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Personal Recovery and Well-being
復元與全人健康

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Agenda

- What is recovery? (復元)
- Current recovery-oriented services (復元為本的服務)
- Importance of provider attitudes
  (服務提供者的態度的重要性)
- Relations between well-being and recovery
  (全人健康與復元的關係)
- Going beyond people with lived experience to the society(超越個人層面)
- Rights to health and well-being for all
  (健康權與全人健康)

Acknowledgments

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Rediscovery of Recovery

"Mental health recovery is a journey of healing(癒合旅程)and transformation enabling a person with a mental health problem to live a meaningful life (過著有意義的生活) in a community of his or her choice (選擇) while striving to achieve his or her full potential (充分發揮全部潛能)."

(SAMHSA, 2003)

Movement towards a Recovery-Oriented Mental Health System (發展復元為本的精神健康系統)

- Major themes in recovery research
  - recovery is possible and has been documented for over 30 years
  - recovery involves more than symptom reduction
  - recovery involves resumption of valued roles, well-being, self-esteem, etc.
  - recovery is a non-linear (起伏中的成長) and multi-dimensional (多面向) process
  - recovery is a highly individualized (個人化) process
  - recovery is dependent upon a fragmented, distracted and often unavailable series of services

(Anthony, Cohen, Farkas & Gagne, 2002)

Differences between Clinical and Personal Recovery

Clinical Recovery (recovery “from”)	Personal Recovery (recovery “in”)
Professional-led(專業人士主導)	Consumer-oriented (服務使用者為本)
Focus on the disorder(疾病)	Focus on the person (人)
Objectively defined, invariant across individuals (客觀,不變)	Subjectively defined, unique and deeply personal (主觀, 獨特)
Recovery as an objective outcome (結果) - symptom management - restoration of social and occupational functioning - relapse prevention	Recovery as a subjective process (進程) - developing meaning and purpose in life - achieving individual potential - reclaiming a positive sense of self

10 Guiding Principles of Recovery (SAMHSA, 2012)

RECOVERY-ORIENTED SERVICES (復元為本的服務)

Recovery-oriented services

"All services for those with a mental disorder should be consumer oriented (服務使用者為本) *and focused on promoting recovery* (促進復元). *That is, the goal of services must not be limited to symptom reduction but should strive for restoration of a meaningful and productive life* (有意義和豐盛的生活)."

(U.S. Department of Health and Human Services, 1999, p. 455)

Recovery-oriented services

- Identify and build upon each individual's assets (資產), strengths (優勢), and areas of health and competence (健康與能力)
- Support the person in managing his or her condition
- Help one to regain a meaningful, constructive, sense of membership in the broader community

(Davidson et al., 2005)

Differences between traditional and recovery-oriented services (Slade, 2009）

Traditional approach 傳統模式	Recovery approach 復元模式
Professional accountability (專業責任)	Personal responsibility (個人責任)
Scientific (科學)	Humanistic (人文)
Control oriented (控制導向)	Oriented to choice (選擇導向)
Deficit based (強調缺陷)	Strength based (重視優勢)
Provider-driven (服務提供者主導): service providers as experts, authorities, initiators and directors in service planning and delivery	Shared decision making (共同參與決策): collaboration and partnership between service providers and service users

Multi-level Transformation within the System for Recovery-oriented Practice
服務系統轉型

1) Vision and persistent leadership (願景和持續的領導)
2) Consumer inclusion and involvement (服務使用者的參與)
3) Integrate recovery-oriented ideas into clinical practice (將復元為本的理念融入臨床實踐)
4) Provide the right level of service at the right time (在合適的時間提供適當的服務)
5) On-site staff recovery training and support (工作人員的復元培訓和支援)
6) Hire recovery-oriented people (聘用復元為本的人)
7) Outcome driven learning and continued quality improvement (成果導向的學習和持續的質量改進)

(Olmos-Gallo, Starks, Lusczakoski, Huff, & Mock, 2012)

Eight Practice Standards for Recovery-oriented Services

(Cohen & Galea, 2011; Davidson et al., 2009)

1. Primacy of participation (參與的重要)

- participation of people in recovery and their significant others in all aspects and phases of service delivery

2. Promoting access and engagement (促進進接與參與)

- promote access to swift and easy to receive, barrier-free services
- engage the person, not the diagnosis or disability

Eight Practice Standards for Recovery-oriented Services

(Cohen & Galea, 2011; Davidson et al., 2009)

3. Ensuring continuity of care (確保服務的連貫性)

- treatment, rehabilitation and support should not be offered through serial episodes of disconnected care by different practitioners
- designed as a holistic system of care that ensures continuity of services by constant healing relationships

4. Employing strength-based assessment (採用重視個人優勢的評估)

- help people in recovery to identify their strengths and capabilities beyond their symptoms, deficits, or impairments

Eight Practice Standards for Recovery-oriented Services

(Cohen & Galea, 2011; Davidson et al., 2009)

5. Offer individualized recovery planning
(提供個人化的復元計劃)

- recovery plans need to be person-centered and developed in full collaboration with people in recovery

6. Functioning as a recovery guide
(作為復元的指導)

- support people in recovery with tools that they can use during their whole recovery process

Eight Practice Standards for Recovery-oriented Services

(Cohen & Galea, 2011; Davidson et al., 2009)

7. Conducting community mapping, development, and inclusion (開展社區作圖、發展和共融)

- community resources and capacities are mapped out to identify possible places where people in recovery will be welcome and valued (e.g., peer community navigators)

8. Identifying and addressing barriers to recovery

(辨認和處理對復元的障礙)

- equip people in recovery with the knowledge and skills needed to locate the barriers to recovery, both in the mental health care system and within the community

“Don’t let procedure get in the way of humanity”

(Rethink, 2010)

STRENGTH-BASED APPROACH
(重視個人優勢的模式)

Differences between Deficit-based and Strength-based Approach

Deficit-based approach 強調缺陷的模式	Strength-based approach 重視優勢的模式
Focus on the weaknesses, problems, dysfunctions, and pathologies of individuals	Focus on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals
what is “wrong” with people	What remains “right” with people
Allow individuals to see their deficiencies and limitations	Allow individuals to view opportunities, capacities, and hopes for growth and change

Implications of Strength-based Approach on Service Delivery

"The failure of an individual to display competencies or strengths is not necessarily attributed to deficits within the person, but may rather, be due to the failure of service system or broader community (服務系統和社區的缺失) to adequately elicit information in this area or to create the opportunities and support (創建機會和支持) needed for these strengths to be displayed (彰顯優勢)"

(Davidson et al., 2009, pp. 105-106)

Implementing Strength-based Assessment

- Acknowledge that people in recovery are the experts on their own recovery (自己是自己的復元專家)

- Involve in-depth discussion of personal strengths (個人優勢的討論)
  - ask people what has worked for them in the past and incorporate these ideas in the recovery plan

- Consider the strengths and resources within people in recovery's family, social network, service system, and community (考慮家庭，社會網絡，服務系統和社區中的優勢和資源)

(Davidson et al., 2009)

Implementing strength-based assessment

- Interpret perceived deficits and limitations within a “strength and resilience” framework (優勢和心理抗逆力的框架)
  (Davidson et al., 2009)

- Aware of the language used (留意語言使用)
  - employ empowering and person-first language
  - avoid the eliciting of pity or sympathy
  - never use stigmatizing and objectifying language (e.g., “case”, “schizophrenic”)

PERSON-CENTERED CARE PLANNING (PCCP)
以人為本的個人復元計劃

Person-centered Care Planning

- Collaborative process between clients and service providers (服務使用者和提供者之間的協作過程) in the development and implementation of individualized service plans (個人化服務計劃) that:
  - are congruent with clients' needs, preferences, experiences and background
  - build on clients' strengths rather than weaknesses in the process
  - enable clients in achieving their unique, personal goals along the journey of recovery

(Tondora, Miller, & Davidson, 2012)

Basic Components of PCCP

1) Primary direction in the planning process coming from the individual (以復元人士為主導)
2) Involvement of significant others and reliance on personal relationships as the primary source of support (人際關係)
3) Focus on capacities and assets (注重能力和資產) rather than on limitations and deficits
4) Emphasis on promoting access to integrated community settings (共融的社區環境) rather than settings designed for people with disabilities
5) Acceptance of uncertainty, setbacks, and disagreements (接受不確定性、挫折和分歧) as natural elements in the path to self-determination

(Borg, Karlsson, Tondora, & Davidson, 2009; O'Brien, & Lovett, 1992)

Implementing PCCP

Discussion of goals (討論個人目標)

- Engage people in recovery in discussing and identifying the things that are important to them and what they want out of the life
  - clinical treatment goals
  - personal goal for employment, education, and social life
- Discuss with people in recovery about the ways to pursue their goals
- Ensure that their goals are used as the basis for the person-centered care plan

Implementing PCCP

Development of care plan (制定服務計劃)

- Diverse, flexible range of resources are available so that people in recovery can choose support that will best assist their recovery (Davidson et al., 2009)
- Shared decision-making on individual treatment and services
- Lay down the plan with specific procedures and clear timelines

Implementing PCCP

Regular review (定期檢討)

- Review the care plan on regular basis as the goals and needs of people in recovery vary over time
- Evaluate whether people in recovery are following and improving progressively with the plan
- Update the procedures and plan if needed

WELLNESS RECOVERY ACTION PLANNING (WRAP)
身心健康行動計劃

WRAP (Copeland 2002)

- Most widely disseminated consumer-led illness self-management (服務使用者主導的自我健康管理) recovery program
  - (1) identification of personalized wellness tools from which one can draw upon in daily life
  - (2) creating a “daily maintenance activities” list that helps one to stay emotionally and physically healthy
  - (3) recognition of “triggers” to prevent crisis
  - (4) addressing the “early warning signs”
  - (5) development of their own action plan when things are not going well
  - (6) crisis plan
  - (7) post-crisis plan

Evidence of WRAP in the USA

- Effective in enhancing
  - **self-advocacy** (自我倡導) (Cook, Floyd, Copeland, Hudson, Hamilton, Macfarlane, Jonikas, Grey, & Razzano, 2009; Jonikas, Grey, Copeland, Razzano, Hamilton, Floyd, Hudson, & Cook, 2011)
  - **hope** (希望) (Cook et al., 2009; Cook, Copeland, Corey, Buffington, Jonikas, Curtis, Grey, & Nichols, 2010; Starnino, Mariscal, Holter, Davidson, Cook, Fukui, & Rapp, 2010; Fukui, Starnino, Susana, Davidson, Cook, Rapp, & Gowdy, 2011)
  - **recovery** (復元) (Cook et al., 2009; Starnino et al., 2010) and **physical health** (Cook et al., 2009) (身體健康)
  - reducing **psychiatric symptoms** (減輕症狀) (Fukui et al., 2011)
  - no significant change in social support (Cook et al., 2009)
  - significant increase in the awareness of early warning signs, symptom triggers, use of wellness tools, having a plan for crisis, symptom management, social support system, and increased responsibility to ones' own wellness (Cook et al., 2010)
- First RCT showed
  - Improvement in **hope** (希望) (Cook, Copeland, Jonikas, Hamilton, Razzano, Grey, Floyd, Hudson, Macfarland, Carter, & Boyd, 2012a), **recovery** (復元) (Cook et al., 2012b), **quality of life** (生活質素) (Cook et al., 2012a), reduction in **symptoms** (減輕症狀) (Cook et al., 2012a; Cook, Razzano, Copeland, Carter, Floyd, Hudson, Jonikas, Grey, Hamilton, & Boyd, 2012b)

PEER SUPPORT SERVICES (PSS)
朋輩支援服務

Peer Support Services

- Peer support workers (朋輩支援工作員)
  - people who have personal experience of mental health problems are employed as service providers in the mental health system (Gates & Akabas, 2007)
  - work within clinical and rehabilitative settings (e.g., hospitals and community mental health centers) as part of the services team within the regular organizational structure
- Use their own knowledge and lived experience to support other persons in recovery, so as to complement professional services (Bradstreet, 2006)
- Having peer support services alone does NOT make a service system recovery-oriented

Roles of Peer Support Workers

- Share lived experiences and recovery stories (分享過來人經驗和復元故事) to instill hope and role modeling
- Demonstrate empathic listening (主動傾聽復元人士的感受)
- Enable peers to make independent choices and work on the objectives of their recovery plan (作出獨立的選擇及定立復元計劃目標)
- Provide socio-emotional support, frequently coupled with instrumental support (社交情緒支援)

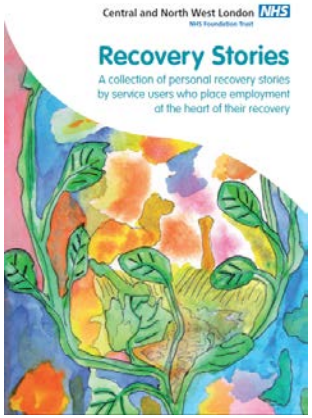
(Solomon, 2004)

Personal Stories 復元故事

- Reclaim one's identity (重申個人身份)
- Reconstruct one's experience (重建個人經驗)
- Instill hope (灌輸希望)
- Set role models (設立榜樣)
- Promote self-care and responsibility (促進自我照顧和責任)
- Connect people (連繫他人)

Story Telling 敘述故事

- In written form (書寫形式)



- Through paintings (繪畫)

[Bobby Baker's diary drawings of her journey through mental illness](http://www.youtube.com/watch?v=ZQjHeXCXpug) (http://www.youtube.com/watch?v=ZQjHeXCXpug)

Benefits of PSS for Service Recipients
朋輩支援服務的效益

Personal aspect (個人方面)**:**

1. Reduce self-stigma (減少自我污名) (Ochocka, Nelson, Janzen, and Trainor, 2006)
2. Increase sense of hope (增加希望) (Davidson et al., 2006)
3. Enhance self-esteem and empowerment (增強自尊和充權) (Corrigan, 2006)
4. Improve quality of life (提高生活質素) (Davidson et al., 1999)

Benefits of PSS for Service Recipients
朋輩支援服務的效益

Social aspect (社交方面)**:**

1. Enhance interpersonal skills (增強人際交往能力) (Forchuk, Martin, Chan, & Jensen, 2005)
2. Improve social functioning (提高社交功能) (Kurtz, 1990)
3. Promote social integration (促進社會融合) (Ochocka et al, 2006)
   - enlarge social networks
   - reduce social isolation

Benefits of PSS for Service Recipients
朋輩支援服務的效益

Clinical aspect (臨床方面)**:**

1. Stabilize participation in treatment 穩定治療過程的參與 (Sells et al., 2006)
   - build trust and engage people in recovery in the process of active participation (Repper & Carter, 2011)
2. Symptom reduction 減輕症狀 (Davidson et al., 1999)
3. Lower rates of re-hospitalization 減低再住院率 (Forchuk et. al, 2005)

Benefits of PSS for Peer Support Workers
朋輩支援服務的效益

- Develop new knowledge and skills (開發新的知識和技能)
- Enhance confidence and self-esteem (增強自信和自尊)
- Foster empowerment (促進充權)
- Promote own recovery (提高個人復元)

(Salzer & Shear, 2002)

IMPORTANCE OF PROVIDER ATTITUDES
服務提供者態度的重要性

Mindset and Attitudes of Providers
服務提供者的心態及態度

- For a system to be successfully transformed to be recovery-oriented, changing the services are not enough
- Providers must have a recovery-oriented mindset (復元為本的思維) and treat each person in recovery with respect and dignity (以尊重和尊嚴對待) that s/he is entitled to as a human being, just like everyone else

Provider Stigma and Recovery
服務提供者對復元人士的污名

Participants:

- 374 people in recovery of mental illness (50.1% male) with a mean age of 43.47 years old (SD = 12.76)
- The majority (42.8%, n = 160) was diagnosed with mood disorders, followed by substance abuse (33.2%, n = 124) and psychotic disorders (24.1%, n = 90)
- They had a mean duration of mental illness of 7.19 years (SD = 7.76)

Method:

- Cross-sectional questionnaire

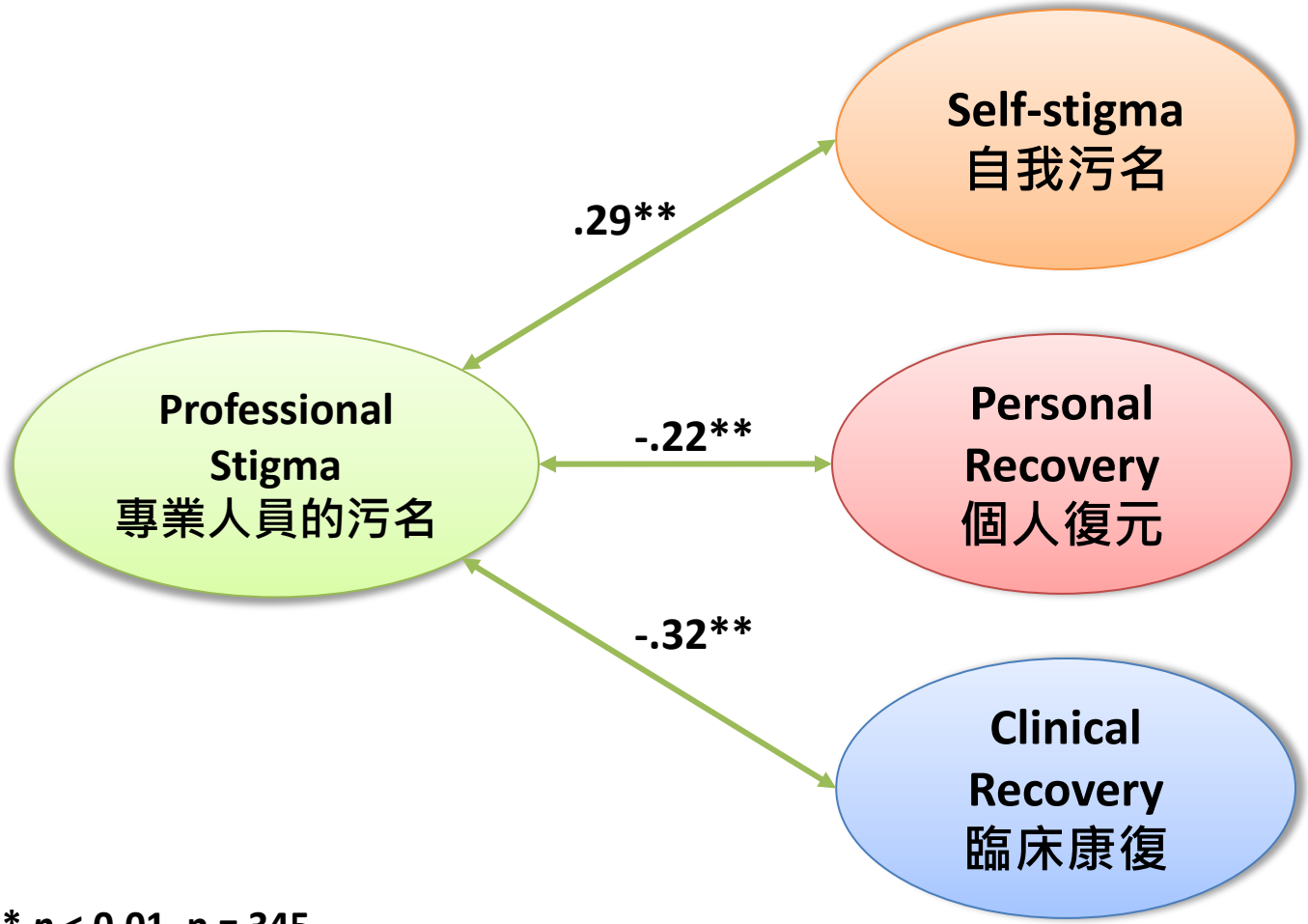
Discrimination experienced by People in Recovery 復元人士被歧視的經驗

The greatest source of stigma was from healthcare professionals

Have you been discriminated by the following individuals? 有否曾經受到以下人士歧視?	Mean (SD)	Disagree 不同意	No comment 沒有意見	Agree 同意
Teachers 教師 (n=235)	3.13 (1.24)	37.0%	22.6%	40.4%
Colleagues 同事 (n=295)	3.17 (1.34)	40.3%	12.2%	47.5%
Employers 雇主 (n=294)	3.20 (1.33)	38.8%	12.6%	48.6%
Police 警察 (n=296)	3.28 (1.38)	35.5%	14.2%	50.3%
Healthcare professionals 專業醫護人員(n=336)	3.59 (1.44)	26.5%	8.9%	64.6%

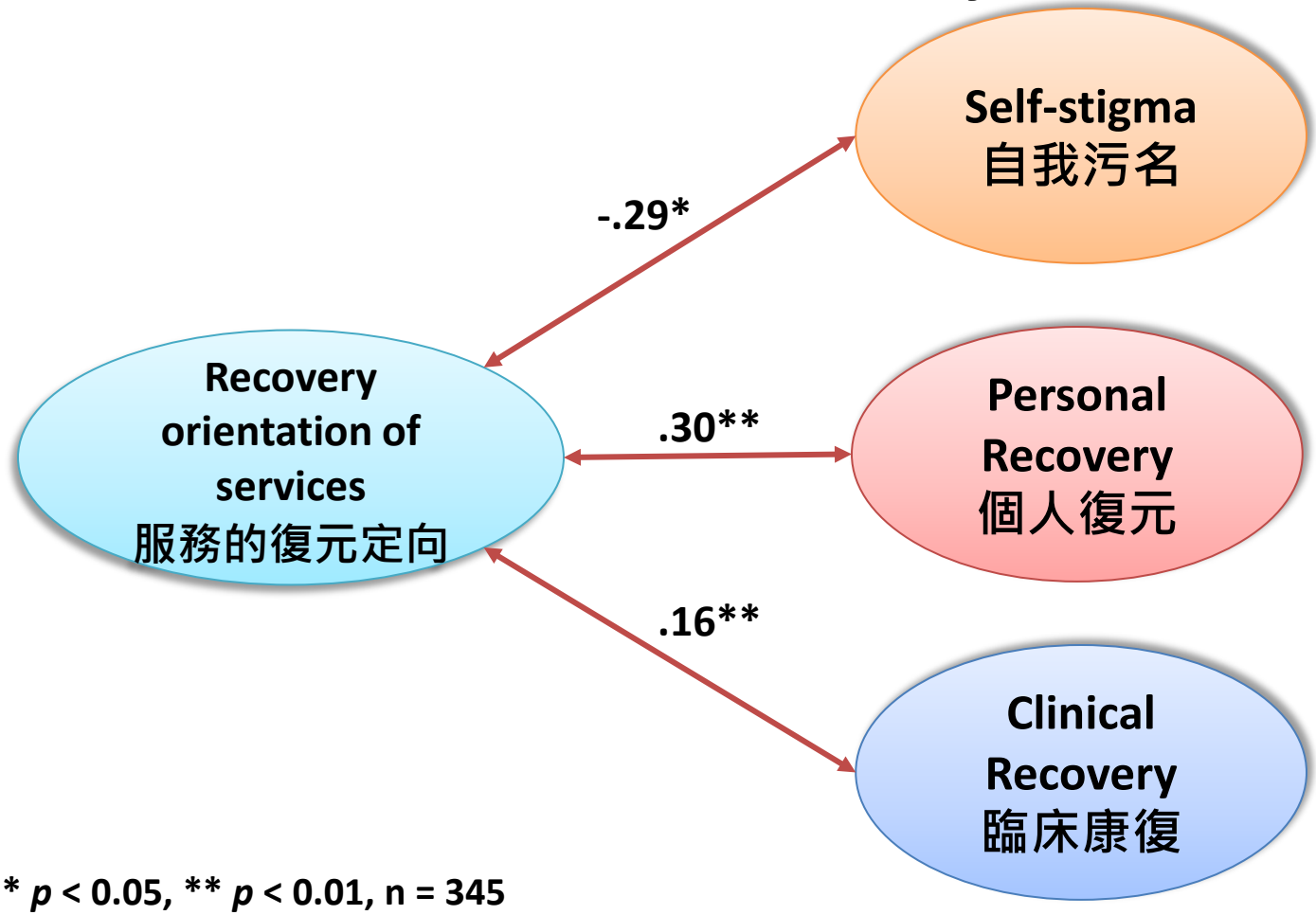
Note: The scale was rated on a 5-point scale from 1 (strongly disagree) to 5 (strongly agree), with the additional option of not applicable.

Professional Stigma and its relationship with Self-stigma, Personal Recovery and Clinical Recovery



Notes: ** $p < 0.01$, n = 345

Recovery Orientation of Mental Health Services and its relationship with Self-stigma, Personal Recovery and Clinical Recovery



Notes: * $p < 0.05$, ** $p < 0.01$, n = 345

RECOVERY AND WELL-BEING
復元與全人健康

Well-Being

- Mental health is defined as *"not just the absence of mental disorder"*, but *"a state of well-being in which individual realizes his or her own abilities, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community "* (WHO, 2001).

- 精神健康定義為「不單是沒有精神病」而且「個人應處於健康狀態，能認識到自己的能力，能處理一般的生活壓力，能有效率地、有成效地工作，亦能貢獻其所屬的社區。」

World Health Organization

Dimensions of Well-Being

- **Emotional well-being** (情緒健康)
  - Positive feelings of happiness and contentment (正向的情感，感覺到愉悅、滿足)
- **Psychological well-being** (心理健康)
  - Actualizing one's potential and contributory to society (能夠實踐自我潛能、貢獻社會)
- **Social well-being** (社交健康)
  - Feeling connected with meaningful social networks (感受到能與有意義的社交網絡互相連繫)

Well-being is not the absence of mental illness
(心理健康不是沒有精神病)

Two continua model of mental health (Keyes, 2003)

World Health Organization

Well-Being

"Mental health and well-being (精神健康與全人健康) *are fundamental to our collective and individual ability as humans to think, emote, interact with each other, earn a living and enjoy life.*

On this basis, the promotion, protection and restoration of mental health can be regarded as a vital concern of individuals, communities and societies (個人、社區和社會的關注) *throughout the world."*
(WHO, 2014)

Recovery and Well-Being

Participants

- 64 people in recovery of mental illness (53.1% male) with a mean age of 31.61 years old (SD = 11.28)
- They were all diagnosed with schizophrenia spectrum disorders with a mean duration of 2.45 years (SD = 1.77)

Methods:

- Semi-structured interview, role functioning assessment, and questionnaire

Clinical, Functional and Personal Recovery on Well-being

Block 1: Clinical Recovery (臨床康復)
- Positive symptoms of psychosis
- Negative symptoms of psychosis *

Block 2: Functional Recovery (功能康復)
- Social and occupational functioning

Block 3: Personal Recovery (個人復元) *
- Recovery orientation of the personal narrative

Well-being
全人健康

Adjusted R^2: 12%

***Note*: * $p < 0.05$, n = 64**

BEYOND INDIVIDUAL LEVEL APPROACHES
超越個人層面

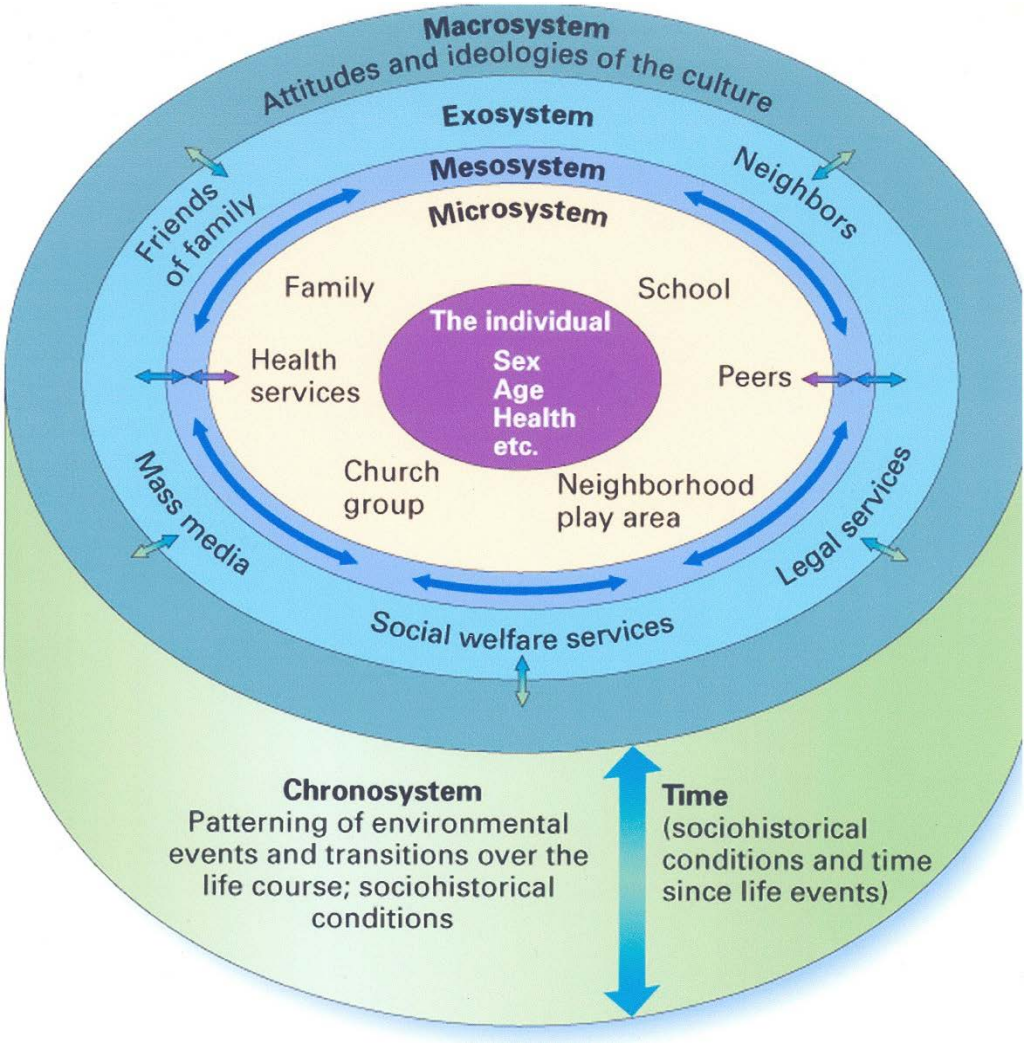
Melbourne Charter (2008)

“Mental health and well-being are determined by multiple and interacting social, environmental, psychological and biological factors (由多個相互影響的社會、環境、心理和生理因素所決定)*, just as health and illness in general are determined .”*

Ecological Model of Well-Being (生態系統理論)

Identify protective and risk factors for cultivating positive well-being in the community

Community-based approaches (社區為本模式)



Bronfenbrenner (1979)

Population-based, Community-level Approaches
以人口群體為基礎的社區層面模式

- **Intersectoral efforts** (跨領域的合作) (i.e., education, housing, mental health services, employment and industry, transport, arts, sports, urban planning and justice)

- **Principles of public participation, engagement, and empowerment** (公眾參與和充權)

- **Action in everyday contexts** (日常環境中介入) (i.e., schools, workplaces, sports clubs, community-based activities, government services, and the natural environment beyond the mental health system)

RECLAIMING OUR RIGHTS TO HEALTH
重申我們的健康權

The Right to Health 健康權 (WHO, 2014)

- **Availability** (可得性)
  - functioning public health and health care facilities, goods, services and programs in sufficient quantity
- **Accessibility** (使用權)
  - non-discrimination, physical accessibility, economic accessibility (affordability), information accessibility
- **Acceptability** (認受性)
  - respectful of medical ethics and culturally appropriate, sensitive to diversity
- **Quality** (質量)
  - scientifically and medically appropriate

"In relation to health, a rights-based approach means integrating human rights norms and principles (將人權規範和準則融入) *in the design, implementation, monitoring, and evaluation of health-related policies and programmes* (與健康相關的政策和計劃)*."*

(WHO, 2014)

Rights-based Approach to Health
(WHO, 2014)

- **Principles of equality and freedom from discrimination** (平等和不受歧視的自由)
  - human dignity
  - attention to the needs and rights of vulnerable groups,
  - health systems are made accessible to all
- **Empowering stakeholders** (為持份者充權) in the participation of decision-making processes and access to accountability mechanisms

Mental Health and Social Action

- **Not just focus on individual-level, disease-focused models**
  (不只是專注於個人層面，疾病為主的模式)
- **Equally emphasize oppressive social forces that thwart wellness and growth for everyone**
  (同樣強調壓迫性的社會力量會損害健康和成長)
- **Promotion of social justice and human rights**
  (推動社會公義和人權)
  - Facilitate self-advocacy of individuals and families
  - Remove systemic barriers that perpetuate injustice

Conclusion

- **Recovery is a deeply personal and unique process**
  - Every individual holds the key to their own transformation and meaningful change process
- **The role as a service provider is to create a supportive environment to nurture recovery**
  - Understand with a strength-based perspective, develop service plans with a person-centered approach, and deliver services with a personal recovery-orientation
  - Listen to and respect what people in recovery have to say
- **We are all human beings and are entitled to the same level of respect and dignity and the right to well-being**

“Wellness cannot thrive in conditions of inequality and injustice.”

(Prilleltensky & Prilleltensky, 2003)