Recovery Research and References

Presbyterian Hospital

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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 f**our** 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

Study	Average Length in Years	Sample Size	Subjects Recovered and/or Improved Significantly
M. Bleuler (1972 a & b) Burgholzli, Zurich	23	208	68%
Huber et al. (1975) Germany	22	502	57%
Ciompi & Muller (1976) Lausanne Investigations	37	289	53%
Tsung et al. (1979) Iowa	35	186	46%
Harding et al. (1987 a & b) Vermont	32	269	68%
Ogawa et al. (1987) Japan	22.5	140	57%
DeSisto et al. (1995 a & b) Maine	35	269	49%

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)

Recovery and National Reform

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.

Study	Design	Outcomes
Forchuk (2005). Therapeutic relationships: from psychiatric hospital to community, *Journal of Psychiatric and Mental Health Nursing 12(5),* 556–564.	Randomized Control Trial to determine the cost and effectiveness of a transitional discharge model (TDM) of care with clients who have a chronic mental illness. This model consisted of: (1) Peer support for 1 year and (2) Ongoing support from hospital staff until a therapeutic relationship was established with the community care provider. Participants (*n* = 390) were interviewed at discharge, 1 month post-discharge, 6 months post-discharge and 1 year post-discharge	Peer support transition program added to psychiatric hospital team had a decrease in the number of hospital days, reduction in readmission rates, increased discharge rates and an increase in quality of social relationships. Intervention subjects were discharged an average of 116 days earlier per person. Based on the hospital per diem rate this would be equivalent to $12M CDN hospital costs.
Clarke et al. (2000)	RCT Longitudinal impact of peer support on hospitalization rates	Individuals receiving peer integrated community support had longer community tenure, reduced need for hospital admission or emergency hospital care.
Min et al. (2007)	Longitudinal impact of peer support on hospitalization rates	Use of peer support resulted in longer community tenure as well as a decrease in hospitalization readmission over a 3 year period of time.
Paulson et al. (1997-2000)	Randomized controlled trial; 3 conditions: assertive community treatment employing users (n=58), employing non-users (n=59), and usual care (n=61)	Clients of peer employees had a longer community tenure before hospital admission, fewer hospitalizations and need for emergency care

Study	Design	Outcome
Klein, A.R., Cnaan, R.A., & 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	Comparative study; 2 case management conditions: with peer support (n=10) and standard (n=51)	Clients of peer support had fewer inpatient days, better social functioning, and some quality of life improvement
Felton, C.J., Stastny, P., Shern, D.L., Blanch, A., Donahue, S.A., Knight, E., Brown, C. (1995). Consumers as peer specialists on intensive case management teams: Impact on client outcomes. Psychiatric Services, 46(10), 1037-1044	Controlled trial.	Greater improvement in satisfaction with living situations and finances, and fewer reported life problems than those in the non-user assistant group.
Dumont, J., & Jones, K. (2002). Findings from a consumer/survivor defined alternative to psychiatric hospitalization. Outlook, 4-6.	Experimental design studying Crisis Hostel compared to inpatient hospitalization with a 6 and 12 month follow up	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.

Study	Design	Outcome
Kaufmann, C.L. (1995). The self help employment center: Some outcomes from the first year. Psychosocial Rehabilitation Journal, 18(4), 145-162.	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.	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).
Lucksted, A., McNulty, K., Brayboy, L., & Forbes, C. (2009). Initial evaluation of the peer-to-peer program. Psychiatric Services, 60(), 250-253.	Pre-post design, including participants receiving peer-to-peer mentoring classes (a structured, experiential group aimed at empowerment, wellness, and relapse prevention)	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
Campbell, J. (2004). Consumer-operated services program (COSP) multisite research initiative: Overview and preliminary findings.	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.	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

Study	Design	Outcome
Nelson, Ochocka, Janzen and Trainor (2006)	Comparison of active participation in drop-in center services versus non active participation at 18 months	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.

Resources

Comfort Rooms

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Resources

Trauma Informed Care

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