

Recovery: The Culture Change

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**Diseases have symptoms,
Machines function, People live.**

AWW, 1989



SAMSHA

National Consensus Conference, 2004

Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.



Recovery is:

- a Philosophy
- a Paradigm
- Programs

It is an approach; with the same resources one program can be recovery oriented and one not.



VHA Transformation to Recovery Model

- 1997: VA Clinical Practice Guideline for Psychosis
 - Evidence Base for Psychosocial Rehabilitation and Recovery
- 2002: President's New Freedom Commission of Mental Health
- 2003-5: VHA Mental Health Strategic Plan
- 2005: VHA Recovery Workgroup
 - Alan Bellack PhD, chair



VA Clinical Practice Guideline

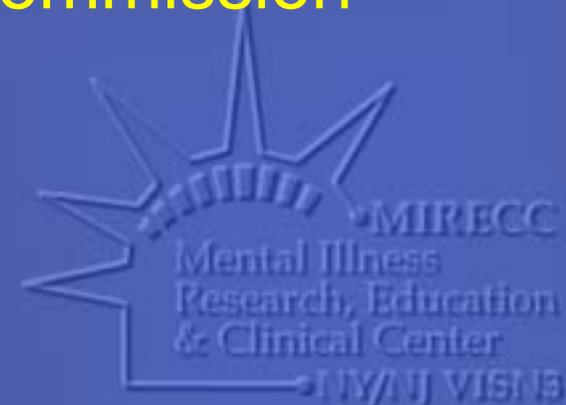
Psychosocial Rehab Checklist

Domain	Is Statement True?	Is Statement False?
1	Fully informed about all aspects of health needs and avoids high risk behavior	Health Education
2	Has self care and independent living skills c/w living arrangement goals	Self-Care/ Independent Living Skills
3	Has safe, decent and affordable housing c/w treatment goals	Housing
4	Family actively supports person and is very well informed	Family Support and Psychoeducation
5	Is sufficiently socially active	Social Skills
6	Has job that provides adequate income and fully utilizes skills	Work Restoration
7	Is able to locate and coordinate needed services	Case Management



The VA is not alone

- The Expert Consensus Guidelines 1996
- The APA Schizophrenia CPGs 1997
- The Schizophrenia PORT 1998
- The US Surgeon General's Report on Mental Health, 1999
- The President's New Freedom Commission on Mental Health, 2002-3



Evidence-Base

- Level I: Randomized Clinical Trials (RCT)
- Level II: Less Rigorous Studies
- Level III: Expert Consensus



Recommendation of the VHA Recovery Workgroup

- National Recovery Coordinator
- Recovery Advisory Workgroup
- VISN Level Planning and Assessment Summit
- Local Recovery Coordinators
- Veteran and Staff Champs
- **Assessment**
- Educate/Inform Veterans
- Recovery Plan rather than treatment Plan
- Cultural Competency
- Vets and Families part of MHEB leadership and LRCs
- Structure for Veteran Input
- Mandatory Recovery Education for Staff
- **Peer Support**
- NRC develop assessment and resources
- **Research Funding**
- Recovery Best Practices and Initiatives
- Dissemination



Evidence Based Treatments for SMI

- Health Education
- Self-Care/Independent Living Skills
- Housing
- Family
- Social Skills
- Work Restoration
- Case Management (ACT)
- Peer Support**

*SAMSHA, multiple recovery publications & websites

**lower level of evidence than others

Recovery Oriented Services for SMI*

- Health and Wellness
- Self Care/Symptom Self Management/Medication Self Management
- Housing and Community
- Family
- Social Skills Enhancement
- Work Restoration
- Case Management
- Peer Support



Barriers to Recovery

- Low expectations of what is achievable by clinicians, families and veterans
- Lack of knowledge about what symptoms are due to illness and what are due to patients and society's reaction to that illness
- Lack of will to provide proven interventions to bring about optimal recovery
- Lack of resources to provide proven interventions to bring about optimal recovery



Hopeless

- Low Expectations are a huge impediment
- Most Clinicians see patients over short slice of time
 - Taught the Kraepelinian Model
 - Schizophrenia has a deteriorating course
- Low Expectation lead to little Hope
- Low Hope, low partnership



Hope

- **Positive Expectations**
- **Partnership towards goals**
- **Future Orientation**
- **Possibility of Improvement**
- **Hope**



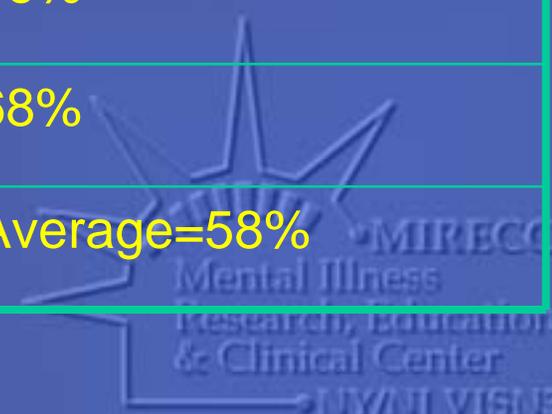
Work : High vs. Low Expectation

(Fairweather Lodges vs. TAU)



Why we should HOPE: People with Schizophrenia Recover

Study	Sample Size	Follow-up (years)	%Recovered/ significantly improved
Bleuler (1974)	208	23	68%
Huber et al (1979)	502	22	57%
Ciampi (1988)	289	37	53%
Tsuang et al (1979)	186	35	46%
Harding et al (1987)	269	32	68%
Total	1454		Average=58%



Key Findings of the Vermont Longitudinal Study

Persons with DSM-III Schizophrenia

- Not in hospital for the past year • 82%
- Met with Friends every week or two • 61%
- One or more moderately close friends • 68%
- Employed in past year • 40%
- Displayed slight or no symptoms • 68%
- Able to meet basic needs • 81%
- Led moderate to very full life • 73%
- GAF > 61 (good functioning) • 61%
- GAF > 71 • 33%



What do Veteran's with SMI want from their lives?

- What do you want from yours?
- Most want
 - family,
 - a safe place to live,
 - meaningful activities,
 - adequate income,
 - job satisfaction, and
 - an enjoyable social life.



Philosophical Changes

Recovery Approach

- Strength based
- Success oriented
- Doing with
- Integrated team/veteran partnership
- Graduated independence
- Community based
- Present focused

Medical Model Care

- Illness focused
- Problem oriented
- Doing for
- Individual provider/team “recommends”
- Long-term dependence
- Office and clinic based
- Past traumas/failures



Some Language/Ideational Changes that Express this Shift

- “doing with” rather than “doing to” or “doing for”
- “person with schizophrenia” rather than “schizophrenic”
- “living and functioning” rather than “illness and disease”
- “living and having symptoms” rather than “living with symptoms”
- Life worth living rather than return to baseline
- Do we really need the word “chronic”?
- “Why not” rather than “you can’t”
- Affirming life’s possibilities not simply disease’s limitations
- “I have symptoms”, my symptoms don’t have me, I am more than just my symptoms



“Recovery is what people with [illnesses and] disabilities do.

Treatment, case management, [support] and rehabilitation are the things that helpers do to facilitate recovery.”

Anthony (2002)



“The concept of Recovery is quite common in the field of physical illness and disability... it does not mean that the suffering has disappeared, all the symptoms removed, and/or the functioning completely restored.”

Recovery does not mean Cure

Anthony (2002)



VISN 3 Recovery Workgroup

JJP	Felicity Laboy PhD Barbara Davidson LCSW	Radames Carlo, VRC
HVHCS	Jennifer Schulkin LCSW	
NJHCS	Maureen Kaune MD Leon Green PhD Risa Goldstein PhD Michelle Smith	
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VISN	Mara Kushner LCSW Henrietta Fishman LCSW	
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VAC	Steve Konyha (NYHarbor) Susan McMillan (Bronx)	



VISN 3 Recovery Conference

September 28th and 29th

Parsippany, New Jersey

