From Occupational Deprivation to Mental Health and Recovery

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Mental Health, Activity and Participation

- Research group at Lund University
- Develop, implement and evaluate psychosocial interventions for meaningful activity and participation in the community life despite mental health problems
- Service user involvement as well performing research that has legitimacy in practice
- Part of the national Centre for Evidence-based research for Psychosocial Interventions, CEPI

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Social Deprivation

- Social deprivation is the reduction or prevention of culturally normal interaction between an individual and the rest of society. This social deprivation is included in a broad network of correlated factors that contribute to social exclusion which include mental illness, poverty, poor education, and low sociodemographic status

  (Bassouk & Donelan, 2003)

  - Limited access to the social world

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Occupational Deprivation

- Occupational Deprivation is a state of preclusion from engagement in occupations of necessity and/or meaning due to factors that stand outside the immediate control of the individual
  (Wilcock, 1998)
- Someone or something external cause the deprivation
  (Whiteford, 2000)
  - Limited access to occupational opportunities and occupational engagement

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Occupational Deprivation

Occupational deprivation results from direct social and cultural exclusions, but also exist as a by-product of institutional policies, technological advancements, economic models and political systems, i.e. workplaces, welfare system

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Occupational Deprivation

- Persons with mental health problems are at risk of occupational deprivation. They are often unemployed, are poor and marginalized and have little or no legitimated ‘voice’ in mainstream society
(Bejerholm & Eklund, 2004, 2006; Porter, Lexén, Johanson, Bejerholm, in press)

WHY?

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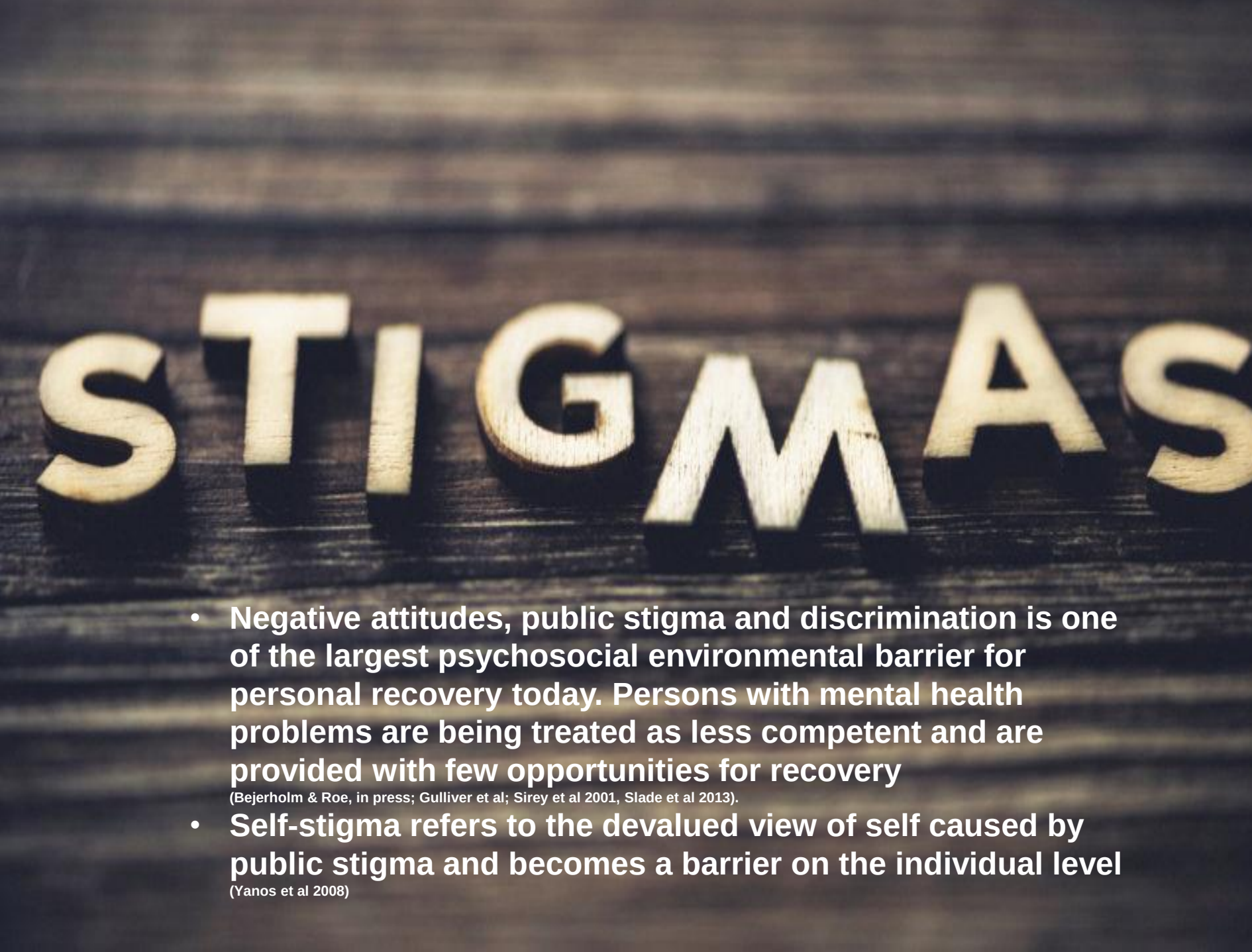
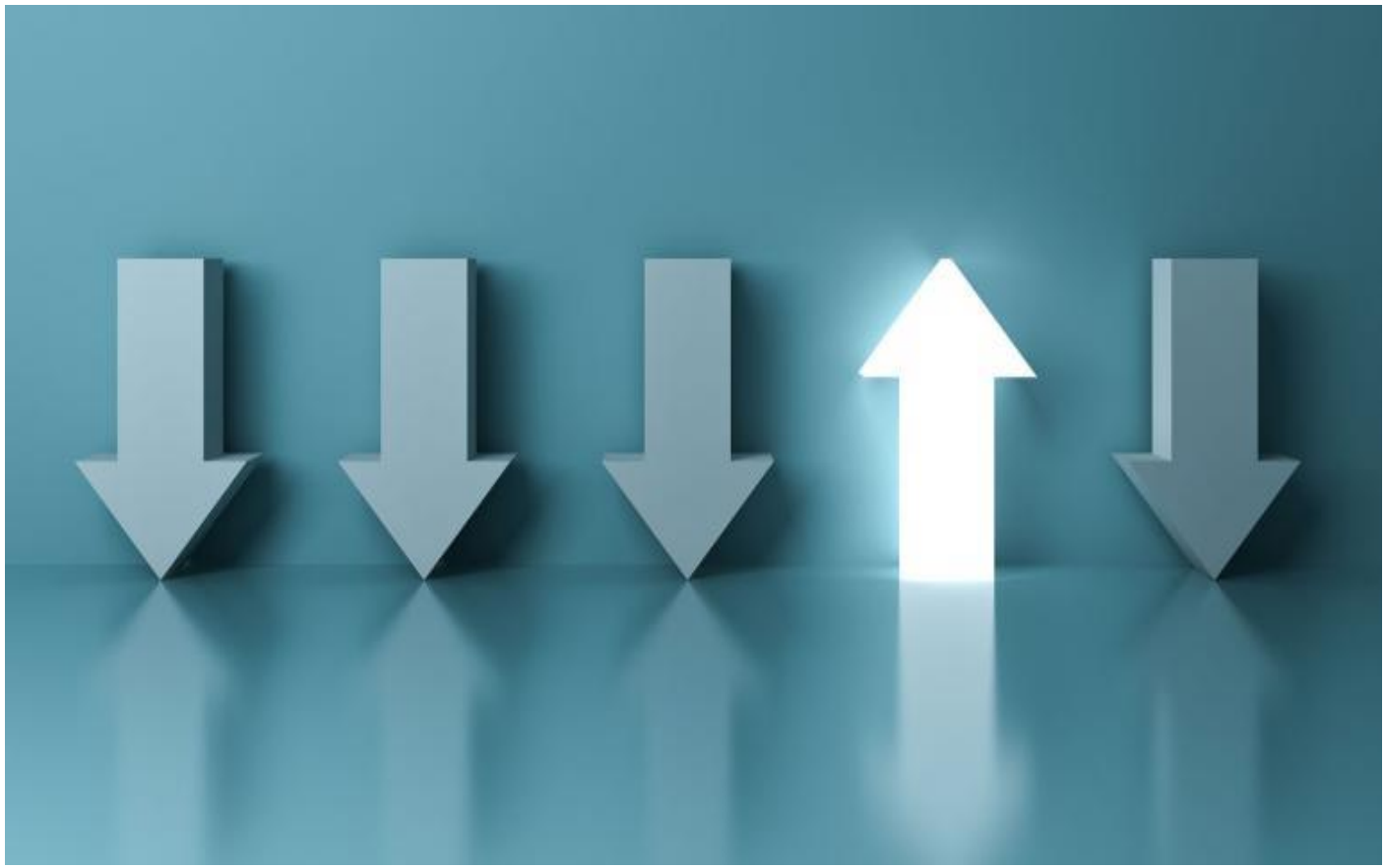


- **Negative attitudes, public stigma and discrimination is one of the largest psychosocial environmental barrier for personal recovery today. Persons with mental health problems are being treated as less competent and are provided with few opportunities for recovery**
  (Bejerholm & Roe, in press; Gulliver et al; Sirey et al 2001, Slade et al 2013).
- **Self-stigma refers to the devalued view of self caused by public stigma and becomes a barrier on the individual level**
  (Yanos et al 2008)

How can we turn this trend around?



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Occupational Engagement

- Occupational engagement describes the extent to which a person has a balanced rhythm of activity and rest, a variety and range of occupations, routines, the ability to move around in society and interact socially, and involves interpretation and comprehension emanating from time use experience (Bejerholm & Eklund, 2006, 2007)
- Occupational engagement includes both objective and subjective dimensions
- Occupational engagement process forms the basis for cyclical means of maintaining a sense of self and well-being.

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Occupational Engagement

- Provides means to mental and physical health, and most of all a sense of meaning and purpose of existence
- Is a lifestyle characteristic that when identified can form the basis for finding strategies that supports occupational strategies and performance
- Time-use reserch has contributed to the understanding of occupational engagement and mental health

(Bejerholm & Lundgren-Nilsson, 2015)

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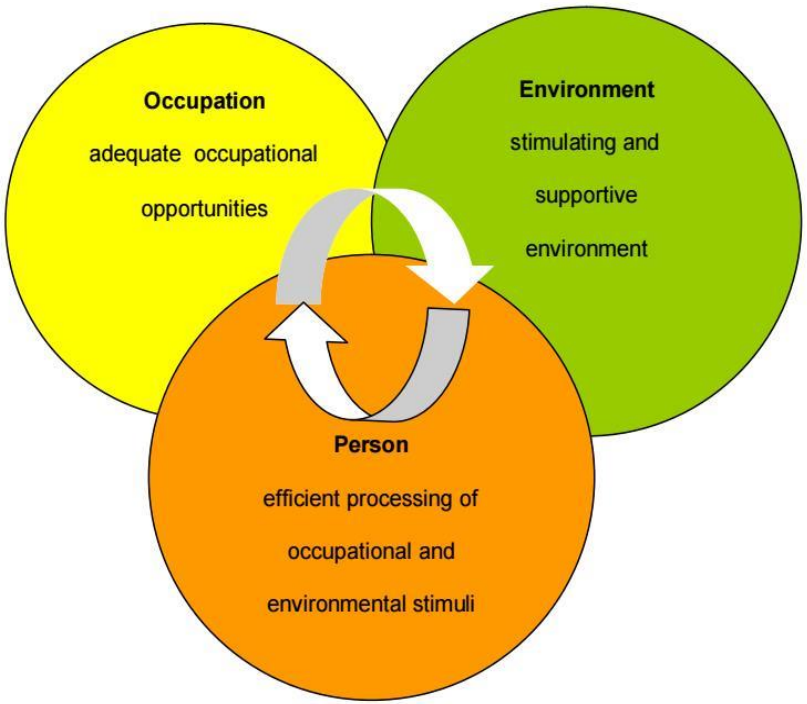
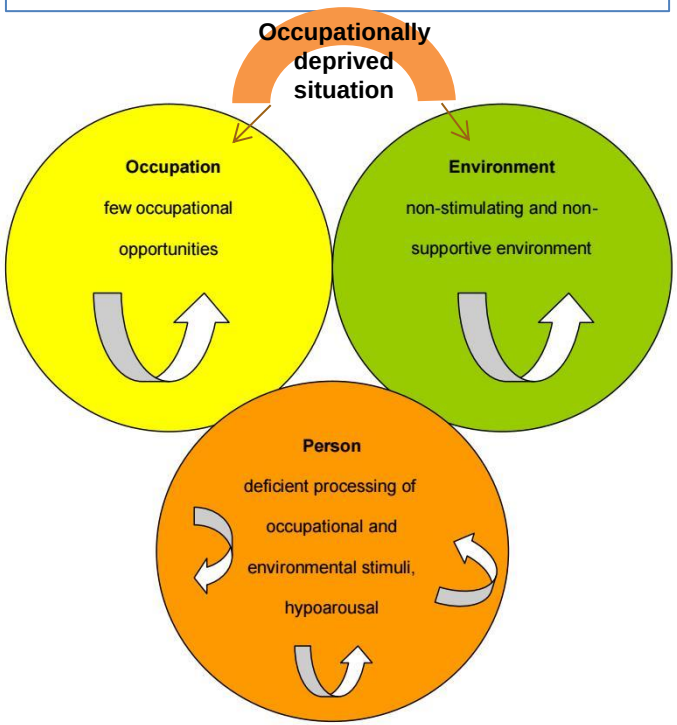
Occupational engagement process



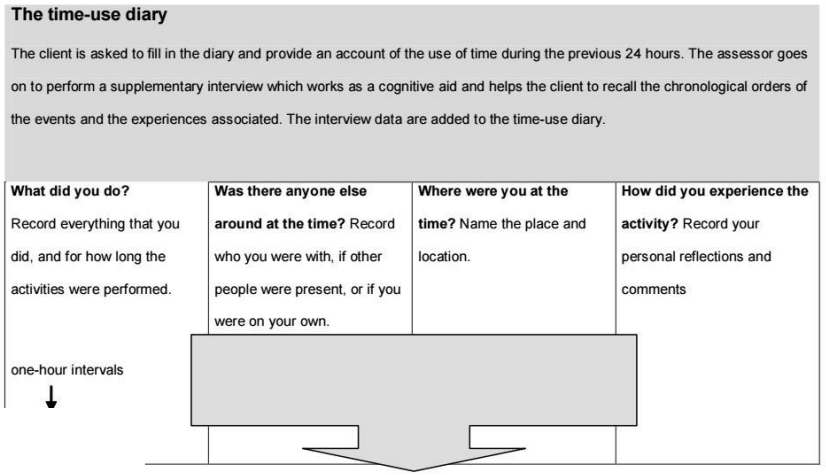
Deficient occupational engagement process
Under-occupied



(Bejerholm, 2007)
http://portal.research.lu.se/ws/files/4769822/547998.pdf

Profiles of Occupational Engagement in persons with Severe mental illness (POES)

- Lack of meaningful time use, occupational engagement, is connected to one of the most problematic dimensions associated occupational deprivation
  - lack of occupational opportunities and engagement
    (Bejerholm & Lundgren-Nilsson, 2015; Bejerholm & Roe, in press)



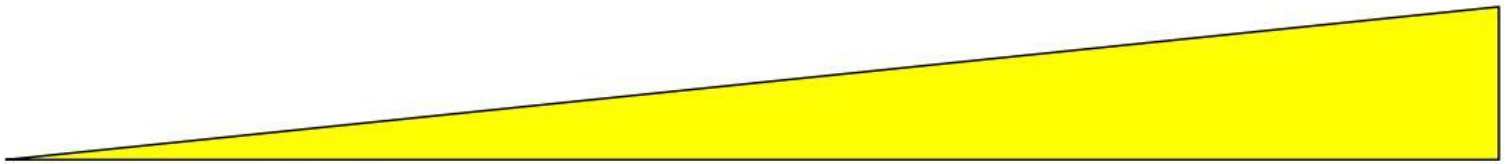
The time-use diary

The client is asked to fill in the diary and provide an account of the use of time during the previous 24 hours. The assessor goes on to perform a supplementary interview which works as a cognitive aid and helps the client to recall the chronological orders of the events and the experiences associated. The interview data are added to the time-use diary.

What did you do? Record everything that you did, and for how long the activities were performed.	**Was there anyone else around at the time?** Record who you were with, if other people were present, or if you were on your own.	**Where were you at the time?** Name the place and location.	**How did you experience the activity?** Record your personal reflections and comments
one-hour intervals ↓			

. The time-use diary.

French version of the profiles of occupational engagement in people with severe mental illness: Translation, adaptation, and validation. (Larivière…Bejerholm, 2017)



Low level of occupational engagement :	High level of occupational engagement
• External locus of control	• Internal locus of control
• Less sense of coherence	• More sense of coherence
• Less sense of mastery	• More sense of mastery
• More negative, positive, depressive symptoms, and general psychopthology	• Less negative, positive, depressive symptoms, and general psychopathology
• Worse psychosocial function	• Better psychosocial function
• Less satisfaction with daily occupations	• More satisfaction with daily occupations
• Low activity level	• High activity level
• Worse quality of life	• Better quality of life
• Worse wellbeing	• Better well-being

(Bejerholm, 2007)
http://portal.research.lu.se/ws/files/4769822/547998.pdf

Mental Health

- A state of well-being in which every individual realizes his or her own potential, can cope with normal stresses of life, can work productively and fruitfully, and is able to make contribution to her or his community.
(WHO 2013)
- Promoting well-being and supporting hope and optimism are core features which are in sharp contrast to the historical deterministic and pessimistic concepts of mental illnesses
(Bejerholm & Roe, in press)

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Recovery

CLINICAL RECOVERY	PERSONAL RECOVERY
Recovery is assessed by experts	Recovery is best defined by the person him- or herself
Recovery can be observed through the clinical language	Recovery is a personal experience
Few persons with mental health problems recover	Many persons with mental health problems recover
If a person does not have psychiatric symptoms, they are dormant	If the person does not have mental illness her or she is not ill anymore
Diagnosis is a robust support for characterizing groups and to predict needs	Diagnosis is not a robust support for recovery
Treatment is needed to increase the outcome- and should by given to all	Treatment is one of many roads in recovery
The effect caused by mental health problems is entirely negative	The effect caused by mental health problems may vary

Personal Recovery

- Personal recovery is described as '*a process of positive adaptation to illness and disability, linked strongly to self-awareness and a sense of empowerment*'
- Conceptual personal recovery framework of CHIME is based on the synthesis of 115 original papers that reflect user experiences of personal recovery (Leamy et al 2011; Slade 2012)

  - ***connectedness*** (support from others and being part of community),
  - ***hope and optimism for the future*** (motivation to change, positive thinking),
  - ***identity*** (overcoming stigma, rebuilding or redefining identity),
  - ***meaning in life*** (meaning of mental illness experiences, quality of life, social roles, goals)
  - ***empowerment*** (personal responsibility, control, focusing on strengths)

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Recovery-oriented services

- *Recovery-oriented services* (ROS) describe mental health treatment and interventions that are informed by an understanding of personal recovery as described above
- Occupational therapy services form part of these services if we forward:
  - person-centeredness
  - respect decision-making
  - recognize the critical role that self-determination plays in improving well-being
  - create a trustful, empowering, and hope-inspiring relationship that is based on choices of ‘what matters’

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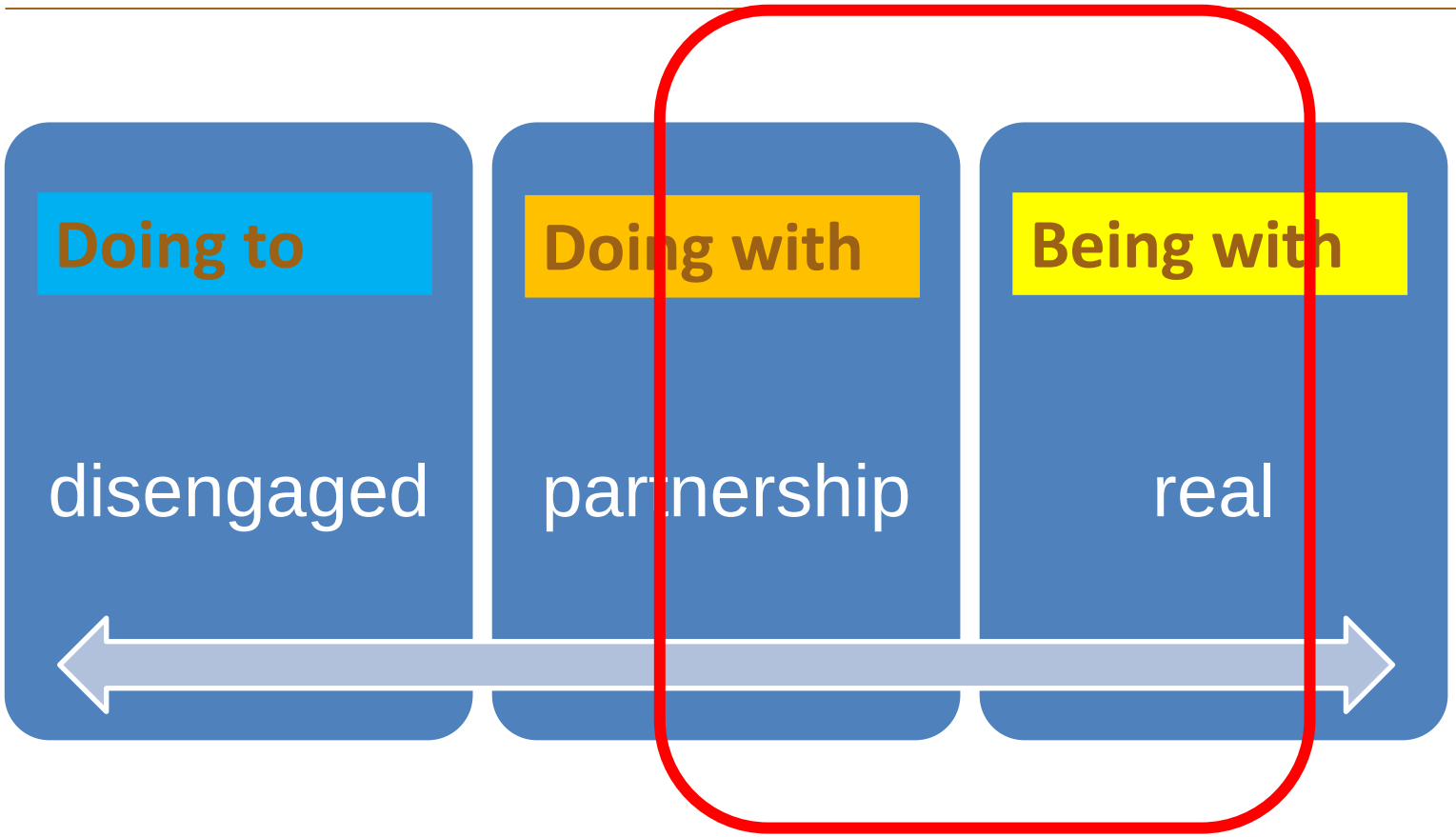
Trustful relationship



(Slade, 2009)

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Recovery-oriented services (examples)

- Assertive Community Treatment
- Peer support
- Self-management strategies
- Supported employment (supported education, housing first)

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Assertive Community Treatement

- Community-based treatment services in the natural living setting; support in medication, housing, substance abuse, everyday life problems, supported employment, and emergencies
  - stabilize housing in the community
  - reduction of hospitalization and long-term inpatient treatment, and homelessness
- Sharing of caseloads across clinicians
- Full-time coverage

(Stein & Santos, 1998)

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Flexible-ACT

- Flexibility regards upscaling and downscaling intensification of team based care with case management
- FACT combines personal recovery and treatment needs
- Forms a creative space for care where 70% of the care delivery is placed in community
- Departs in a person-centered care and planning
- Peer support workers are included in every team
  (Bähler et al 2017; van Veldhuizen, 2007).

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Peer support

- Peers share the assumption that people who have dealt with mental illness, or have *lived experience of mental illness*
- Peers are in a unique position to provide support and hope to others coping with similar challenges
- Peers help individuals become active participants in their own recovery process, breaking out of the passive and isolating ‘mental patient’ role, and identify strengths and goals
- Peers become models for community integration as well as personal autonomy and self-worth
- Peers work collaboratively with other team members and are part of the professional staff

(Lloyd-Evans et al, 2014)

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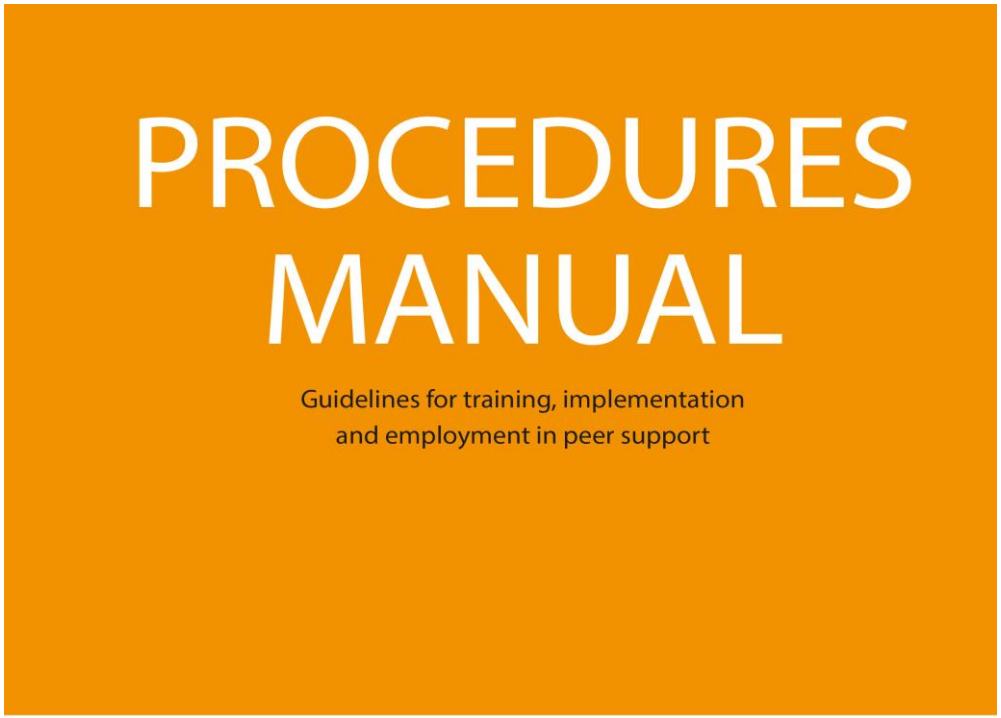

http://www.nsph.se/wp-content/uploads/2018/05/PeerSupport-eng-web.pdf

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Self-management

- Illness Management and Recovery
  - psychoeducation about mental illness and treatment
  - incorporating medication into one's daily routine
  - developing a relapse prevention plan
  - coping strategies for persistent symptoms
    (McGuire et al, 2014)

- Wellness Recovery Action Planning
  - explores individual key values of and goals for recovery
  - provides a structured process for developing individualized WRAP plans
    (Cook et al, 2012)

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Self-management

- Narrative Enhancement and Cognitive Training (group)
  - share their experience of self and illness
  - discuss stigma in relation to myths, generalized negative attitudes, research, and personal experience,
  - cognitive restructuring techniques to identify to combat self-stigmatization
  - facilitate meaning-making and challenge self-stigma through narratives (Yanos et al, 2012)
- Sensory Modulation (group)
  - recognize triggers of distress to assess own sensory profile
  - learn about senses and common sensory inputs that can be used for calming and alerting
  - create a sensory kit and plan for use in everyday life (Lipskaya-Velikovskya et al, 2015)

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Supported Employment

- Competitive employment is the goal
- Eligibility is based on client choice
- Rapid job placement, within a month
- Integrated with mental health services
- Client preferences, interests, choice and strengths guides service
- Benefit counseling and contact with vocational services and insurance agencies at an early stage
- Continous and time-unlimited support
- Systematic job development and establishment of relationship with employers

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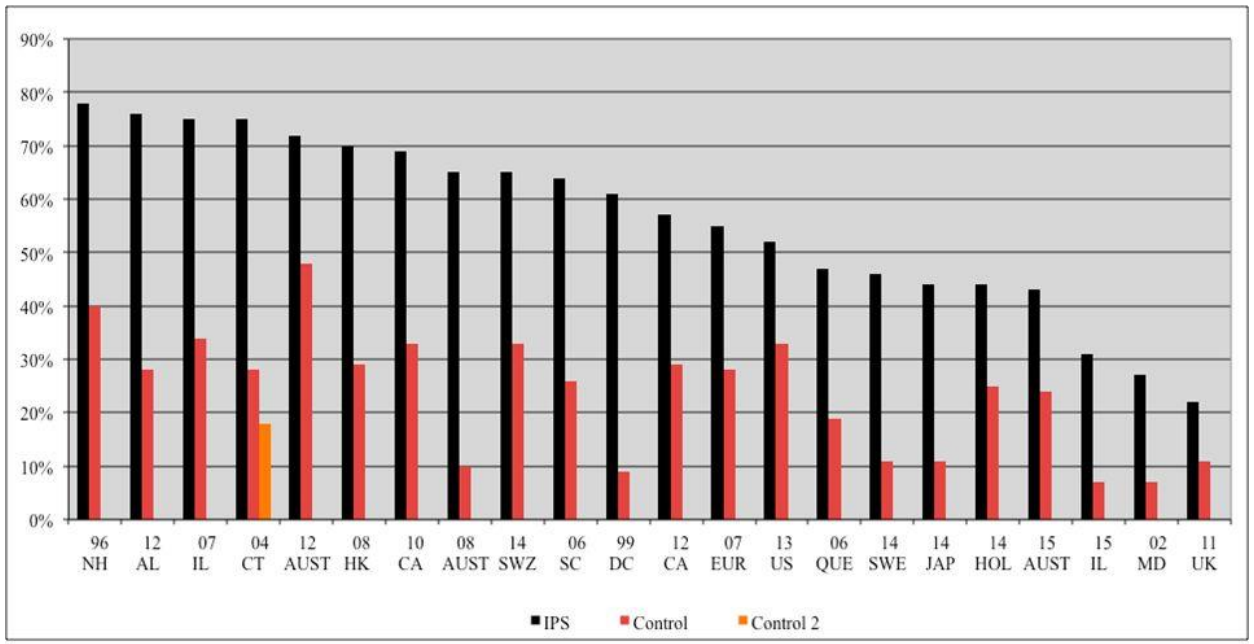
Is it effective?

Competitive Employment Rates in 22 Randomized Controlled Trials of IPS



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Is it effective?

Psychosis

Vocational outcomes

- After 18 months employment: 46% (IPS) versus 11% (TVR) *(35% differences)*

80% in IPS returned to work or internship

90% in IPS returned to work, internship or studies

only 20% in TVR returned to work, internship, or studies

Difference in income within and between groups

(Bejerholm, Areberg, Hofgren, Sandlund, Rinaldi, 2015)

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Is it effective?

Psychosis

- Nonvocational outcomes

Significant within and between group differences:

- Quality of Life (MANSA) (within and between)
- Empowerment (ES) (between)
- Occupational Engagement (POES) (within)
- Work motivation (between)

(Areberg & Bejerholm, 2013)

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Is it effective?

Affective disorders

Vocational outcomes

After 12 months employment: 42.4% (IES) versus 4% (TVR) *(38% differences)*

- ca 80% in IES reached employment or internship
- over 90% in IPS reached employment, internship or studies
- only 28% in TVR reached employment, internship, or studies

Difference in income within and between groups

(Bejerholm et al, 2017)

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Is it effective?

Affective disorders

Nonvocational outcomes

Significant within and between group differences:

- Quality of Life (MANSA) (within and between)
- Empowerment (ES) (within and between)
- Occupational Engagement (POES) (within, both groups)
- Depression (within and between)

(Porter & Bejerholm, 2018)

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Take home message

- We need to focus on occupational engagement and provide opportunities personal recovery services
- We need to develop and evaluate interventions in RCTs
- We need to integrate our services with other community services
- We need to think and act at a broader social and cultural level

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