Module:

Mental Health in the Community

Week 4: Psychosocial approaches to care in the community

Topic 4: The recovery paradigm (Part 2 of 3)

Lecture transcript

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Slide 4

There are many empirically supported recovery-promoting interventions, which mean interventions that aim to promote the processes of recovery, namely connectedness, hope, identity, meaning in life, and empowerment. In this part of the lecture, we will look at peer support, wellness recovery action planning, illness management and recovery, and individual placement and support.

Slide 5

Peer support is an intervention that emerged from the survivor movement. The survivor movement gained prominence in the '70s when people with mental illness started to be more vocal and to protest against paternalistic, coercive, oppressive, and demeaning practices of mental health services. People who had survived the abuses from mental health services united to support each other and work towards healing. In this context, people's lived experiences started to be valued and heard. And those with successful recovery stories started to share those stories to inspire and help others with similar lived experiences. People with the lived experience of a mental health problem started to be considered experts by experience. As mentioned before, an experience that can inspire others. Peer support as a formal intervention, emerged in this context. Peer support is the support provided by a person with a mental illness to a person who also experiences mental illness. Peer support

providers use their lived experience to help others who also have a lived experience of mental health problems. Formal peer support can occur within peer-run services or within traditional mental health services.

Slide 6

There is a lot of confusion or lack of clarity regarding terminology related to peer support. People with the lived experience of a mental health condition supporting others with the lived experience are often called one of the following: peer workers, peer providers, peer support providers, peer supporters, or even peer support specialists. This lack of consensus related to terminology may be at least partially related to the different roles people with a lived experience can perform. Peers can perform a role otherwise performed by a mental health professional. For example, facilitating a particular therapy, or offer support as a separate or adjunct intervention. The intervention being peer support. In this context, peers share their own lived experience and their recovery story to support others with a similar lived experience. This role cannot be filled by a professional without the lived experience.

Slide 7

In 2016, Rita Cronise, myself, and colleagues at Boston University, and at the interNational Association of Peer Supporters, published results of a large US survey of peer support providers. We collected information about a variety of aspects of peer providers work life, the roles and tasks they perform, the training that they need to do to get certification, and also their satisfaction with their job. We obtained responses from around 600 peers. The most reported role was direct peer support, which can only be performed by a person with a lived experience. The second most reported role was a rehabilitation role. For example, case manager, employment specialist, and job coach, which can be performed by non peers.

Slide 8

We also collected information about peer satisfaction and also about their experience of stigma in the workplace. Peers mentioned to feel satisfied by the fact that they help others but also themselves through their roles. However, 40% mentioned to be dissatisfied with their pay. And around 20% expressed to be dissatisfied with the level of recognition of their role. More than 60% reported feeling discriminated by non-peer co-workers. And 30% reported feeling discriminated by leadership. Surprisingly, around 20% reported feeling stigma from the peers they supported. The most frequent forms of stigma and discrimination were related to inequality in compensation, job advancement opportunities, and hiring practices.

Slide 9

Despite the expansion of peer support, it is still not always clear how peer support is different from support provided by mental health professionals. In fact, peer support is often unspecified in empirical studies. However, the literature has identified some values that underpin peer support. Unlike professional support, peer support is characterised by the use of experiential knowledge rather than knowledge that is acquired through formal education. Peer support is based on reciprocity. It involves the development of a connection which is

grounded in shared experiences. It is bi-directional in the sense that both provider and receiver share their lived experiences. This bi-directionality is not common in clinician-patient relationships.

Slide 10

First and foremost, and as mentioned previously, peers use their own recovery story to help a peer recover with the premise that healed people help others heal. They share their recovery story and encourage the peer they are supporting to do the same. Peer providers encourage the peers they support to develop a recovery story instead of an illness story. They listen to others lived experiences and provide trauma informed emotional support. Peers are trained to acknowledge the role of trauma. As an example, questions should be framed as what happened to you, instead of what is wrong with you. They share what was helpful and what was unhelpful in their recovery journey. They identify beliefs and values that peers hold that work against their recovery. They recognise and are able to decide when and how much of their recovery story to share. This can vary between different stages of the recovery process and between the peers receiving support. They share their own tools for taking care of themselves. They help peers identify recovery goals. They promote a transformation of peers' dissatisfaction into motivation to set goals. They explain the shared decision-making process to help the peer prepare for a visit with a mental health provider. They teach peers to advocate for their rights.

Slide 11

A Cochrane review by Pitt and colleagues comparing peer workers or consumer providers utilising the author's terminology with professionals on similar roles found no significant differences in several outcomes such as quality of life and mental health symptoms. These findings suggested peers were no better or worse than other mental health workers. There was slightly less use of crisis services for those receiving care from peers. The authors also compared mental health services with and without peer support as an adjunct to professional care. And the findings were somehow discouraging since no differences were found. However, a recent meta-analysis by White and colleagues suggested that although one-to-one peer support does not seem to impact clinical outcomes such as symptomatology, it does seem to improve empowerment and personal recovery. Empowerment in the studies pooled was measured with standardised instruments that evaluate hope and whether individuals can access and make use of the health care and support they need. Pooled studies that assessed recovery measured domains such as personal confidence, willingness to ask for help, coping strategies, overcoming stuckness, self redefinition, well-being, and advocacy. Interestingly, the studies that contributed data to analysis of outcomes related to recovery and empowerment were studies of peer support offered as an adjunct or autonomous intervention. The studies comparing peer workers with other mental health workers performing a similar role have not contributed data for the analysis showing positive benefits in terms of recovery and empowerment. These results suggest a possible beneficial role, peer support as an autonomous intervention in itself, may have within mental health services.

Slide 12

The Wellness Recovery Action Plan whose commonly used acronym is WRAP was developed in the late 90s by people who were disillusioned with the mental health system. A peer called Dr. Mary Ellen Copeland surveyed other peers about their personal recovery strategies and tricks for feeling better. She then led an eight-day peer support retreat in Vermont, USA where participants discussed what help them to feel better. They discussed several strategies to maintain wellness. However, one of the participants, Jess Parker, noted that although these tools were indeed important she did not know how to implement or organise them in her daily life. This constatation gave impetus to the systematisation of these tools into the WRAP intervention which was co-developed by Mary Ellen Copeland and Jane Winterling.

Slide 13

WRAP, Wellness Recovery Action Plan is a group intervention facilitated by peers with the aim of promoting the development of a recovery plan. It typically comprises 8-10 sessions. WRAP provides a safe and non-judgmental environment where participants are encouraged to reflect about what strategies they used in the past and were helpful. They are also encouraged to consider strategies used by others. The goal is to create a wellness toolbox with tools that promote well-being and tools that help recognise and deal with triggers and stressors.

Slide 14

WRAP is considered an evidence-based program. A recognition that was made by the US Substance Abuse and Mental Health Services Administration. Evaluations of WRAP suggest benefits in several areas such as reduction in symptoms and increased quality of life and hopefulness. However, a meta-analysis published in 2019 showed that in comparison to inactive control conditions (inactive controls were a waiting list or treatment as usual comparison groups), WRAP was superior for promoting recovery outcomes which were measured by standardised measures such as the mental health recovery measure, but not superior for reducing psychiatric symptoms. This should not be seen as discouraging since WRAP is an intervention targeted at improving personal recovery rather than clinical recovery as discussed in the first part of this lecture. Also, this outcome also suggests the possibility of personal recovery without substantial decrease of symptoms. As postulated by Anthony in the 90s the possibility of living a satisfying life within the limitations imposed by the Illness.

Slide 15

So far, we have covered peer-led interventions. Now let's turn our attention to recovery promoting interventions that are mainly facilitated by clinicians. Illness Management and Recovery or IMR for short is a standardised intervention that as the name suggests aims to teach people with mental illness strategies to manage their illness and to help them achieve personally meaningful recovery goals. Illness management strategies are used to reduce symptoms and to improve functioning and quality of life. Recovery goals are broken down into smaller steps so that pursuing those goals is more manageable. IMR is a curriculum-based intervention composed of several modules delivered throughout several months, usually between six months to one year. IMR can be delivered in group or individually. Both

formats present benefits. IMR provided individually allows for a more personal focus, while the group format allows for opportunities to share experiences and also for social support.

Slide 16

On this slide we can see the modules that compose the intervention. Modules that compose the intervention include recovery, practical facts about mental illness, the stress vulnerability model, building social support, using medication effectively, drugs and alcohol, reducing relapses, coping with stress, coping with persistent symptoms, getting your needs met in the mental health system and living a healthy lifestyle.

Slide 17

Module 1 is dedicated to the discussion of recovery. In this module clients are encouraged to set personal goals and develop a plan to achieve them. However, it is important to note that some clients lack a goal orientation. They accept their current circumstances passively. The lack of goal orientation is protective for clients because it prevents them from having to deal with failure in case goals are not achieved. However, this also prevents them from taking control of their lives. Past disappointments where clients failed to achieve their goals or where other people set goals for them that they didn't want may lead clients to avoid setting goals in the present. So instead of discussing goals in the module a better strategy is to discuss the meaning of recovery for clients and which life areas they are satisfied with and which areas they are not satisfied with. The identification of the areas which clients are not satisfied with will create the opportunity for a conversation about goals.

Slide 18

Module 2 is dedicated to teaching facts about mental illness. Clinician and client will discuss symptoms associated with schizophrenia, bipolar disorder, major depressive disorder, or other disorder relevant to the client's situation. The clinicians will dispel myths about these mental health conditions and also make clients aware of people with these mental health problems who lead productive lives.

Slide 19

In Module 3 the clinicians will explain how the combination of stress and biological vulnerability may contribute to symptoms. Clinicians may also inform clients about treatment options.

Slide 20

Module 4 is dedicated to building social support. Clinicians teach strategies for increasing support such as conversation skills and places to meet people. Social skills training is an important component of this module. It involves learning interpersonal skills such as starting a conversation, expressing feelings, making a request and active listening.

Slide 21

Module 5 addresses the use of medication. In this module the clinician teaches the client about the benefits of taking medication but also about the side effects of medication. The clinician helps the client to weigh the pros and cons of taking medication.

Slide 22

Drug and alcohol use is discussed in Module 6. Clinicians teach clients about the interactions between alcohol, drugs, medication, and mental illness. If clients decide to stop using drugs or alcohol, the clinician helps the client develop a sobriety plan.

Slide 23

Module 7 is dedicated to reducing relapses. Clinicians discuss the fact that relapses are predictable and preventable. Relapse usually occurs gradually over several weeks. It is usually preceded by subtle changes in mood and behaviour. Relapse prevention training involves teaching clients to recognise triggers and warning signs.

Slide 24

In Module 8 and 9, clients learn strategies to cope with stress, problems and persistent symptoms.

Slide 25

In module 10, clients are taught to advocate for themselves in the mental health system.

Slide 26

The third edition of IMR also contains a module dedicated to living a healthy lifestyle. IMR participants are provided with information about exercise, nutrition, sleep, and other areas that may help them to live a healthier lifestyle.

Slide 27

Each module is taught throughout several sessions and makes use of educational, motivational, and cognitive behavioural strategies. The use of educational handouts in an interactive way, such as taking turns reading aloud or checking the client's understanding of the handout may facilitate learning. One of the most useful motivational strategies is connecting the client's goals to a skill being taught in the module. For example, if a client has the goal of living independently and is working on the module about building social support, the clinician can teach social skills which will be useful in this specific context. For example, doing a role-play about how to ask the landlord for help to fix a leakage in the house. The most commonly used cognitive behavioural strategies are reinforcement, modelling, behavioural rehearsal, and shaping (reinforcing successive approximations to the desired goal).

Slide 28

Randomised Controlled Trials or RCTs on the efficacy of IMR have mixed results. Some RCTs found improved illness self-management for clients that received IMR, and some RCTs reported no significant differences. These inconsistent findings may be related to model fidelity, which means the degree of adherence to the protocol and IMR completion. Recently, Roosenschoon and colleagues published an RCT with 187 outpatients receiving either IMR plus treatment as usual or treatment as usual only. Findings suggested that in comparison with the control group, the IMR group demonstrated improved illness self-management, and self-esteem. Also, findings suggest that completing the programme and fidelity in terms of its delivery, seem to be associated with better outcomes.

Slide 29

Individual Placement and Support, or IPS for short, is an evidence-based practice aimed at helping people with mental illness to get and keep a job in the mainstream competitive market. In the past, people with mental illness were generally considered unemployable. Those that were given the opportunity to work were placed in sheltered positions, created specifically for people with mental illness. The Individual Placement and Support Programme is an evidence-based supported employment programme to help people with mental illness to find and keep regular jobs. IPS is composed of several principles.

Slide 30

The first principle is that the goal of IPS is competitive employment, which means regular jobs in the community. The second principle is zero exclusion, which means that every person with mental illness who wants to work can receive IPS. In the past, people eligible for vocational rehabilitation services had to demonstrate that they met several eligibility criteria, such as readiness and a specific symptom threshold. In IPS, everyone that wants to work is given the opportunity to participate. The third principle is attention to client's preferences. The choice about the job pertains to clients only. The staff role is not to tell people what clients can or should do. Rapid job search is another characteristic of IPS. Unlike past practices where people would spend a very long time in assessments and training, IPS specialists help people with mental health problems to search for a job as soon as they express that they want to start looking for a job. The fifth principle is targeted job development. Based on client's preferences, IPS staff establish relationships with employers. They then introduce employers to job seekers who seem to be a good fit for the roles available. In the past, treatment services and vocational services would operate separately and contact between the teams was limited. A principle of IPS is to integrate employment services with mental health treatments. IPS staff help clients obtain personalised and clear information about how their disability benefits may be impacted by having a job. Finally, IPS staff provide individualised long-term support for as long as the client wants and needs it. In the past, vocational rehabilitation services would seize when the client got a job. This proved to be ineffective since many clients need support not only to get a job but also to keep a job.

Slide 31

There is strong evidence on the effectiveness of IPS in helping clients to obtain competitive employment. In 2020, Bond and colleagues published an update of the evidence on IPS. They reported that out of 28 RCTs that tested its effectiveness, 27 demonstrated better competitive employment outcomes for people who received IPS. In the 28 studies including thousands of people, 55 percent of people receiving IPS versus 25 percent of people receiving other vocational rehabilitation interventions obtained competitive employment.

Slide 32

In this part of the lecture, you were provided with an overview of four recovery-promoting interventions and their evidence base.