REFOCUS masterclass

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University of Nottingham

10 January 2018

Goals

Overview of recovery and recovery support

Understanding of pro-recovery interventions

Knowledge about REFOCUS intervention

Values / attitude reflection

Existing expertise noticed and valued

Introductions

Who we are

Why we're here!

What is recovery?

DESCRIPTION

OF

THE RETREAT,

AN INSTITUTION NEAR YORK

For Insane Persons

OF THE

SOCIETY OF FRIENDS.

CONTAINING AN ACCOUNT OF ITS

ORIGIN AND PROGRESS,

The Modes of Treatment,

AND

A STATEMENT OF CASES.

By SAMUEL TUKE.

With an Elevation and Plans of the Building.

Includes an Introduction by
Richard Hunter and Ida Macalpine
and a new Foreword by Kathleen Jones

Number.	Age of Males.	Age of Fem.	Single or Mar.	Old or Recent.	Description of Disorder.	When admitted. Mo.	Discharged, Deceased, &c. Mo.	In what state.
6		25	S	OC	Man.	7, 1796	Remains	
7		50	S	OC	Man.	8,	Remains	
8	45		M	OC	Man.	8,	Remains	
9		26	S	RC	Mel.	8,	4, 97 *D.*	Imp.
10		52	S	OC	Man.	9,	Remains	
11		52	S	OC	H. M.	9,	8, 1800	Recov.
12	30		S	OC	Dem.	9,	Remains	
13	39		M	OC	Mel.	11,	5, 1800	Recov.
14		55	M	OC	Mel.	12,	11, 1798	Recov.
15	32		S	OC	Mel.	12,	Remains	
16	45		S	OC	Man.	2, 1797	12, 1798	M. I.
17	74		W	OC	H. M.	4,	10, 1804	M. I.
18		54	S	OC	Man.	5,	1, 1811	Imp.
19		72	S	OC	Man.	7,	Remains	
20		47	S	OC	Man.	7,	7, 05 *D.*	Imp.
21	45		S	RC	Man.	1, 1798	1, 1799	M. I.
22	24		S	OC	Man.	2,	7, 09 *D.*	
23		20	S	RC	Man.	3,	6, 1798	Recov.
24		45	S	OC	Man.	3,	7, 1806	Recov.
25		45	S	OC	Man.	6,	3,	Recov.

APPARENT CAUSE, &c.

No. 10. Succeeded a disappointment of the affections — 19
No. 13. Constitutional. — (6 Recovered)
No. 15. Constitutional.
No. 16. Succeeded disappointment in business. — 3 MI
No. 17. Constitutional. — 3 I
No. 19. Succeeded disappointment of affections.
No. 21. Constitutional. — 7 Remain
No. 23. Succeeded family misfortunes. — 3 D
No. 25. Succeeded disappointment of affections.

1813

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.

Long-term (>20 year) schizophrenia outcome

Team	Location	Yr	n	F-up (yrs)	Recovered / sig. improved (%)
Huber	Bonn	1975	502	22	**57**
Ciompi	Lausanne	1976	289	37	**53**
Bleuler	Zurich	1978	208	23	**53-68**
Tsuang	Iowa	1979	186	35	**46**
Harding	Vermont	1987	269	32	**62-68**
Ogawa	Japan	1987	140	23	**57**
Marneros	Cologne	1989	249	25	**58**
DeSisto	Maine	1995	269	35	**49**
Harrison	18-site	2001	776	25	**56**

Slade M, Amering M, Oades L (2008) Recovery: an international perspective. *Epidemiology e Psichiatrica Sociale*, **17**, 128-137.

Effects of eating disorders

Amenorrhea, Anemia, Arrhythmia, Atrophy, Low White Blood Cell Count, Cardiovascular Risk, Cathartic Colon, Digestion Health, Head Dizziness, Edema, Electrolyte imbalance, Emaciation, Esophagitis, Estrogen Levels, Tooth Enamel Erosion, Forgetfulness, Glandular Problems, Heart Attack, Hypoglycemia, Hypometabolic State, Hypothermia, Impulse Control Disorder, Irritable Bowel Syndrome, Judgment, Musculoskeletal Problems, Osteoporosis, Osteomalacia, Parotid Gland Enlargement, Pituitary Gland Problems, Low Potassium, Renal Problems, Salivary Glands, Seizures, Thyroid Problems, Vision Impairment, Vitamin Deficiencies

Long-term (>20 year) AN outcome

Team	Location	Yr	n	F-up (yrs)	Recovered / sig. improved (%)
Löwe	Heidelberg	2001	84	21	**51 Full** **21 Partial**
Ratnasuriya	London	1991	41	20	**61 good / intermediate**

Recovery in eating disorders

Maturation
"Waking up"
Increased self-esteem
Willpower

Supportive relationships
Supportive friendship
Support from other patients

Leaving home
Religion
"Good loss"
Children/pregnancy
Job

Therapy
Medications

Tozzi F et al (2003) *Causes and Recovery in Anorexia Nervosa: The Patient's Perspective*, International Journal of Eating Disorders, **33**, 143-154.

Another view

Recovery means…

- Living without obsessing on food, weight and body image
- Gaining or regaining the power to see our options, to make careful choices in our lives
- Rebuilding trust with ourselves...

As we learn and practice careful self-honesty, self-care and self-expression, we gain authenticity, perspective, peace and empowerment.

What is recovery?

Clinical	Symptoms, functioning
Existential	Hope, empowerment, agency
Functional	Valued societal roles
Physical	Health, lifestyle
Social	Relationships

Whitley R, Drake R (2010) *Psychiatric Services*, **61**, 1248-1250.

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.

Recovery - a short definition

Recovery involves living as well as possible.

South London and Maudsley NHS Foundation Trust (2010) *Social Inclusion and Recovery (SIR) Strategy 2010-2015*, London: SLAM.

One word – two meanings

CLINICAL RECOVERY

- focus on professional imperatives
- partly operationalised
- not highly concordant with consumer views

PERSONAL RECOVERY

- focus on personal meaning and purpose
- not operationalised for research purposes
- ideological and oppositional, not empirical


Fire exit
Fire exit

Unmeetable expectations

Keep people safe, stop them coming to harm, versus let them be autonomous and make their own decisions.

People want help and advice, versus they want to be able to decide their own future

Society must be protected from mad people, versus vulnerable people must be protected from society

A wide range of treatment options should be available, versus everything must be regulated.

Whitwell D (2005) *Recovery Beyond Psychiatry*. London: Free Association Books.


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Malgusto.com

Adm Policy Ment Health
DOI 10.1007/s10488-014-0585-x

ORIGINAL ARTICLE

Competing Priorities: Staff Perspectives on Supporting Recovery

Clair Le Boutillier · Mike Slade · Vanessa Lawrence · Victoria J. Bird · Ruth Chandler · Marianne Farkas · Courtenay Harding · John Larsen · Lindsay G. Oades · Glenn Roberts · Geoff Shepherd · Graham Thornicroft · Julie Williams · Mary Leamy

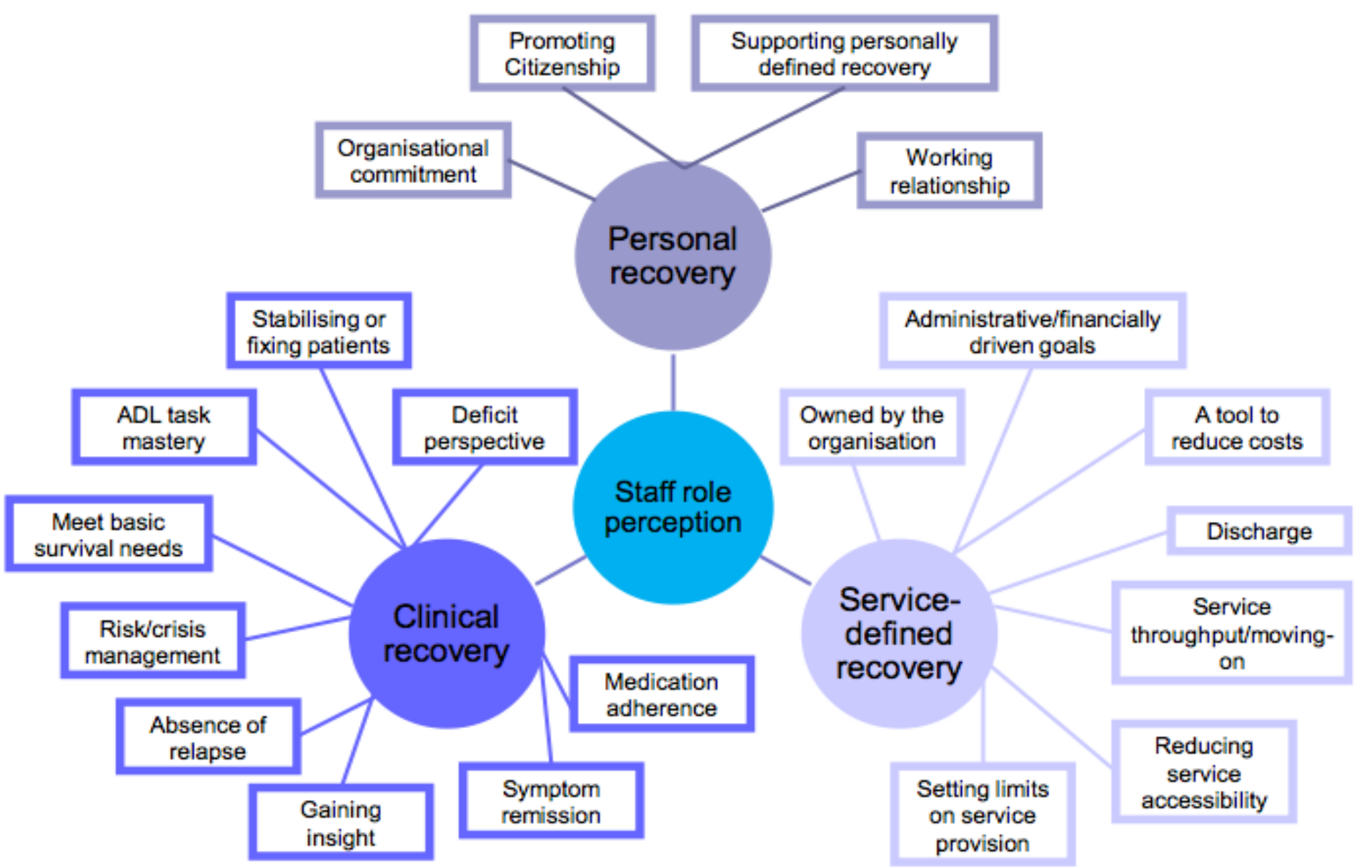
Abstract Recovery has come to mean living a life beyond mental illness, and recovery orientation is policy in many countries. The aims of this study were to investigate what staff say they do to support recovery and to identify what they perceive as barriers and facilitators associated with providing recovery-oriented support. Data collection included ten focus groups with multidisciplinary clinicians (n = 34) and team leaders (n = 31), and individual interviews with clinicians (n = 18), team leaders (n = 6) and senior managers (n = 8). The identified core category was Competing Priorities, with staff identifying conflicting system priorities that influence how recovery-oriented practice is implemented. Three sub-categories were: Health Process Priorities, Business Priorities, and Staff Role Perception. Efforts to transform services towards a recovery orientation require a whole-systems approach.

Keywords Mental health service provision · Recovery orientation · Staff perspective · Competing priorities

Introduction

Mental health staff are encouraged to support the recovery of individuals living with severe mental illness (Department of Health 2011a, b; Department of health human services 2003) by transforming services towards a recovery orientation (Bracken et al. 2012). Recovery is a unique, personal self-directed process of transformation, and discovery of a new self to overcome mental illness and reclaim control and responsibility for one's life decisions (Anthony 1993). It is a journey of hope and empowerment, connectedness, identity, and meaning and purpose (Leamy

2015



Le Boutillier C, Chevalier A, Lawrence V, Leamy M, Bird V, Macpherson R, Williams J, Slade M (2015) *Staff understanding of recovery-orientated mental health practice: a systematic review and narrative synthesis*, Implementation Science, **10**, 87.

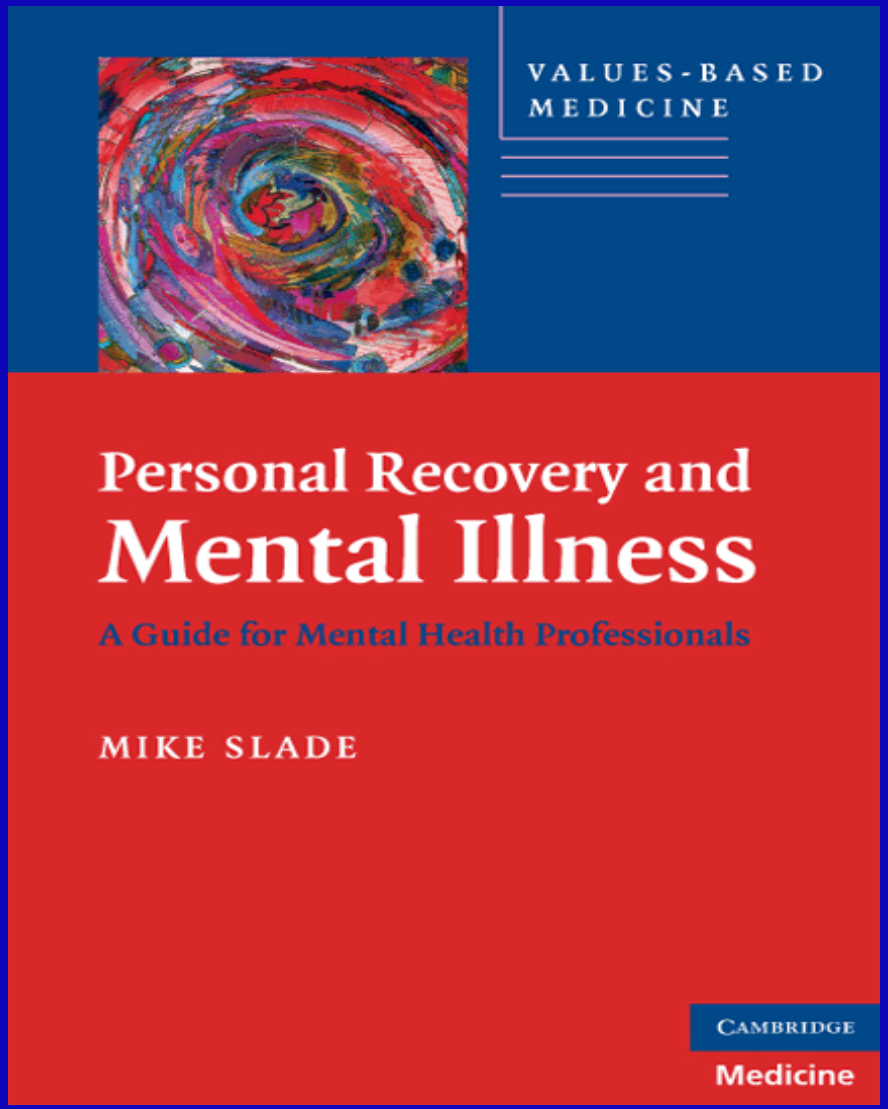
Exercise

Discuss any competing or unmeetable expectations you experience in your work

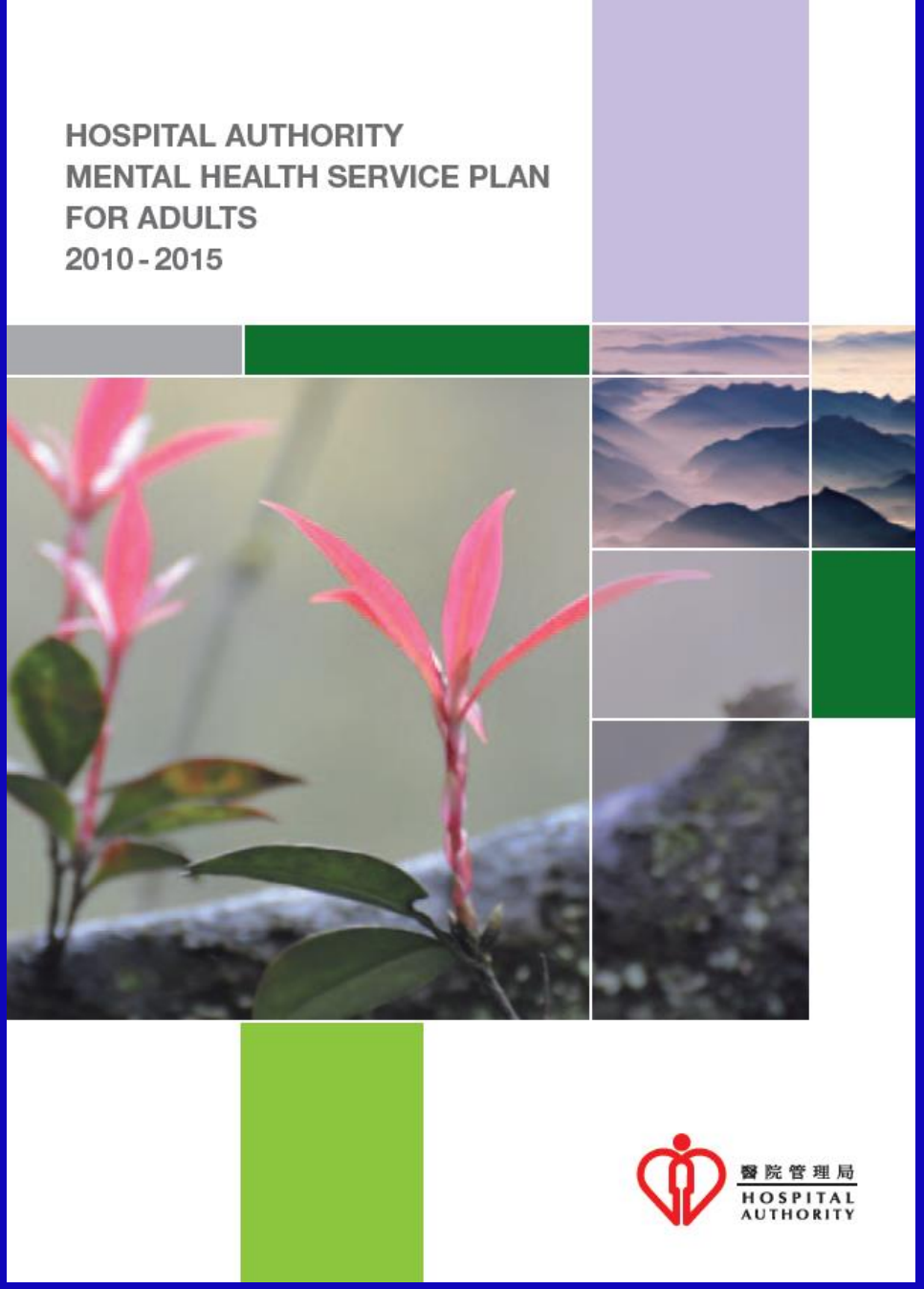
Feedback the broad themes.

Which type of recovery should be the mental health system goal?

1. Epistemological
2. Ethical
3. Empowerment
4. Effectiveness
5. Policy



2009



2011

Hong Kong

The vision of the future is of a person-centred service based on effective treatment and the recovery of the individual

2016

Hong Kong

Our mission…is to facilitate the recovery of SMI patients by providing them and their families with personalised, holistic, timely and coordinated services

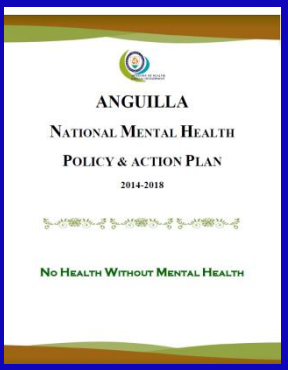
…recovery does not limit to "clinical recovery" which is defined in terms of symptoms. It also includes "social recovery", which is the building of a meaningful life beyond illness, without necessarily eliminating all the symptoms

Hong Kong

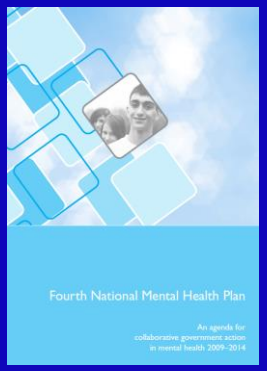
Recovery is the common vision of HA, SWD and NGOs when providing services to adults with SMI in the community

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

2017

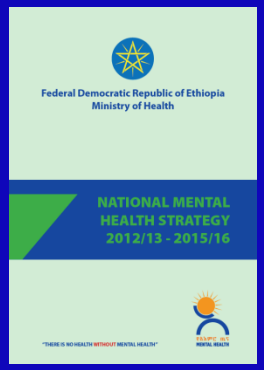


Anguilla

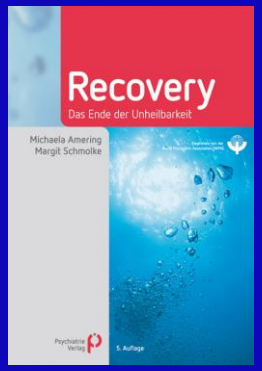


Australia

Canada



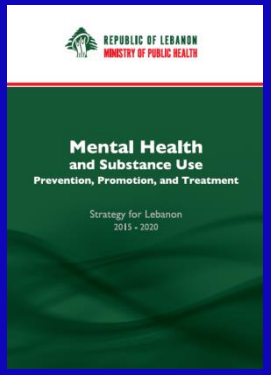
Ethiopia



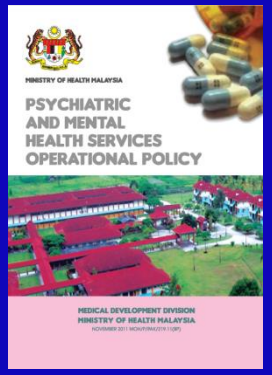
Germany

Hong Kong

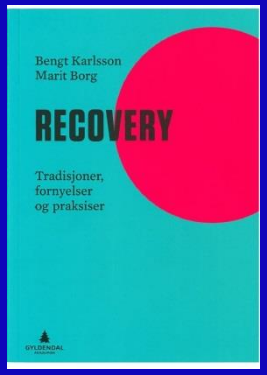
Italy



Lebanon

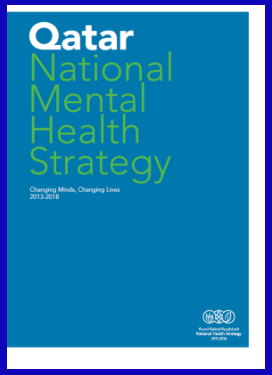


Malaysia



Norway

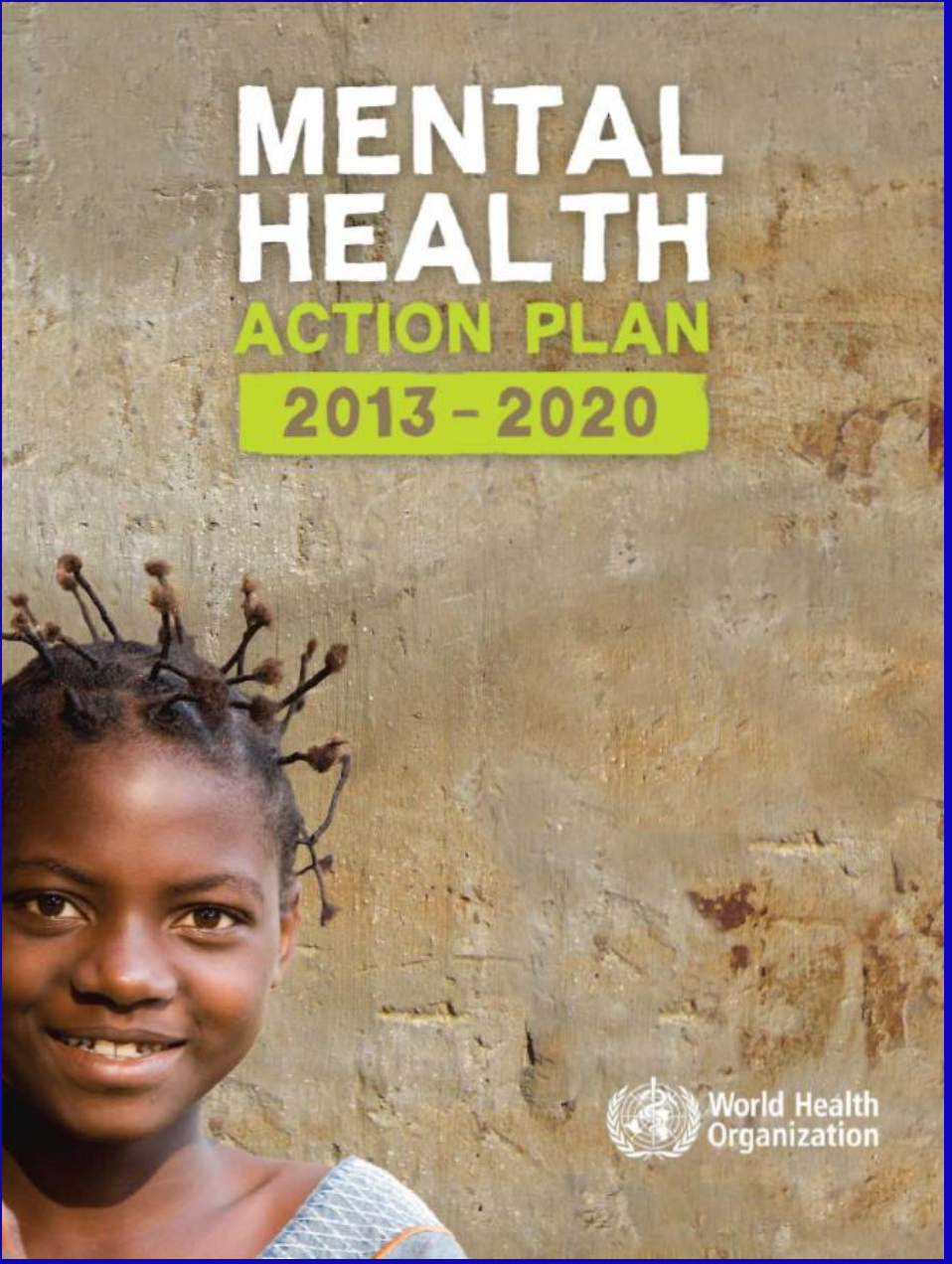
Palestine



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

Exercise

Think about - you

- your work setting

In terms of behaviour (not language), what type of recovery is the focus of effort? What constitutes success?

Feedback the broad themes.

Is anything really new here?


STOP

Stories

Stories matter. Many stories matter.

Stories have been used to dispossess and malign, but stories can also be used to empower and to humanise.

Stories can break the dignity of a people, but stories can also repair that broken dignity

Chimamanda Adichie

Different stories

Flat. Lacking in motivation, sleep and appetite good. Discussed aetiology. Cont. LiCarb 250mg qid. Levels next time.

Today I wanted to die. Everything was hurting. My body was screaming. I saw the doctor. I said nothing. Now I feel terrible. Nothing seems good and nothing good seems possible. I am stuck in this twilight mood where I go down into a lonely black hole. Where there is room for only one.

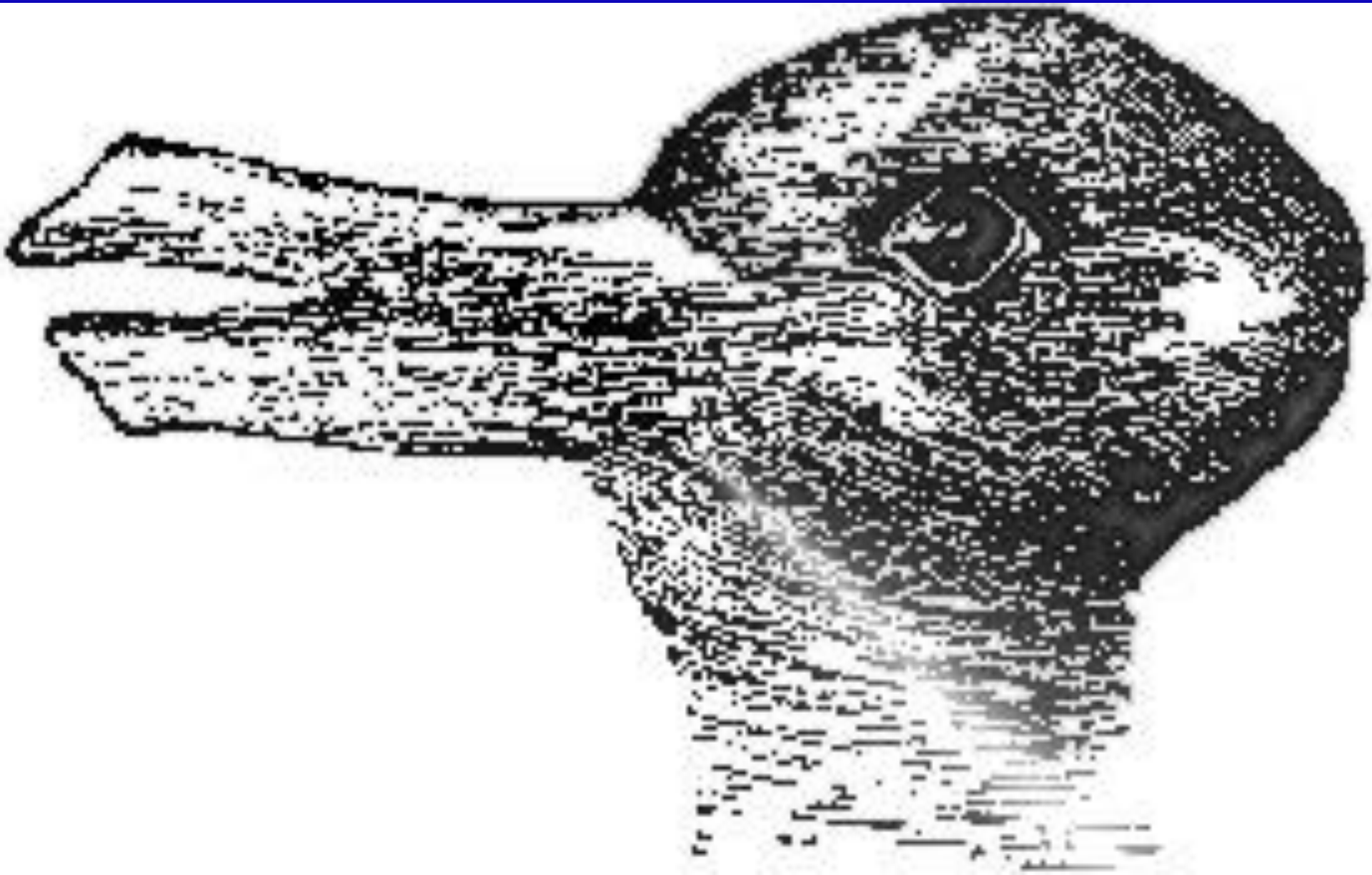
O'Hagan M (1996) *Two accounts of mental distress*, In: Read J, Reynolds J (eds) "Speaking our Minds", London: Macmillan.

Paradigm shift?

1. The central intellectual challenge comes from outside the system of belief

2. The previous body of knowledge becomes a special case

3. What was previously peripheral becomes central



Unpacking recovery

Components of personal recovery

Sources

12 bibliographic databases, web, experts, ToC, hand searching

Data

5,208 identified, 376 full papers retrieved, 97 included

Analysis

Systematic review, modified narrative synthesis

Stages of recovery

Moratorium	Denial, confusion, hopelessness, identity confusion, self-protective withdrawal
Awareness	The first glimmer of hope for a better life, that recovery is possible. Can emerge from within or be triggered by significant other, role model, clinician
Preparation	The person resolves to start recovery work, taking stock of personal resources, values, limitations
Rebuilding	Forging a more positive identity, setting & striving towards personal goals, reassessing old values
Growth	Whether or not symptom-free, can manage illness & stay well (resilience, self-confidence, optimism)

Characteristics of recovery journey

Active process

Individual & unique process

Aided by supportive environment

Recovery without cure

Stages or phases

A struggle

Can occur without professional intervention

Gradual process

Life-changing experience

Non-linear

A journey

Multidimensional

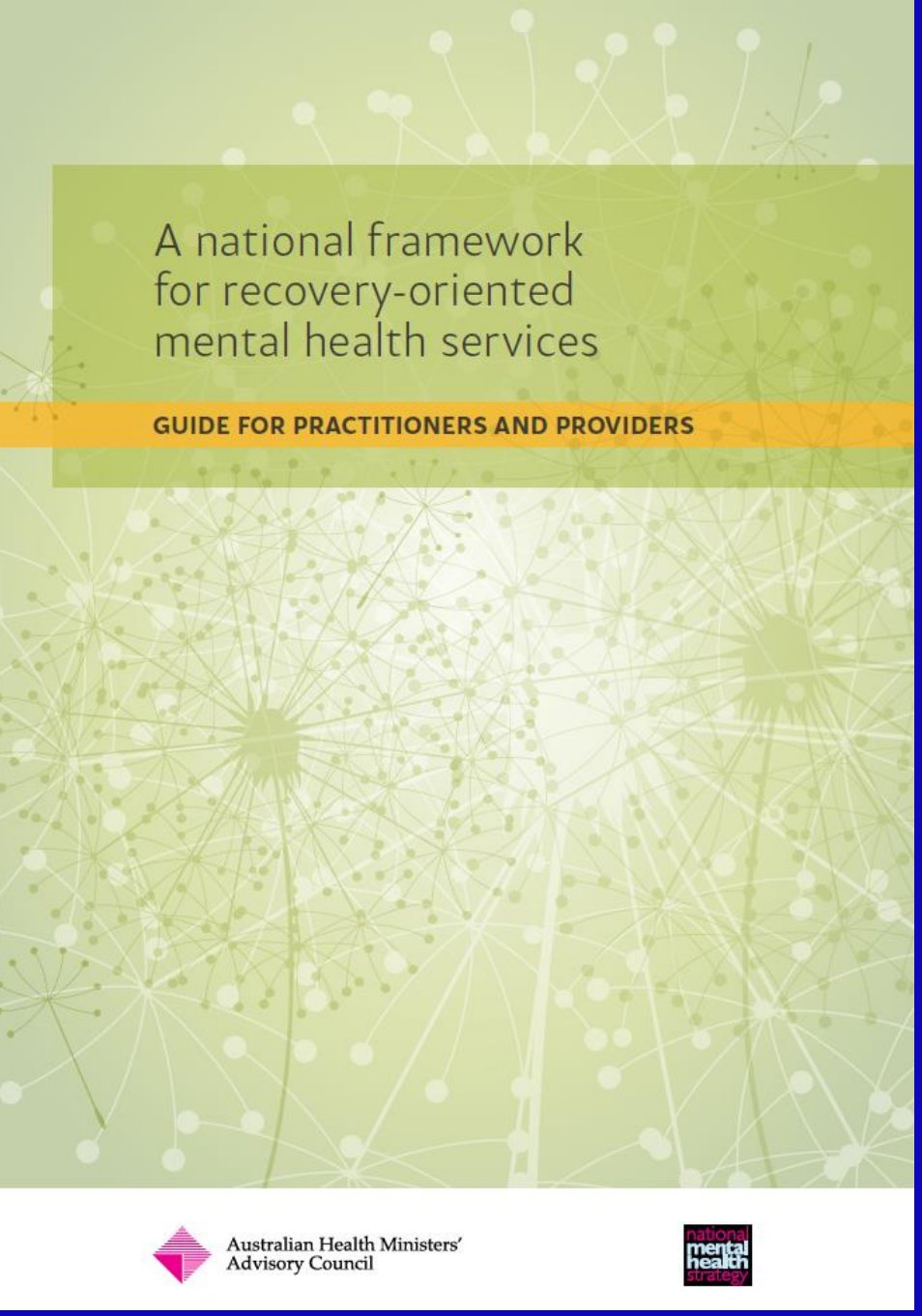
Trial and error process

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

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.

Connectedness



2013

Australia

Recovery approaches challenge traditional notions of professional power and expertise by helping to break down the conventional demarcation between consumers and staff

Hope


EVENINGS AT 7
IN THE PARISH HALL
MON ALCOHOLICS ANONYMOUS
TUE ABUSED SPOUSES
WED EATING DISORDERS
THU SAY NO TO DRUGS
FRI TEEN SUICIDE WATCH
SAT SOUP KITCHEN
SUNDAY SERMON
9 A.M.
"AMERICA'S JOYOUS FUTURE"

The central importance of hope

Hope predicts:

Self-harm and suicide — Klonsky D et al (2012) Suic Life Threat Behav **42**, 1-10.

Symptomatology — Cheavens J et al (2006) Social Indicators Research **77**, 61–78.

Social network — Connell J et al (2012) Health and Quality of Life Outcomes **10**, 138.

Quality of life — Werner S (2012) Psychiatry Res **30**, 214-9.

Instilling hope is the first objective of self-management

National Institute for Health and Clinical Excellence (2014) *Psychosis and schizophrenia in adults: treatment and management*. London: NICE.

Interventions exist (collaboration, relationships, peers, control)

Schrank B et al (2012) Social Science and Medicine, **74**, 554-564.

Identity

Meaning

Mental health as a source of meaning

Survivor testimony indicates that the process of surviving mental health challenges – including psychosis – can ultimately be transformative, enriching and a source of personal and social growth

Slade M, Longden E (2015) *The empirical evidence about mental health and recovery*, MI Fellowship: Victoria.

For example

- Post-traumatic growth
- Heightened capacity e.g. political engagement, creativity, fortitude, compassion, self-knowledge
- Survivor mission

Empowerment


LANE CLOSED
TO EASE
CONGESTION

How can your practice support recovery?

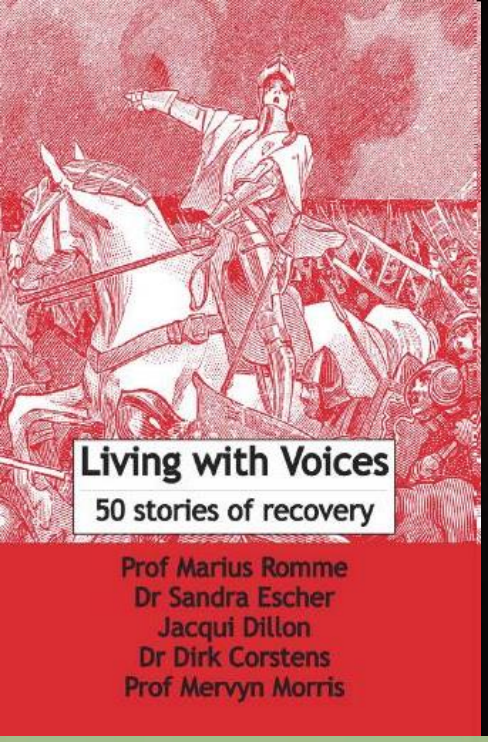
Exercise

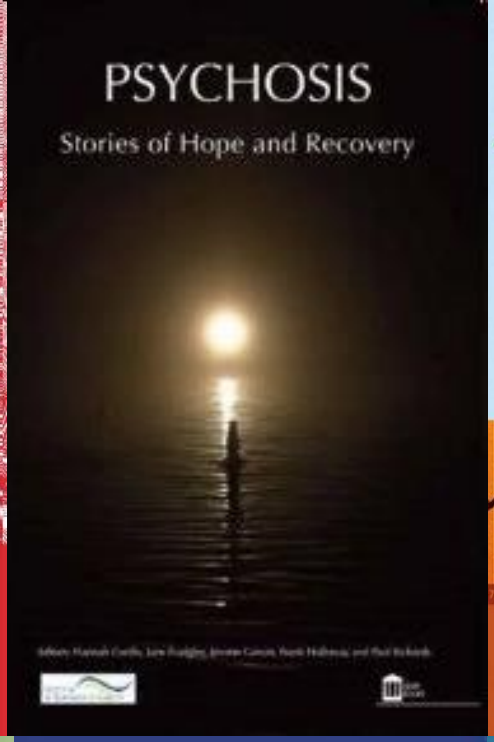
Think about what you do currently.

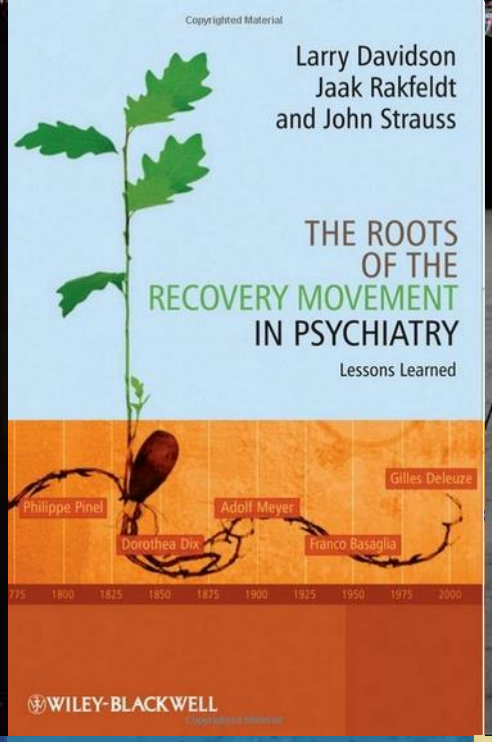
How much is the focus of work on:

- Connectedness
- Hope
- Identity
- Meaning
- Empowerment

Feedback the broad themes.


Living with Voices
50 stories of recovery
Prof Marius Romme
Dr Sandra Escher
Jacqui Dillon
Dr Dirk Corstens
Prof Mervyn Morris


PSYCHOSIS
Stories of Hope and Recovery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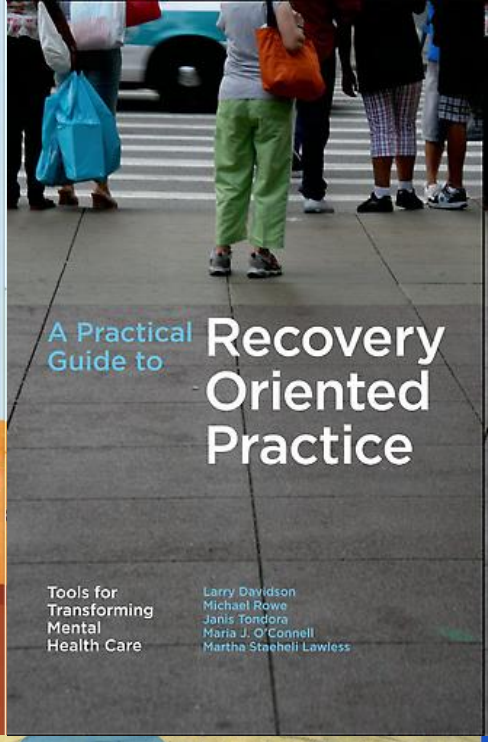
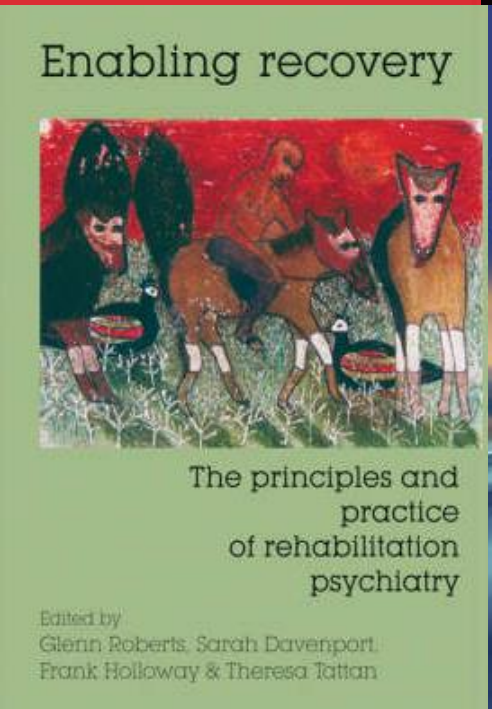
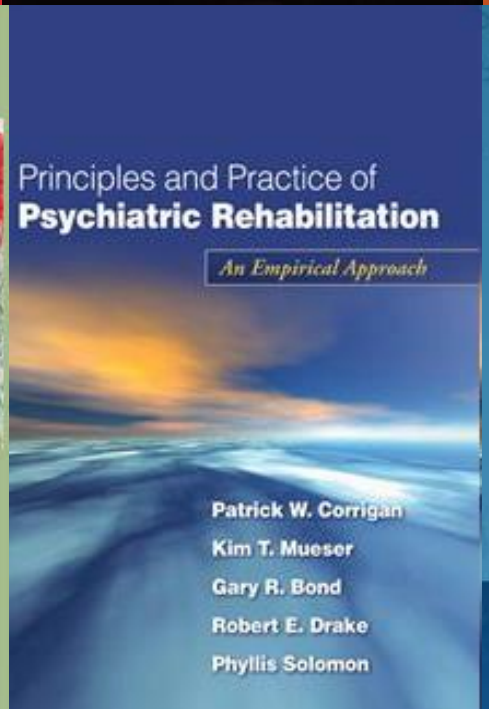
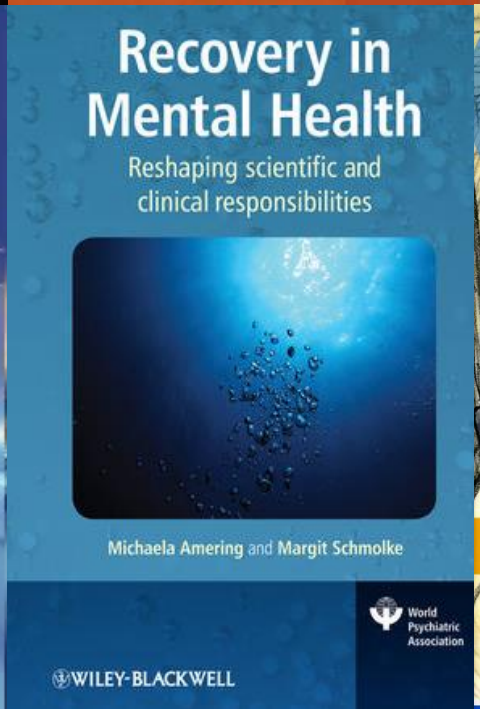
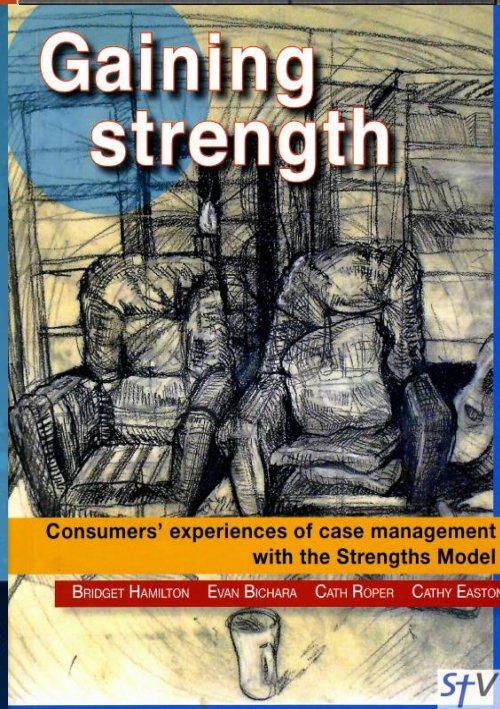
THE ROOTS OF THE RECOVERY MOVEMENT IN PSYCHIATRY
Lessons Learned
Philippe Pinel
Dorothea Dix
Adolf Meyer
Franco Basaglia
Gilles Deleuze
1775 1800 1825 1850 1875 1900 1925 1950 1975 2000
WILEY-BLACKWELL


A Practical Guide to
Recovery Oriented Practice
Tools for Transforming Mental Health Care
Larry Davidson
Michael Rowe
Janis Tondora
Maria J. O'Connell
Martha Staeheli Lawless


Enabling recovery
The principles and practice of rehabilitation psychiatry
Edited by
Glenn Roberts, Sarah Davenport, Frank Holloway & Theresa Tattan


Principles and Practice of
Psychiatric Rehabilitation
An Empirical Approach
Patrick W. Corrigan
Kim T. Mueser
Gary R. Bond
Robert E. Drake
Phyllis Solomon


Recovery in Mental Health
Reshaping scientific and clinical responsibilities
Michaela Amering and Margit Schmolke
World Psychiatric Association
WILEY-BLACKWELL


Gaining strength
Consumers' experiences of case management with the Strengths Model
Bridget Hamilton
Evan Bichara
Cath Roper
Cathy Easton
StV

Best practice

Sources

International policy, practice guidance, Google, reference lists

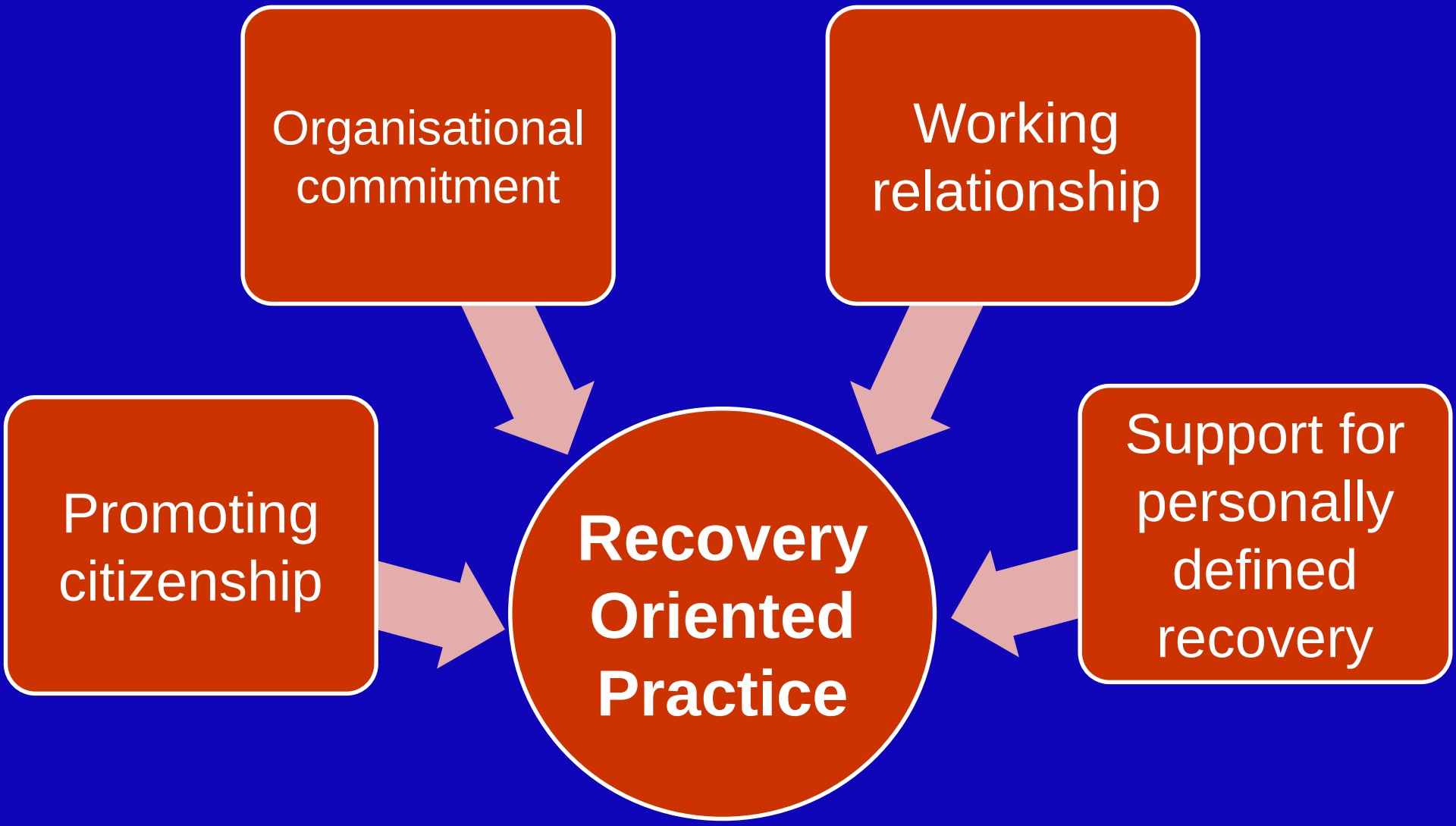
Data

30 documents from Denmark, England, Ireland, New Zealand, Scotland, USA

Analysis

Inductive thematic analysis, interpretive analysis

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.



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.

Exercise

What's going well?

What do (a) you and (b) your service currently do that supports recovery?

Consider the four levels:

- Promoting citizenship
- Organisational commitment
- Working relationship
- Supporting personally-defined recovery

Feedback the broad themes.

Cantonese

Hungarian

Indonesian

Icelandic

Norwegian

Japanese

Free from researchintorecovery.com

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

Uses and abuses of recovery

7 Abuses

Mis-uses of the concept

10 Uses

Empirically supported interventions

Slade M, Amering M, Farkas M, Hamilton B, O'Hagan M, Panther G, Perkins R, Shepherd G, Tse S, Whitley R (2014) *Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems*, World Psychiatry, **13**, 12-20.

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.

Approach 1: Peer support

A “credible role model”

Davidson L, Rakfeldt J, Strauss J (2010)
The roots of the recovery movement in psychiatry,
Chichester: Wiley-Blackwell

All mental health services will be expected to recruit and train service users as part of the workforce

Department of Health (2001) *The Journey to Recovery – The Government’s vision for mental health care*, London: Department of Health.

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.*

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Original article

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

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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

Nothing new...

I have often noticed that when I employed a madman who had just recovered his senses either to sweep or to assist a servant, and then to become himself a servant…that his state improved every month, and that somewhat later he was totally cured.

Jean-Baptiste Pussin, Governor of the Asylym at Bicêtre, 1793

Approach 2: Advance Directive

Goal: remain in control during crisis

Specifies action(s) to be taken for the person's health if capacity is lost in the future

May involve treatment or specify a proxy decision-maker

Strong empirical support

Campbell LA, Kisely SR. Advance treatment directives for people with severe mental illness. Cochrane Database of Systematic Reviews 2009(1):CD005963.

Joint crisis plan

AD variant increasingly used in mental health

Developed with the clinical team

Advantages:

- Reduces the Ulysses pact ethical dilemma
- Collaboration
- Implementation more likely

JCP RCT evidence in psychosis

Reduced compulsory treatment

Henderson et al. *Effect of joint crisis plans on use of compulsory treatment in psychiatry: single blind randomised controlled trial*. BMJ 2004;329:136-40.

Service use

Flood et al. *Joint crisis plans for people with psychosis: economic evaluation of a randomised controlled trial*. BMJ 2006;333:729.

Increased control

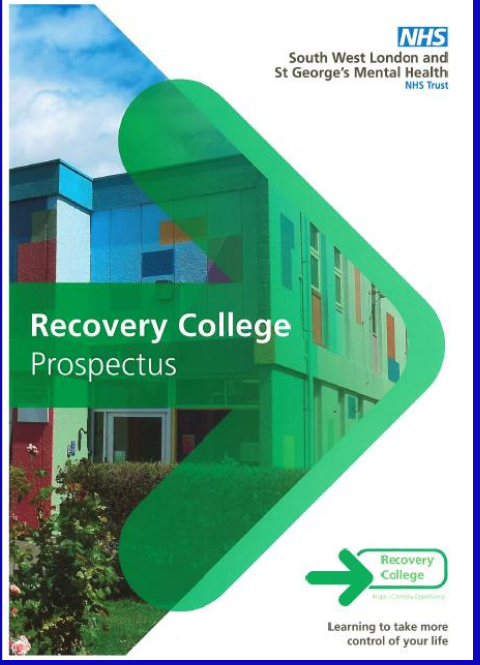
Henderson et al. *Views of service users and providers on joint crisis plans: single blind randomized controlled trial*. Soc Psychiatry Psychiatr Epidemiol 2009;44:369-76.

Approach 7: Recovery Colleges

1. Co-production between people with personal and professional experience of mental health problems
2. There is a physical base (building) with classrooms and a library where people can do their own research
3. It operates on college principles
4. It is for everyone
5. A Personal Tutor offers information, advice and guidance
6. It is not a substitute for traditional assessment and treatment
7. It is not a substitute for mainstream colleges
8. It must reflect recovery principles in all aspects of its operation

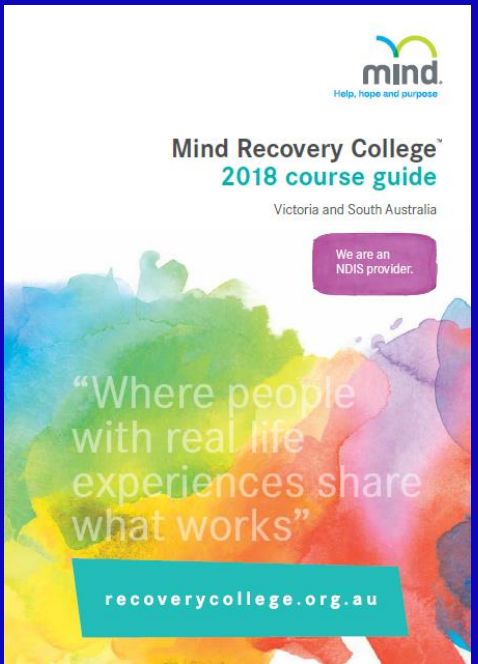
Perkins R et al (2012) *ImROC 1. Recovery Colleges*. London: Centre for Mental Health.

Since 1984: Boston University Center for Psychiatric Rehabilitation (bu.edu/cpr)



England

Hong Kong



Australia

Japan

Approach 8: Individual Placement and Support

1. Competitive employment is the primary goal
2. Everyone who wants it is eligible for employment support
3. Job search is consistent with individual preferences
4. Job search is rapid: beginning within one month
5. Employment specialists and clinical teams work and are located together
6. Employment specialists develop relationships with employers based upon a person's work preferences
7. Support is time-unlimited and individualised to both the employer and the employee
8. Welfare benefits counselling supports the person through the transition from benefits to work

Grove B et al (2009) *Doing what works - Individual Placement and Support into Employment*. London: Sainsbury Centre for Mental Health.

IPS evidence

Cochrane review (18 RCTs) compared 18-month employment rates

34% IPS vs 12% pre-vocational training.

Crowther et al (2010) *Vocational rehabilitation for people with severe mental illness*, Cochrane Database of Systematic Reviews. CD003080.

8-12 follow-up confirm sustained benefits

Becker et al (2007) *Critical strategies for implementing supported employment*, Journal of Vocational Rehabilitation **27**: 13-20.

Salyers et al (2004) *A ten-year follow-up of a supported employment program*, Psychiatric Services **55**(3): 302-8.

Cost savings: mental health service use and welfare benefits

Sainsbury Centre for Mental Health (2009) *Commissioning what works: The economic and financial case for supported employment*, London: SCMH.


MHA Village
An Integrated Service Agency
of the National Mental Health
Association of Greater Los Angeles
456 Elm Avenue

RCT evidence from the Village

Demonstration sites re employment and crisis / outreach vs. TAU (n=516)

- Reduced hospital use (40% to 21%)
- More employment (11% to 36%)

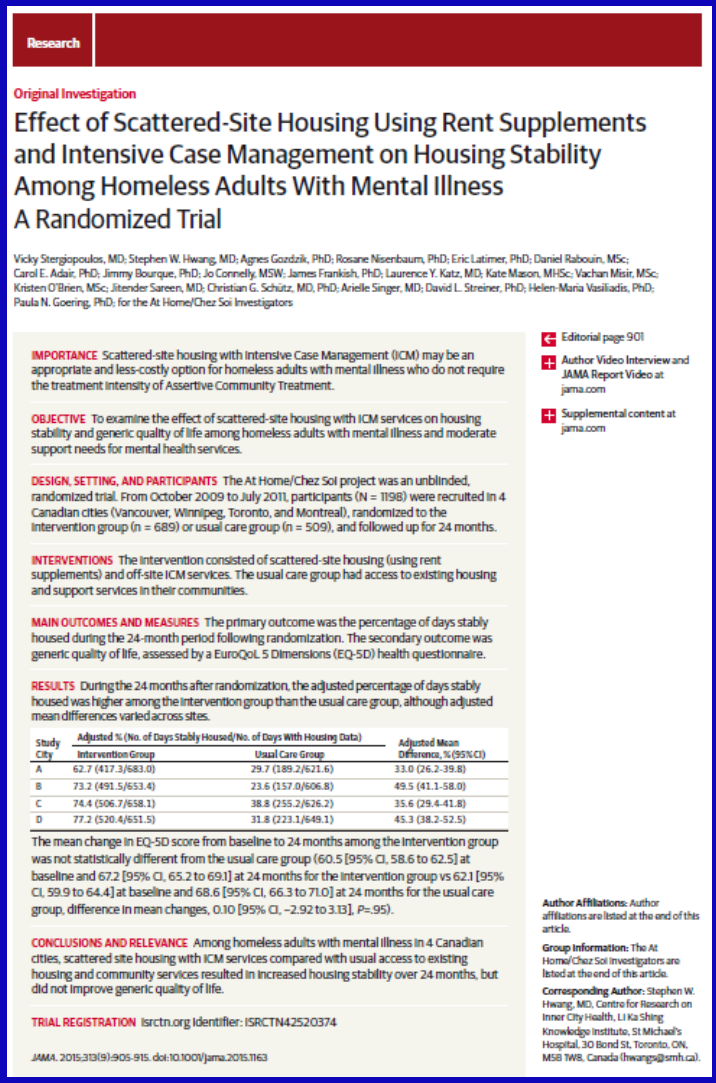
Chandler D et al (1996) *Client Outcomes in Two Model Capitated Integrated Service Agencies*, Psychiatric Services, **47**, 175-180.

Saving $650,000 over three years

Chandler D et al (2007) *A Capitated Model for a Cross-Section of Severely Mentally Ill Clients*, Community Mental Health Journal, **34**, 13-26.

Approach 9: Housing First

2014



Research

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

Supporting recovery


CAUTION
WATER ON ROAD
DURING
RAIN


TATTOO'S
While U Wait


ENTRANCE
ONLY
DO NOT
ENTER


THIS LIGHT
NEVER TURNS
GREEN

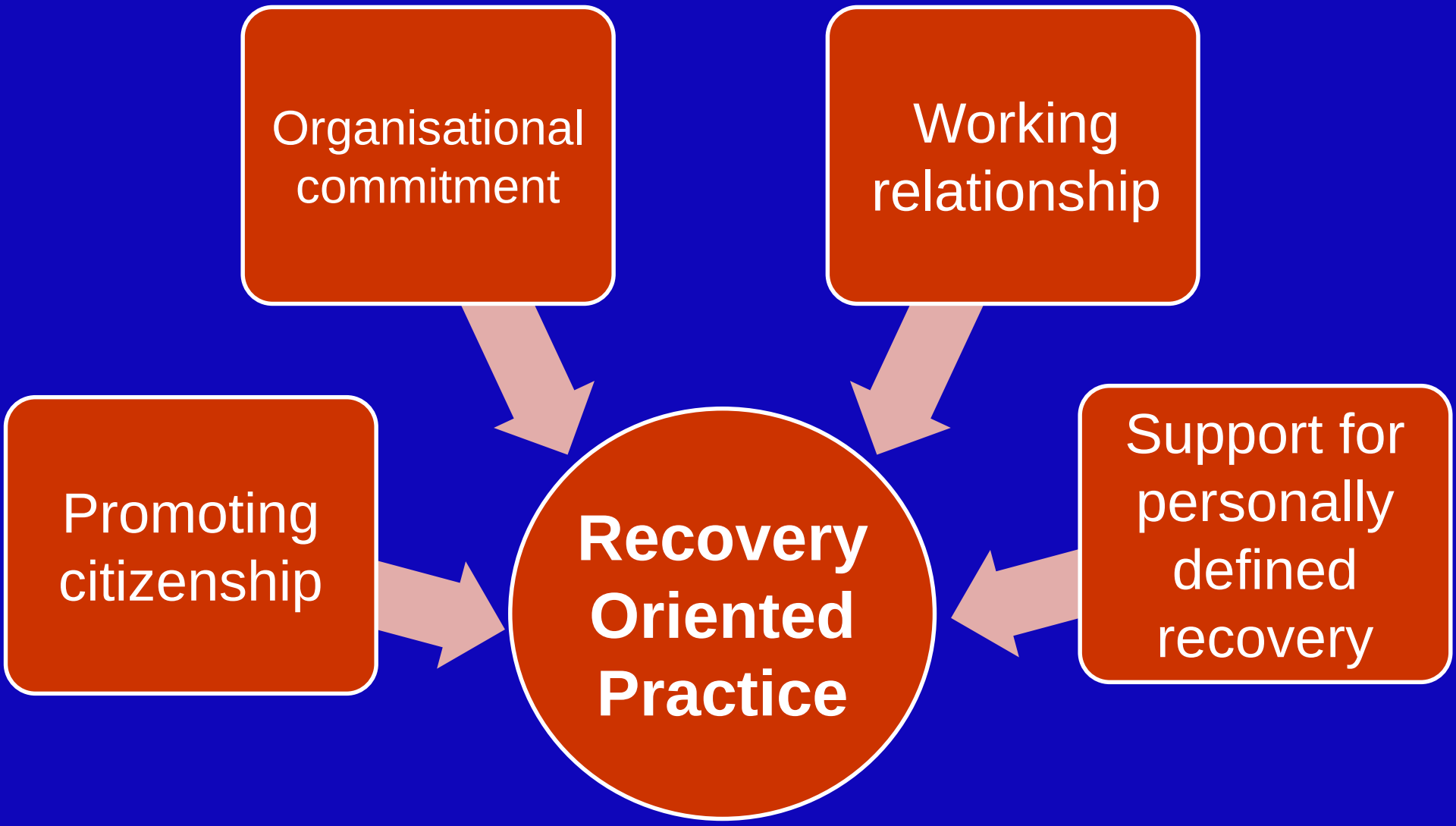
Central messages

1. It’s not obvious!

2. We’re not already doing it (as well as we could)

3. Workers have a lot to offer

4. Worker expertise can support recovery – when combined with the expertise of lived experience



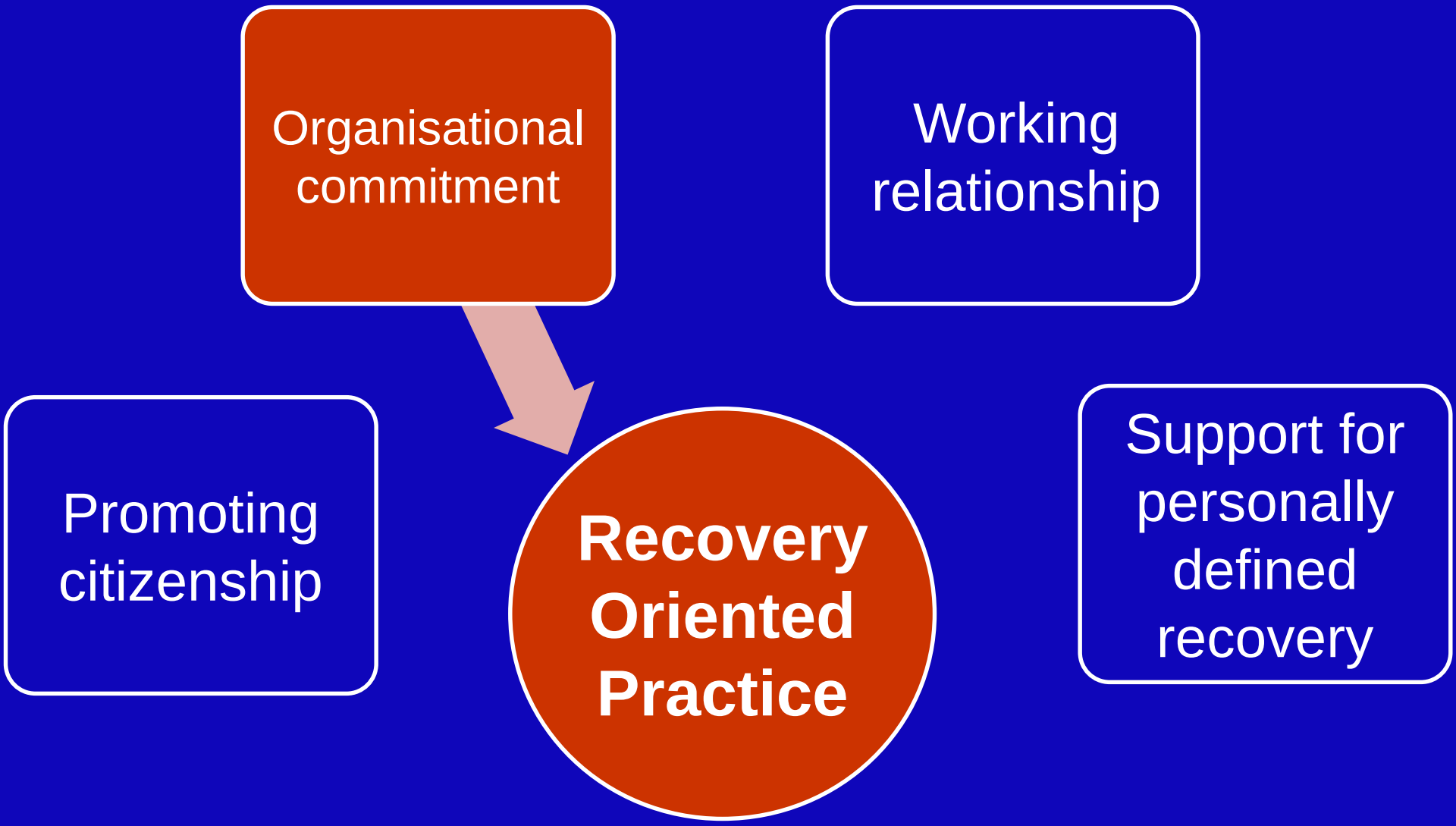
Le Boutillier C, Leamy M, Bird V, Davidson L, Williams J, Slade M (2011) *What does recovery mean in practice? A qualitative analysis of international recovery-oriented practice guidance*, Psychiatric Services, **62**, 1470-1476.

Exercise – large group discussion

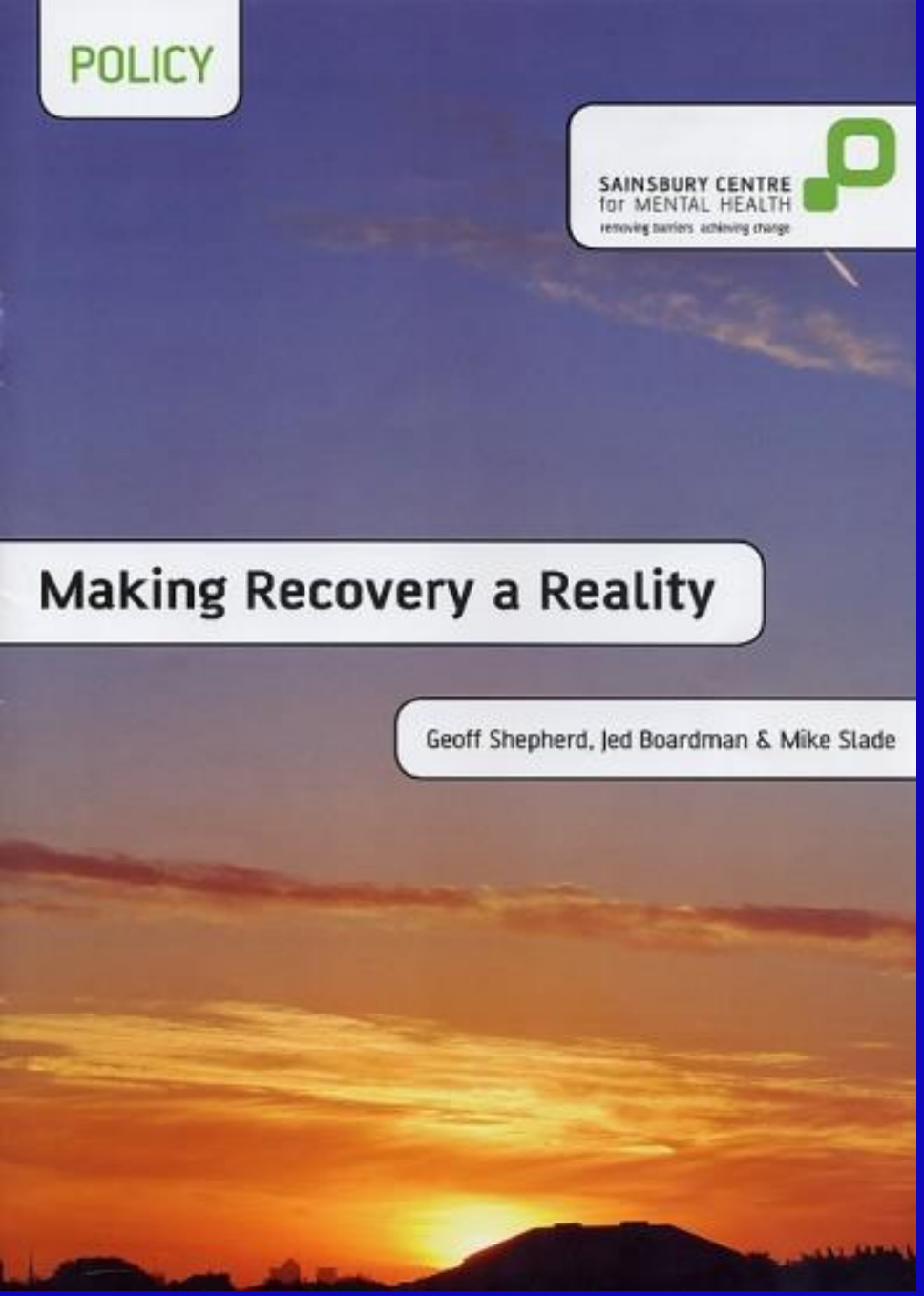
Think about practice and culture where you work

To fully support recovery, (Promoting citizenship, Organisational Commitment, Working relationship, Support for personally defined recovery) what needs to be:

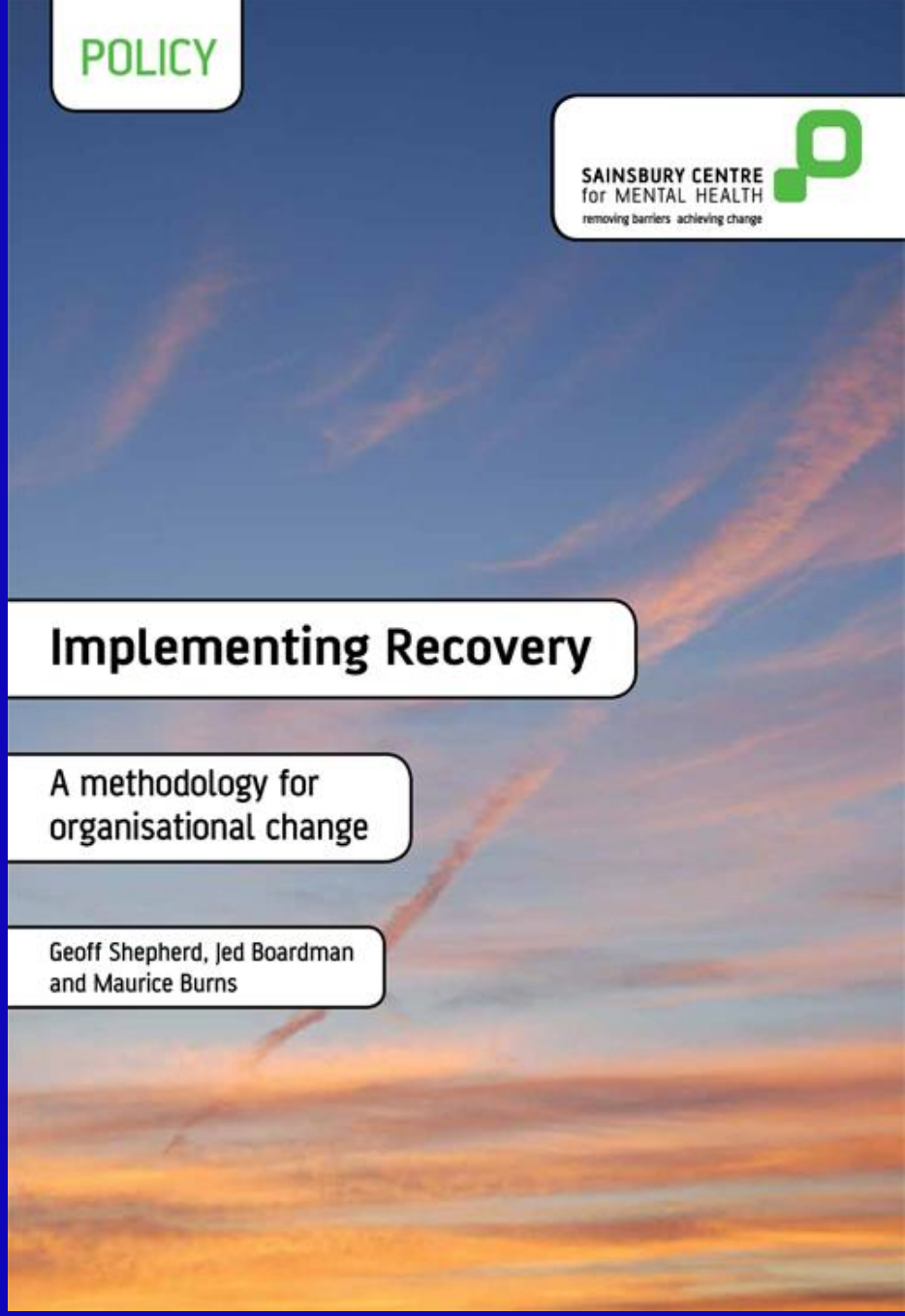
- done more
- done less
- changed
- stopped
- added



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.


POLICY
SAINSBURY CENTRE
for MENTAL HEALTH
removing barriers achieving change
Making Recovery a Reality
Geoff Shepherd, Jed Boardman & Mike Slade

2008


POLICY
SAINSBURY CENTRE
for MENTAL HEALTH
removing barriers achieving change
Implementing Recovery
A methodology for
organisational change
Geoff Shepherd, Jed Boardman
and Maurice Burns

2010

Learning from experience

ImROC Briefing Papers

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http://imroc.org/resource_tag/our-briefings/

BRIEFING

Implementing Recovery through Organisational Change

Centre for Mental Health

Mental Health Network NHS CONFEDERATION

1. Recovery Colleges

Rachel Perkins, Julie Repper, Miles Rinaldi and Helen Brown

2012

BRIEFING

Implementing Recovery through Organisational Change

Centre for Mental Health

Mental Health Network NHS CONFEDERATION

2. Recovery, Personalisation and Personal Budgets

Vidhya Alakeson and Rachel Perkins

2012

BRIEFING

Implementing Recovery through Organisational Change

Centre for Mental Health

Mental Health Network NHS CONFEDERATION

3. Recovery, Public Mental Health and Wellbeing

Jed Boardman and Lynne Friedli

2012

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Mental Health Network NHS CONFEDERATION

Briefing

4. Recovery: a carer's perspective

Karen Machin and Julie Repper

INTRODUCTION

An estimated 1.5 million people in the UK care for or support a relative or friend who experiences mental health problems. We all want to know what it means for the person we care for and for ourselves. We all know the importance of trying to understand what is happening to them, listening to their accounts of what it feels like, providing practical and emotional support in a manner that they find acceptable and walking alongside them – 'being there' and believing in them. Yet it can be difficult to know how best to do this.

The concept of Recovery offers a framework which is relevant and constructive for both the person who experiences distress and their family and friends. Since it is not prescriptive, it can also facilitate the development of mutually supportive relationships.

This briefing paper examines what Recovery means for the families and friends of people with mental health conditions. It suggests ways in which these informal carers can support Recovery and looks at how mental health services can give the best possible help to do this. It also provides information about key resources, including the Triangle of Care and a Wellbeing Recovery Plan for families and friends.

2013

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Briefing

5. Peer Support Workers: Theory and Practice

Julie Repper
with contributions from **Becky Aldridge, Sharon Gilfoyle, Steve Gillard, Rachel Perkins and Jane Rennison**

INTRODUCTION

Peer support is *"offering and receiving help, based on shared understanding, respect and mutual empowerment between people in similar situations"*. In this paper we will examine the concepts and principles of peer support and present examples from organisations which now have peers in their workforce.

The ImROC programme has recommended the use of peer workers to drive recovery-focused organisational change. ImROC recognises the value of a range of *different roles* for peers in all types of mental health services. Whether they are paid or voluntary, working in public, private or independent services, peer workers have a valuable role to play.

We have concentrated on the contribution of peers working inside mental health services because of the multiple benefits that they can bring. Working together, 'co-producing' services alongside traditional mental health professionals, they can offer a truly comprehensive and integrated model of care.

We also have to be concerned with maximising 'value for money' and we believe that peers – properly selected, trained and supported – can improve the quality of services at no extra cost, possibly even with cost reductions. This would put the voice of those with lived experience truly at the centre of mental health services – which is where it belongs.

2013

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Briefing

6. The Team Recovery Implementation Plan: a framework for creating recovery-focused services

Julie Repper and Rachel Perkins

INTRODUCTION

Creating more recovery-focused services requires a change in culture and practice at every level of the organisation (Shepherd *et al.*, 2010). In modern mental health services, the basic building block is the multidisciplinary team, whether in a hospital ward or in the community.

Supporting recovery through working with the whole team is at the centre of the processes of organisational change and a necessary complement to changing the attitudes and behaviour of front-line staff (Whiteley *et al.*, 2009).

The 'Team Recovery Implementation Plan' (TRIP) was initially developed by Julie Repper and her colleagues in Nottingham and is a tried and tested instrument designed to assist with this goal. This paper describes the instrument and its practical use in a variety of settings.

Successfully embedding recovery ideas and practice into the day-to-day work of individual teams requires two parallel processes:

1. Empowering teams (their staff and people using services) to translate abstract ideas about recovery into practice.
2. Utilising the skills and resources of everyone at the front line (staff and people using services) to develop innovative ways of promoting recovery and recovery environments.

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Briefing

7. Peer Support Workers: a practical guide to implementation

Julie Repper
with contributions from **Becky Aldridge**, **Sharon Gilfoyle**, **Steve Gillard**, **Rachel Perkins** and **Jane Rennison**

INTRODUCTION

Our experience with the ImROC programme has led us to the conclusion that the widespread introduction of people with lived experience of mental health problems into the mental health workforce is probably the single most important factor contributing to changes towards more recovery-oriented services. In the first paper on this topic (Repper, 2013) we discussed the theoretical background, core principles and the range of potential benefits. In this paper we will discuss practical issues of implementation in more detail.

When developing peer worker posts, it is useful to think of four sequential phases. The first involves **preparation** – of the organisation as a whole, of the teams in which peers will be placed, and, perhaps most obviously, of the peers themselves. The second phase involves **recruitment** of peers to the posts that have been created or existing posts that have been modified for peer workers. Given the likelihood that peer applicants may have not worked for some time, nor been through an interview process with all of the formalities and checks that this brings, the whole process needs careful support. Thirdly, there is the safe and effective **employment** of peer workers in mental health organisations. Finally, the **ongoing development** of peer worker opportunities and contributions needs to be considered in the context of the wider healthcare system and the changing culture of services. These different phases are shown in Box 1 below.

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Briefing

8. Supporting recovery in mental health services: Quality and Outcomes

Geoff Shepherd, Jed Boardman, Miles Rinaldi and Glenn Roberts

INTRODUCTION

The development of mental health services which will support the recovery of those using them, their families, friends and carers is now a central theme in national and international policy (DH/HMG, 2011; Slade, 2009). In order to support these developments we need clear, empirically-informed statements of what constitutes high-quality services and how these will lead to key recovery outcomes. This is what the present paper aims to do.

We have had to be selective in terms of the evidence we have considered and, in many cases, we have had to make subjective judgements to come to simple recommendations. We understand that not everyone will agree with our conclusions. Nevertheless, we hope that, at the very least, they will provide a useful framework within which discussions about quality and outcome can take place at a local level in a more informed way. We therefore hope that the paper will be of value to both commissioners and providers.

2014

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Briefing

9. Risk, Safety and Recovery

Jed Boardman and Glenn Roberts

INTRODUCTION

The ways in which risk is assessed and safety assured in mental health services are subjects of constant concern to all stakeholders – and so it should be. However, there are many different views as to how these challenges should be addressed and how best to meet the needs of service users, professionals and the public. Managing risk in a way that is supportive of individual recovery then presents an additional test.

We are concerned that current approaches to risk assessment and management may present an obstacle to recovery. On the other hand, some practitioners are concerned that adopting a 'recovery-oriented' approach to risk assessment and management sometimes sounds naive, possibly even dangerous.

This briefing paper examines current approaches to risk assessment and management and how these need to be changed so as to be more supportive of people's personal recovery. In doing so we will identify means of moving towards recovery-oriented risk assessment and safety planning based on shared decision making and the joint construction of personal safety plans. We believe that this presents an approach which respects service users' needs, while recognising everyone's responsibilities – service users, professionals, family, friends – to behave in ways which will uphold and maintain personal and public safety.

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ImROC
Implementing Recovery through Organisational Change

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Briefing

10. Making Recovery a Reality in Forensic Settings

Gerard Drennan and James Wooldridge
together with Anne Aiyegbusi, Debbie Alred, Joe Ayres, Richard Barker, Sally Carr, Helen Eunson, Hilary Lomas, Estelle Moore, Debbie Stanton & Geoff Shepherd

INTRODUCTION

Forensic settings are probably among the most difficult places to think of applying recovery principles. People in forensic services are doubly stigmatised with repeated or prolonged contact with the criminal justice system in addition to mental health problems. Many also often have a range of pre-existing social disadvantages – family problems, educational failure, poor work record, etc. – but the process of recovery is as important for them as it is for anyone else. Indeed, precisely because of their other disadvantages, recovery is, perhaps, even more important. Given all their difficulties, how can people with mental health problems and frequent contact with forensic services be expected to have positive *hopes* for the future? How can they achieve a sense of *control* over their lives and their symptoms when so many of their choices are so restricted? How they can build a life 'beyond illness' when faced with the toxic combination of stigma and low expectations of those around them? To some people these ambitions may seem desirable in theory, but unrealistic in practice. These are the issues which we hope to address in this paper.

Our aims are threefold. Firstly, we want to present a credible discussion of the challenges of applying the principles of recovery in forensic settings and describe how recovery values can be expressed in a meaningful, non-tokenistic, fashion. Secondly, we want to address the implications of these challenges for staff from all disciplines and at all levels in forensic services – front-line staff, support workers, middle managers, consultant psychiatrists and senior managers. We also want to engage and involve service users and carers. Finally, we will describe current best practice within forensic services, acknowledging that not all services have achieved this, but also point towards the horizons of progressive practice within the criminal justice system and non-forensic mental health services.

2014

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Implementing Recovery through Organisational Change

A joint initiative from
Centre for Mental Health
Mental Health Network NHS Confederation

Briefing

11. Advocacy – a stepping stone to recovery

Karen Machin and Karen Newbigging

INTRODUCTION

This briefing paper examines the role of advocacy in empowering people to express their views and preferences and also their understanding of the meaning of mental distress. It provides an overview of the different types of advocacy, and the situations in which advocacy might be particularly important. It also addresses some of the misunderstandings surrounding the concept of advocacy. Finally, it outlines the contribution that advocacy can make to supporting and facilitating peoples' recovery and discusses the role of advocates compared with peer workers. The paper ends with a discussion of the ways in which mental health services and commissioners can better support the development of advocacy. It is aimed at people with lived experience, carers, advocates, mental health professionals, commissioners and all those with a stake in recovery-oriented mental health.

2015

ImROC

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12. 'Continuing to be me'[1] – Recovering a life with a Diagnosis of Dementia

Rachel Perkins, Laura Hill, Stephanie Daley, Mike Chappell and Jane Rennison

INTRODUCTION

The purpose of this briefing paper is to explore what 'recovery' might mean for those with a diagnosis of dementia.

Ideas about recovery have typically focused on younger adults, and have not considered people living with progressive conditions for which there is no known 'cure'. However, recovery is essentially the process of rebuilding your life following events that 'knock the bottom out of your world'. A diagnosis of dementia is certainly, for most people and those who are close to them, a devastating and life changing event. Images of a decent life with dementia are few and far between. In this briefing paper, our aim is to contribute to changing the narrative from 'living death' to 'living well': to show how many people have found ways of living a meaningful and fulfilling life with a diagnosis of dementia. Recognising some of the parallels between 'recovery focused practice' and ideas about 'person centred care', we explore what enables people to regain hope and live positively, maintain personal control and have the opportunity to do the things they value, remain a valued part of their community and participate not as victims, but as citizens.

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13. Co-Production – Sharing Our Experiences, Reflecting On Our Learning

Anna Lewis, Toni King, Lesley Herbert and Julie Repper

INTRODUCTION

There can be little doubt that the term 'co-production' has a growing profile in public services, and particularly within the mental health sector. Look at any conference programme, recent policy document, training event or even your Twitter feed, and it is likely that you will find mention of it. It features in the Five Year Forward View for Mental Health (2016), Prudent Health Care for Wales (Bradley & Willson 2014), the Scottish Co-Production Network and Learn to Lead in schools (Frost & Stenton 2010). The NHS is talking about it. Local Government is talking about it. Education is talking about it. Many have been working diligently and authentically to do it over many years. Others are just embarking on their journey and may feel overwhelmed by the challenges lying ahead.

So what is 'it' and why does it matter? Co-production offers a unique approach through which to interpret and address the challenges faced in our communities. It opens up opportunities we haven't yet spotted. It represents something fundamentally different in the way that relationships between services and communities are understood and developed. And yet this has not happened suddenly or dramatically. Slowly, people, communities, partnerships, groups are responding to shared challenges by evolving new ways of problem solving together.

2017

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14. Recovery: the Business case

Mike Slade[1], David McDaid[2], Geoff Shepherd[3], Sue Williams[4] and Julie Repper[5]

EXECUTIVE SUMMARY

This paper makes the Business Case for supporting recovery. We believe that this should be informed by three types of data: evaluative research (such as randomised controlled trials); the perceived benefits for service users – what might be termed 'customer satisfaction'; and best evidence about value for money.

Some of the ImROC 10 key challenges have a very strong research base. For example, there is substantially more randomised controlled trial evidence supporting the value of peer support workers (challenge 8) than exists for any other mental health professional group, or service model.

Similarly, the scientific evidence for supporting self-management (challenge 1) is compelling. Other challenges have a strong evidence base indicating that they improve people's experience of services. The positive experiences of students at Recovery Colleges (challenge 3) and the beneficial impact on experience of more involvement in safety planning (challenge 6) are clear.

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2 Associate Professorial Research Fellow, Personal Social Services Research Unit, London School of Economics and Political Science

3 Senior Consultant, ImROC

4 Senior Peer Trainer, CNWL Recovery and Wellbeing College

5 Director, ImROC

2017

Emergent findings from ImROC

We conclude that the principles of recovery can be operationalised...It depends on changing basic, everyday interactions between staff, service users and carers

NHS Confederation (2012) *Supporting recovery in mental health*, London: NHS Confederation.

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

Slade M et al (2017) *Recovery: the business case*, Nottingham: ImROC

REFOCUS

REFOCUS principles

1. Lived experience
2. Minority groups
3. Transdiagnostic

REFOCUS value 1

The primary goal of mental health services is to support personal recovery.

Supporting personal recovery is the first and main goal of mental health services. Providing treatment can be an important contribution towards this goal, but is a means not an end. Similarly, intervening in crisis or addressing risk issues may sometimes need to take precedence, but should be orientated around the primary goal of supporting recovery.

REFOCUS value 2

Actions by mental health professionals will primarily focus on identifying, elaborating and supporting work towards the person's goals.

If people are to be responsible for their own life, then supporting this process means avoiding imposing clinical assumptions about what matters, and instead offering support which is consistent with the person's values as they work towards their life goals.

REFOCUS value 3

Mental health services work as if people are, or (when in crisis) will be, responsible for their own lives.

It is not the job of mental health professionals to fix people, or lead them to recovery. The primary job is to support people to develop and use self management skills in their own life.

Exercise

Reflect on these values:

1. The primary goal of mental health services is to support personal recovery.
2. Actions by mental health professionals will primarily focus on identifying, elaborating and supporting work towards the person's goals.
3. Mental health services work as if people are, or (when in crisis) will be, responsible for their own lives.

Do you agree with them?

Do they contradict your values?

REFOCUS: building blocks

1. What is recovery?

2. How is recovery supported?

3. Measuring recovery

What is recovery?

CHIME Framework

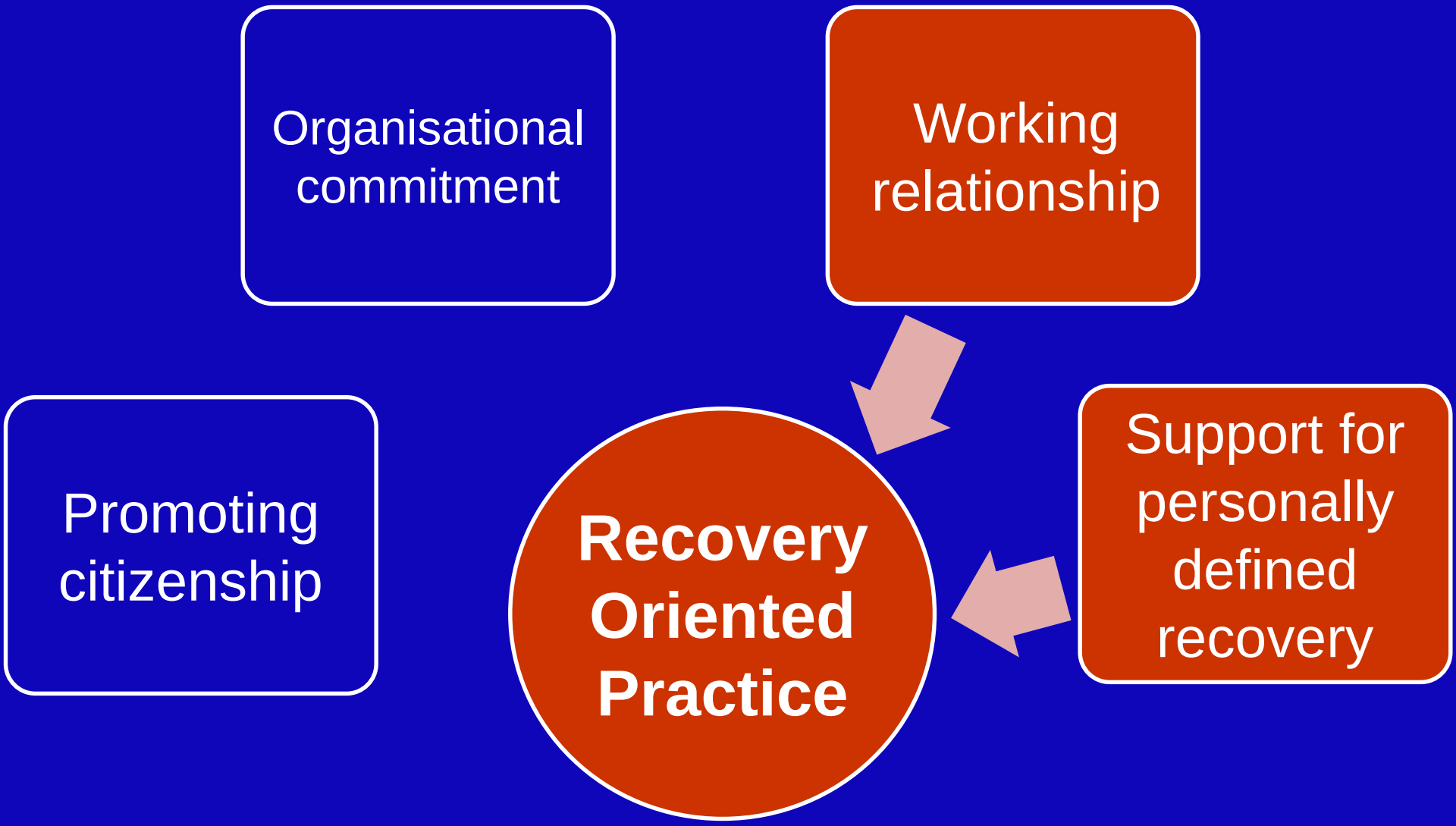
Leamy M et al (2011) *A conceptual framework…*, Br J Psychiatr, **199**: 445-452.

Cultural validity

Slade M et al (2012) *International differences…*, Epid Psychiatr Sci, **21**, 353-364.

Valid with current service users

Bird V et al (2014) *Fit for purpose?...* Aust New Z J Psychiatr, **48**, 644-653.



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.

Systematic reviews of measures

Strengths (n=12) Strengths Assessment Worksheet

Bird V, Le Boutillier C, Leamy M, Larsen J, Oades L, Williams J, Slade M (2012) *Assessing the strengths of mental health service users - systematic review*, Psychological Assessment, **24**, 1024-1033.

Recovery (n=33) QPR

Shanks V, Williams J, Leamy M, Bird V, Le Boutillier C, Slade M (2013) *Measures of personal recovery: systematic review*, Psychiatric Services, **64**, 974-980.

Measuring recovery support

Sources

7 bibliographic databases, web, experts, ToC, hand searching

Data

15,738 identified, 371 full papers retrieved, 13 measures identified, 6 included

Analysis

Rating against CHIME, psychometric quality criteria

Williams J et al (2012) *Measures of the recovery orientation of mental health services: systematic review*, Social Psychiatry and Psychiatric Epidemiology, **47**, 1827-1835.

Soc Psychiatry Psychiatr Epidemiol (2015) 50:777–786
DOI 10.1007/s00127-014-0983-0

ORIGINAL PAPER

Development and evaluation of the INSPIRE measure of staff support for personal recovery

Julie Williams · Mary Leamy · Victoria Bird · Clair Le Boutillier · Sam Norton · Francesca Pesola · Mike Slade

Received: 23 April 2014 / Accepted: 10 November 2014 / Published online: 20 November 2014

Abstract
Background No individualised standardised measure of staff support for mental health recovery exists.
Aims To develop and evaluate a measure of staff support for recovery.
Method Development: initial draft of measure based on systematic review of recovery processes; consultation ($n = 61$); and piloting ($n = 20$). Psychometric evaluation: three rounds of data collection from mental health service users ($n = 92$).
Results INSPIRE has two sub-scales. The 20-item Support sub-scale has convergent validity (0.60) and adequate sensitivity to change. Exploratory factor analysis (variance 71.4–85.1 %, Kaiser-Meyer-Olkin 0.65–0.78) and internal consistency (range 0.82–0.85) indicate each recovery domain is adequately assessed. The 7-item Relationship sub-scale has convergent validity 0.69, test–retest reliability 0.75, internal consistency 0.89, a one-factor solution (variance 70.5 %, KMO 0.84) and adequate sensitivity to change. A 5-item Brief INSPIRE was also evaluated.
Conclusions INSPIRE and Brief INSPIRE demonstrate adequate psychometric properties, and can be recommended for research and clinical use.

Keywords Recovery · Support · Measurement · Psychometrics

Introduction

Personal recovery has been defined as: 'a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.' [1]. It is different to clinical recovery which has traditionally focussed on symptom reduction and increasing functioning [2].

Supporting personal recovery has become a key aim for mental health services in many countries [3–5] and the clinical implications of this are emerging [6]. One challenge in supporting recovery is how this is measured [7]. There are published guidelines for how to support recovery, but a recent systematic review of measures of the recovery orientation of services concluded that there is an absence of standardised service user-rated measures of staff

2015

Support section

Please read each question and decide whether it is important to you or not. If you circle No then go to the next question.
If your answer is Yes, then circle the grey box to rate how much support you get from your worker.

An important part of my recovery is...			I feel supported by my worker with this...				
S1 Feeling supported by other people	No	Yes:	Not at all	Not much	Somewhat	Quite a lot	Very much
S2 Having positive relationships with other people	No	Yes:	Not at all	Not much	Somewhat	Quite a lot	Very much
S3 Having support from other people who use services	No	Yes:	Not at all	Not much	Somewhat	Quite a lot	Very much
S4 Feeling part of my community	No	Yes:	Not at all	Not much	Somewhat	Quite a lot	Very much
S5 Feeling hopeful about my future	No	Yes:	Not at all	Not much	Somewhat	Quite a lot	Very much
S6 Believing that I can recover	No	Yes:	Not at all	Not much	Somewhat	Quite a lot	Very much
S7 Feeling motivated to make changes	No	Yes:	Not at all	Not much	Somewhat	Quite a lot	Very much

Relationship section

Circle the option that best matches your relationship with your wo

R1 I feel listened to by my worker	Stongly disagree	Disagree	Neutral	Agree	Strongly agree
R2 I feel supported by my worker	Stongly disagree	Disagree	Neutral	Agree	Strongly agree
R3 I feel that my worker takes my hopes and dreams seriously	Stongly disagree	Disagree	Neutral	Agree	Strongly agree

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)

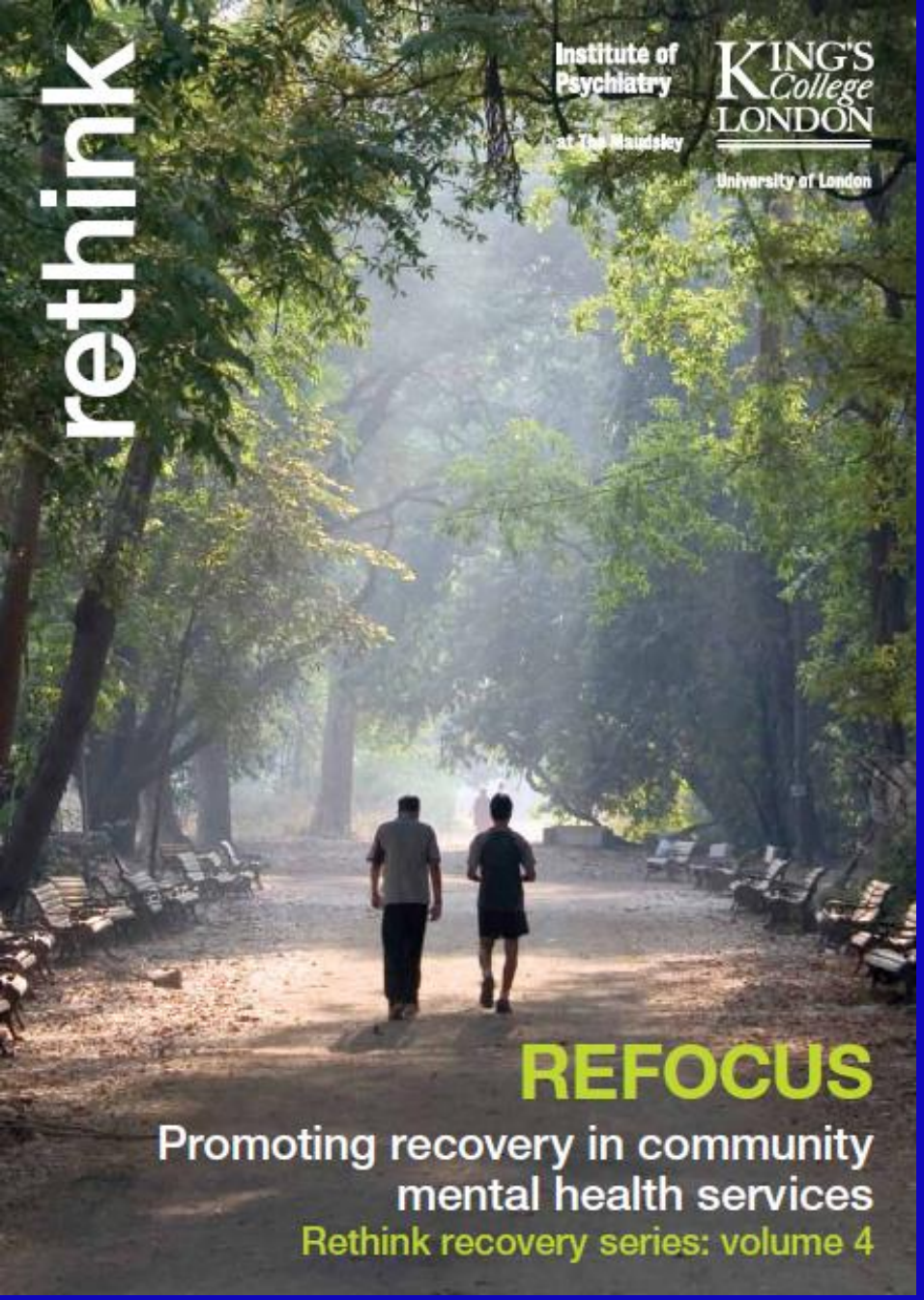
Circle the response that best fits how you feel your worker supports your recovery

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

REFOCUS development

1. Draft structure (4 core, 5 optional modules)
2. Consultation (56 experts)
3. Draft manual (Relationship, Support)

Slade M et al (2015) *Development of the REFOCUS intervention to increase mental health team support for personal recovery*, British Journal of Psychiatry, **207**, 544-550.



2011

Bird V et al (2011) *REFOCUS: Promoting recovery in community mental health services*, London: Rethink Mental Illness.

Free to download:
researchintorecovery.com/refocus

What is REFOCUS?

REFOCUS is an intervention for workers.

Aim: to increase recovery support for people with mental health problems

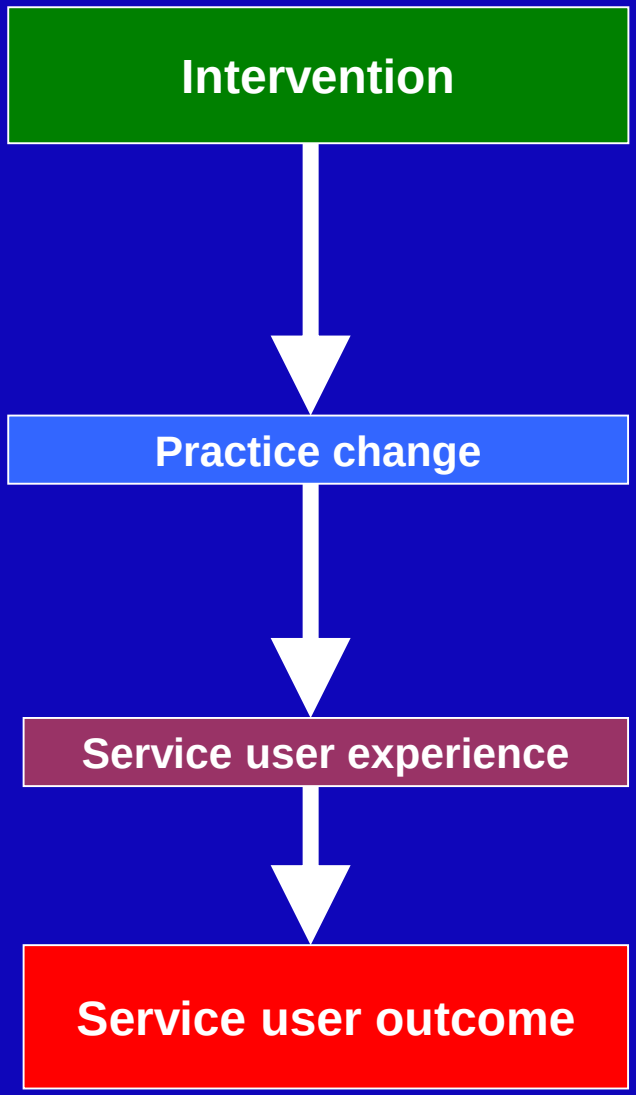
Involves: 3 Working practices

Coaching

Working Practices

1. Understanding values and treatment preferences
2. Assessing and amplifying strengths
3. Supporting goal-striving

REFOCUS Model



Relationships

Working practices
Values – Strengths - Goals

Values

Knowledge

Skills

Intent

Behaviour

Content

Process

Proximal
Hope – Empowerment - Quality of life

Distal
Personal recovery

Pragmatic cluster RCT

27 teams – 14 intervention, 13 control

Outcome evaluation

403 consumers, 532 staff

Process evaluation

37 consumers, 52 staff

Casenote audit

950 consumers x 7 time points

What did we find?

REFOCUS intervention has an impact on (a) standardised measures and (b) service user experience **when implemented** – and not when not implemented!

Supporting recovery in patients with psychosis through care by community-based adult mental health teams (REFOCUS): a multisite, cluster, randomised, controlled trial

Mike Slade, Victoria Bird, Eleanor Clarke, Clair Le Boutillier, Paul McCrone, Rob Macpherson, Francesca Pesola, Genevieve Wallace, Julie Williams, Mary Leamy

Summary

Background Mental health policy in many countries is oriented around recovery, but the evidence base for service-level recovery-promotion interventions is lacking.

Methods We did a cluster, randomised, controlled trial in two National Health Service Trusts in England. REFOCUS is a 1-year team-level intervention targeting staff behaviour to increase focus on values, preferences, strengths, and goals of patients with psychosis, and staff–patient relationships, through coaching and partnership. Between April, 2011, and May, 2012, community-based adult mental health teams were randomly allocated to provide usual treatment plus REFOCUS or usual treatment alone (control). Baseline and 1-year follow-up outcomes were assessed in randomly selected patients. The primary outcome was recovery and was assessed with the Questionnaire about Processes of Recovery (QPR). We also calculated overall service costs. We used multiple imputation to estimate missing data, and the imputation model captured clustering at the team level. Analysis was by intention to treat. This trial is registered, number ISRCTN02507940.

Findings 14 teams were included in the REFOCUS group and 13 in the control group. Outcomes were assessed in 403 patients (88% of the target sample) at baseline and in 297 at 1 year. Mean QPR total scores did not differ between the two groups (REFOCUS group 40·6 [SD 10·1] *vs* control 40·0 [10·2], adjusted difference 0·68, 95% CI –1·7 to 3·1, p=0·58). High team participation was associated with higher staff-rated scores for recovery-promotion behaviour change (adjusted difference –0·4, 95% CI –0·7 to –0·2, p=0·001) and patient-rated QPR interpersonal scores (–1·6, –2·7 to –0·5, p=0·005) at follow-up than low participation. Patients treated in the REFOCUS group incurred £1062 (95% CI –1103 to 3017) lower adjusted costs than those in the control group.

Interpretation Although the primary endpoint was negative, supporting recovery might, from the staff perspective, improve functioning and reduce needs. Implementation of REFOCUS could increase staff recovery-promotion behaviours and improve patient-rated recovery.

Funding National Institute for Health Research.

Lancet Psychiatry 2015

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See Online/Comment
http://dx.doi.org/10.1016/S2215-0366(15)00100-5

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2015

Soc Psychiatry Psychiatr Epidemiol (2016) 51:1275–1284
DOI 10.1007/s00127-016-1257-9

ORIGINAL PAPER

Service user experiences of REFOCUS: a process evaluation of a pro-recovery complex intervention

Genevieve Wallace[1] · Victoria Bird[2] · Mary Leamy[1] · Faye Bacon[1] · Clair Le Boutillier[1] · Monika Janosik[1] · Rob MacPherson[3] · Julie Williams[1] · Mike Slade[4]

Received: 24 November 2015 / Accepted: 15 June 2016 / Published online: 30 June 2016

Abstract

Purpose Policy is increasingly focused on implementing a recovery-orientation within mental health services, yet the subjective experience of individuals receiving a pro-recovery intervention is under-studied. The aim of this study was to explore the service user experience of receiving a complex, pro-recovery intervention (REFOCUS), which aimed to encourage the use of recovery-supporting tools and support recovery-promoting relationships.

Methods Interviews ($n = 24$) and two focus groups ($n = 13$) were conducted as part of a process evaluation and included a purposive sample of service users who received the complex, pro-recovery intervention within the REFOCUS randomised controlled trial (ISRCTN02507940). Thematic analysis was used to analyse the data.

Results Participants reported that the intervention supported the development of an open and collaborative relationship with staff, with new conversations around values, strengths and goals. This was experienced as hope-inspiring and empowering. However, others described how the recovery tools were used without context, meaning participants were unclear of their purpose and did not see their benefit. During the interviews, some individuals struggled to report any new tasks or conversations occurring during the intervention.

Conclusion Recovery-supporting tools can support the development of a recovery-promoting relationship, which can contribute to positive outcomes for individuals. The tools should be used in a collaborative and flexible manner. Information exchanged around values, strengths and goals should be used in care-planning. As some service users struggled to report their experience of the intervention, alternative evaluation approaches need to be considered if the service user experience is to be fully captured.

Keywords Recovery · Health service and population research · Process evaluation · Complex intervention

Introduction

2016

Rethink Mental Illness.

Institute of Psychiatry at The Maudsley

KING'S College LONDON

REFOCUS

Promoting recovery in mental health services

Free to download:
researchintorecovery.com

2014

How is REFOCUS implemented?

Four parts:

1. **Recovery and REFOCUS Workshop**
2. Working Practice training
3. REFOCUS Coaching for Recovery training
4. Support for practice change

Using REFOCUS in practice

The intervention involves

(a) Using coaching values and techniques in interactions with service users

(b) With a specific focus on values, preferences, strengths and goal-striving.

Working Practice 1

Understanding values and treatment preferences

Working practice 1: Theory

1. People are different!
2. Clinician's illusion
3. Traditional clinical assessment processes can inadvertently reinforce an identity as a patient, whereas if services are to be oriented around the individual (i.e. patient-centred) then the starting point for assessment needs to be a rich understanding of a person's identity.
4. Consistent with values-based medicine, this involves a strong focus on understanding what matters to the individual (i.e. their values) and what if any support they want from mental health services (i.e. their treatment preferences)
5. The aim is for recovery support to be a partnership process rather than 'something done to' the person.

Working practice 1: Understanding values and treatment preferences

- Learning more about the individual's life history – where does the person come from and what important influences have shaped their personality?
- Learning more about their rich identity – considering race, culture, ethnicity, gender, spirituality, sexual orientation, etc.
- Supporting the development of their personal narrative – what is their story about how they came to be where they are in their life?
- Understanding values – what matters to the person?
- Treatment preferences – what kind of help does the person want from both mental health services and other sources?

Exercise

How do you currently seek to understand:

- the person's values?
- where they come from?
- where they are going?
- what the person wants from services and you?

What works well?

What doesn't work well?

No feedback.

REFOCUS Approaches

1. Conversational
2. Narrative
3. Visual

Conversational approach – interview guide

Appendix 3: Values and Treatment Preferences (VTP) interview guide

Name of person using the service: _____

Name of worker: _____

VALUES

For each area ask: What would be helpful for me to know? What is important to you?

Cultural identity including race, culture and ethnicity
How would you describe your ethnicity? Prompts: language, parent's background...
Tell me a little bit about your self and your culture Prompt preferred diet, social life, cultural behaviours, beliefs, involvement with cultural group

Religion / spirituality
Is spirituality or religion important to you? Prompts: how, in what ways?
What is your spiritual / religious background?
How do your beliefs affect your feelings towards your mental health experiences?

Narrative approach – prompt questions

- Your life so far, including significant positive and negative life events
- What is important to you?, What things in your life do you value?
- How would you describe yourself to another person? E.g. your background, your values, beliefs and experiences
- How have your mental health experiences shaped your life?
- What makes your life meaningful?
- What has helped or would help you on your recovery journey?
- What things have had a negative effect on your wellbeing and recovery journey?
- How would you describe your mental health experiences, what have you learned from your experiences?
- I know people respect me when…

Visual approach – life mapping

Relationship Map

The relationship map can be divided into sections such as family, friends, community, and mental health staff or providers. People can place pictures or words of individuals who are important or close to them on the map.

Background Map

This map focuses on what life has been like for the person. Many people find it helpful to include a timeline usually from birth to the present time and record events and experiences which they feel have been significant. The timeline may include positive experiences and achievements as well as times of trauma, loss and grief.

Who am I? Map

This map may be used to find out about areas of a person's identity which are important to them and their treatment. Individuals may wish to include sections for ethnicity, gender, culture, spirituality etc. as well as other areas important to them. The VPT interview guide may be a useful tool for some people to help identify important areas to include.

Preferences Map

This map describes the person's personal preferences, interests and gifts. It may be linked to many of the other maps, particularly the Background and Who am I? maps. People should be encouraged to include what they like as well as dislike. Although this may be related to mental health services, this doesn't have to be the case.

Choices Map

One way to draw the Choices map is to divide a page into two, with one half representing the decisions the person makes in their life, with the decisions made by other people in the opposite half. This map could also be used to demonstrate areas in which individuals would like more control over their life, and the barriers they may face (re)gaining this control.

Respect Map

One question that may be included in this map is "I feel respected when…". It may also be used to highlight times when the person has and hasn't felt respected and to illustrate what the person respects and values about themselves and others. Some people may also chose to include barriers to respect in their maps.

Working Practice 2

Assessing and amplifying strengths

Working practice 2: Theory

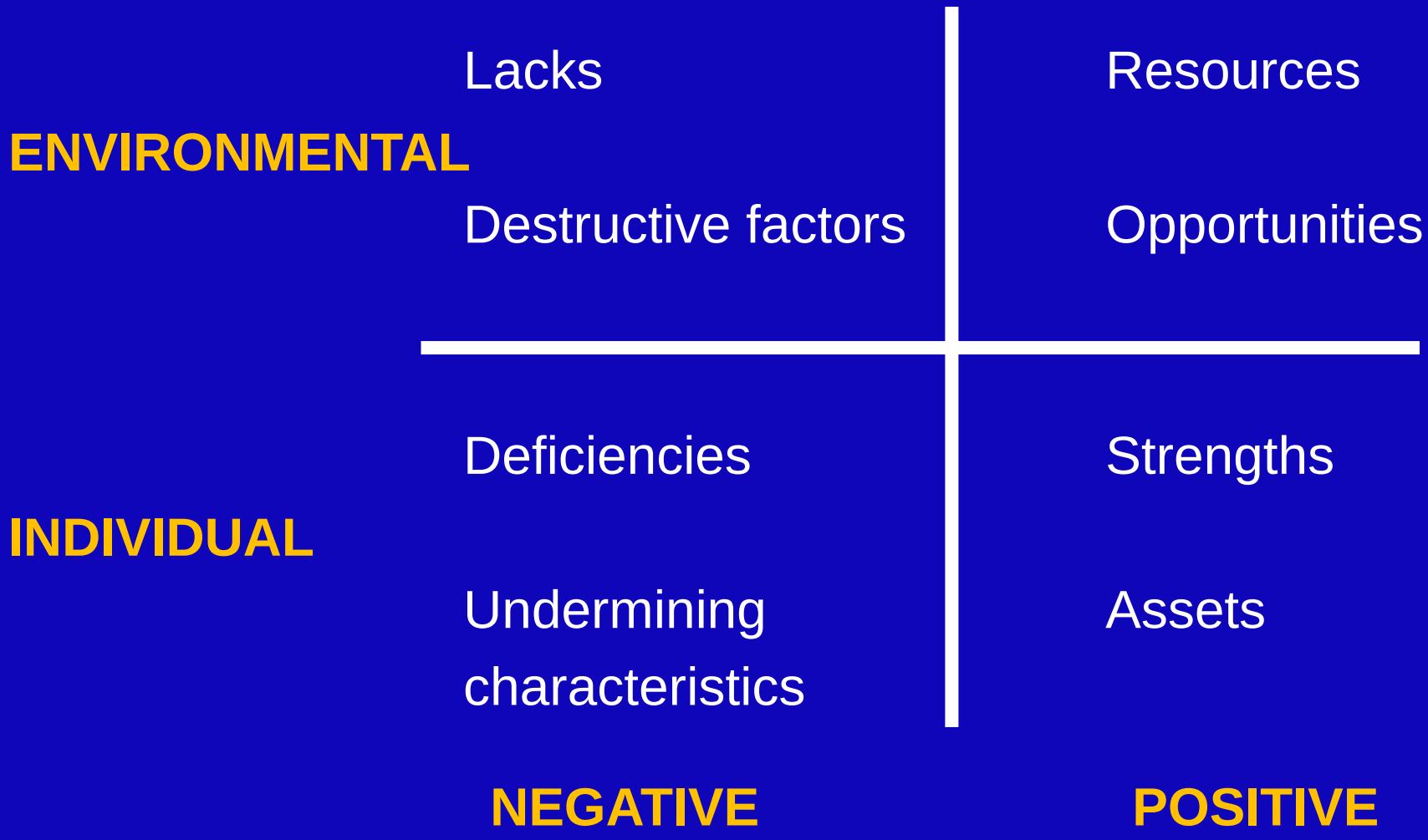
1. Health is more than the absence of illness

2. Amplifying strengths builds resilience

3. Focussing on strengths is associated with

- increased engagement
- increased goal-striving
- better recovery

Assessment quadrants



Wright B, Lopez S (2009) *Widening the diagnostic focus. A case for including human strengths and environmental resources*. In: Snyder C, Lopez S, eds. "Handbook of Positive Psychology, 2nd edition", New York: OUP. 71-88.

Exercise

Which quadrant(s) do your assessments focus on?

What do you currently do to notice and amplify strengths?

What works well?

What doesn’t work well?

No feedback.

Working practice 2: Assessing strengths

Appendix 5: Strengths worksheet

Name of person using the service: _____ Name of worker: _____

Currently What's going on today? What's available now?	**Desires and aspirations** What do I want?	**Personal and social resources** What have I used in the past?
Daily living situation		
e.g. Where are you living now? What things do you like about your current living situation? How do you get around?	e.g. Do you want to remain where you are, or would you like to move? If you could change anything about your living situation what would it be?	e.g. Where have you lived in the past? What was your favourite living situation? Why?
Financial		
e.g. What are your current sources of income, and how much money do you have each month to spend?	e.g. What do you want to happen regarding your financial situation?	e.g. What was the most satisfying time in your life regarding your financial circumstances?
Occupational e.g. educational, vocational, leisure		
e.g. What kind of things do you do that make you happy, and give you a sense of personal satisfaction?	e.g. What kind of activities or things would you like to do or be involved in?	e.g. What are the most satisfying activities that you have ever been involved in?

Working practice 2: Assessing strengths

Appendix 6: Strengths worksheet checklist

This checklist give some example prompt questions for areas to discuss in completing the Strengths Worksheet. The checklist has been adapted from elsewhere[9], and is not a definitive list of areas. Individuals have unique talents, interests and abilities which may not be covered by the below.

Daily living

Current situation:

- Where the person lives and for how long
- Does the person live with anyone else?
- Advantages of the person's living arrangements e.g. quiet neighbourhood, close to town
- Transport options
- Pets or animals
- Personal possessions available to the person (e.g. internet, exercise bike etc.) – this can be used to identify what is wanted

Personal and social resources:

- Past living arrangements
- What did the person like about past living arrangements?
- Favourite accommodation and living situation
- Anything from past living situations which the person would like to have now

Financial

Current situation:

- Sources of income

Working Practice 3

Supporting goal-striving

Principles

1. The person's goals are the primary focus of action planning
2. Approach goals are more achievable and sustainable than avoidance goals
3. Goal-striving is based on the person's values and treatment preferences
4. Goal-striving builds on strengths
5. Actions should be focussed on supporting the person to do as much as possible for themselves

Who is responsible?

Responsibility	n	%
Staff	4,977	70
Consumer	594	8
Staff and consumer	1,526	21
Carer	8	0
Staff and carer	29	0
Consumer and carer	21	0
Staff, consumer, carer	0	0
Total	**7,134**	**100**

Gilburt H, Slade M, Bird V, Oduola S, Craig T (2013) *Promoting recovery-oriented practice in mental health services: quasi-experimental mixed methods study*, BMC Psychiatry, 13, 167.

Exercise

What do you currently do to support people to strive towards their personally-valued goals?

What works well?

What doesn’t work well?

No feedback.

Four steps

1. Identify goals
2. Plan actions
3. Implement the plan
4. Review progress

REFOCUS Intervention

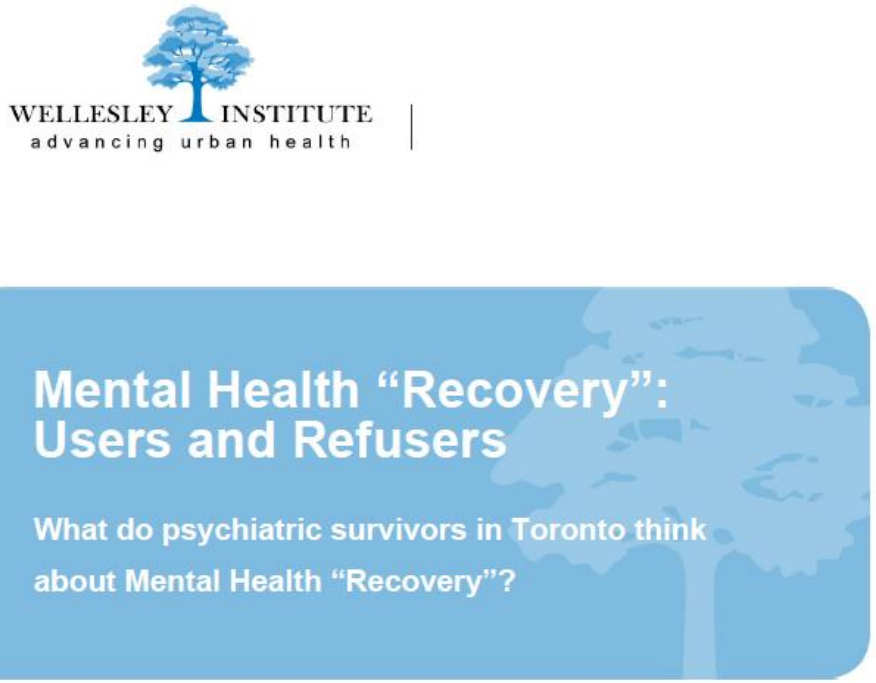
Support for personally defined recovery

1. Understanding values and treatment preferences
2. Assessing strengths
3. Supporting goal-striving

The international issue

How can we avoid ‘recovery’ being just the next thing that services do to people?

We need to do more than just ‘try the next thing’



Many argued that the original notion of "recovery" had been "hijacked" by professionals

2009


Come on! It can‘t go wrong every time...
PERSCHEID

Communication styles

1. Mentoring

Deegan G (2003) *Discovering recovery*, Psychiatric Rehabilitation Journal, **26**, 368-376.

2. Co-learning

Bock T, Priebe S (2005) *Psychosis seminars: an unconventional approach*. Psychiatric Services, **56**, 1441-1443.

3. Coaching

Green LS, Oades LG, Grant AM (2006) *Cognitive-Behavioural, Solution-Focused Life Coaching: Enhancing Goal Striving, Well-Being and Hope*, Journal of Positive Psychology, **1**, 142-149.

Why coaching?

1. It assumes the person is or will be competent to manage their life. The capacity for personal responsibility is a given
2. The focus is on facilitating the process of recovery to happen, rather than on the person.
3. Coaching is about how the person can live with mental illness, not on treating the mental illness
4. The role of the coach is to enable this self-righting capacity to become active, rather than to fix the problem for the person. This leads to strengths and existing supportive relationships being amplified
5. Effort in the coaching relationship is directed towards the goals of the person using the service, not the coach
6. Both participants must make an active contribution for the relationship to work

Coaching skills

- Contracting
- Exquisite listening
- Use of powerful questions
- Skills to challenge and confront
- Goal setting and goal striving
- Feedback

REFOCUS Coaching Conversations for Recovery

Participant Manual

Barbara Grey, Sheena Bailey, Mary Leamy, Mike Slade

September 2014

REFOCUS Coaching Conversations for Recovery

Trainer Manual

Barbara Grey, Sheena Bailey, Mary Leamy, Mike Slade

September 2014

2014

REFOCUS Intervention

Support for personally defined recovery

1. Understanding values and treatment preferences
2. Assessing strengths
3. Supporting goal-striving

Working relationship

- Coaching

The invitation

Give it a go!

What really struck me was when she [staff member] said 'oh I tried out one of these [REFOCUS] tools and I found that absolutely fantastic (laugh)'. She was totally onboard with it and I would not have expected that and getting her to use that. I think that shows how good the intervention was, I mean, she's not someone who would just do it. She's an open person as well, but she had set her mind against it [using REFOCUS tools] *but still in spite of that actually tried it out, and then was able to say 'oh yes, that was actually really helpful'*.

(Psychiatrist participant)

Thank you

More information

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