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Actualizing and Sustaining Recovery-Oriented Care

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Many adults with severe mental illness (SMI) need intensive case management services. So I was excited to read about the randomized controlled trial conducted by Compton and colleagues[1] of their Opening Doors to Recovery (ODR) program. The ODR program is described as a 12-month community navigation and recovery support program that involves an interdisciplinary team of case managers, peer specialists, and local resources. Interestingly, a family member of someone with SMI also serves on the team to help with navigation and developing natural supports. It seems the ODR program has many components as the team works with various local partners, including law enforcement, employers, and housing providers. I applaud the researchers in working to develop a program that seeks to embody the principles of the recovery movement that began over 40 years ago now.[2,3]

There are some similarities between ODR and intensive case management (ICM) or assertive community treatment (ACT) models, which have been successful in reducing hospitalization among adults with SMI[4,5] and have aimed to be recovery-oriented.[6] However, not all ICM/ACT programs are as embedded with local resources as ODR or have the same unique features such as peer specialists and family members. Also importantly, ODR is described as time-limited (lasting 12 months), whereas ICM and ACT have been conceptualized as time-unlimited, although some ICM/ACT programs are starting to develop graduation procedures for clients.[7] It may be informative to outline how ODR clients are transitioned out of the program since program transitions can be difficult for clients and providers.

I have two comments about the intensity of ODR that I hope are worth considering and perhaps reflect what the authors are planning as next steps for ODR. First, the researchers described substantial participant attrition early in the study, with over half of the participants dropping out by 4 months, but nearly all participants were retained thereafter through 12 months. One may deduce that the intensity of ODR works well for some clients, and those clients will stay engaged, but may not well work for others. It may be clinically useful to find out which clients are most likely to drop out and why. It certainly is not surprising that some clients drop out, as they do in all treatments, but teasing out the driving factors may help provide better tailored care to this population.

Second, with intensive and involved programs like ODR, there may be questions about scalability and costs. Since ODR was developed in southeast Georgia and seems to be so embedded locally, could it be replicated in other parts of the country? There certainly is a need for it, and perhaps a development toolkit of the researchers' process in developing ODR with diverse stakeholders would be useful as a guide for other regions. Lastly, there is the important question of costs. The researchers found reduced hospitalizations, reduced criminal justice involvement, and greater improvements in recovery, which may translate to cost-effectiveness. However, this is hard to determine definitively because the study did not include a cost evaluation, which may go a long way toward support scaling and sustaining the intervention in other regions.

In conclusion, recovery-oriented programs like ODR are important to develop for this population. Considering ways to test, scale, and sustain them over time may be important for administrators and clinicians to make informed decisions about implementation.

Published online: January 16, 2023.
Relevant financial relationships: None.
Funding/support: None.

REFERENCES

1. Compton MT, Kelley ME, Anderson S, et al. Opening Doors to Recovery: a randomized controlled trial of a recovery-oriented community navigation service for individuals with serious mental illnesses and repeated hospitalizations. *J Clin Psychiatry.* 2023;84(1):22m14498.
2. Anthony WA. Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. *Psychosoc Rehabil J.* 1993;16(4):11–23.
3. Salyers MP, Tsai J, Stultz TA. Measuring recovery orientation in a hospital setting. *Psychiatr Rehabil J.* 2007;31(2):131–137.
4. Schaedle R, McGrew JH, Bond GR, et al. A comparison of experts' perspectives on assertive community treatment and intensive case management. *Psychiatr Serv.* 2002;53(2):207–210.
5. Marshall M. What have we learnt from 40 years of research on intensive case management? *Epidemiol Psichiatr Soc.* 2008;17(2):106–109.
6. Salyers MP, Tsemberis S. ACT and recovery: integrating evidence-based practice and recovery orientation on assertive community treatment teams. *Community Ment Health J.* 2007;43(6):619–641.
7. Tsai J, Huang M, Petering R, et al. Graduation practices and outcomes in intensive case management programs for severe mental illness: a systematic review. *Psychiatr Rehabil J.* 2022;45(1):61–70.

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J Clin Psychiatry 2023;84(2):22com14697

To cite: Tsai J. Actualizing and sustaining recovery-oriented care. *J Clin Psychiatry.* 2023;84(2):22com14697.
To share: https://doi.org/10.4088/JCP.22com14697