Home as part of the journey of recovery

Mike Slade

Professor of Mental Health Recovery and Social Inclusion
University of Nottingham

4 August 2016

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

Where has recovery come from?

Version 1: Modernisation

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.

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

Schizophrenia outcome: 20+ year follow-up

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.

Where has recovery come from?

Version 2: Lived experience

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.

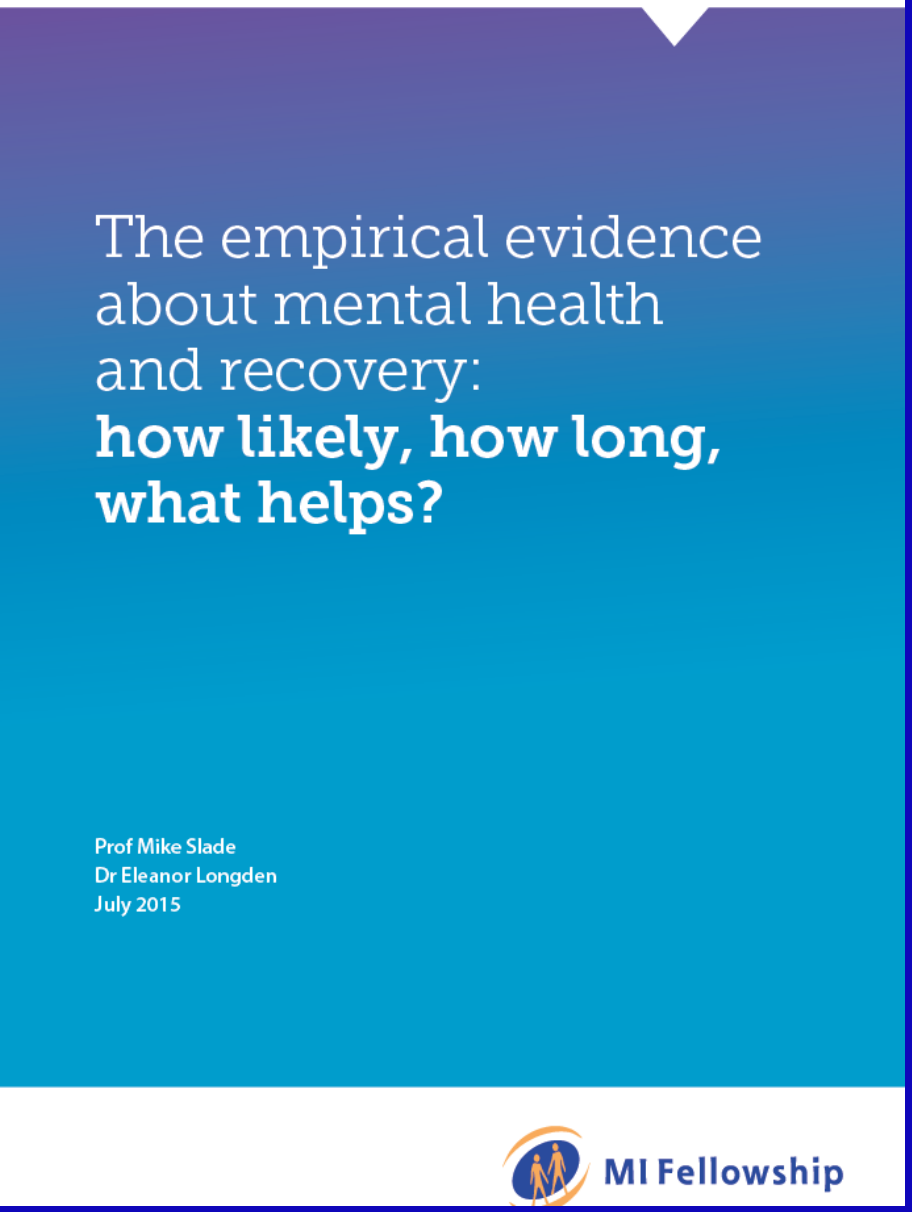
South London and Maudsley NHS Foundation Trust (2010) *Social Inclusion and Recovery (SIR) Strategy 2010-2015*, London: SLAM.

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.



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

2015 – free from researchintorecovery.com

Trajectories of Recovery Among Formerly Homeless Adults With Serious Mental Illness

Deborah K. Padgett, M.P.H., Ph.D., Bikki Tran Smith, M.A., M.S.W., Mimi Choy-Brown, M.S.W., Emmy Tiderington, M.S.W., Ph.D., Micaela Mercado, M.S.W., Ph.D.

Objective: Recovery from mental illness is possible, but individuals with co-occurring disorders and homelessness face challenges. Although a nonlinear recovery course is assumed, few studies have analyzed recovery over time. This mixed-methods study examined recovery trajectories over 18 months after enrollment in supportive housing programs of 38 participants with *DSM* axis I diagnoses.

Methods: Qualitative interview data were quantified through consensual ratings to generate a recovery score for four waves of data collection based on eight recovery domains culled from the literature. Case study analyses were conducted of participants whose scores varied by one standard deviation or more between baseline and 18 months to identify which domains were important.

Results: Most of the 38 participants (N=23) had no significant change in recovery; seven had a negative trajectory, and eight had a positive trajectory. Case studies of these 15 participants indicated domains that contributed to change: significant-other relationships (N=9), engagement in meaningful activities (N=9), mental health (N=7), family relationships (N=6), general medical health (N=5), housing satisfaction (N=5), employment (N=2), and substance use (N=1). Except for mental health and substance use (which contributed only to negative trajectories), the influence of domains was both positive and negative. Domains were intertwined; for example, variation in relationships was linked to changes in meaningful activities.

Conclusions: This study showed little change in recovery over time for most participants and a decline in mental health for a small minority. Findings underscore the importance of social relationships and meaningful activities among individuals with serious mental illness, who experience complex challenges.

Psychiatric Services 2016; 67:610–614; doi: 10.1176/appi.ps.201500126

2016

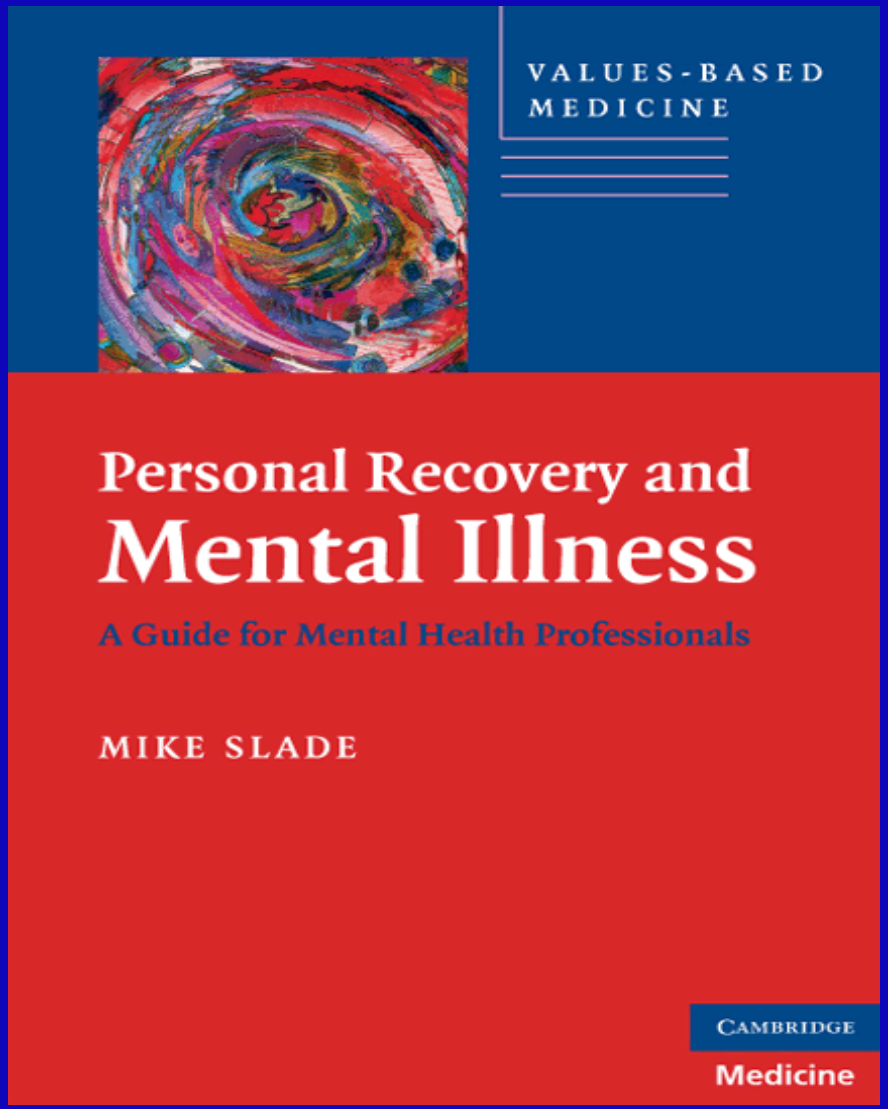
18-month outcome (n=35)

+ - Significant-other relationships
+ - Meaningful activities
  - Mental health
+ - Family relationships
+ - General health
+ - Housing satisfaction
+ - Employment
  - Substance use

Padgett D et al (2016) *Trajectories of recovery…*, Psychiatric Services, **67**, 610-614.

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

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



2009

Where is recovery now?

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.

Foresight five ways to wellbeing

1. Connect
2. Be active
3. Take notice
4. Keep learning
5. Give

Foresight Mental Capital Wellbeing Project (2008)

Mental Capital and Wellbeing: Making the most of ourselves in the 21st century, London: Government Office for Science.

Connectedness

What do people want?

Someone to love

Somewhere to live

Something to do

Something to hope for

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.

Interventions exist (collaboration, relationships, peers, control)

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

BMJ Open

The promise of recovery: narratives of hope among homeless individuals with mental illness participating in a Housing First randomised controlled trial in Toronto, Canada

Maritt Kirst,[1,2] Suzanne Zerger,[1] Deborah Wise Harris,[1] Erin Plenert,[1] Vicky Stergiopoulos[1,3]

2014

To cite: Kirst M, Zerger S, Wise Harris D, *et al*. The promise of recovery: narratives of hope among homeless individuals with mental illness participating in a Housing First randomised controlled trial in Toronto, Canada. *BMJ Open* 2014;**4**: e004379. doi:10.1136/bmjopen-2013-004379

► Prepublication history for this paper is available online. To view these files please visit the journal online (http://dx.doi.org/10.1136/bmjopen-2013-004379).

ABSTRACT

Objectives: Hope is widely embraced as an important factor in the recovery process. The role of housing in inspiring hope and facilitating recovery has been explored with homeless populations but is not well understood. This study explores perspectives on hopes for recovery and the role of housing on these hopes from the perspective of homeless adults experiencing mental illness participating in a multisite Housing First randomised controlled trial in Canada. The study draws on data from in-depth qualitative interviews with participants from the Toronto, Ontario site of the 'At Home/Chez Soi' Project.

Design: In-depth interviews were conducted with a subsample of participants from a larger Housing First randomised controlled trial.

Setting: The research took place in Toronto, Canada.

Strengths and limitations of this study

- Limitations of the study include that these findings reflect the experiences of individuals experiencing homelessness and mental health issues at one point in time.
- Findings emerged from a large sample embedded within a larger randomised controlled trial. Findings contribute to existing research in this area by highlighting that housing can activate the mechanism of hope, through which recovery for individuals experiencing homelessness and mental illness can be pursued.
- The study has emphasised that given the important role of hope, Housing First and other housing programmes need to explicitly integrate hope-inspiring, recovery-oriented approaches.

Housing is an integral factor that can facilitate hope and support dimensions of recovery

Identity

The problem of permanence

1. Who judges it?
2. It encourages giving up – consumers and workers
3. It makes stigma worse
4. It takes away hope
5. It reduces the chance to live well outside services
6. It maintains a world-view of mental health experiences as a problem to get rid of

The British Psychological Society
Promoting excellence in psychology

Division of Clinical Psychology

Inclusivity Strategy

2016–2018

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

2016

NATIONAL FINAL REPORT

Cross-Site At Home/Chez Soi Project

Mental Health Commission of Canada

Commission de la santé mentale du Canada

www.mentalhealthcommission.ca

2014

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

24-month outcome (n=1,198)

Scattered-site housing, rent supplements, ICM

% days stably housed

City	HF/CS	no HF/CS
A	63	30
B	73	24
C	74	39
D	77	32

Stergiopoulos V et al (2016) *Effect of scattered-site housing…*, JAMA, **313**, 905-915.

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

REFOCUS Intervention

Support for personally defined recovery

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

Working relationship

Coaching

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

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

Published Online
May 6, 2015
http://dx.doi.org/10.1016/S2215-0366(15)00086-3

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

King's College London, Health Service and Population Research Department, Institute of Psychiatry, Psychology and Neuroscience, Denmark Hill, London, UK (Prof M Slade PhD, V Bird BSc, E Clarke MBBS, C Le Boutillier MSc, P McCrone PhD, F Pesola PhD, G Wallace BSc, J Williams MSc, M Leamy PhD); **and 2Gether NHS Foundation Trust, Rikenell, Montpellier, Gloucester, UK** (R Macpherson MD)

Correspondence to:
Prof Mike Slade, King's College London, Health Service and Population Research Department, Institute of Psychiatry, Psychology and Neuroscience, Denmark Hill, London SE5 8AF, UK
mike.slade@kcl.ac.uk

2015

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

Empowerment


LANE CLOSED
TO EASE
CONGESTION

Slade M (2013) *100 ways to support recovery, 2nd edition*, London: Rethink Mental Illness

Free to download: researchintorecovery.com

Thank you

More information at researchintorecovery.com

Email: m.slade@nottingham.ac.uk