Community Psychiatrists (AACP) Guidelines for Recovery Oriented Services [2, 7].

Developing the Psychiatry Curriculum

The Recovery to Practice effort was designed to increase awareness, acceptance, and adoption of recovery principles and practices among mental health providers and to put recovery into practice in day-to-day clinical work. The Recovery-Oriented Care in Psychiatry curriculum is part of this initiative. The project is a collaboration of the AACP and the American Psychiatric Association (APA) with assistance from an advisory group of psychiatrists, other mental health professionals, and individuals with lived experience of mental illness and family members.

The first phase of the project focused on a review of the literature and gathering information from various stakeholders, including psychiatrists, service users, family members, mental health clinicians, and administrators. Interviews were conducted by phone and face to face, both in individual and group formats [8]. Challenges and barriers to recovery-oriented practice in psychiatry were identified. The lack of practical knowledge and skills to put concepts into action, time constraints, and scarce resources was commonly cited.

A number of recommendations for the curriculum emerged:

- Connect to participants' prior knowledge and experiences
- Demonstrate recovery-oriented practices that address common clinical challenges
- Focus on how to use recovery principles in real situations (e.g., within time/resource limitations)
- Include a prominent role for people with lived experience as trainers and use personal recovery stories
- Offer opportunities for interaction and debate
- Create a format that is adaptable to different levels of experience and practice situations
- Present information that is accessible, flexible, and concise
- Make available continuing medical education credit

The recommendations gleaned from our information gathering process are very much in tune with adult learning models [9, 10]. The target audience was defined very broadly to include both trainees and seasoned psychiatrists. Goals and objectives were developed for the series as a whole and for each major conceptual area. The overall objectives for the curriculum are to familiarize psychiatrists with:

- The principles of integrated, trauma-informed, recovery-oriented care for people with mental health and/or substance use conditions;
- The benefits of a recovery approach for both psychiatrists and people living with mental disorders; and
- Practical strategies and tools to implement recovery-oriented practices in the clinical setting.

Recovery-Oriented Care Modules

The second phase of the project involved developing the curriculum content by addressing the specific areas of knowledge, skill, and resource deficits that were identified in the initial phase. The curriculum includes a series of nine modules (Table 1) addressing specific aspects of recovery-oriented practice. The following section provides a general description of the content of each module. The content of the modules correlates with several key dimensions of physician competency elaborated in the Psychiatry Milestones [11]. Table 2 relates Recovery-Oriented Care modules to Milestone competencies. While this is not an exhaustive review of Milestones covered in the curriculum, it addresses the principal areas of intersection.

Module 1: Introduction to Recovery-Oriented Care It addresses the concepts of recovery-oriented care and the reasoning behind it, describes the differences between a recovery-oriented approach and a traditional approach to behavioral health care, and identifies benefits of recovery-oriented care for individuals in treatment and for psychiatrists. It describes the use of recovery principles to deliver integrated treatment for multiple issues in a variety of settings and circumstances.

Table 1 Recovery-oriented care in psychiatry curriculum modules

1. Introduction to Recovery-Oriented Care
2. Engagement and the Welcoming Environment
3. Person-Centered Planning and Shared Decision-Making
4. Peer Supports in Recovery
5. The Role of Medication
6. Health and Wellness Focused Care
7. Developing Living Skills and Natural Supports
8. Culturally Appropriate Care
9. Trauma-Informed Care

Module 2: Engagement and Welcoming Environment It addresses the importance of creating welcoming environments in which persons in recovery will feel valued and respected. The module discusses strategies for overcoming mistrust and apprehension and describes approaches to welcoming individuals with mental health conditions and active substance use, including aspects of communication, physical environment, and the organization [12].

Module 3: Person-Centered Planning and Shared Decision-Making It addresses recognizing the value of integrated person-centered planning and individualized care and mechanisms to implement them. A person-centered plan is an action plan to assist a person in achieving his or her unique, personal goals along the journey of recovery, developed in a collaborative process between the person and his or her supporters including the clinical practitioner. The module discusses the role of the psychiatrist in developing and implementing a person-centered plan and engaging in shared decision-making, and it identifies tools and programs clinicians can use [13]. Shared decision-making is an approach where clinicians and patients share information and make decisions together based on the best available evidence.

Module 4: Peer Supports in Recovery It addresses the importance of peer support—social support services designed to fill the needs of people in or seeking recovery that are delivered by people who have experienced mental illness and/or substance use disorder and recovery. The module describes how peer support helps people become and stay engaged in the recovery process, helps reduce the likelihood of relapse, and can extend the reach of treatment beyond the clinical setting. The module addresses methods to successfully incorporate peer specialists in recovery-oriented health services. It identifies potential barriers to use of peer supports and strategies to create successful working environments with peer specialists [14].

Module 5: The Role of Medication It addresses the concept of collaborative medication management and its relationship to other therapeutic options and recovery. It describes strategies for working in a successful prescribing partnership with individuals and the evaluation of possible options considering both advantages and disadvantages of each. It addresses issues related to decisions by individuals who choose not to take medication and how psychiatrists can be most beneficial in these situations. While medication may be a primary consideration in treatment, it is important to recognize that a treatment plan does not necessarily have to include medication. Other forms of treatment, such as psychotherapy and psychiatric rehabilitation, should be acknowledged and considered.

Module 6: Health and Wellness Focused Care It addresses the importance of providing a comprehensive and integrated approach to recovery-oriented care, including all aspects of a person's well-being (mental, physical, spiritual, social, etc.) [15]. It describes the interrelationship between physical health and psychological well-being and identifies strategies to address specific health concerns common among people with mental illness. It describes strategies to support maintaining health and wellness, including incorporating recreation, socialization, and productivity in life vision; identifies complementary options to biologic approaches that can facilitate recovery; and recognizes the potential role of spirituality in recovery.

Module 7: Developing Living Skills and Natural Supports It addresses methods of assisting people in recovery to build life skills and undertake productive/creative activities of their choosing. It discusses the psychiatrist's role in coaching life skills and illness management skills and in supporting autonomy and self-advocacy [16]. This module discusses the role of family and friends, support groups, 12 step approaches, faith communities, and other natural supports in supporting individuals and strategies for helping individuals develop and strengthen their support systems.

Module 8: Culturally Appropriate Care It addresses characteristics of quality care including cultural self-awareness (introspection), awareness of the individual's cultural influences, and ability to adapt to cultural differences and needs. It discusses cultural influences on mental health, including on the understanding of illness and the healing process. It addresses methods to incorporate an understanding of an individual's beliefs, cultural identity, spirituality, and experiences into recovery planning [17].

Module 9: Trauma-Informed Care It addresses the key elements of trauma-informed care, a treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma on a person's well-being and behavior. Trauma-informed care emphasizes physical, psychological, social, and moral safety and helps survivors

Table 2 Linking recovery-oriented care modules with psychiatry milestones

Recovery-Oriented Care in Psychiatry module	Competency domains/subcompetencies	Examples of Milestones
1. Introduction	Patient Care/Psychiatric Formulation and Differential Diagnosis (PC2, 2.3/B)	Identification of contributing factors and contextual features
	Systems-Based Practice/Community-Based Care (SBP3, 3.3/D)	Foundations of recovery and the recovery care model
	Professionalism/Compassion, Integrity, Respect for Others (PROF1, 1.1/A)	Demonstration of behaviors that convey caring, honesty, genuine interest, and respect for people with mental disorders and their families
2. Engagement and welcoming	Patient Care/Psychotherapy (PC4, 1.3/C) Interpersonal and Communications	Demonstrates a professional interest in the patient's story
	Skills/Information Sharing and Record Keeping (ICS2, 1.3/B)	Active listening and communication strategies to ensure understanding on the part of the individual or family
3. Person-centered planning and shared decision-making	Patient Care/Treatment Planning and Management (PC3, 2.2/A)	Sets treatment goals in collaboration with the patient
	Patient Care/Psychotherapy (PC4, 4.4/C)	Tailoring treatment, including psychotherapy to the needs of the individual
	Systems-Based Practice/Community-Based Care (SBP3, 4.4/D)	Uses principles of evidence-based practice and patient-centered care in the management of chronically ill patients
	Professionalism/Compassion, Integrity, Respect for Others (PROF1, 4.1/A)	Develops a mutually agreeable care plan in the context of conflicting physician and patient and/or family values and beliefs
	Interpersonal and Communications Skills/Information Sharing and Record Keeping (ICS2, 3.2/B)	Consistently engages patients and families in shared decision-making
4. Peer supports in recovery	Interpersonal and Communications Skills/Relationship Development and Conflict Management (ICS1, 1.3/C)	Identifies team-based care as preferred treatment approach, and collaborates as a member of the team
5. The role of medication	Patient Care/Treatment Planning and Management (PC3, 2.3/A)	Addresses consideration of side effects' impact on treatment
6. Health and wellness focused care	Patient Care/Treatment Planning and Management (PC3, 2.3/A and PC3, 3.2/A)	Recognizing comorbid conditions and applying understanding of psychiatric, neurologic, and medical comorbidities to treatment selection
	Systems-Based Practice/Consultation to nonpsychiatric medical providers and nonmedical systems (SBP4, 3.3/C)	Discusses methods for integrating mental health and medical care in treatment planning
7. Developing living skills and natural supports	Systems-Based Practice/Community-Based Care (SBP3, 1.2/B)	Routinely uses self-help groups, community resources, and social networks in treatment
8. Culturally appropriate care	Medical Knowledge/Development Through the Life Cycle (MK1, 3.2/B)	Describes the influence of psychosocial factors (gender, ethnic, cultural, economic) etc. on personality development
	Professionalism/Compassion, Integrity, Respect for Others (PROF1, 3.2/A)	Routinely displays sensitivity to diversity in psychiatric evaluation and treatment
	Interpersonal and Communications Skills/Information Sharing and Record Keeping (ICS2, 3.3/D)	Gives examples in which communication can be compromised (e.g., cultural differences)
9. Trauma-informed care	Medical Knowledge/Development Through the Life Cycle (MK1, 2.3/B)	Describing the effects of emotional and sexual abuse on the development of personality and psychiatric disorders across the age spectrum

rebuild a sense of control and empowerment [18]. The module describes strategies for assessing the impact of an individual's experiences of exposure to trauma and explains the use of universal precautions and circumstances that may contribute to re-traumatization of service users.

Creating the Educational Material

The third phase of the project was developing an educational product that could be used in a variety of situations. Making accessibility a priority, the content was incorporated into a digital slide presentation, which includes both audio and video components. Interviews, vignettes, cases, and relevant film clips are used to emphasize various aspects of recovery-oriented care, and the content is described by a narrator. Each module runs between 20 and 30 min.

This slide presentation can be viewed independently from an online learning site or used in a group format in conjunction with a live, facilitated discussion [19]. When the training is conducted in a group setting, the presentation is used as a starting point for discussion, which is facilitated jointly by a psychiatrist and an individual with lived experience of mental or substance use disorders. Each module requires about 1 h in this format. The face-to-face trainings are preferred since they provide the opportunity for questions, discussion, and interaction.

A packet of materials was developed for use by facilitators in conducting trainings, including general background on the project and curriculum and suggested discussion questions for each module. Presentation of the modules involves an introduction of the project and recovery concept, then the presentation of the recorded module, pausing periodically for discussion if desired. This is followed by a group discussion moderated by trained facilitators, which may include a review of some case vignettes if time permits.

In the fourth phase of the project, the curriculum was pilot tested with diverse audiences in a variety of settings around the country, such as part of psychiatry grand rounds presentations, in conjunction with APA and AACP meetings, in special educational sessions for residents and medical students, and at a meeting of public health psychiatrists. Overall, the responses were quite positive from the 113 individuals that pilot tested one or more modules. Participants found the curriculum well presented and thought provoking in both online and face-to-face formats, but face-to-face piloters felt that the opportunity for discussion was an important part of their learning experience. Eighty-five percent of pilot participants said the curriculum was useful, that their level of recovery-oriented care knowledge was moderately or highly improved, and 95 % said that they would likely or very likely incorporate the objectives presented in the module in practice. While this did not provide rigorous outcome data on the educational effectiveness, it did provide useful feedback for improving the curriculum. A number of adaptations were made in response to feedback, including adding a second vignette to the first module to more clearly demonstrate basic recovery principles, adding more case studies, shortening the introductory material, and adding video interviews with individuals in recovery. The pilot study was deemed to be exempt by the Institutional Review Board of the American Psychiatric Association/American Psychiatric Foundation.

A New Tool to Help Assess Recovery-Oriented Service

As part of the project a self-evaluation tool was developed, the Psychiatric Recovery Oriented Practice Evaluation and Rating (PROPER), to help clinicians improve their ability to provide recovery-oriented services. PROPER includes three scales, each containing about 25 questions, to be completed by different individuals: (1) psychiatrist (self-rating), (2) colleagues and supervisors, and (3) service recipients. Each item in the scales is rated from 1 to 5 yielding a composite score. This process allows psychiatrists to see how their own perceptions of their practice compare with those of their peers and people who receive mental health services. PROPER is intended to be administered to participants prior to taking part in the recovery-oriented care training, and subsequently it can be used to gauge the effectiveness of the training in improving service provision over time. The tool was vetted by behavioral health professional and advocacy groups and went through several iterations to incorporate valuable feedback. PROPER is a self-assessment tool developed through expert consensus, but it has not yet been validated.

Dissemination of the Curriculum

The final challenge for the project is to disseminate the learning material as broadly as possible by creating plentiful opportunities for psychiatrists and psychiatrists-in-training to be exposed to the curriculum. A key is to ensure availability of trained facilitators. Twenty facilitator pairs have been trained to date in series of day-long in-person sessions. These training sessions allow the trainees to observe the presentation of a module by experienced facilitation partners and an opportunity to conduct a mock discussion of a module. The trainees then give and receive feedback about the facilitation and what did and did not work well.

With the expiration of the SAMHSA support at the end of 2014, new resources to support the dissemination of the curriculum must be generated. In this light, the dissemination plan relies, in part, on the initiatives of the trained facilitators who have been asked to promote and seek support for training

through APA district branches, behavioral health provider agencies, and psychiatric residency training programs in their regions. In Texas, the Hogg Foundation is supporting implementation of this Recovery-Oriented Care in Psychiatry curriculum, and curriculum in other mental health disciplines, across the state.

On the national level, a group of AACP members consisting of the Recovery-Oriented Care in Psychiatry project director, co-director, and several members of the advisory group is engaging in fundraising, professional awareness activities such as presentations at a variety of professional organization meetings, and the ongoing training of facilitators. The AACP group will serve as a hub for recruiting psychiatrists to become trainers and to work with psychiatric training program directors. Another positive development has been the additional funding from SAMHSA to support the dissemination of the Recovery-Oriented Care in Psychiatry curriculum. Involvement of the American Association of Directors of Psychiatric Residency Training (AADPRT) will also be critical in promoting the inclusion of the curriculum in training programs across the country.

Discussion

In the past, recovery-oriented care lacked definition. In the curriculum discussed here, a coherent vision of recovery-oriented care is constructed from a variety of inputs. Although some of the components of this vision may not appear to be related to each other at first glance (i.e., shared decision-making, peer supports, engagement, and welcoming environment), their interrelationship becomes clear as they are tied together in a comprehensive package. This curriculum puts all of the elements together for psychiatry in an easily accessible and unified format. Moreover, the Recovery-Oriented Care in Psychiatry curriculum enables psychiatrists to broaden their view of how they can contribute to patients' recovery beyond prescribing medication. When engaged in the recovery-oriented care paradigm, it is not only people with mental illness who benefit but their psychiatrists as well.

There will be aspects of this vision that will be threatening to seasoned psychiatrists who are accustomed to taking a more directive approach, and change may not come without a struggle. Giving opportunities to discuss any reservation is critical to a viable change process. Introduction of these concepts and practices early in training will be the best way to ensure a future workforce that is well grounded in recovery-oriented principles. Most psychiatrists may understand and appreciate recovery-oriented care principles but may not know what to do in their practice. The curriculum is designed to help them apply the range of recovery-oriented care practices.

Obviously, what a curriculum of this type can accomplish is limited. It can provide the information needed for change, but not necessarily the motivation for doing so. The treatment environment must change in a way that supports recovery-oriented practices. Supervision and encouragement from service systems will be necessary elements in creating change. Although the modules may be used by an individual online, an interactive experience enhances the value of the training significantly. Even with an opportunity for discussion after viewing the modules, the training experience in and of itself will be of limited value if there are not opportunities to put the principles into practice without delay. The availability of clinical supervision for the implementation of recovery-oriented practices would also enhance the benefit of the training experience. To develop these resources, significant efforts will be required to put then into practice across the country. The cost of sustaining those efforts will not be insubstantial, so the search for adequate funding will be challenging. An additional challenge will be to develop a solid evidence base for the various aspects of recovery-oriented practice.

In conclusion, the Recovery-Oriented Care in Psychiatry curriculum project developed a vision of psychiatry and behavioral health care in which a nurturing, integrated, recovery-oriented behavioral healthcare community, with psychiatry in a prominent leadership role, works to facilitate recovery of people with mental illnesses and substance use disorders. Putting recovery into practice mirrors a great deal of work across all of medicine in engaging people in their own care and ensuring they have an active role in decisions about their care. It is important to note that this vision is a global one—the recovery-oriented care curriculum, and concepts more generally have relevance not only in the USA but internationally as well. Indeed, recovery-oriented care practices are increasingly being used in several other countries, including Canada and Australia [20].

The curriculum familiarizes psychiatrists with the tools they need to provide recovery-oriented psychiatric care no matter where they practice or under what conditions. It facilitates the transformation of the field of psychiatry into one in which psychiatrists enter into partnership with individuals, place the individual at the center of care planning, and keep the goals and dreams of the individual in the forefront as a pathway to hope, wellness, and a satisfying life. Changing practice and instilling a culture of recovery will additionally require the capacity to coach practitioners as they attempt to alter what they do. The development of the recovery-oriented care curriculum, addressing the multiple aspects of recovery-oriented practice, is a step toward realizing this vision.

Compliance with Ethical Standards

Disclosure The Recovery-Oriented Care in Psychiatry Curriculum was prepared for Development Services Group, Inc. and SAMHSA, under Subcontract No. DSG – ApA 2010–01, to promote the adoption of recovery-oriented practice into behavioral health care. The views, opinions, and content of the curriculum are those of the authors and do not necessarily reflect the views, opinions, or policies of SAMHSA or HHS.

References

1. SAMHSA. Frequently asked questions: thirty of the most frequently asked questions about recovery and recovery-oriented practice (along with some beginning answers). 2011. http://media.samhsa.gov/recoverytopractice/RTPFAQ.aspx. Accessed 15 Dec 2014.
2. American Association of Community Psychiatrists (AACP). Guidelines for recovery oriented services guidelines. 2003 http://www.communitypsychiatry.org/pages.aspx?PageName=AACP_Guidelines_for_Recovery_Oriented_Services. Accessed 15 Dec 2014.
3. McQuistion HL, Sowers WE, Ranz JM, Feldman JM. Handbook of community psychiatry. New York: Springer; 2013.
4. Chamberlin J. The ex-patients movement: where we've been and where we're going. 1990. http://www.power2u.org/articles/history-project/ex-patients.html. Accessed 15 Dec 2014.
5. Davidson L, Harding C, Spaniol L, editors. Recovery from severe mental illnesses: research evidence and implications for practice, Volume 1. Boston: Boston University Center for Psychiatric Rehabilitation; 2005.
6. Roberts G, Boardman J. Becoming a recovery-oriented practitioner. Adv Psychiatr Treat. 2014;20:37–47. http://apt.rcpsych.org/content/20/1/37. Accessed 15 June 2015.
7. Substance Abuse and Mental Health Services Administration. SAMHSA's working definition of recovery. http://store.samhsa.gov/product/SAMHSA-s-Working-Definition-of-Recovery/PEP12-RECDEF. 2012.
8. American Psychiatric Association and American Association of Community Psychiatrists. Psychiatry and recovery-oriented practices: a situational analysis. 2011. http://www.psychiatry.org/psychiatrists/practice/professional-interests/recovery-oriented-care Accessed 20 October 2015.
9. Merriam S. Andragogy and self-directed learning: pillars of adult learning theory. New Dir Adult Contin Educ. 2001;89:3–14.
10. Mezirow J. Transformative learning: theory to practice. New Dir Adult Contin Educ. 1997;74:5–12.
11. The Psychiatry Milestone Project. J Grad Med Educ. 2014; 6(1 Suppl 1): 284–304. /www.ncbi.nlm.nih.gov/pmc/articles/PMC3966577/, Accessed 8 June 2015.
12. Ashcraft L, Anthony WA. What a recovery organization looks like. Behav Health. 2009; May 31. http://www.behavioral.net/article/what-recovery-organization-looks. Accessed 5 Dec 2014.
13. Adams N, Grieder DM. Treatment planning for person-centered care: the road to mental health and addiction recovery. Burlington: Academic Press; 2004.
14. Chinman M, Hamilton A, Butler B, et al. Mental health consumer providers: a guide for clinical staff. RAND Corporation. 2008. http://www.rand.org/pubs/technical_reports/2008/RAND_TR584.pdf. Accessed 5 Dec 2014.
15. Pandya A, Myrick KJ. Wellness and recovery programs: a model of self-advocacy for people living with mental illness. J Psychiatr Pract. 2013;19(3):242–6.
16. Liberman RP. Recovery from disability: manual of psychiatric rehabilitation. Washington, DC: American Psychiatric Publishing; 2010.
17. Lim RF, editor. Clinical manual of cultural psychiatry. Secondth ed. Arlington: American Psychiatric Publishing; 2015.
18. Substance Abuse and Mental Health Services Administration. Treatment improvement protocol: trauma-informed care in behavioral health services. 2014. http://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816. Accessed 15 Dec 2014.
19. American Psychiatric Association, http://education.psychiatry.org. (The curriculum modules can also be viewed online without access to CME at www.psychiatry.org).
20. Commonwealth of Australia. A national framework for recovery oriented mental health services. 2013. http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-recovgde. Accessed 17 June 2015.