

Recovery-oriented Medical Training: A Narrative Literature Review for the University of Recovery as a New Concept of Co-learning between Patients and (Future) Healthcare Providers

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Abstract

Recovery has undoubtedly gained traction throughout the world, and much effort is going into the transformation of mental health policies and systems to achieve recovery-oriented outcomes. There is also a growing argument that emphasizes the interconnectedness of mental and somatic health dimensions, with one dimension affecting the state of the other, and the recovery vision has thus also begun to influence chronic physical illness management. As mental and physical health integration may include colocation, by which the mental health specialist sees patients with various physical health conditions in the same primary care setting, it has been suggested that this colocation could also be conceptual and, in fact, favored by the sharing of a common and global recovery vision for a genuine holistic and person-centered approach. A rapid review of literature was performed to inform the development of a series of workshops to train psychiatry residents and medical students to recovery. Although a plethora of writings exists on ways to transform existing practices to make them more recovery-oriented, not much is known about training techniques meant to inculcate recovery values and principles within the initial training of doctors and other professionals. Through this review, we could not find any faculty of medicine-based class with official institutional credentials specifically and explicitly meant to train future professionals to recovery. The University of Recovery emerged as a new approach to training, not only on recovery, but more importantly for training in recovery. In effect, at the 'with-no-walls' University of Recovery, professors learn from students and conversely through a 'flipped classes' approach by which patients and (future) providers experiment with recovery together, for example, with inverted role plays and other small group techniques of co-learning, as discussed in this paper.

Keywords: Patient engagement; Recovery-oriented transformation; Medical education; Therapeutic education; Person-centeredness; Global health; Andragogy

Background

Mortality from physical illnesses is over 70% higher in psychiatric patients in relation to that of the general population, even after adjusting for demographics, including socio-economic status [1]. Excess mortality rates due to the complications of a chronic physical illness in such patients are two or three times higher, corresponding to a 10-25 years reduction in life expectancy [2]. Studies have shown that even when accepted for the treatment and management of a chronic physical illness, patients with a psychiatric condition are less likely to have comprehensive reviews. There is also a greater delay for medical and surgical interventions when compared to the general population [3]. The possible explanations for this disparity include: unhealthy habits (e.g. smoking; lack of exercise); side-effects of psychotropic medication; delays in the detection or initial presentation of a symptom leading to a more advanced disease at diagnosis; and inequity of access to services partly due to a lack of thorough investigation and poor patient-doctor and doctor-patient communication skills [4-6].

Indeed, difficult communication, social distance, and the overall poor quality of interactions between healthcare providers and patients with a lower socioeconomic status have been identified as barriers to healthcare for such disadvantaged populations [7,8]. Problems with attention and concentration can further harm the understanding of the doctor's explanation, and can affect adherence to treatment. Also, there is still a stigma surrounding mental illness, often worsened when patients present with a psychotropic drug list or an extensive medical history, or when they are known to pay frequent visits to medical services or the emergency departments. The over attribution of symptoms to an underlying psychiatric condition can thus result in missed diagnoses, the improper management of conditions, and therefore worsened prognostics [9,10].

The main causes of mortality in patients with schizophrenia, for example, are the same as for the rest of the population (e.g. cardiovascular diseases, cancer, complications of diabetes). Such individuals are prone to many different physical health problems [11]; while these diseases are also prevalent in the general population, their impact on such individuals is significantly increased [12]. Responding to the needs of this disadvantaged group with high medical requirements, is challenging for family physicians and primary care teams [13,14]. For example, diabetes represents a significant medical illness among individuals with schizophrenia [15], the prevalence of diabetes being usually increased 2 to 3 fold with them [16]. In effect,

the association between schizophrenia and diabetes has been known at least since 1879 [17]. It can be explained by potential cellular and genetic links [18,19] or physical inactivity, poor diet, and cigarette smoking [20,21]. Social health determinants, such as income, housing and gender [22] can also contribute, while the uptake of psychotropic medication is particularly associated with Type 2 diabetes [23].

Social determinants are believed to be reasons as to why the prevalence of diabetes is so high among these patients, but there is now a growing argument that emphasizes the interconnectedness of mental and somatic health dimensions [24], with one dimension affecting the state of the other. This relation has been intuitively known for centuries, but unfortunately, modern mental healthcare and physical healthcare are still often working in silos, if not one against the other [25], and with very important, if not tragic consequences in terms of poorer quality of life and shortened lifespan.

Management of chronic physical illnesses in primary care is already very complex [26], even more so when these conditions come in multiple combinations and involve comorbidity with mental illness. Knowing the common causes and disease mechanisms of interactions should allow a more effective and proactive approach in their prevention and treatment. Nevertheless, it is likely that treating psychiatric symptoms on one side alone will not improve life expectancy for those also afflicted by a chronic physical condition, while managing chronic physical illness on the other side separately will not significantly improve the overall outcomes in terms of social inclusion and quality of life, which are key social determinants and predictors of both mental health and physical health [27]. A life-course approach is warranted, much beyond a typically curative approach to illness, since the formative stages of life can affect mental well-being over decades [28,29]. Patients are probably the best placed persons to incarnate such an approach in order to transcend these historic silos, which are artificial from their own daily life-course perspectives and trajectories.

Methods and Materials

Recovery has undoubtedly gained traction throughout the world, and much effort is going into the transformation of mental health policies and systems to achieve recovery-oriented outcomes [30,31]. Generally speaking, two portrayals of recovery stand out amidst the diversity of views: restoration of functioning and deepening wellness [32]. When recovery is mainly seen as symptom management, the primary focus of personal choice and responsibility in the process of recovery becomes seeking and complying with treatment. Such a “clinical” model does include social functions, but from a professional point of view. Instead of focusing primarily on symptom relief and management, a second view casts a wider spotlight on restoration of self-esteem and identity, and on attaining meaningful roles in society [33]. While the clinical-recovery model has focused upon the remission of symptoms and restoration of functioning, a rehabilitative view of recovery has been a more subjective and consumer-oriented concept that focuses on the full lives that are lived in the face of, or despite, enduring disability. This second axiom of recovery derives from the Mental Health Consumer/Survivor Movement, and refers to a person’s rights to self-determination and inclusion in community life regardless of disability status.

Since there are multiple associations between mental health and chronic physical conditions that significantly impact the quality of life of concerned individuals and the demands on healthcare, is it possible

that the abovementioned second axiom of recovery could also apply to living with a chronic physical condition? That is with the promotion of a person’s rights to self-determination and inclusion in community life regardless of disability status?

Mental health and physical health are indeed fundamentally linked and this relationship is particularly evident in the area of chronic conditions. It has thus been suggested that recovery values and principles, which were until recently almost exclusively associated with mental health, could also be most relevant to chronic physical health management [34] in order to better integrate these two complementary dimensions of health, and therefore for a genuine holistic person-centered approach to care. In effect, even though several aspects of mental health care differ from other health-care contexts (e.g. forms of coercion, questions about service users’ insight and disempowerment, stigma against the mentally ill) [35], we postulate that there is no objective a priori reasons to exclude that such phenomena might also exist with chronic physical illness; they may be simply less readily observable.

To inform the development of medical training of residents and medical students to recovery, a rapid review of literature was performed [36]. Rapid reviews are a type of knowledge synthesis used to inform health-related policy decisions and discussions, especially when information needs are immediate. Rapid reviews streamline systematic review methods – for example, by focusing the literature search [37]. Our search focused on English, peer-reviewed full abstracts in MEDLINE with the terms “recovery-oriented; medical training; university”, from 2006 to 2016.

Results

The initial MEDLINE search yielded 19 references, 18 of which are about specialized mental health or psychiatric services and published in medical journals of mental health, psychiatry or addictions. One paper is about physicians being trained to psychiatric/psychosocial rehabilitation (PSR) principles [38]. Several are about improving already established practices for inpatients [39,40], for instance through the implementation of advance directives [41], and at a system’s level [42].

Training for staff is also addressed [43], including for psychiatric nurses [44] or staff in housing facilities [45]. Some are thus about changing already practicing professionals’ attitudes or that of patients [46,47], while others target specific categories of patients like veterans [48,49] or youth [50]. One paper discusses issues related to confidentiality [51], while another mainly focuses on shared-decision making [35].

The abovementioned categories for classifying the material are not necessarily mutually exclusive. Some themes are cross-cutting, for instance that of engaging doctors [52] or patients [53]. Indeed, besides engagement of patients in their own recovery journey, the active participation of patients in research [54] or in medical training is a key feature of a recovery-oriented approach [55].

Authors	Target audience	Main focus	Training of medical students or residents
Agrawal et al. [55]	residents	engagement	yes

Beentjes et al. [46]	patients (general)	e-mental health	no
Cusack et al. [44]	professionnals (nurses)	communication	no
Eisen et al. [48]	patients (veterans)	peers mentors	no
Hackman et al. [40]	inpatients (general)	satisfaction	no
Kemp et al. [41]	system/institution	advance directives	no
Kidd et al. [42]	systems/institution	engagement	no
Koval et al. [39]	system/institution	nursing	no
Marynowski-Traczyk et al. [49]	emergency department	nursing	no
Morant et al. [35]	providers	shared decision making	no
Munson et al. [50]	youth	engagement	no
Petrik et al. [51]	providers	confidentiality	no
Piat et al. [45]	housing facilities	attitudes	no
Polacek et al. [53]	inpatients	engagement	no
Rabenschlag et al. [47]	patients (general)	peers mentors	no
Rudnick and Eastwood [38]	physicians	attitudes	yes
Salyers et al. [43]	providers	attitudes	no
Sowers and Marin [52]	providers/patients	engagement	yes
Stratford et al. [54]	research community	engagement	yes

Table 1: Results to the search with the key words “recovery-oriented”, “medical training”, and “university”.

State of knowledge

As per Table 1, four papers reported interventions meant to introduce, in the curriculum of medical students or psychiatry residents, different formulas for them to be exposed and trained to recovery principles and values.

Thus, Rudnick and Eastwood [38] describe a program to train physicians to psychiatric/psychosocial rehabilitation (PSR), for example to the importance of self-determination. This revision of the curriculum for psychiatry residency is guided by adult education principles (andragogy), emphasizing the importance of addressing attitudes in addition to knowledge and skills, and as recommended by the Canadian Medical Education Directives for Specialists (CanMEDS) [56]. The learning methods are interactive lecturing, guided reading with problem based learning (PBL), and simulations (role playing). These authors recommend peer support providers, and service users in

the PSR education of psychiatrists, psychiatry residents, and other physicians involved in service provision and policy making.

As for Stratford et al. [54], they discuss, too, the importance of involving people with a lived experience (patients) in research activity. Medical students are often hired as research staff like research assistants or auxiliaries, and residents are invited, at times, to be involved in clinical research. Engaging people with the lived experience extends beyond their participation as “subjects”. In effect, the authors recall, the recovery paradigm conceptualizes people with the lived experience of mental ill health as experts by experience. They conclude that this engagement improves sensitivity and respect, for example through recognizing the importance of having a shared language that moves away from a problem-saturated view to a shared language about hope and possibility.

In the same vein, while describing a number of recovery oriented leadership and fellowship programs and post graduate seminars in the states of New York and Pennsylvania, Sowers and Marin [52] postulate that to support the transformation process, psychiatrists must be able to move beyond a role defined primarily by diagnosis and medication management. Therefore, they argue, psychiatrists, like all providers, must acquire the skills and understanding to develop trusting and nurturing relationships with service users and their families. Transformation calls for person centered collaborative care and focuses on helping individuals reach their potential and live more satisfying lives in the community. These authors thus suggest that recovery oriented system requires engaging the communities in which people live and, at the same time, the community based provider system which provides the foundation for care, including universities.

Finally, Agrawal et al. [55] describe a novel course that pairs service users as advisors to senior psychiatry residents with the goals of improving the residents’ understanding of recovery, reducing negative stereotypes about people in recovery, and empowering the service users. Based on the evaluation of the course, changes were made to its structure to create more opportunities for small group learning. Small group learning is an educational approach that allows participants to develop problem solving, interpersonal, presentational and communication skills that are difficult to develop in isolation, and that require feedback and interaction with other individuals [6,57]. Interesting to note is that service users are directly involved in these small learning groups.

In summary, results of pre and post-surveys evaluating inter-professional seminars of continuing education, including for residents and postgraduate medical students, and assessments of mental health staff knowledge and attitudes about recovery, are available. The same goes for organizational change and reform at a systems level. There are some add-on workshops and seminars offered to practitioners on a continuing education basis or to medical students in existing medical classes, on broader topics like rehabilitation, for example, and they all are invited to attend conferences and presentations on recovery, an invitation that at times also extends to the public. A plethora of writings exists on ways to possibly transform existing practices to make them more recovery-oriented, but not much is known, according to this review, on training techniques meant to inculcate recovery values and principles within the initial training of doctors and other professionals, be they from the fields of mental health and psychiatry or from any other fields of health sciences and medicine.

Discussion

People with mental health conditions are at high risk of experiencing chronic physical conditions, while people with chronic physical conditions are at risk of developing poor mental health [58]. Collaboration between physical and mental health service providers in a model of shared-care to be provided by professionals of various backgrounds working in synchronicity to offer complementary services and mutual support, is now becoming the norm. As mental and physical health integration may include colocation, by which the mental health specialist sees patients with chronic physical health conditions in the same primary care setting, this colocation could also be conceptual and, in fact, favored by the sharing of a common recovery vision for a genuine holistic and person-centered approach which can be successfully conveyed by active patients and patients' assumed leadership.

Even if there is still progress to be achieved, recovery is somehow well known in the fields of psychiatry and mental health. At least it should be, given that, in recent decades, mental health and psychiatric rehabilitation services have officially and increasingly endorsed a recovery-based approach [59]. One challenge to better integration of physical health with mental health in primary care would thus be to make the former more knowledgeable of recovery as a guiding vision for transformation, with the latter being, in principle, already aware that recovery (not cure) is now the ultimate overarching goal of a transformed system of care.

The rapidly changing health care landscape that has placed more demands on physicians, combined with an increasing fragmentation of organized medicine, has impacted the overall public role and community participation of physicians [60]. It is much more difficult now to find time to change already ongoing practices than to positively influence pre-practice and future practitioners as early as possible in their initial medical training. We have thus combined the abovementioned principles of andragogy and problem based learning (Rudnick and Eastwood), within an inclusive approach for developing attitudes among future professionals for them to engage themselves in trusting and nurturing relationships with service users and their families (Sowers and Marin). In effect, the University of Recovery (UR) [61] is a formula that includes two medical courses on recovery (PST1000-Recovery and Global Health and PST 1001 Ethics of recovery) for which any pre-graduate health sciences student could obtain institutional credits, at least as an out-of-program course [62]. This formula combines features of the Recovery Colleges in Great Britain, the Recovery University or Recovery Collegiate Programs in the USA, and of Université des patients in France [63].

The UR is a 'with-no-walls' approach to training not only on recovery, but more importantly to training in recovery because it is based on the importance of involving people with a lived experience (Stratford et al.). In fact, the UR classes are also opened to them, so they too can learn about, and experiment recovery in the classroom. At the UR, professors learn from students through a 'flipped classes' approach, or 'inversed therapeutic education' principle [64] by which patients and (future) providers experiment with recovery together, for example, through inversed role plays and other small group co-learning techniques [65] (as recommended by Agrawal et al.). Typically, therapeutic patient's education offered by health care professionals helps the patients to learn and to develop numerous competencies, to adapt behaviors leading to an improvement of different health parameters, including bio-markers and quality of life [66]. On the other way around, patients can also, and in fact, are more

and more involved in medical and recovery-oriented training [6,67,68]. At the UR as a concept, patients and medical students can study and experiment attitudes like empathy, altruism, rigor or reflexivity together through mentorship and reciprocal, positive emulation (as per the above mentioned CanMEDS). They relate to each other on an equal basis and there is not, on one side the professor, and on the other side the student: the UR is a co-learning principle and experience among all of its members.

Limitations

Generally speaking, two different types of literature review research are available: systematic review and narrative review (update). The traditional method of integration in the literature has been the narrative review but it has two basic weaknesses. First, there is no rule on how to get primary data, and how to integrate results; that is the subjective criterion of the reviewer. Second, the narrative reviewer does not quantitatively synthesize the data found in the different publications; therefore, these revisions are susceptible to inaccuracies and biases. Rapid reviews are a type of knowledge synthesis used to inform health-related policy decisions and discussions, especially when information needs are immediate or almost so. Rapid reviews streamline systematic review methods—for example, by focusing the literature search, as performed here. Despite these important limitations, this rapid review proved to be informative about an emerging field—that of recovery-oriented medical training in universities (including residencies). Seven out of the 19 papers (37%) that this search yielded for a ten year period (2006-2016) were published in 2016, which is a confirmation of an expected increase in the volume of literature on the topic over time.

Conclusion

As suggested by John Strauss, an emeritus professor of psychiatry; for theory, practice, research, and training, a better comprehension of the experiential aspects of subjectivity is essential in order for the mental health field to be a true human science [69]. The integration of mental health and physical health, we suggest, can be favorably fostered through a shared recovery approach and vision that is possible with enhanced consideration and interest for the expression of the lived and subjective experience of going through and beyond the chronic illness continuum—mental and/or physical. It is about relating: between doctors and patients, and between mental and physical health.

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