Recovery as a disruptive innovation

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Professor of Mental Health Recovery and Social Inclusion
University of Nottingham

12 January 2018
Defining recovery
Clinical Recovery

Full symptom remission, full or part time work / education, independent living without supervision by informal carers, having friends with whom activities can be shared – sustained for a period of 2 years

Personal recovery

A deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful and contributing life even with limitations caused by the illness.

Recovery is the common vision of HA, SWD and NGOs when providing services to adults with SMI in the community.

The core values of recovery (personal recovery rather than clinical recovery) include hope, autonomy and opportunity.
A recovery-based approach that puts the emphasis on supporting individuals with mental disorders and psychosocial disabilities to achieve their own aspirations and goals.
Recovery processes: CHIME framework

Predictors of personal recovery for persons with psychiatric disabilities: An examination of the Unity Model of Recovery
Li-ju Song
Graduate Institute of Social Work, National Chengchi University, 11565,Taipei, ROC

ARTICLE INFO

Abstract
This study examined a comprehensive set of potential correlates of recovery based on the Unity Model of Recovery. Thirty-two community psychiatric rehabilitation centers in Taiwan agreed to participate in this study. A sample of 592 participants were administered the questionnaires. Five groups of independent variables were included in the model: socio-demographic variables, illness variables, resilience, informal support, and formal support. The results of regression analysis provided support for the validity of the Unity Model of Recovery. The independent variables explained 50.5% of the variance in recovery for the full sample, and 58.8% for the subsample of the consumers who have been ever employed. The significance of the three corresspondences (resilience, family support, and symptoms) for recovery was confirmed. Other critical support variables, including the extent of rehabilitation service use, professional relationship, and professional support were also found to be significant factors. Among the significant correlates, resilience, family support, and extent of rehabilitation service use ranked in the top three. The findings could shed light on paths to recovery. Implications for psychiatric services were discussed and suggested.

Relational recovery: beyond individualism in the recovery approach
Rhys Price-Robertson a, Angela Obradovic b and Brad Morgan b
a Faculty of Arts, School of Social Sciences, Monash University, Clayton, VIC, Australia; b Emerging Minds, North Adelaide, SA, Australia

ARTICLE HISTORY
Received 8 July 2016
Accepted 27 September 2016

KEYWORDS
Recovery; family recovery; individualism; connectedness; relational; mental illness
An overly optimistic, professionally imposed view of recovery might homogenise or even blame individuals rather than empower them.
The CHIME framework shows a clear need to diagnose not only on the basis of symptoms, but also on the basis of where the person is in the process of personal recovery.
Brief INSPIRE

People talk about recovery in different ways but one way to talk about it is ‘living a satisfying and hopeful life’. This questionnaire asks how your worker supports your recovery.

Please answer all of the questions about .................................................................
(name of worker)

Circle the response that best fits how you feel your worker supports your recovery

<table>
<thead>
<tr>
<th>1. My worker helps me to feel supported by other people</th>
<th>Not at all</th>
<th>Not much</th>
<th>Somewhat</th>
<th>Quite a lot</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. My worker helps me to have hopes and dreams for the future</td>
<td>Not at all</td>
<td>Not much</td>
<td>Somewhat</td>
<td>Quite a lot</td>
<td>Very much</td>
</tr>
<tr>
<td>3. My worker helps me to feel good about myself</td>
<td>Not at all</td>
<td>Not much</td>
<td>Somewhat</td>
<td>Quite a lot</td>
<td>Very much</td>
</tr>
<tr>
<td>4. My worker helps me to do things that mean something to me</td>
<td>Not at all</td>
<td>Not much</td>
<td>Somewhat</td>
<td>Quite a lot</td>
<td>Very much</td>
</tr>
<tr>
<td>5. My worker helps me to feel in control of my life</td>
<td>Not at all</td>
<td>Not much</td>
<td>Somewhat</td>
<td>Quite a lot</td>
<td>Very much</td>
</tr>
</tbody>
</table>

English and translations free to download: researchintorecovery.com/inspire
「支援」部分
請閱讀每個問題，並確定該問題對您是否重要。
如果您圈出「否」，則跳至下一個問題。
如果您回答「是」，則請評價您認為在該方面獲得醫護工作者的支援程度，並圈出合適的灰色方框。

我復元的一個重要部分是……

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>S1</td>
<td>覺得獲得他人的支援</td>
<td>是 / 否</td>
<td>一點也沒有</td>
<td>少</td>
</tr>
<tr>
<td>S2</td>
<td>與他人有積極正面的關係</td>
<td>是 / 否</td>
<td>一點也沒有</td>
<td>少</td>
</tr>
<tr>
<td>S3</td>
<td>獲得其他服務使用者的支持</td>
<td>是 / 否</td>
<td>一點也沒有</td>
<td>少</td>
</tr>
<tr>
<td>S4</td>
<td>覺得我是社區的一份子</td>
<td>是 / 否</td>
<td>一點也沒有</td>
<td>少</td>
</tr>
<tr>
<td>S5</td>
<td>對未來充滿信心和盼望</td>
<td>是 / 否</td>
<td>一點也沒有</td>
<td>少</td>
</tr>
<tr>
<td>S6</td>
<td>相信我可以復元</td>
<td>是 / 否</td>
<td>一點也沒有</td>
<td>少</td>
</tr>
<tr>
<td>S7</td>
<td>有動力作出改變</td>
<td>是 / 否</td>
<td>一點也沒有</td>
<td>少</td>
</tr>
</tbody>
</table>
Empirical evidence for recovery
Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems

Mike Slade¹, Michaela Amering², Marianne Farkas³, Bridget Hamilton⁴, Mary O’Hagan⁵, Graham Panther⁶, Rachel Perkins⁷, Geoff Shepherd⁷, Samson Tse⁸, Rob Whitley⁹

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An understanding of recovery as a personal and subjective experience has emerged within mental health systems. This meaning of recovery now underpins mental health policy in many countries. Developing a focus on this type of recovery will involve transformation within mental health systems. Human systems do not easily transform. In this paper, we identify seven mis-uses (“abuses”) of the concept of recovery: recovery is the latest model; recovery does not apply to “my” patients; services can make people recover through effective treatment; compulsory detention and treatment aid recovery; a recovery orientation means closing services; recovery is about making people independent and normal; and contributing to society happens only after the person is recovered. We then identify ten empirically-validated interventions which support recovery, by targeting key recovery processes of connectedness, hope, identity, meaning and empowerment (the CHIME framework). The ten interventions are peer support workers, advance directives, wellness recovery action planning, illness management and recovery, REFOCUS, strengths model, recovery colleges or recovery education programs, individual placement and support, supported housing, and mental health trialogues. Finally, three scientific challenges are identified: broadening cultural understandings of recovery, implementing organizational transformation, and promoting citizenship.

Key words: Recovery, mental health services, peer support workers, advance directives, wellness recovery action planning, individual placement and support, supported housing, mental health trialogues, organizational transformation, promoting citizenship

(World Psychiatry 2014;13:12–20)
## Approaches to supporting recovery

<table>
<thead>
<tr>
<th>Approach</th>
<th>RCT evidence?</th>
<th>SR evidence?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer Support</td>
<td>11</td>
<td>Yes</td>
</tr>
<tr>
<td>Advance Directives / JCPs</td>
<td>4</td>
<td>Yes</td>
</tr>
<tr>
<td>WRAP</td>
<td>1</td>
<td>No</td>
</tr>
<tr>
<td>IMR</td>
<td>3</td>
<td>No</td>
</tr>
<tr>
<td>REFOCUS</td>
<td>2</td>
<td>No</td>
</tr>
<tr>
<td>Strengths Model</td>
<td>4</td>
<td>No</td>
</tr>
<tr>
<td>Recovery Colleges</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>IPS</td>
<td>18</td>
<td>Yes</td>
</tr>
<tr>
<td>Supported Housing</td>
<td>1</td>
<td>No</td>
</tr>
<tr>
<td>Trialogues</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

Cochrane review

11 RCTs – employing consumers in statutory mental health services

Involving consumer-providers in mental health teams results in psychosocial, mental health symptom and service use outcomes for clients that were no better or worse than those achieved by professionals employed in similar roles, particularly for case management services.

Effectiveness of one-to-one peer support for patients with severe mental illness – a randomised controlled trial

C.I. Mahla, S. Priebe, K. Heumann, A. Daubmann, K. Wegscheider, T. Bock

ARTICLE INFO
Article history:
Received 17 August 2016
Revised 29 October 2016
Accepted 11 December 2016
Available online 19 December 2016

Keywords:
Peer support
Severe mental disorder
Social and cross-cultural psychiatry

ABSTRACT
Background: One-to-one peer support is a resource-oriented approach for patients with severe mental illness. Existing trials provided inconsistent results and commonly have methodological shortcomings, such as poor training and role definition of peer supporters, small sample sizes, and lack of blinded outcome assessment.

Methods: This is a randomised controlled trial comparing one-to-one peer support with treatment as usual. Eligible were patients with severe mental illness; psychosis, major depression, bipolar disorder or borderline personality disorder of more than two years' duration. A total of 216 patients were recruited through in- and out-patient services from four hospitals in Hamburg, Germany, with 114 allocated to the intervention group and 102 to the control group. The intervention was one-to-one peer support delivered by trained peer supporters according to a defined role specification. In addition to treatment as usual over the course of six months, as compared to treatment as usual alone. Primary outcome was self-efficacy measured on the General Self-Efficacy Scale at six-month follow-up. Secondary outcomes included quality of life, social functioning, and hospitalisations.

Results: Patients in the intervention group had significantly higher scores of self-efficacy at the six-month follow-up. There were no statistically significant differences on secondary outcomes in the intention to treat analyses.

Conclusions: The findings suggest that one-to-one peer support delivered by trained peer supporters can improve self-efficacy of patients with severe mental disorders over a one-year period. One-to-one peer support may be regarded as an effective intervention. Follow-up research should explore the impact of improved self-efficacy on clinical and social outcomes.
Effect of Scattered-Site Housing Using Rent Supplements and Intensive Case Management on Housing Stability Among Homeless Adults With Mental Illness: A Randomized Trial

Vicky Strengos, PhD; Stephen W. Hwang, MD; Agnes Gezziak, PhD; Rosane Nisenbaum, PhD; Eric Latimer, PhD; Daniel Rabot, MSc; Carol E. Adams, PhD; Jimmy Bourque, PhD; In Connelly, MOW; James Frankish, PhD; Laurence Y. Kato, MD; Kate Mason, MD; Alan Yee; Christy O’Donnell, MSc; Kristen O’Donnell, MSc; Amanda Sarr, MD; Christian G. Schuie, MD; PhD; Andrea Singh, MD; David L. Steiner, PhD; Helen Maria Vasiliadis, PhD; Paul N. Goering, PhD; for the At Home/Chêz Soi Investigators

IMPORTANCE Scattered-site housing with intensive case management (ICM) may be an appropriate and less-costly option for homeless adults with mental illness who do not require the treatment intensity of Assertive Community Treatment.

OBJECTIVE To examine the effect of scattered-site housing with ICM services on housing stability and generic quality of life among homeless adults with mental illness and moderate support needs for mental health services.

DESIGN, SETTING, AND PARTICIPANTS The At Home/Chêz Soi project was an unblinded, randomized trial. From October 2009 to July 2011, participants (N = 1196) were recruited in 4 Canadian cities (Vancouver, Winnipeg, Toronto, and Montreal) and randomized to the intervention group (n = 619) or usual care group (n = 577), and followed up for 24 months.

INTERVENTIONS The intervention consisted of scattered-site housing (using rent supplements) and ICM services. The usual care group had access to existing housing and support services in their communities.

MAIN OUTCOMES AND MEASURES The primary outcome was the percentage of days stably housed during the 24-month period following randomization. The secondary outcome was generic quality of life, assessed by a EuroQOL 5 Dimensions (EQ-5D) health questionnaire.

RESULTS During the 24 months following randomization, the adjusted percentage of days stably housed was higher among the intervention group than the usual care group, although a mean difference varied across sites.

<table>
<thead>
<tr>
<th>Study</th>
<th>Intervention Group</th>
<th>Usual Care Group</th>
<th>Adjusted Mean Difference: Mean (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>62.7 (43.7-60.2)</td>
<td>29.7 (18.9-61.1)</td>
<td>33.0 (32.2-33.8)</td>
</tr>
<tr>
<td>B</td>
<td>73.2 (45.9-60.6)</td>
<td>38.7 (25.2-60.2)</td>
<td>35.6 (34.8-36.4)</td>
</tr>
<tr>
<td>C</td>
<td>74.4 (50.5-68.3)</td>
<td>38.5 (25.2-60.2)</td>
<td>36.5 (35.7-37.4)</td>
</tr>
<tr>
<td>D</td>
<td>77.2 (50.5-68.3)</td>
<td>31.9 (22.3-64.1)</td>
<td>45.3 (38.2-52.5)</td>
</tr>
</tbody>
</table>

The mean change in EQ-5D score from baseline to 24 months across the intervention group was not statistically different from the usual care group (60.3% [95% CI, 56.0 to 62.5] at baseline and 67.2% [95% CI, 62.5 to 69.0] at 24 months for the intervention group vs 62.3% [95% CI, 59.9 to 64.4] at baseline and 66.8% [95% CI, 63.6 to 70.1] at 24 months for the usual care group). Difference in mean changes, 0.0% (95% CI, −2.7% to 3.0); P = .96.

CONCLUSIONS AND RELEVANCE Among homeless adults with mental illness in 4 Canadian cities, scattered-site housing with ICM services compared with usual access to existing housing and community services resulted in increased housing stability over 24 months, but did not improve generic quality of life.

TRIAL REGISTRATION Isrctn.org: Identifier, ISRCTN42520374

JAMA. 2015;313(9):905-916. DOI:10.1001/jama.2015.3163
RECOLLECT Study

Mechanisms of action in Recovery Colleges:

1. Empowering environment
   Choice, control, respect, safe

2. Enabling different relationships
   Co-production, peer trainers, making friends

3. Facilitating personal growth
   Becoming a student, shared learning, strengths

researchintorecovery.com/recollect
There is now sufficient evidence to justify a focus on recovery as the ‘core business’ of the mental health and social care system.
Is anything really new here?
The empirical evidence about mental health and recovery:
how likely, how long, what helps?

Prof Mike Slade
Dr Eleanor Longden
July 2015

Seven messages

1. Recovery is best judged by the person living with the experience

2. Many people with mental health problems recover

3. If a person no longer meets criteria for a mental illness, they are not ill

4. Diagnosis is not a robust foundation

5. Treatment is one route among many to recovery

6. Some people choose not to use mental health services

7. The impact of mental health problems is mixed.
Disruptive innovation

An innovation that creates a new market and value network and eventually disrupts an existing market and value network, displacing established market leading firms, products, and alliances.
Examples

Phones
Televisions
Radios
Calculators

Shopping
Holidays
‘Office’
A disruptive innovation initially offers a lower performance according to what the mainstream market has historically demanded.

At the same time, it provides some new performance attributes, which in turn make it prosper in a different market.

As it improves along the traditional performance parameters it eventually displaces the former technology.
Old paradigm

As compared to 30 years ago, there have been no new drugs or other biological treatments that are clearly more effective than what was available then. All current major psychotherapy schools had already outlined their models, and the common service models, including community mental health teams and day hospitals, had all been introduced.

Priebe S (2016) A social paradigm in psychiatry – themes and perspectives, Epidemiology and Psychiatric Sciences, 25, 521-527
A growing research base has produced evidence that the status quo, preoccupied with biomedical interventions, including psychototropic medications and non-consensual measures, is no longer defensible in the context of improving mental health.
Innovations

Knowledge
Expertise by experience

Roles
Peer workers / trainers / leaders

Services
Recovery Colleges
Housing First
Individual Placement and Support

Relational approaches
Open Dialogue
Shared decision making

Mad Studies
No Force First
Peer-led services
Trialogues
Co-production
Disruptive innovations

1. Based in the (real) community
Social marketing

Interdisciplinary, strategic and multifaceted marketing based approach to facilitating or maintaining social good.

Disruptive innovations

1. Based in the (real) community
2. Trauma-informed
Experiencing multiple childhood traumas appears to give approximately the same risk of developing psychosis as smoking does for developing lung cancer.
Disruptive innovations

1. Based in the (real) community
2. Trauma-informed
3. Lived experience is an asset
Recovery practice in community mental health teams: national survey


Background
There is consensus about the importance of ‘recovery’ in mental health services, but the link between recovery orientation of mental health teams and personal recovery of individuals has been underresearched.

Aims
To investigate differences in team leader, clinician and service user perspectives of recovery orientation of community adult mental health teams in England.

Method
In six English mental health National Health Service (NHS) trusts, randomly chosen community adult mental health teams were surveyed. A random sample of ten patients, one team leader and a convenience sample of five clinicians were surveyed from each team. All respondents rated the recovery orientation of their team using parallel versions of the Recovery Self Assessment (RSA). In addition, service users also rated their own personal recovery using the Questionnaire about Processes of Recovery (QPR).

Results
Team leaders (n=22) rated recovery orientation higher than clinicians (n=109) or patients (n=120) (Wald(2)=7.0, P=0.03), and both NHS trust and team type influenced RSA ratings. Patient-rated recovery orientation was a predictor of personal recovery (b=0.58, 95% CI 0.31–0.85, P<0.001). Team leaders and clinicians with experience of mental illness (39%) or supporting a family member or friend with mental illness (76%) did not differ in their RSA ratings from other team leaders or clinicians.

Conclusions
Compared with team leaders, frontline clinicians and service users have less positive views on recovery orientation. Increasing recovery orientation may support personal recovery.

Declaration of interest
None.

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Peer workers strive towards constructing a positive identity...
by using their lived experience perspective as an asset, liberating themselves out of restrictive role patterns, and by breaking down stigma and taboo.
Disruptive innovations

1. Based in the (real) community
2. Trauma-informed
3. Lived experience is an asset
4. ‘We are in this together’
Civilisation is the process in which one gradually increases the number of people included in the term “we” or “us” and at the same time decreases those labelled “you” or “them” until that category has no one left in it.

(Howard Winters)
Disruptive innovations

1. Based in the (real) community
2. Trauma-informed
3. Lived experience is an asset
4. ‘We are in this together’
5. Wellbeing not recovery
<table>
<thead>
<tr>
<th>WELLBEING</th>
<th>RECOVERY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross wellbeing product</td>
<td>‘Recovery approach’</td>
</tr>
<tr>
<td>Workplace wellbeing</td>
<td>Individual Placement and Support</td>
</tr>
<tr>
<td>Positive education</td>
<td>Recovery Colleges</td>
</tr>
</tbody>
</table>
Not everyone agrees...

We object to therapeutic techniques like 'mindfulness' and "positive thinking" being used to pacify patients and stifle collective dissent.

Recovery in the bin, key principle 7
Disruptive innovations

1. Based in the (real) community
2. Trauma-informed
3. Lived experience is an asset
4. ‘We are in this together’
5. Wellbeing not recovery
6. Human rights and social justice are the ‘core business’
Mental health care in Hong Kong falls woefully short amid social stigma and lack of policy direction

Alfred C.M. Chan calls for a long-term government strategy on mental health care reform and tackling the shortage of psychiatric staff, along with greater social empathy for the mentally ill.

Mental health has been in the news lately. After the World Health Organisation last month announced a year-long campaign to raise awareness about depression, Britain's Prince Harry spoke openly about his stifled grief and near-mental breakdown following the death of his mother.

Then there was Hong Kong's much-discussed film Mad World, with its young protagonist struggling with bipolar disorder.
Growing political consciousness

**Medicine**

*To be a health professional is to be an agent of resistance for justice, rights, and equity*


**Psychiatry**

Critical groups in England

Recovery in the bin
recoveryinthebin.org

Psychologists for Social Change
psychchange.org

Critical Mental Health Nurses’ Network
criticalmhnursing.org

Critical Psychiatry Network
criticalpsychiatry.co.uk
Can we manage innovation?
This House believes that peer support should be an accredited mental health profession.
The future…?

Peer-led services


Human rights focus


Power shift – money, leadership, ‘service’ structures


Political consciousness and engagement

Thank you

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