Recovery as a disruptive innovation

Mike Slade

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

Liberman RP, Kopelowicz A (2002)
Recovery from schizophrenia,
International Review of Psychiatry, **14**, 245-255.

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.

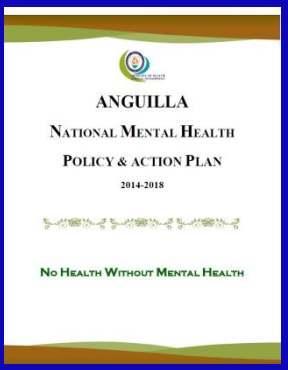
Anthony WA (1993) Recovery from mental illness:
the guiding vision of the mental health service system in the 1990s,
Psychosocial Rehabilitation Journal, **16**, 11-23.

Hong Kong

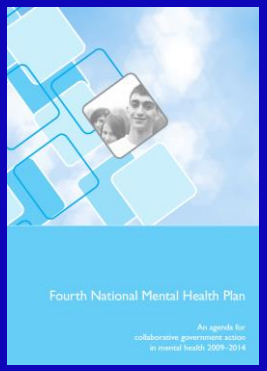
Recovery is the common vision of HA, SWD and NGOs when providing services to adults with SMI in the community

The core values of recovery (personal recovery rather than clinical recovery) include hope, autonomy and opportunity

2017

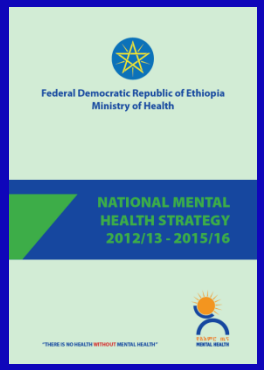


Anguilla

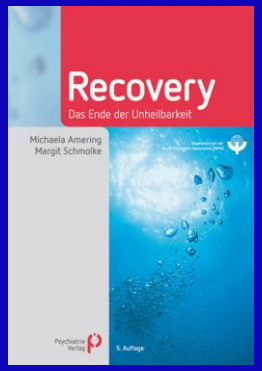


Australia

Canada



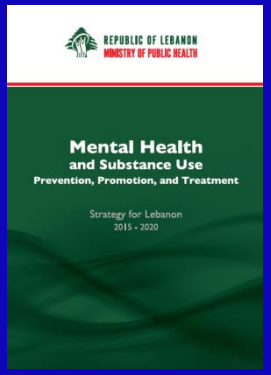
Ethiopia



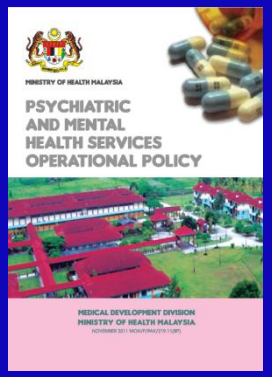
Germany

Hong Kong

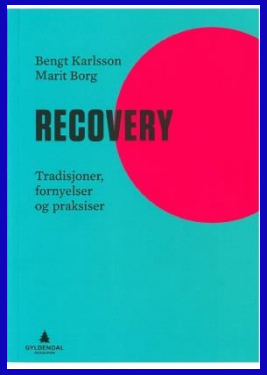
Italy



Lebanon

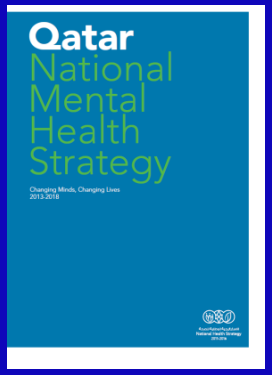


Malaysia



Norway

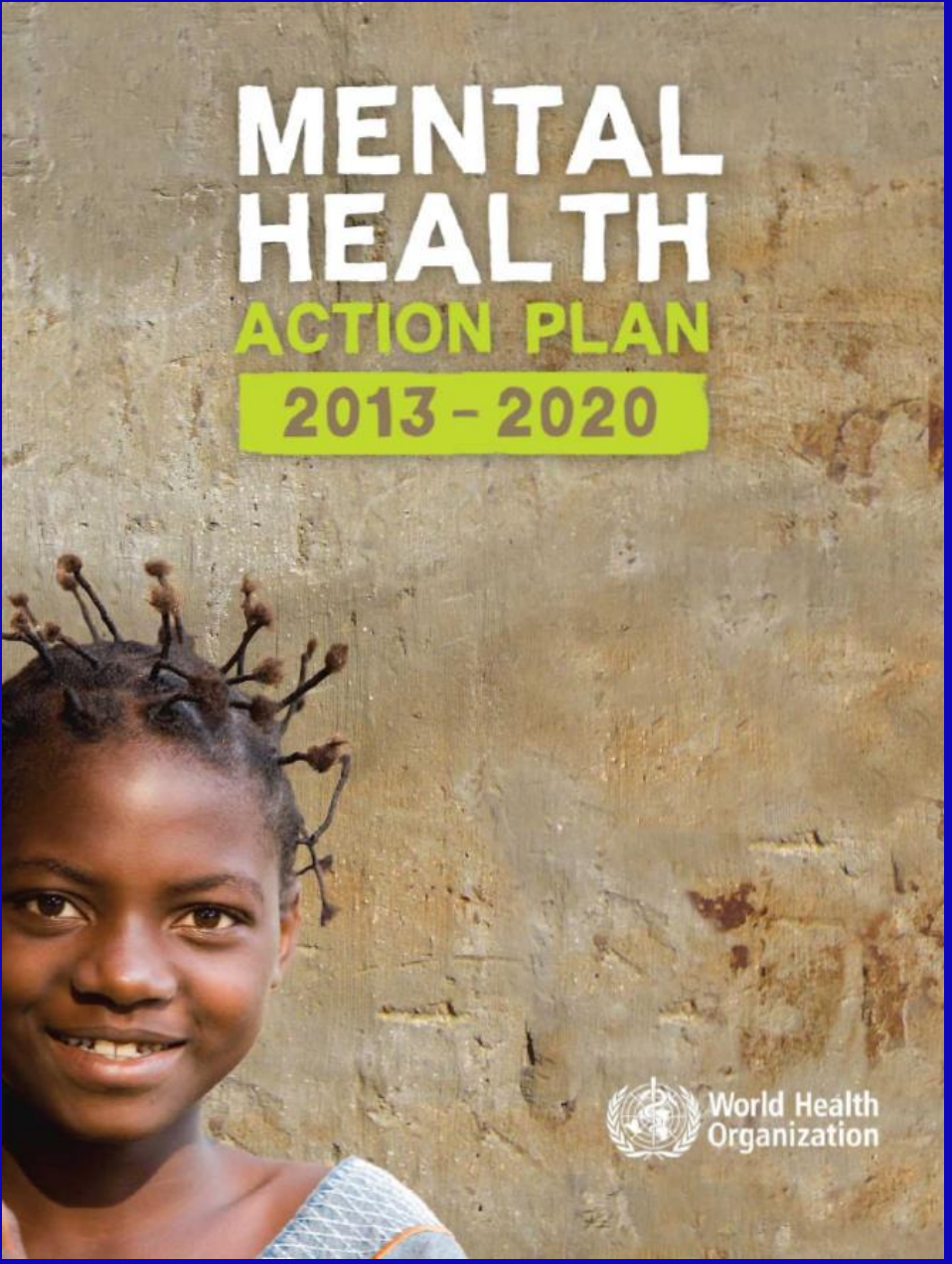
Palestine



Qatar

Scotland

South Africa



A recovery-based approach that puts the emphasis on supporting individuals with mental disorders and psychosocial disabilities to achieve their own aspirations and goals.

2013

Recovery processes: CHIME framework

Leamy M, Bird V, Le Boutillier C, Williams J, Slade M (2011) *A conceptual framework for personal recovery…systematic review and narrative synthesis*, British Journal of Psychiatry, **199**, 445-452.

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Contents lists available at ScienceDirect

Psychiatry Research

journal homepage: www.elsevier.com/locate/psychres

Predictors of personal recovery for persons with psychiatric disabilities: An examination of the Unity Model of Recovery

Li-yu Song

Graduate Institute of Social Work, National Chengchi University, 11605, Taiwan, ROC

ARTICLE INFO

Keywords:
Recovery
Resilience
Family support
Professional relationship
Rehabilitation service

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 53.5% of the variance in recovery for the full sample, and 55.5% for the subsample of the consumers who have been ever employed. The significance of the three cornerstones (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 all 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.

2017

ADVANCES IN MENTAL HEALTH, 2017
VOL. 15, NO. 2, 108–120
https://doi.org/10.1080/18387357.2016.1243014

Routledge
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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

ABSTRACT

Objective: While the recovery approach in mental health currently enjoys immense support, it is not without its critics. The most persistent criticisms focus on the individualism underpinning many conceptualisations of recovery. In this paper, we outline the shortcomings of individualistic approaches to recovery, and explore the alternative notion of *relational recovery*.

Method: We begin this article by reviewing recent research and theory that critiques individualistic approaches to recovery. We then draw together disparate bodies of research that view recovery as an inherently social process.

ARTICLE HISTORY
Received 8 July 2016
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KEYWORDS
Recovery; family recovery; individualism; connectedness; relational; mental illness

2017

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http://tandfonline.com/ijmh
ISSN: 0963-8237 (print), 1360-0567 (electronic)
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REVIEW ARTICLE

2017

What we talk about when we talk about recovery: a systematic review and best-fit framework synthesis of qualitative literature

Simon Robertson Stuart[1,2,3], Louise Tansey[2], and Ethel Quayle[3]

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Abstract

Background: The recovery approach is increasingly popular among mental-health services, but there is a lack of consensus about its applicability and it has been criticised for imposing professionalised ideas onto what was originally a service-user concept.
Aims: To carry out a review and synthesis of qualitative research to answer the question: "What do we know about how service users with severe and enduring mental illness experience the process of recovery?" It was hoped that this would improve clarity and increase understanding.
Method: A systematic review identified 15 peer-reviewed articles examining experiences of recovery. Twelve of these were analysed using best-fit framework synthesis, with the CHIME model of recovery providing the exploratory framework.
Results: The optimistic themes of CHIME accounted for the majority of people's experiences, but more than 30% of data were not felt to be encapsulated. An expanded conceptualisation of recovery is proposed, in which difficulties are more prominently considered.
Conclusions: An overly optimistic, professionally imposed view of recovery might homogenise or even blame individuals rather than empower them. Further understanding is needed of different experiences of recovery, and of people's struggles to recover.

Keywords

Recovery, qualitative, synthesis

History

Received 1 November 2015
Revised 24 March 2016
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Published online 14 September 2016

An overly optimistic, professionally imposed view of recovery might homogenise or even blame individuals rather than empower them

Psychological Medicine, Page 1 of 16. © Cambridge University Press 2017
doi:10.1017/S0033291717001775

REVIEW ARTICLE

The slow death of the concept of schizophrenia and the painful birth of the psychosis spectrum

2017

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[2] *Department of Psychiatry, Yale University School of Medicine, New Haven, CT, USA*
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The concept of schizophrenia only covers the 30% poor outcome fraction of a much broader multidimensional psychotic syndrome, yet paradoxically has become the dominant prism through which everything 'psychotic' is observed, even affective states with mild psychosis labelled 'ultra-high risk' (for schizophrenia). The inability of psychiatry to frame psychosis as multidimensional syndromal variation of largely unpredictable course and outcome – within and between individuals – hampers research and recovery-oriented practice. 'Psychosis' remains firmly associated with 'schizophrenia', as evidenced by a vigorous stream of high-impact but non-replicable attempts to 'reverse-engineer' the hypothesized biological disease entity, using case–control paradigms that cannot distinguish between risk for illness onset and risk for poor outcome. In this paper, the main issues surrounding the concept of schizophrenia are described. We tentatively conclude that with the advent of broad spectrum phenotypes covering autism and addiction in DSM5, the prospect for introducing a psychosis spectrum disorder – and modernizing psychiatry – appears to be within reach.

Received 3 January 2017; Revised 1 June 2017; Accepted 2 June 2017

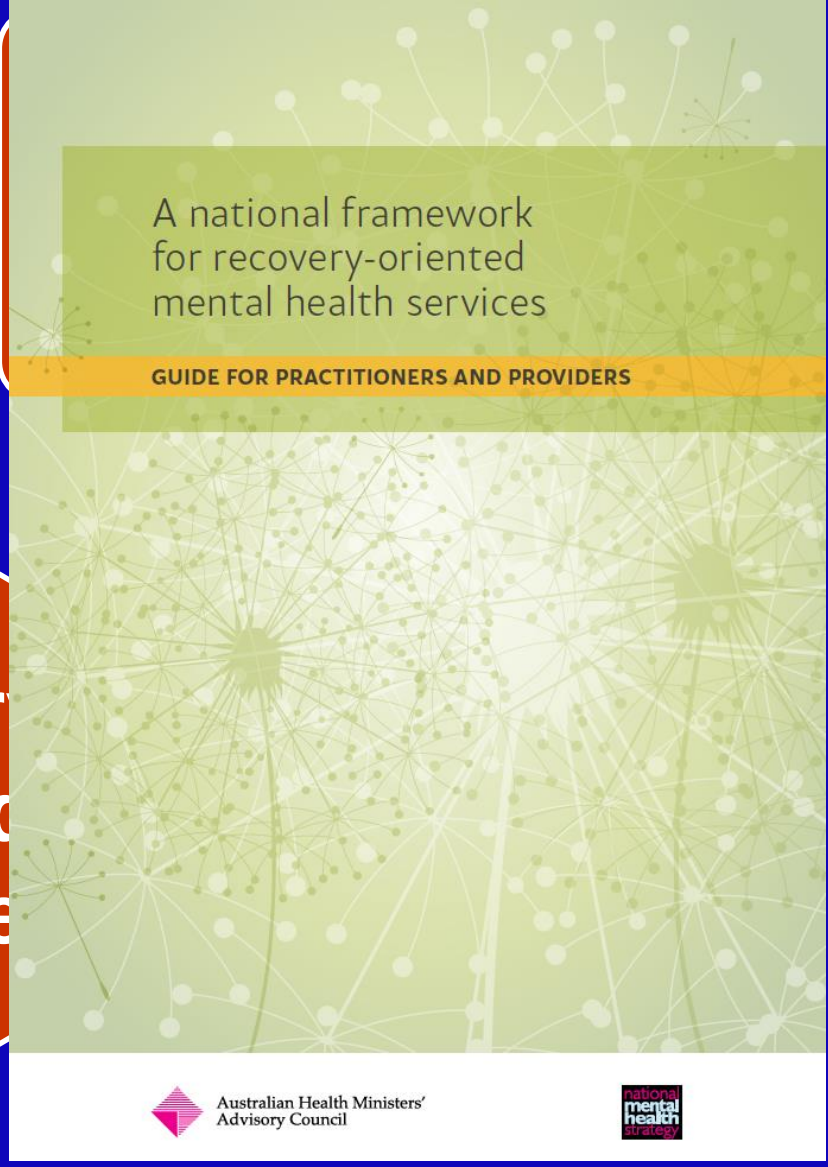
Key words: Classification, clinical staging, diagnosis, DSM, outcome, psychosis spectrum disorder.

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

Organisational commitment

Promoting citizenship

Oriented Practice



2013

Le Boutillier C, Leamy M, Bird V, Davidson L, Williams J, Slade M (2011) *What does recovery mean in practice? A qualitative analysis of international recovery-oriented practice guidance*, Psychiatric Services, **62**, 1470-1476.

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

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

Translations

Arabic
Danish
Dutch
Estonian
French
German
Italian
Norwegian
Russian
Slovene
Spanish

English and translations free to download:
researchintorecovery.com/inspire

INSPIRE 香港繁體中文版 2017

人們談論復元的意義有所不同。有人認為復元是「過著滿意及有希望的生活」。
本問卷是詢問您的醫護工作者怎樣支援您的復元。
「支援」部分詢問您認為在復元中屬重要的方面以及您的醫護工作者在該等方面支援您的程度。
「關係」部分是關於您與醫護工作者的關係。如果您不想回答該問題，請保留空白。

請回答所有問題

（醫護工作者姓名）

「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……		我覺得在這方面獲得醫護工作者的支援是……				
S1 覺得獲得他人的支援	是 / 否	一點也沒有	很少	有一點	相當多	非常多
S2 與他人有積極正面的關係	是 / 否	一點也沒有	很少	有一點	相當多	非常多
S3 獲得其他服務使用者的支持	是 / 否	一點也沒有	很少	有一點	相當多	非常多
S4 覺得我是社區的一份子	是 / 否	一點也沒有	很少	有一點	相當多	非常多
S5 對未來充滿信心和盼望	是 / 否	一點也沒有	很少	有一點	相當多	非常多
S6 相信我可以復元	是 / 否	一點也沒有	很少	有一點	相當多	非常多
S7 有動力作出改變	是 / 否	一點也沒有	很少	有一點	相當多	非常多

Traditional Chinese HK translation (Rose Chiu)
Free to download: researchintorecovery.com/inspire

Empirical evidence

for recovery

SPECIAL ARTICLE

Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems

Mike Slade[1], Michaela Amering[2], Marianne Farkas[3], Bridget Hamilton[4], Mary O'Hagan[5], Graham Panther[6], Rachel Perkins[7], Geoff Shepherd[7], Samson Tse[8], Rob Whitley[9]

[1]King's College London, Health Service and Population Research Department, Institute of Psychiatry, Denmark Hill, London SE5 8AF, UK; [2]Department of Psychiatry and Psychotherapy, Medical University of Vienna, Austria; [3]Center for Psychiatric Rehabilitation, Boston University, West Boston, MA 02215, USA; [4]University of Melbourne, School of Health Sciences, Parkville, Melbourne 3010, Australia; [5]Education House, Wellington, New Zealand; [6]Redpanther Research, Auckland, New Zealand; [7]Centre for Mental Health, Maya House, London, UK; [8]Department of Social Work and Social Administration, University of Hong Kong, Hong Kong; [9]Douglas Hospital Research Centre, McGill University, Montreal, Canada

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)

2014

Approaches to supporting recovery

	Approach	RCT evidence?	SR evidence?
1	Peer Support	11	Yes
2	Advance Directives / JCPs	4	Yes
3	WRAP	1	No
4	IMR	3	No
5	REFOCUS	2	No
6	Strengths Model	4	No
7	Recovery Colleges	No	No
8	IPS	18	Yes
9	Supported Housing	1	No
10	Trialogues	No	No

Slade M et al (2014) *Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems*, World Psychiatry, **13**, 12-20.

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.

Pitt V et al (2013) Consumer-providers of care for adult clients of statutory mental health services. *Cochrane Database of Systematic Reviews 2013, Issue 3. Art. No.: CD004807.*

European Psychiatry 42 (2017) 103–110

Contents lists available at ScienceDirect

European Psychiatry

journal homepage: http://www.europsy-journal.com

Original article

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

C.I. Mahlke[a,*], S. Priebe[b], K. Heumann[a], A. Daubmann[c], K. Wegscheider[c], T. Bock[a]

[a] Center for Psychosocial Medicine, University Medical Center Hamburg Eppendorf, Martinistr. 52, 20249 Hamburg, Germany
[b] Queen Mary University of London, Unit for Social and Community Psychiatry (WHO Collaborating Centre for Mental Health Service Development), Newham Centre for Mental Health, E13 8SP London, United Kingdom
[c] University Medical Center Hamburg Eppendorf, Department of Medical Biometry and Epidemiology, Martinistr. 52, 20249 Hamburg, Germany

ARTICLE INFO

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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 assessments.
Methods: This is a randomised controlled trial comparing one-to-one peer support with treatment as usual. Eligible were patients with severe mental illnesses: 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 peers and 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. Future research should explore the impact of improved self-efficacy on clinical and social outcomes.

2017

Peer support:
What is it and does it work?

Summarising evidence from more than 1000 studies

Nesta

National Voices
People shaping health and social care

2015

Rethink Mental Illness.

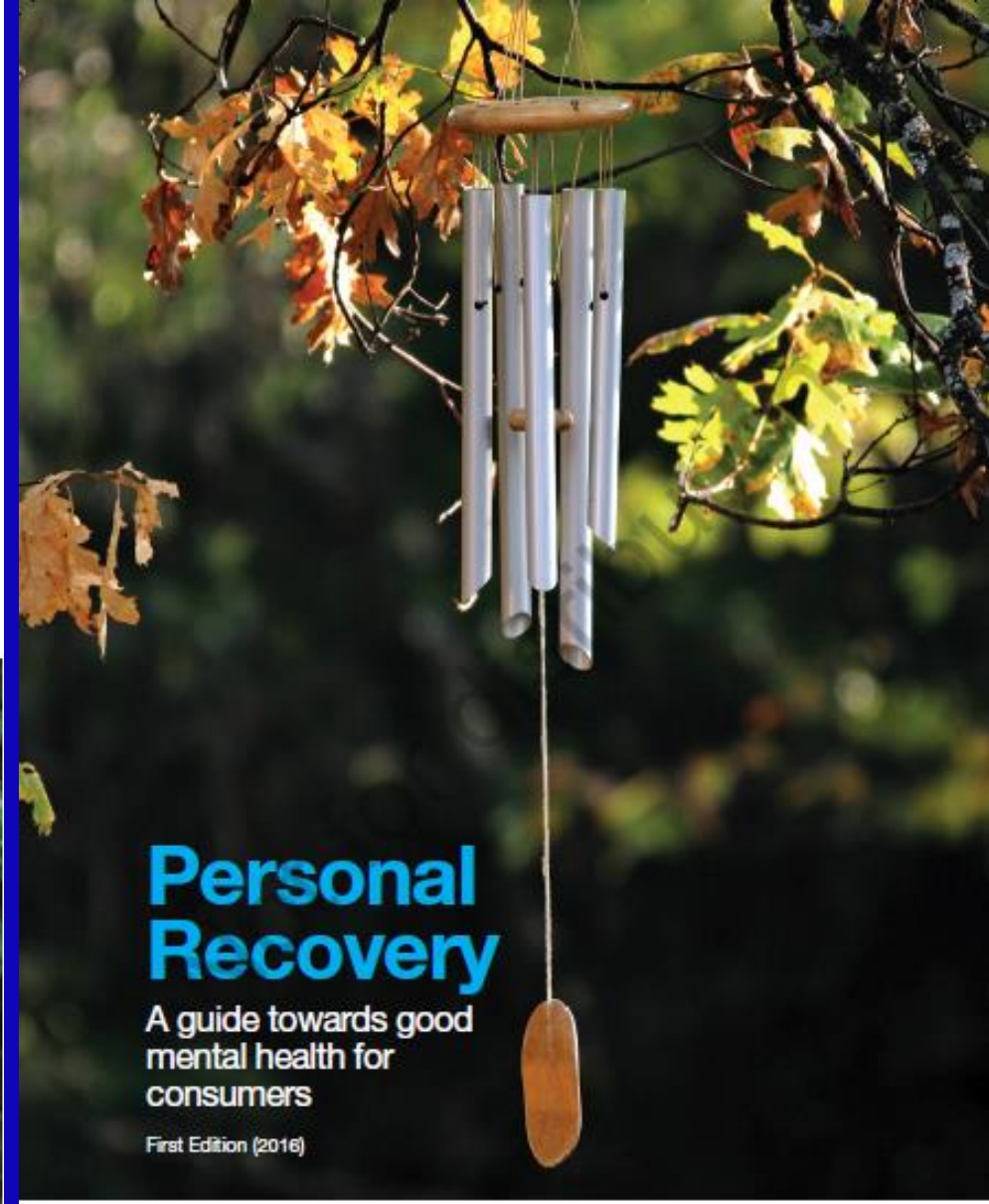
Institute of Psychiatry at The Maudsley

KING'S College LONDON

REFOCUS

Promoting recovery in mental health services

2014



MONASH University

PULSAR

SOUTHERN SYNERGY

2016

NATIONAL FINAL REPORT

Cross-Site At Home/Chez Soi Project

Mental Health Commission of Canada

Commission de la santé mentale du Canada

www.mentalhealthcommission.ca

2014

Original Investigation

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 Stergiopoulos, MD; Stephen W. Hwang, MD; Agnes Gozdzik, PhD; Rosane Nisenbaum, PhD; Eric Latimer, PhD; Daniel Rabouin, MSc; Carol E. Adair, PhD; Jimmy Bourque, PhD; Jo Connelly, MSW; James Frankish, PhD; Laurence Y. Katz, MD; Kate Mason, MHSc; Vachan Misir, MSc; Kristen O'Brien, MSc; Jitender Sareen, MD; Christian G. Schütz, MD, PhD; Arielle Singer, MD; David L. Streiner, PhD; Helen-Maria Vasiliadis, PhD; Paula N. Goering, PhD; for the At Home/Chez 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/Chez Soi project was an unblinded, randomized trial. From October 2009 to July 2011, participants (N = 1198) were recruited in 4 Canadian cities (Vancouver, Winnipeg, Toronto, and Montreal), randomized to the intervention group (n = 689) or usual care group (n = 509), and followed up for 24 months.

INTERVENTIONS The intervention consisted of scattered-site housing (using rent supplements) and off-site 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 after randomization, the adjusted percentage of days stably housed was higher among the intervention group than the usual care group, although adjusted mean differences varied across sites.

Study City	Adjusted % (No. of Days Stably Housed/No. of Days With Housing Data)		Adjusted Mean Difference, % (95% CI)
	Intervention Group	Usual Care Group	
A	62.7 (417.3/683.0)	29.7 (189.2/621.6)	33.0 (26.2-39.8)
B	73.2 (491.5/653.4)	23.6 (157.0/606.8)	49.5 (41.1-58.0)
C	74.4 (506.7/658.1)	38.8 (255.2/626.2)	35.6 (29.4-41.8)
D	77.2 (520.4/651.5)	31.8 (223.1/649.1)	45.3 (38.2-52.5)

The mean change in EQ-5D score from baseline to 24 months among the intervention group was not statistically different from the usual care group (60.5 [95% CI, 58.6 to 62.5] at baseline and 67.2 [95% CI, 65.2 to 69.1] at 24 months for the intervention group vs 62.1 [95% CI, 59.9 to 64.4] at baseline and 68.6 [95% CI, 66.3 to 71.0] at 24 months for the usual care group, difference in mean changes, 0.10 [95% CI, −2.92 to 3.13], P=.95).

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):905-915. doi:10.1001/jama.2015.1163

Editorial page 901

Author Video Interview and JAMA Report Video at jama.com

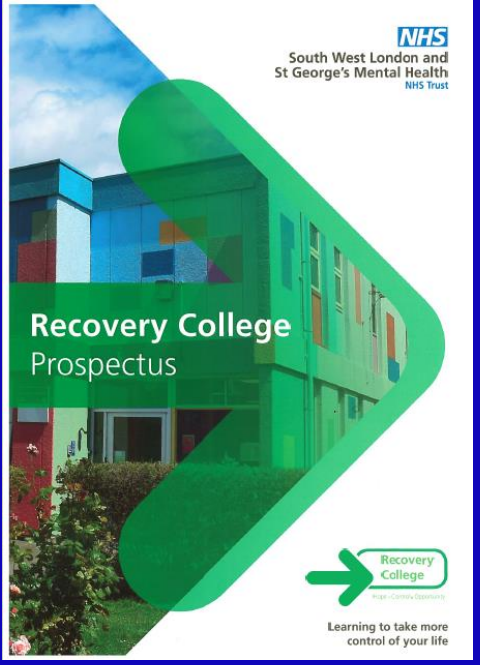
Supplemental content at jama.com

Author Affiliations: Author affiliations are listed at the end of this article.

Group Information: The At Home/Chez Soi Investigators are listed at the end of this article.

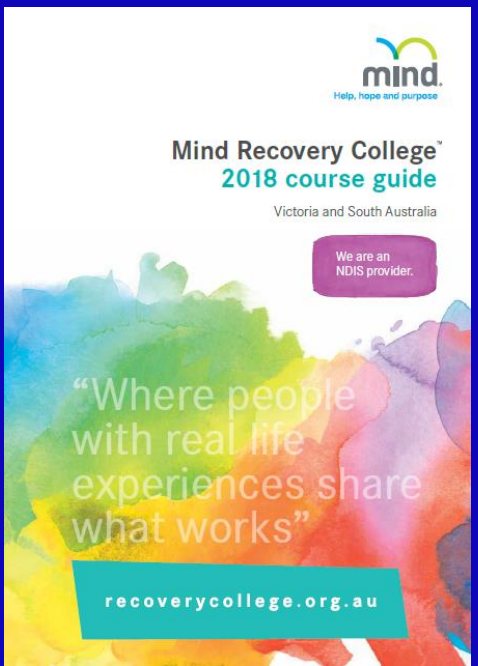
Corresponding Author: Stephen W. Hwang, MD, Centre for Research on Inner City Health, Li Ka Shing Knowledge Institute, St Michael's Hospital, 30 Bond St, Toronto, ON, M5B 1W8, Canada (hwangs@smh.ca).

2015



England

Hong Kong



Australia

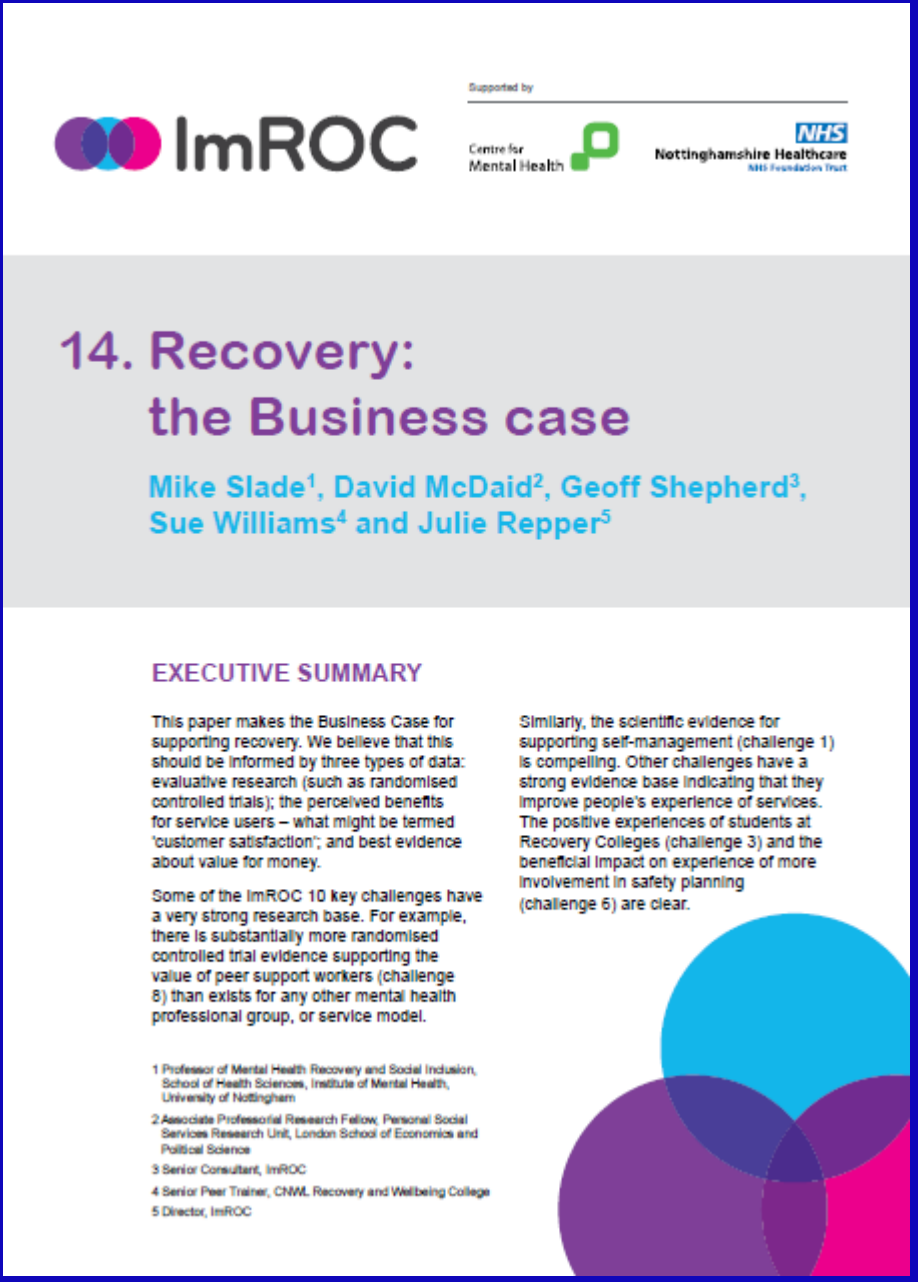
Japan

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

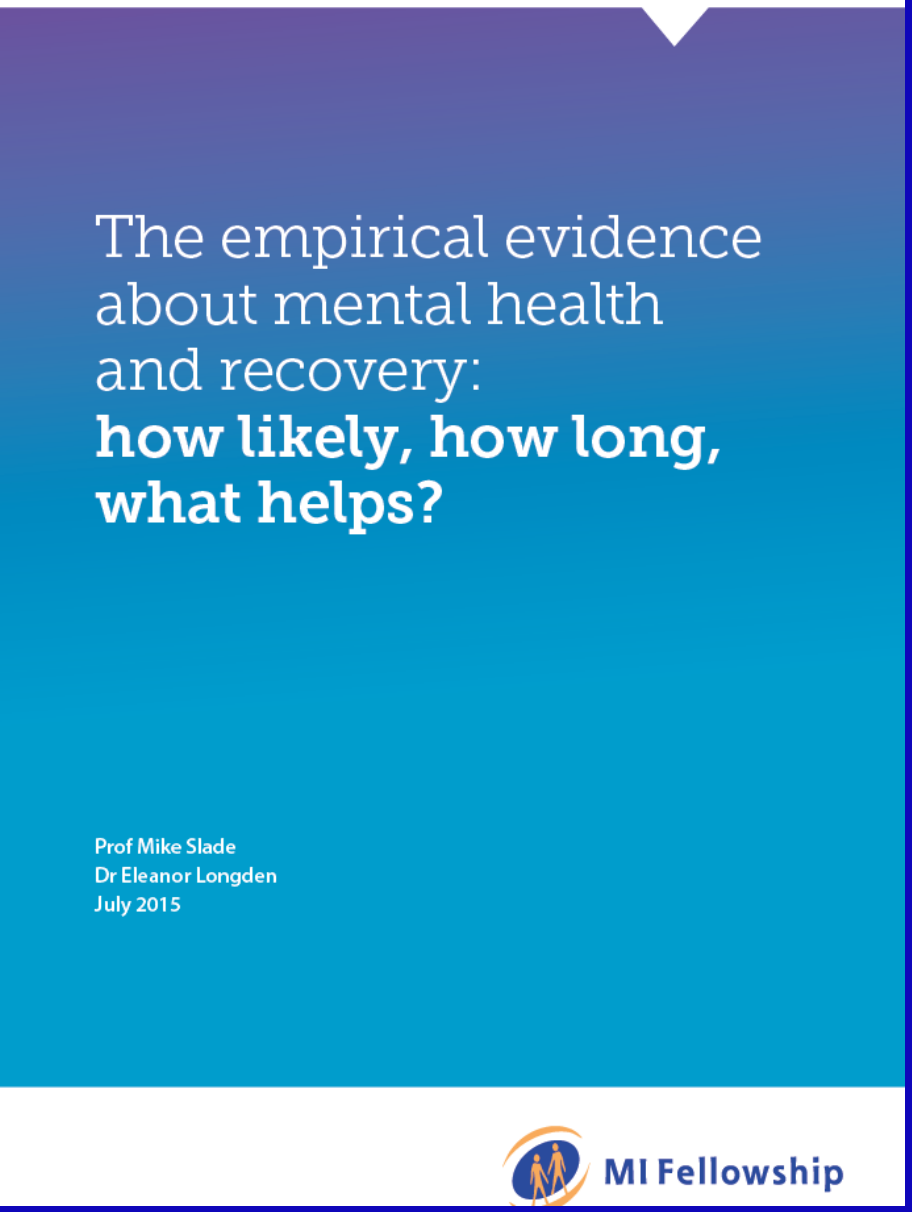


There is now sufficient evidence to justify a focus on recovery as the 'core business' of the mental health and social care system

2017

Free to download: researchintorecovery.com

Is anything really new here?



2015

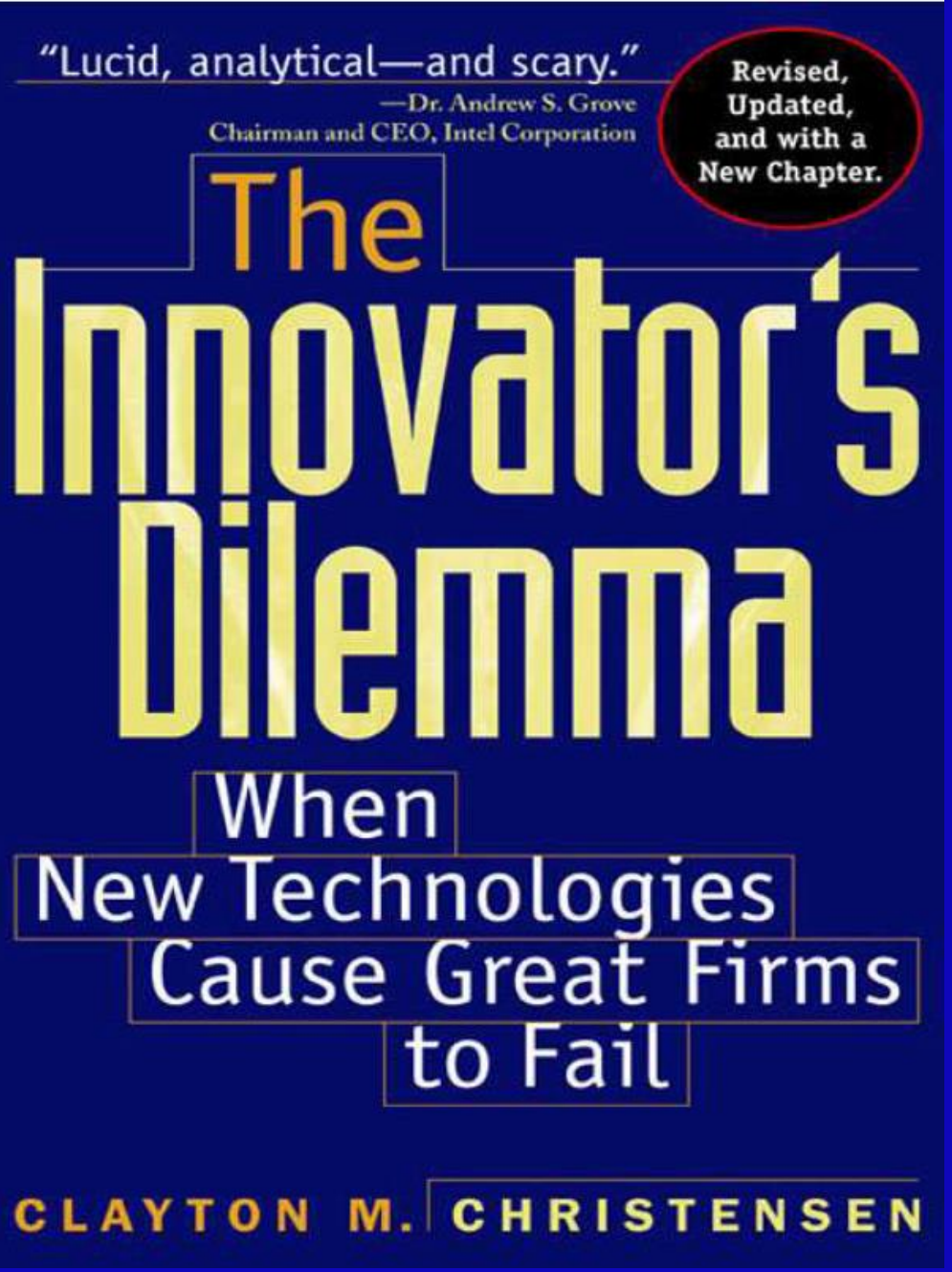
Slade M, Longden E (2015) *Empirical evidence about mental health and recovery*, BMC Psychiatry, **15**, 285.

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



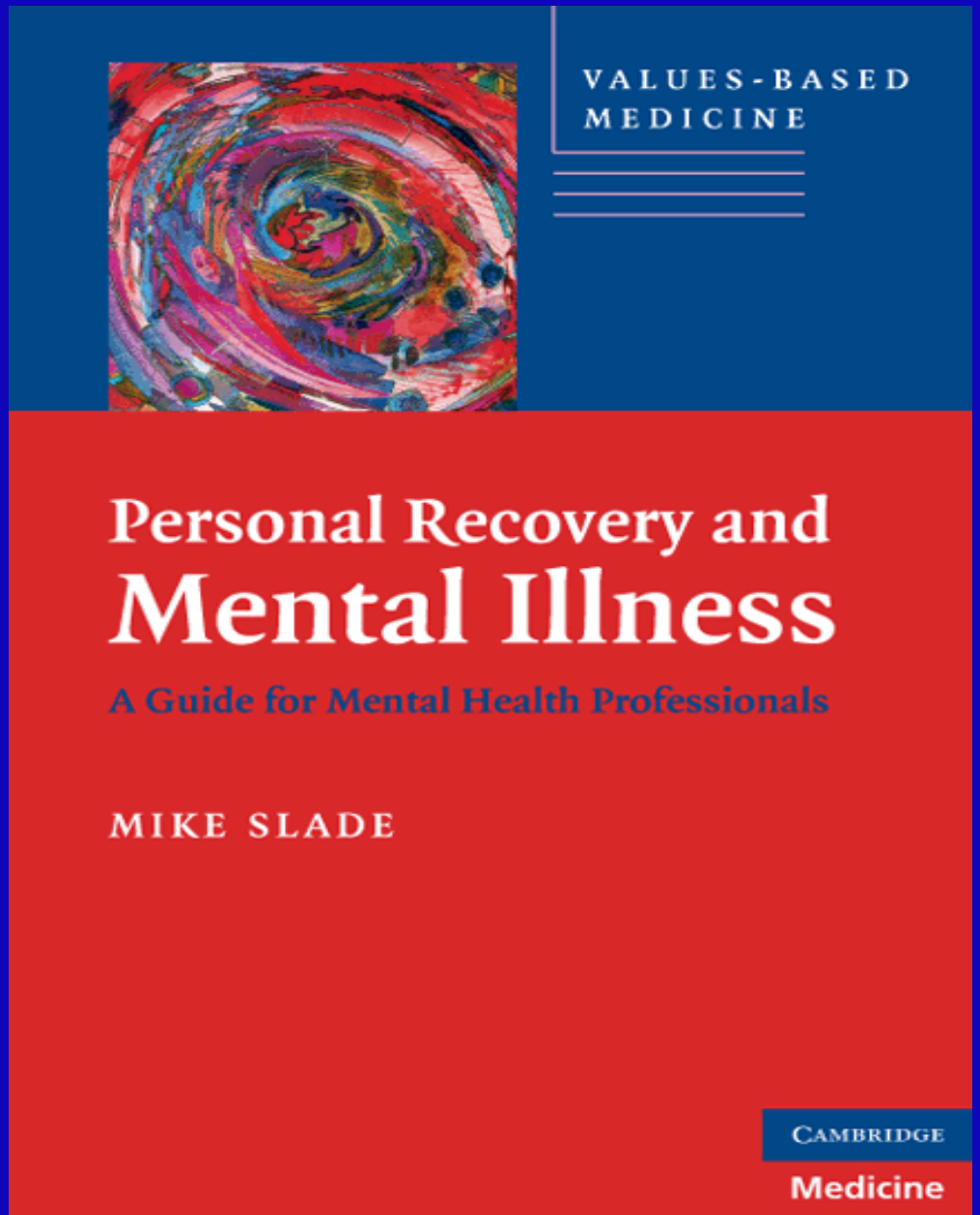
1997

Examples

Phones
Televisions
Radios
Calculators

Shopping
Holidays
'Office'

My beach book…



2009

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

United Nations A/HRC/35/21

General Assembly

Distr.: General
28 March 2017

Original: English

Human Rights Council
Thirty-fifth session
6-23 June 2017
Agenda item 3
Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

2017

A growing research base has produced evidence that the status quo, preoccupied with biomedical interventions, including psychotropic medications and non-consensual measures, is no longer defensible in the context of improving mental health.

Innovations

Knowledge

- Expertise by experience
- Mad Studies

Roles

- Peer workers / trainers / leaders

Services

- Recovery Colleges
- Housing First
- Individual Placement and Support
- No Force First
- Peer-led services

Relational approaches

- Open Dialogue
- Shared decision making
- Trialogues
- Co-production

Disruptive innovations

1. Based in the (real) community

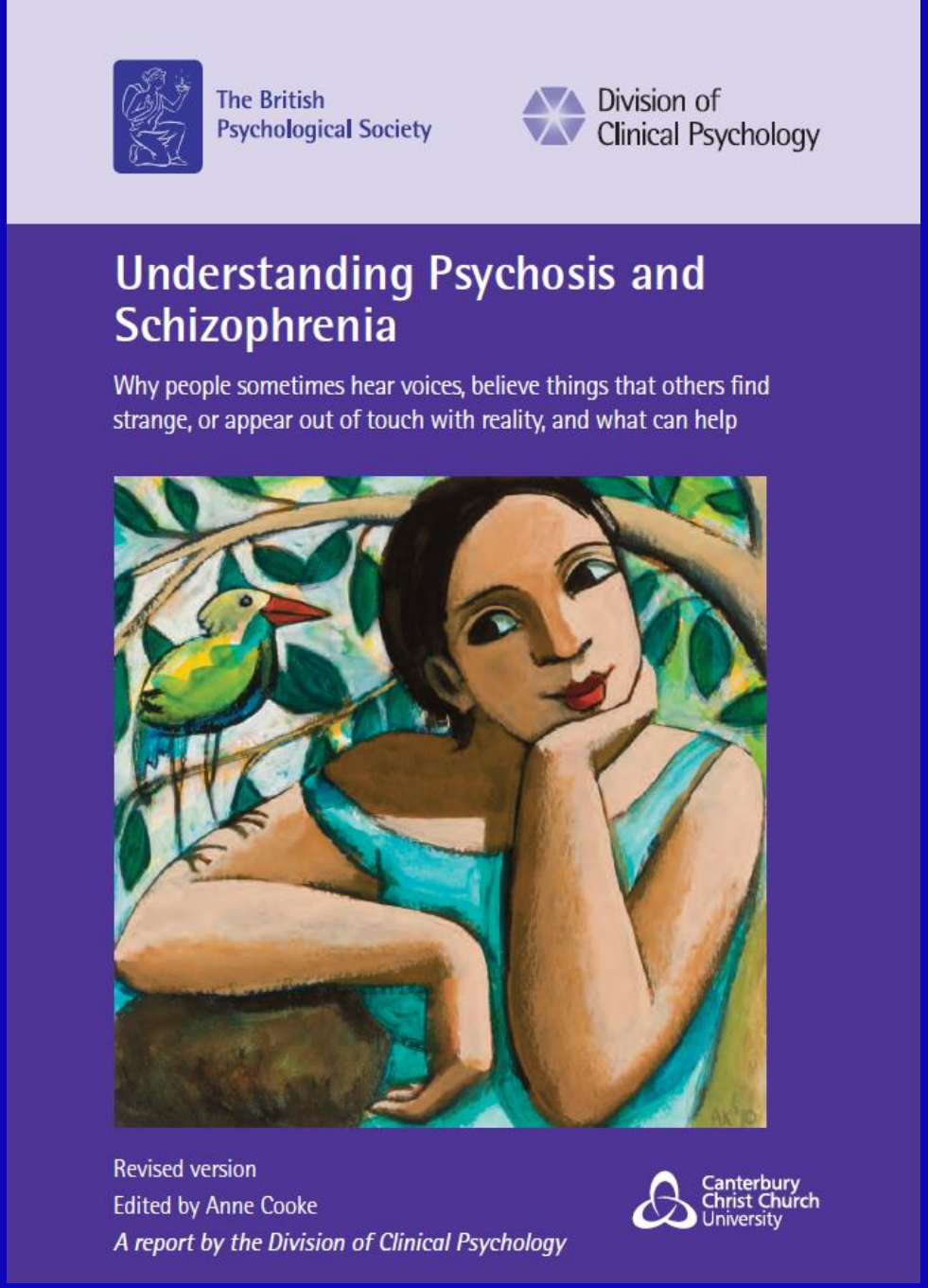
Social marketing

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

French J, Gordon R (2015) *Strategic Social Marketing*, London: Sage.

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

BJPsych The British Journal of Psychiatry (2016)
209, 340–346. doi: 10.1192/bjp.bp.114.160739

Recovery practice in community mental health teams: national survey

M. Leamy, E. Clarke, C. Le Boutillier, V. Bird, R. Choudhury, R. MacPherson, F. Pesola, K. Sabas, J. Williams, P. Williams and M. Slade

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.

2016

39% Personal experience
76% Family / friend experience

International Journal of Mental Health Nursing (2017) ••, ••–••
doi: 10.1111/inm.12332

ORIGINAL ARTICLE

Constructing a positive identity: A qualitative study of the driving forces of peer workers in mental health-care systems

Joeri Vandewalle,[1,2,3] Bart Debyser,[1,2,4] Dimitri Beeckman,[1] Tina Vandecasteele,[1,4] Eddy Deproost,[1,2] Ann Van Hecke[1,5] and Sofie Verhaeghe[1,4]

[1]*Department of Public Health, University Centre for Nursing and Midwifery, Ghent University, Ghent,* [2]*Psychiatric Hospital Pittem, Pittem,* [3]*Research Foundation-Flanders, Brussels,* [4]*Department Health Care, VIVES University College, Roeselare, and* [5]*Department of Nursing, Ghent University Hospital, Ghent, Belgium*

ABSTRACT: *There is growing recognition in mental health for the perspective of individuals with lived experience of mental health problems and mental health service use. As peer workers, these individuals can use their specific experience to benefit and support peers and professional caregivers, and to participate at all levels of mental health-care systems. The aim of the present study was to develop a conceptual framework representing the driving forces of peer workers to fulfil their position in mental health-care systems. A qualitative interview approach was employed using principles of grounded theory. Over a period of 5 months in 2014–2015, semistructured interviews were conducted with 14 peer workers in residential and community mental health-care systems. The emerged conceptual framework reveals that peer workers strive towards constructing a positive identity. This process is powered by driving forces reflecting a desire for normalization and an urge for self-preservation. Peer workers realize a meaningful employment by using their lived experience perspective as an asset, liberating themselves out of restrictive role patterns, and by breaking down stigma and taboo. As a precondition to engage in these normalization processes, peer workers perceive they need to secure their self-preservation by balancing the emergence of adverse emotional fluctuations. The conceptual framework can inform the development of work contexts in which peer workers have an authentic and meaningful contribution, while being offered sufficient support and learning opportunities to manage their well-being.*

KEY WORDS: *identity, mental health care, nurse, peer worker, qualitative research.*

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Sofie Verhaeghe, RN, MSc, PhD.
Accepted February 12 2017.

INTRODUCTION

Background

In many regions, and particularly in Anglophone countries, the recovery model increasingly influences the mission and policies of mental health-care systems (Ahmed *et al.* 2012; Slade *et al.* 2008). In contrast with the traditional 1-D biomedical focus on symptoms of illness and clinical outcomes, the recovery model centralizes the whole person by emphasizing the empowerment and social inclusion of service users and their self-determination in goal-setting and decision-making

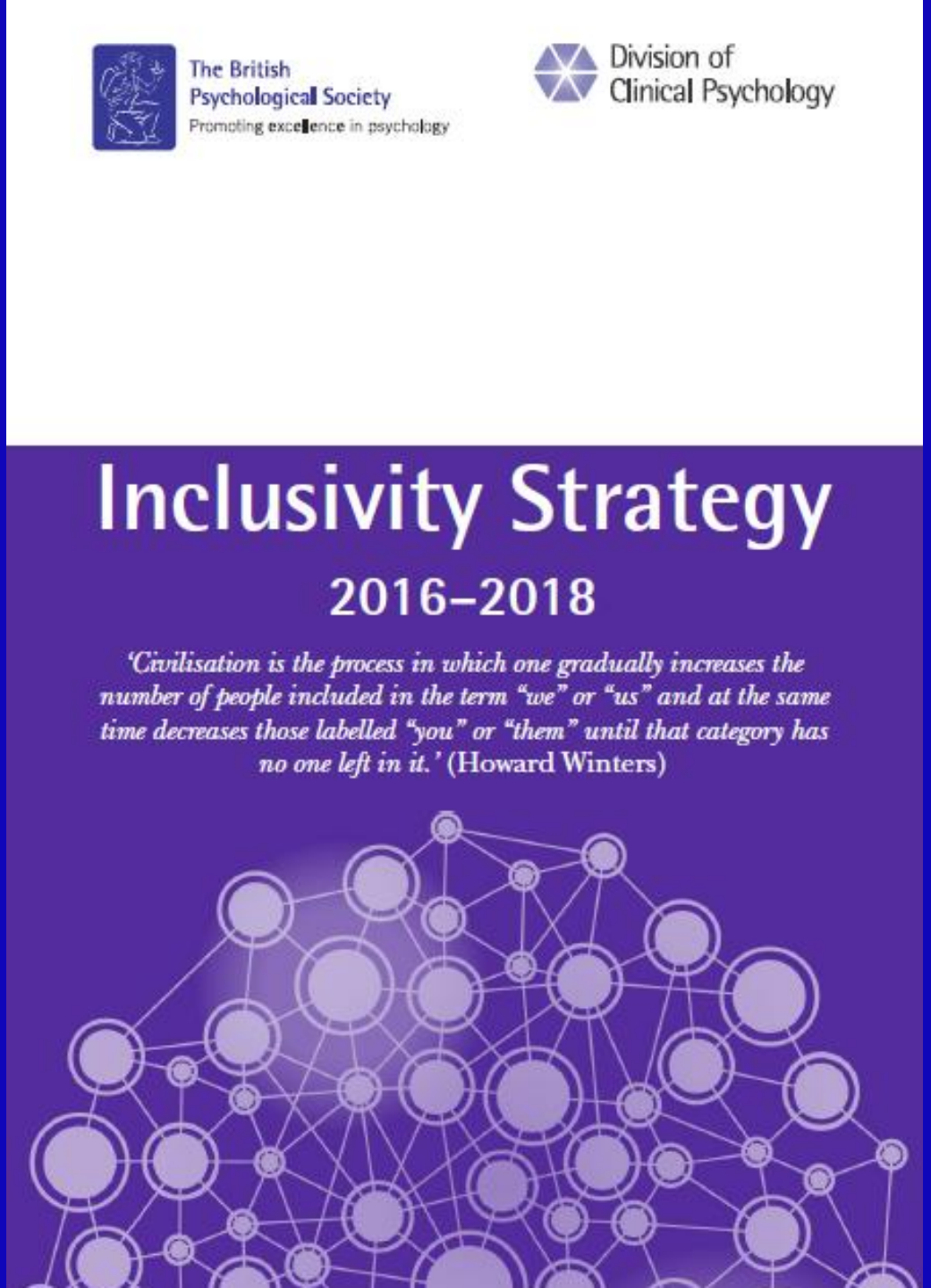
2017

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’

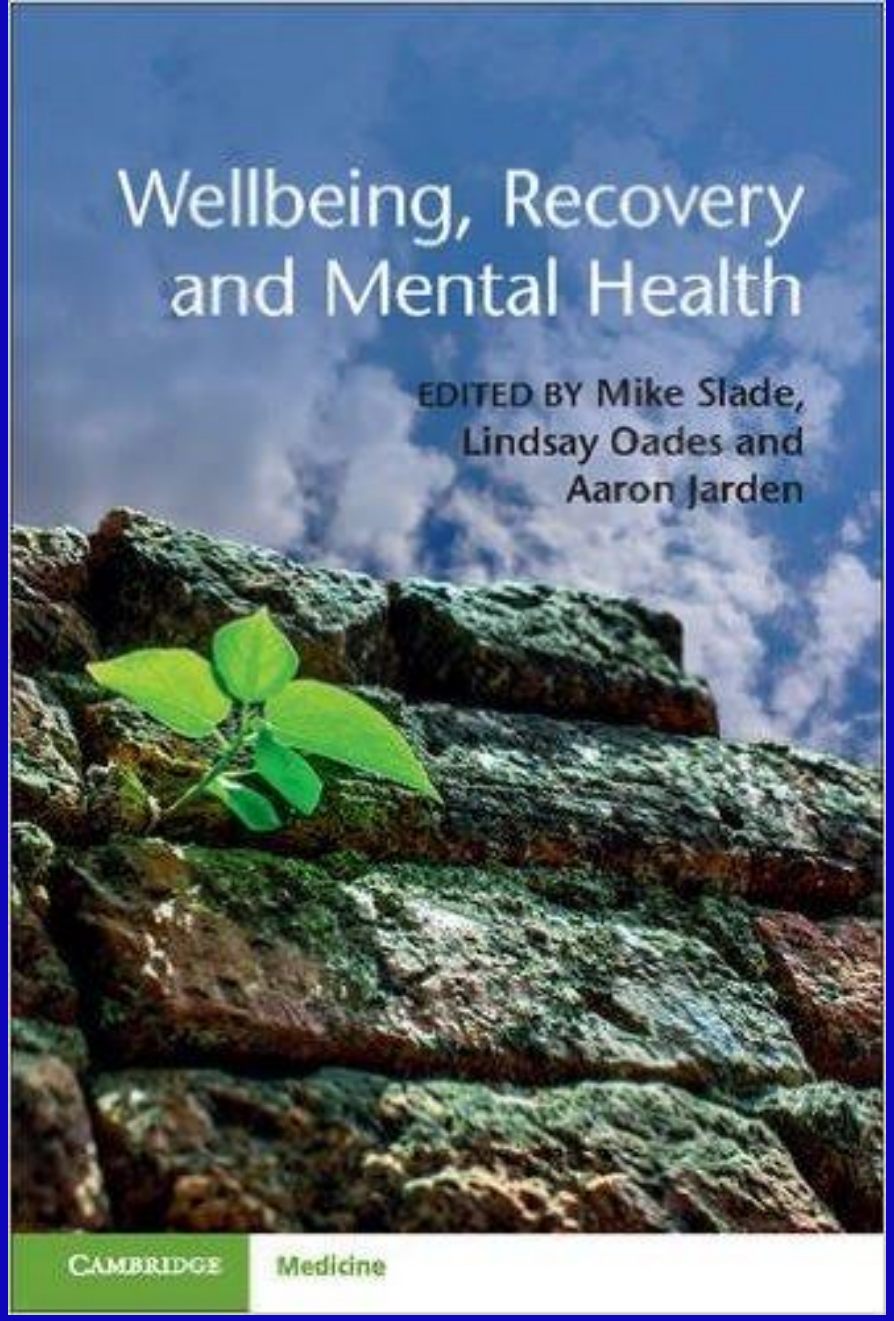


Civilisation is the process in which one gradually increases the number of people included in the term "we" or "us" and at the same time decreases those labelled "you" or "them" until that category has no one left in it.

2016

Disruptive innovations

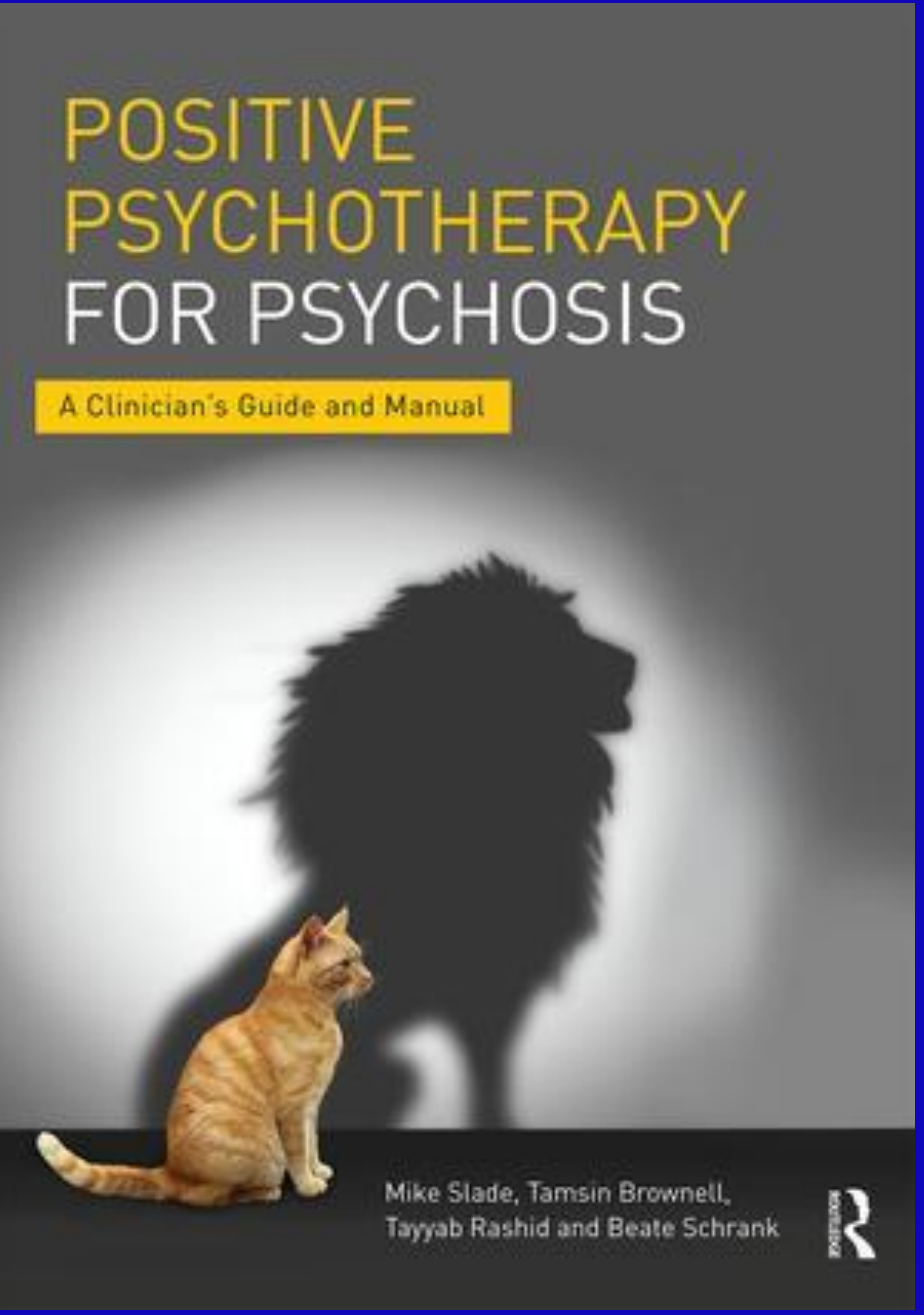
1. Based in the (real) community
2. Trauma-informed
3. Lived experience is an asset
4. ‘We are in this together’
5. Wellbeing not recovery


Wellbeing, Recovery and Mental Health
EDITED BY Mike Slade, Lindsay Oades and Aaron Jarden
CAMBRIDGE
Medicine

2017

Wellbeing and recovery coming together

WELLBEING	RECOVERY
Gross wellbeing product	‘Recovery approach’
Workplace wellbeing	Individual Placement and Support
Positive education	Recovery Colleges


POSITIVE
PSYCHOTHERAPY
FOR PSYCHOSIS
A Clinician's Guide and Manual
Mike Slade, Tamsin Brownell,
Tayyab Rashid and Beate Schrank

2017


樂活集注
思覺失調患者正向心理治療介入手冊
中文版翻譯

2015

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

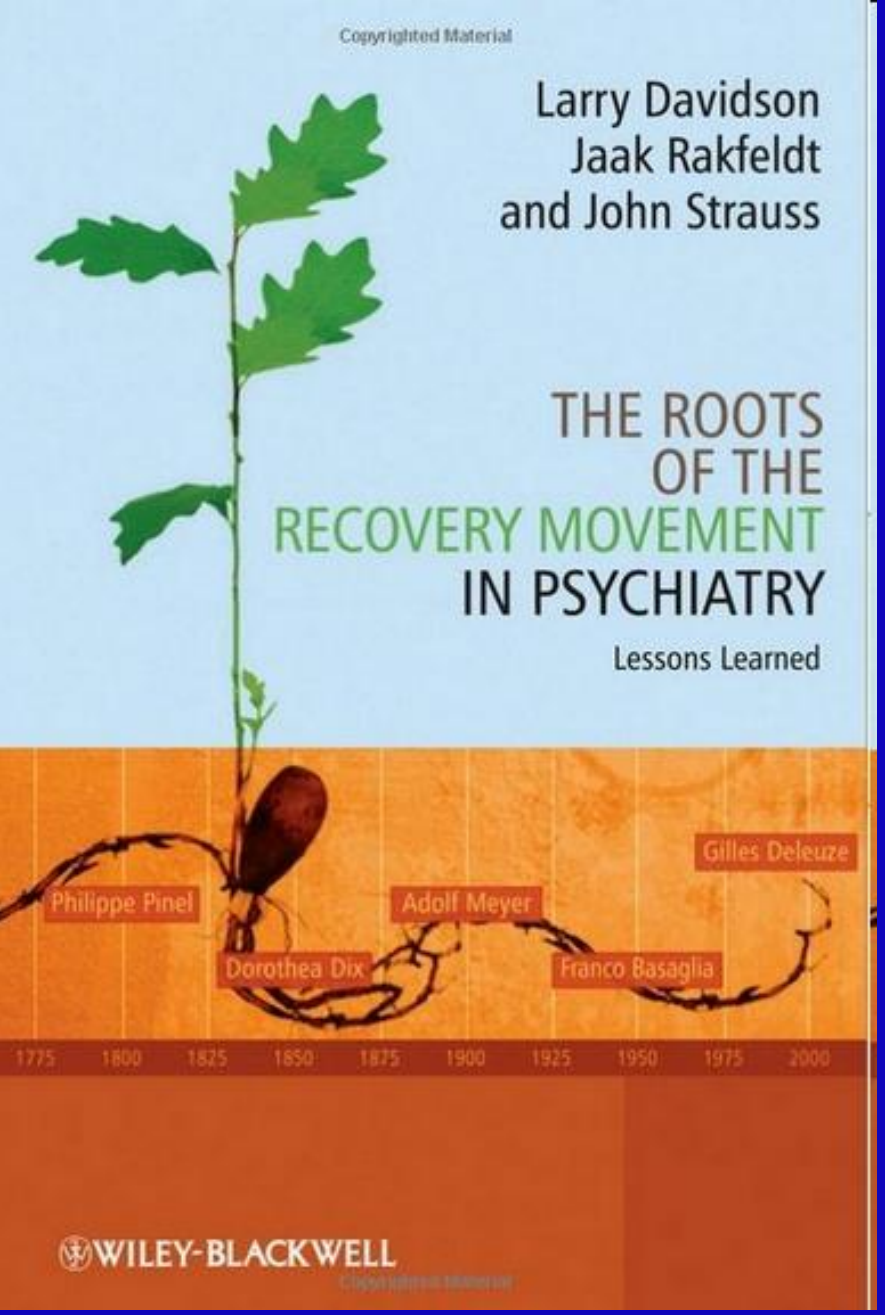
PUBLISHED : Sunday, 14 May, 2017, 11:33am
UPDATED : Sunday, 14 May, 2017, 8:02pm

Alfred C. M. Chan

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.

14 May 2017
South China Morning Post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THE ROOTS OF THE RECOVERY MOVEMENT IN PSYCHIATRY
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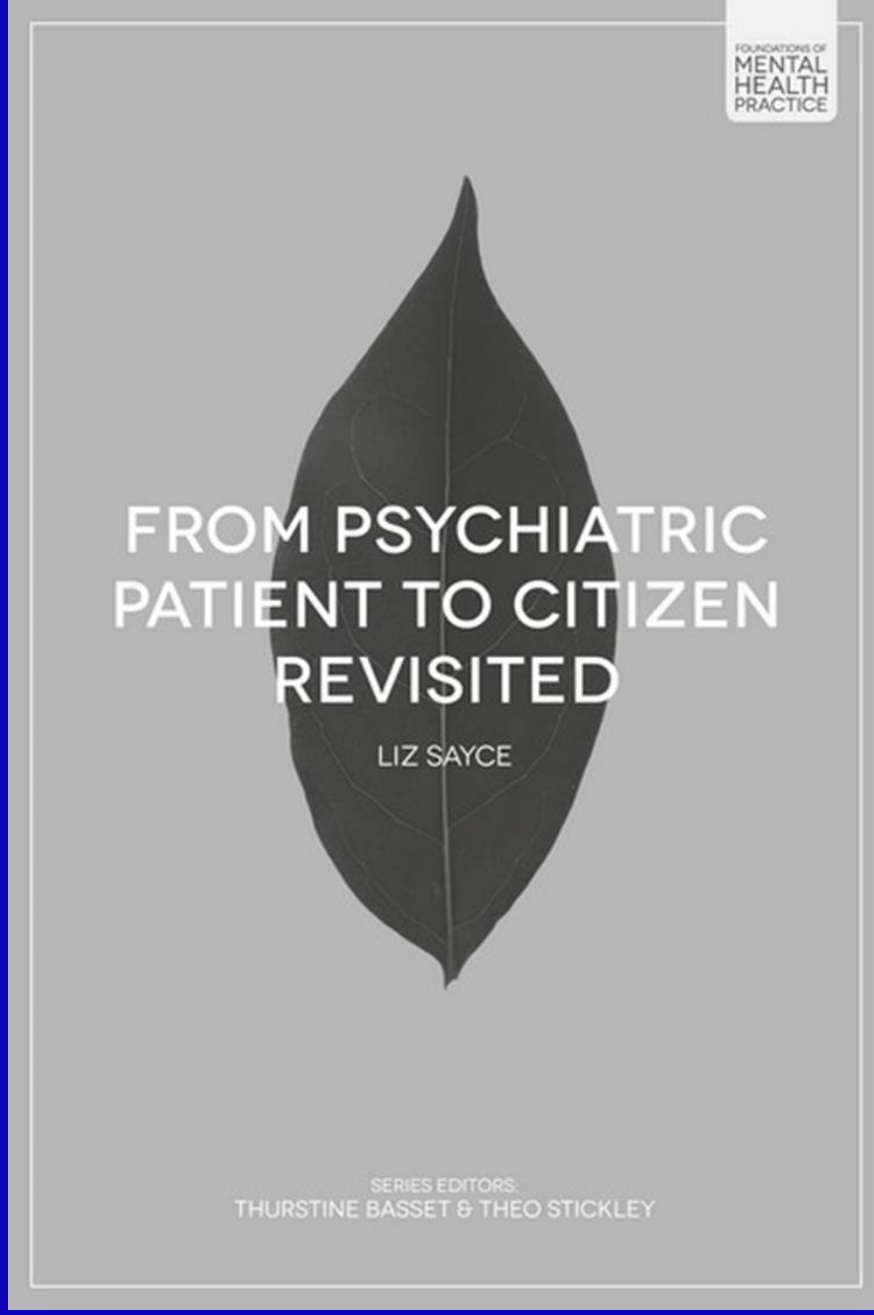
Gilles Deleuze
1775 1800 1825 1850 1875 1900 1925 1950 1975 2000
WILEY-BLACKWELL

2009


FOUNDATIONS OF MENTAL HEALTH PRACTICE
FROM PSYCHIATRIC PATIENT TO CITIZEN REVISITED
LIZ SAYCE
SERIES EDITORS:
THURSTINE BASSET & THEO STICKLEY

2015

Growing political consciousness

Medicine

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

Horton R (2015) *Offline: 13/11 – the flames of war*, Lancet, **386**, 2041.

Psychiatry

Priebe S (2015) *The political mission of psychiatry*, World Psychiatry, **14**, 1-2.

Critical groups in England

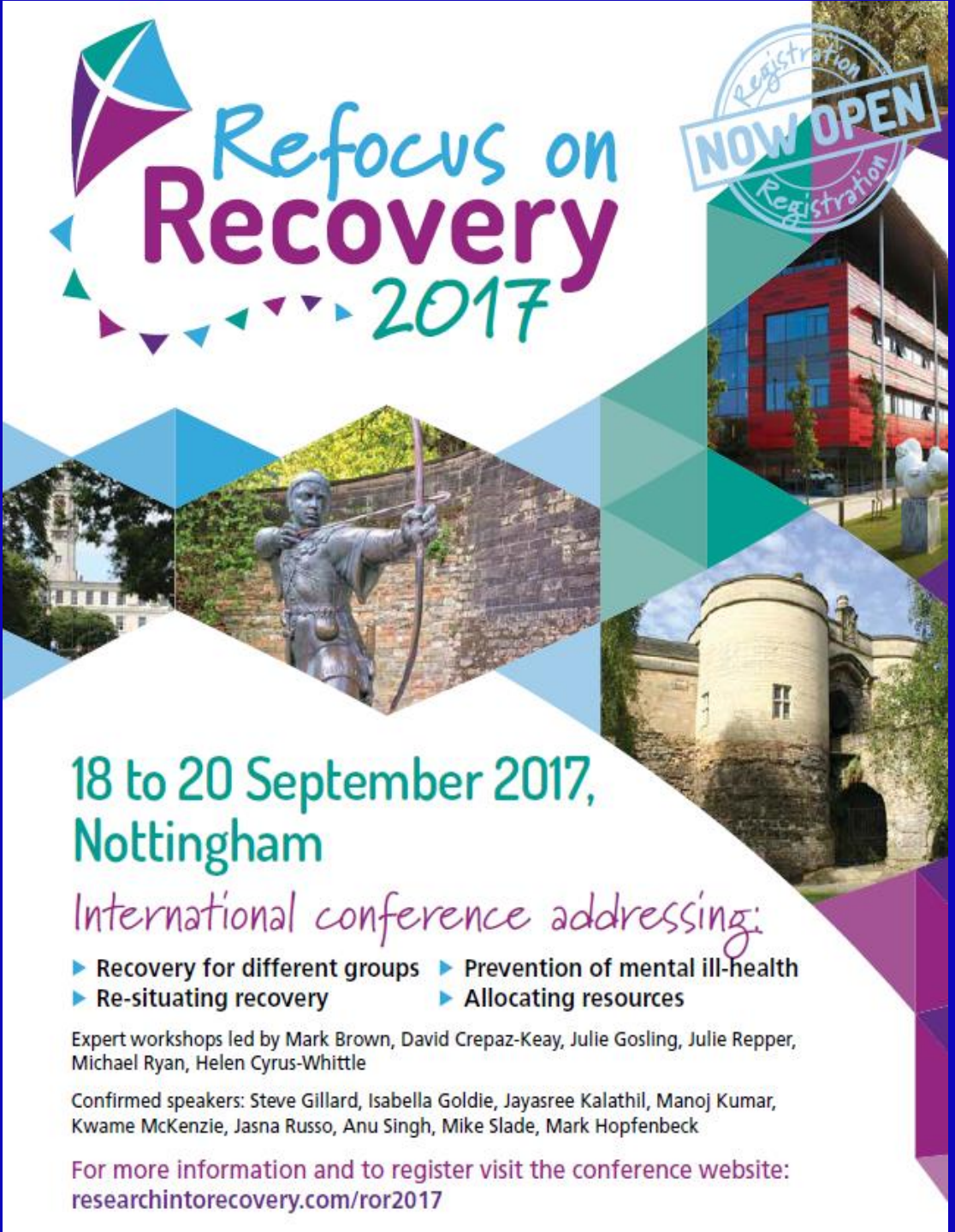
Recovery in the bin recoveryinthebin.org

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

Rose D et al (2016) *Service user led organisations in mental health today*, Journal of Mental Health, **25**, 254-259.

Human rights focus

Forrest R (2014) *The implications of adopting a human rights approach to recovery in practice*, Mental Health Practice, **17**, 29-33.

Power shift – money, leadership, 'service' structures

Brosnan L (2012) *Power and Participation: An Examination of the Dynamics of Mental Health Service-User Involvement in Ireland*, Studies in Social Justice, **6**, 45-66.

Political consciousness and engagement

Watson D (2012) *The Evolving Understanding of Recovery: What the Sociology of Mental Health has to Offer*, Humanity & Society, **36**, 290-308.

Thank you

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