Recovery Research and References

Presbyterian Hospital
October 5, 2012
Is Recovery Possible?
Outcome Studies

Several studies have been conducted to determine the impact of a recovery philosophy on consumers’ well-being.

Harding and Colleagues (1987) The Vermont Study

A 32 year longitudinal outcome study on recovery and how it is impacted by mental health services.

Dr. Harding studied the success of a recovery oriented system in Vermont through a planned deinstitutionalization process, to a rehabilitation program with community supports. Subjects were then followed 32 years later.

Population studied

Most severely disabled bottom 19% in their state hospital.

Lifelong institutionalization; ill on average for 16 years, totally disabled for 10 years, continuously hospitalized for 6 years and most had been at the hospital for over 10 years.

No hope for Recovery; animal-like behavior
Is Recovery Possible?
The Vermont Study

Results

• 62-68% fully recovered or significantly improved.

32 years later, 97% of the original 269 patients were involved in a follow up study:

• 34% of those people with a diagnosis of schizophrenia experienced full recovery in psychiatric status and social functioning.

• An additional 34% of the people who attended the rehabilitation program were significantly improved in both areas.

Of the 62-68%, half met all four of the recovery criteria, the other half met three out of four criteria, usually continuing to take medications while meeting the other criteria.

It should be noted that this cohort is the least functional ever studied.

Recovery was based on the following criteria:

• Having a social life indistinguishable from your neighbor (being integrated into the community)
• Holding a job for pay or volunteering
• Being symptom free (no current signs and symptoms of mental illness)
• Being off medication
<table>
<thead>
<tr>
<th>Study</th>
<th>Average Length in Years</th>
<th>Sample Size</th>
<th>Subjects Recovered and/or Improved Significantly</th>
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</thead>
<tbody>
<tr>
<td>M. Bleuler (1972 a &amp; b) Burgholzli, Zurich</td>
<td>23</td>
<td>208</td>
<td>68%</td>
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<tr>
<td>Huber et al. (1975) Germany</td>
<td>22</td>
<td>502</td>
<td>57%</td>
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<td>Ciompi &amp; Muller (1976) Lausanne Investigations</td>
<td>37</td>
<td>289</td>
<td>53%</td>
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<td>Tsung et al. (1979) Iowa</td>
<td>35</td>
<td>186</td>
<td>46%</td>
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<tr>
<td>Harding et al. (1987 a &amp; b) Vermont</td>
<td>32</td>
<td>269</td>
<td>68%</td>
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<tr>
<td>Ogawa et al. (1987) Japan</td>
<td>22.5</td>
<td>140</td>
<td>57%</td>
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<tr>
<td>DeSisto et al. (1995 a &amp; b) Maine</td>
<td>35</td>
<td>269</td>
<td>49%</td>
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These are six other studies of a longitudinal nature, all over 20 years in length and demonstrating similar recovery rates. Recovery percentages are based on criteria similar to Dr. Harding’s definition, except for the Iowa study, which added marriage as a criterion.

(Center for the Study of Issues in Mental Health, 2003)
Beginning in the 1990’s, Recovery began to be used to guide changes in the mental health system, earning it the label “the decade of recovery.” In 1993 Ohio was one of the first states to both divest and then reform their system based on a recovery approach. Wisconsin did so in 1996, and Illinois in 1998.
Recovery and National Reform

With the success generated from other states, the recovery model has become a tool for guiding system reform at the state level in both policy and practice throughout the United States.

Some states have taken it upon themselves, others have been influenced by President Bush’s New Freedom Commission Report, a process that began in 2001 to promote increased access to educational and employment opportunities for people with disabilities, to maximize the use and effectiveness of existing resources, to improve coordination of treatments and services and to promote community integration.

To make comprehensive recommendations, the New Freedom Commission analyzed public along with private mental health systems, visited innovative programs, and met with consumers, families, advocates, providers, researchers and administrators. Feedback was provided from 2,500 people from all 50 states.

Their final report, “Achieving the Promise: Transforming Mental Health Care in America” concluded that recovery from mental illness is real; however, due to a fragmented system and inadequate resources, efforts toward recovery are thwarted.
<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Outcomes</th>
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<tbody>
<tr>
<td>Forchuk (2005). Therapeutic</td>
<td>Randomized Control Trial to determine the cost and effectiveness of a</td>
<td>Peer support transition program added to psychiatric hospital team had a</td>
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<td>relationships: from psychiatric</td>
<td>transitional discharge model (TDM) of care with clients who have a</td>
<td>decrease in the number of hospital days, reduction in readmission rates,</td>
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<td>hospital to community, <em>Journal</em></td>
<td>chronic mental illness. This model consisted of: (1) Peer support for 1</td>
<td>increased discharge rates and an increase in quality of social relationships. Intervention subjects</td>
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<td>of Psychiatric and Mental</td>
<td>year and (2) Ongoing support from hospital staff until a therapeutic</td>
<td>were discharged an average of 116 days earlier per person. Based on the</td>
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<td>Health Nursing 12(5), 556–</td>
<td>relationship was established with the community care provider.</td>
<td>hospital per diem rate this would be equivalent to $12M CDN hospital</td>
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<td>564.</td>
<td>Participants ( n = 390 ) were interviewed at discharge, 1 month</td>
<td>costs.</td>
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<td>post-discharge, 6 months post-discharge and 1 year post-discharge</td>
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<td>Clarke et al. (2000)</td>
<td>RCT Longitudinal impact of peer support on hospitalization rates</td>
<td>Individuals receiving peer integrated community support had longer</td>
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<td></td>
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<td>community tenure, reduced need for hospital admission or emergency</td>
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<td>hospital care.</td>
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<td>Min et al. (2007)</td>
<td>Longitudinal impact of peer support on hospitalization rates</td>
<td>Use of peer support resulted in longer community tenure as well as a</td>
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<td>decrease in hospitalization readmission over a 3 year period of time.</td>
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<td>Paulson et al. (1997-2000)</td>
<td>Randomized controlled trial; 3 conditions: assertive community</td>
<td>Clients of peer employees had a longer community tenure before hospital</td>
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<td>treatment employing users ( n=58 ), employing non-users ( n=59 ),</td>
<td>admission, fewer hospitalizations and need for emergency care</td>
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<td>Klein, A.R., Cnaan, R.A., &amp; Whitecraft, J. (1998). Significance of peer social support with dually diagnosed clients: Findings from a pilot study. Research on Social Work Practice, 8(5), 529-551</td>
<td>Comparative study; 2 case management conditions: with peer support (n=10) and standard (n=51)</td>
<td>Clients of peer support had fewer inpatient days, better social functioning, and some quality of life improvement</td>
</tr>
<tr>
<td>Dumont, J., &amp; Jones, K. (2002). Findings from a consumer/survivor defined alternative to psychiatric hospitalization. Outlook, 4-6.</td>
<td>Experimental design studying Crisis Hostel compared to inpatient hospitalization with a 6 and 12 month follow up</td>
<td>Increased empowerment, quality of life (i.e. healing and satisfaction), and decreased hospital admission rates were associated with the Crisis Hostel alternative. Participants receiving the peer delivered hostel residential service had better “healing outcomes” and greater empowerment. The experimental group had greater levels of service satisfaction and significantly lower psychiatric hospital costs.</td>
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<td>Study</td>
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<td>Outcome</td>
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<td>Kaufmann, C.L. (1995). The self help employment center: Some outcomes from the first year. Psychosocial Rehabilitation Journal, 18(4), 145-162.</td>
<td>Randomized controlled trial with 161 individuals assigned to control or experimental group. Outcomes measured in intervals of six months. Individuals assigned to the experimental group received a 5-stage model of intervention: a) engagement; 2) job skills training; 3) individual job seeking and support; 4) support; 5) graduate groups. Stages 1 and 2 were delivered by professionals and Stages 3, 4 and 5 were delivered by peers.</td>
<td>Results suggested no differences between groups at the 6 month follow-up (19% of experimental and 16% of control groups were working at a paid job for 16 hours per week or more) but were significant at the 12-month follow-up (19% of experimental and 7% of control were working at a paid job for 16 hours per week or more).</td>
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<td>Lucksted, A., McNulty, K., Brayboy, L., &amp; Forbes, C. (2009). Initial evaluation of the peer-to-peer program. Psychiatric Services, 60(), 250-253.</td>
<td>Pre-post design, including participants receiving peer-to-peer mentoring classes (a structured, experiential group aimed at empowerment, wellness, and relapse prevention)</td>
<td>Participants receiving a peer-to-peer showed significant positive gains in terms of self reported ability to manage their mental illness; their sense of confidence about their lives, and their and their sense of connection with others</td>
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<tr>
<td>Campbell, J. (2004). Consumer-operated services program (COSP) multisite research initiative: Overview and preliminary findings.</td>
<td>Experimental study of a large (n=1,827) (COS) multisite study in which participants were randomly assigned to consumer-operated service programs using three models of services: drop-in, advocacy and education, and mutual support programs/groups. They also received their traditional mental health services. Those receiving COS services were compared to individuals who received only traditional mental health services.</td>
<td>Experimental participants showed greater improvement in well-being over the course of the study than participants randomly assigned to receive only traditional mental health services.</td>
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<td>Nelson, Ochocka, Janzen and Trainor (2006)</td>
<td>Comparison of active participation in drop-in center services versus non active participation at 18 months</td>
<td>Active participants had fewer emergency room visits and better quality of life. Significant differences were found in greater social support, greater instrumental role involvement and decreases in psychiatric hospitalization when examining changes from baseline to 18 months among active participants.</td>
</tr>
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</table>
Resources

**Comfort Rooms**
Bluebird, G. (Summer/Fall 2002). *Comfort and communication help minimize conflicts, Networks*, p.18. Alexandria, VA: National Technical Assistance Center, National Association of State Mental Health Program Directors
Bluebird, G. (Spring 2005) Comfort Rooms: reducing the need for seclusion and restraint, *Residential Group Home Quarterly* Vol. 5 No.4, p5

**Personal Safety Plans**
Resources

**Trauma Informed Care**


Herman, J. (1992). *Trauma and recovery: The aftermath of violence – from domestic abuse to political terror.* New York, NY: Basic Books


Consumer Roles in Mental Health Settings
**Stories and Experiences**


**Dialogues and Communication**


SAMHSA, (2000). *Participatory Dialogues, A guide to organizing interactive discussions on mental health issues among consumers, providers and family members, On line: http://store.mentalhealth.org/consumersurvivor/publications.aspx (SMA)-3472*

**Peer Support Resources**

Mazelis, R. *The Cutting Edge: A Newsletter for People Living with Self-Inflicted Violence.*
www.sidran.org

Copeland, Mary Ellen, MS, MA. *Wellness Recovery Action Plan.* Online at:
www.mentalhealthrecovery.com


**Seclusion and Restraint Reduction (Children and Adults)**


Dialogues and Communication

Guidelines for Hiring Peer Specialists
Salzer, M.S., &Mental Health Association of Southeastern Pennsylvania Best Practices Team (2002). Consume Delivered Services as a Best Practice I Mental Health Care and the Development of Practice Guidelines. Psychiatric Rehabilitation Skills, 7, 355-382. (Available by contacting pennrrtc@mail.med.upenn.edu)
Peer to Peer Resource Center: Promoting peer support and recovery for people living with mental illness www.peersupport.org/LatestNews.htm. 