The Pathfinder Project – a recovery (ad)venture

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What is new with the «personal recovery» way of thinking?

- It is not a model. Rather, it is a way of defining mental illness and mental health as societal constructions as well as biopsychomedical problems. This opens up new doors for healing and for efficacy
  - Utilizes patient's own resources
  - Utilizes carer's and friends' resources
  - Trains people with lived experience to work alongside professionals
  - Supports patients' agency and citizen rights and duties
- Couples the caring and humanistic professional with a respect for citizen's rights
- Professional knowledge is better utilized because it becomes better tailored to individual goals and therefore more relevant

Look at the research – recovery supportive interventions work – and patients want them

Lancet 2018; 392: 409–18 *Sonia Johnson, et al.*

Peer-supported self-management for people discharged from a mental health crisis team: a randomised controlled trial

At 4 months of follow-up, overall satisfaction with mental health-care received was greater in the intervention group than in the control group.

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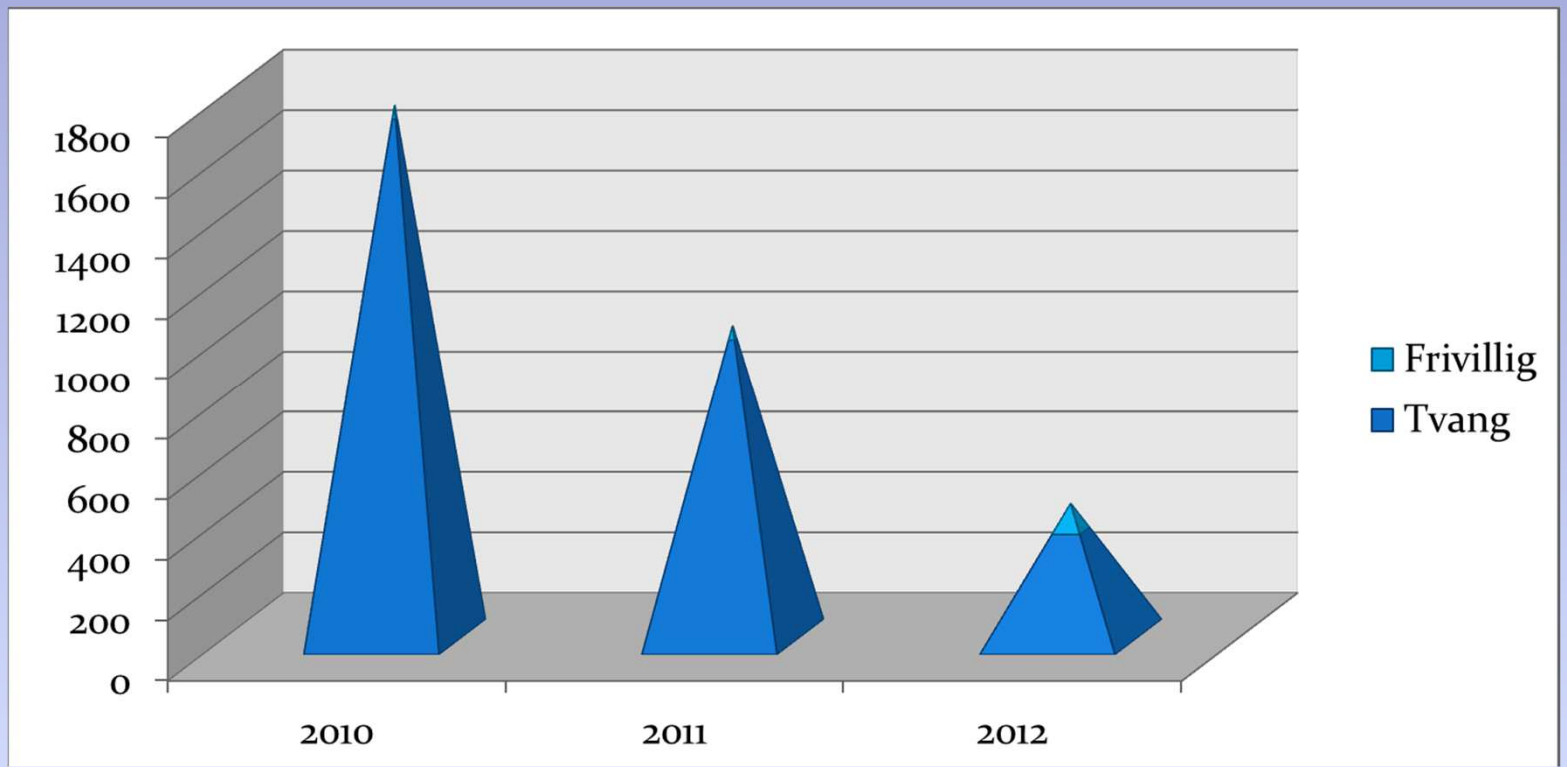
2014: «More help at home» – 12 beds closed down, and the resources were planned to be used for the same patients, but in their homes and in group activities and recovery teaching.

Sandnes DPS. After 2 years with a recovery based rehabilitation program, in bed days/nights for 30 patients were reduced from 1776 til 441. Voluntary stays increased from 46 to 91



2013
2014
2015

When we began piloting these ideas, many different projects were in place. Some patients, but not all, met important, well researched recovery support:

- «Housing First»
- Individual Placement and Support (JobPrescription, SchoolPrescription)
- Recovery focus in one psychosis ward
- «The strengths model»-FACT/ACT
- Open Dialogue in a district psychiatric center
- Peer support in some teams

«The ten (most important) recovery supporting 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."*

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*Slade, M, Amering, M, Farkas, M, Hamilton, O\Hagan M, Panther, G, Perkins, R, Shepherd,G, Tse, S, Whitley, R, Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. World Psychiatry2014;13:12-20.

The Pathfinder Project went from grand design to what we could actually do – today we can see surprising results, considering. Conclusion: there is an enormous potential in working together with patients, carers/personal networks as resources.

In the organization: A long uphill struggle

In the decision process through 2015 the project plan was met with questions and demands for ever new write-ups. One year passed with requests for revisions before an adapted project was decided upon in the leadership group of the largest hospital.

«We do not need this – we are already doing it!»

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Planning in partnership 2014

- Assessment of success factors in the different «recovery» modalities in USA, UK, Australia, Europe: analysis of similarities and differences.
- These elements were chosen:
  - Peer support for patients in addiction and psych treatment
  - Training for these new employees which could secure results fro the patient/user, safe work for the new Peer supports, and their colleagues, and their leaders
  - Wellness plans for self-help
  - Advanced directive and crisis plans to secure agency in crises
  - Supported decision making
  - Training for all colleagues on personal recovery practices and how to help patients build on their own strengths

Planning in partnership 2014

- And a recovery college for coordinationg all training of staff, Peers and patients.
- We sent an open invitation to join in working groups with professionals and patient/carer groups and individuals. The work created great interest and enthusiasm
- All participants agreed that the plans needed to include community care as well as self-help and private services. Patients live in the community, and use different services in all sectors. No translations should be necessary.

New questions were asked - too radical for some:

What if we actually

- respected the patients' ownership of their lives – in the ward, in treatment situations, in the housing facility, in the day care center (CRPD)
- asked: What matters to you? And how do you wish to be helped? And then supported the patient's own choice? Every time?
- What if we actually followed the evidence base that «continuity in treatment» was a must?

Regardless of funding structures?

The project plans were delayed. January 2015:

What if we did not wait for the project? The working group volunteers decided we needed the recovery self help tools. 15-24 people met every 3 weeks for half a year, 2 professionals, the rest with lived experience, in the afternoons.

In January, two Wellness and crisis plans/advance directives were translated from English, then revised, then piloted in June, and then we began anew, with an agreed product ready in October, piloted and revised and printed.

February 2016, the project design was decided upon and we could begin with a flying start!

The Pathfinder
The Toolbox

I have set my course –you can set yours

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Resources?
The Person
The Illness
The Person
The Illness
The Person
Organizations
Play
The Illness
Work
Friends
Family
Ron Diamond, Madison, Wisconsin 2011

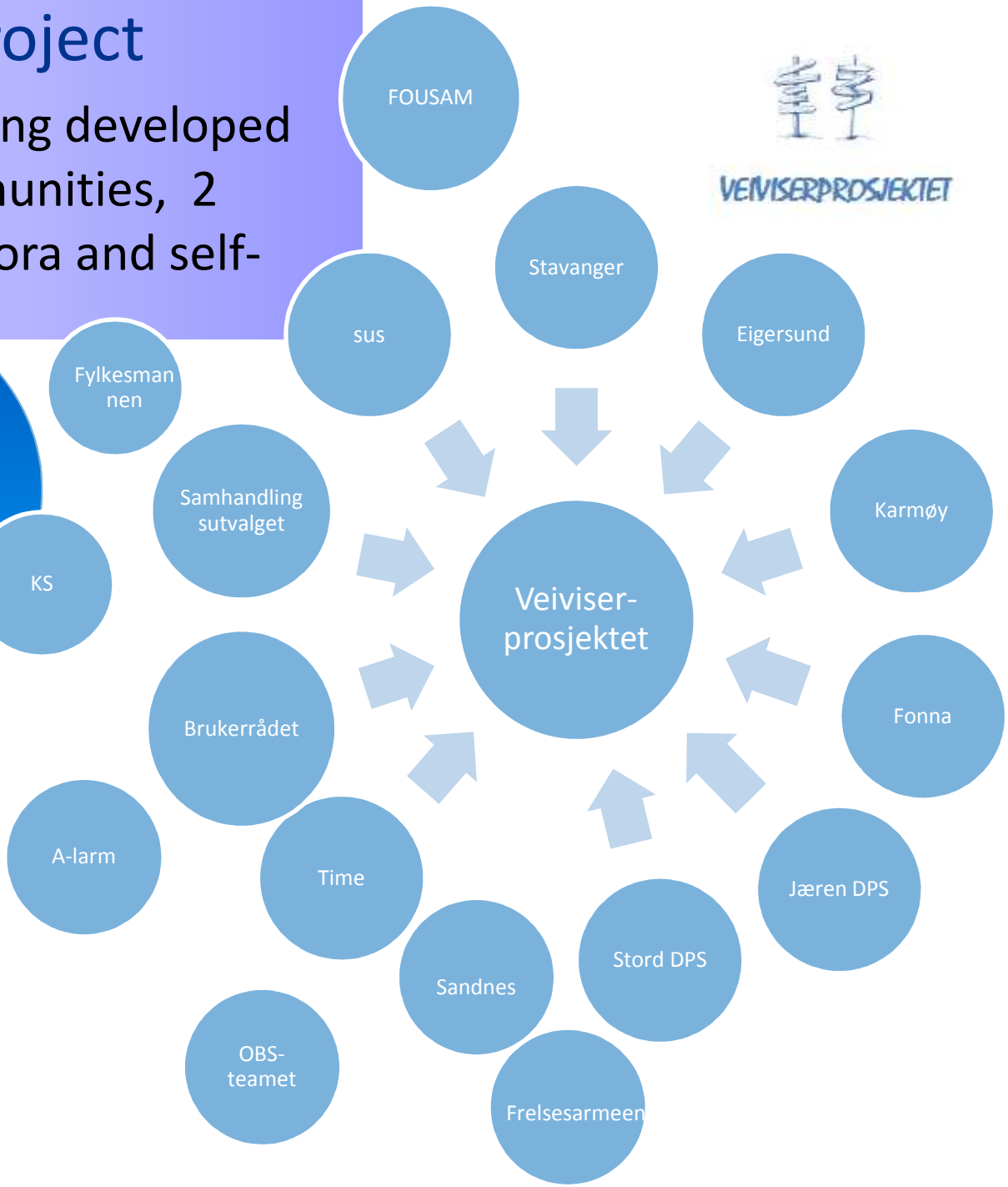
2105 A Network Project

Recovery values were being developed and discussed in 35 communities, 2 hospitals and many user fora and self-help groups

National recovery network of communities pilot

A Network Pr

- All participants bring in the projects and results they wish to and retain control of their own project
- The Pathfinder Project's role is to support the participants and build consensus where possible.
- Participants share their experience and results.
- Users and carers take part broadly



A grand design without a grant

- Financial Situation: actual state: An office,
- One Project Leader salary in place, three people with 20% of their jobs giving room for project work, one secretarial support through Social Services (part time for four months). Support from top leadership in one of 3 hospital clinics plus in hospital/community collaboration fora with 27 municipalities.
- 18 communities already had Peer positions in place, through community grants funds for mental health and addiction, but with no training or support. Risk analysis: red, for patients, Peer supports and services

A grand design without a grant

- Financial Situation:
  - o requirements:
    - 2 50% Project Leaders with lived experience,
    - funds to pay people working with LE in project groups,
    - funds to teach Peers to be Peer Support,
    - funds to teach professionals about recovery, etc.
  - o Problems: The Pathfinder Project was expected to create external funding, and as grants passed us by, hopelessly underfunded.

Lateral thinking had had its consequences: What if we did not wait for funding?

- The original design took into account the fact that resources are tied into already existing structures and practices, embedded in research based treatments and care programs which are sociologically reinforced by everyday practice.
- We had planned on low cost innovation practices (snowballs) and beginning where we could harvest results fast (avalanches). Timing and sequence of sub-projects were aligned to achieve success in overall design
- What had we learned in the planning phase?

Resources exist where we are not accustomed to looking for them

Open the doors to new resources

Knut-Jarle: I think we should create a course for the Wellness plan, Inger Kari. Is it ok if I come to work at around 7.15? My social worker says I can have it as a work training plan

- What had we learned in the planning phase? Priorities must be in line with the original plan: but sequence did not matter that much. We went with the energy, and what our users in the project team said was important, now.

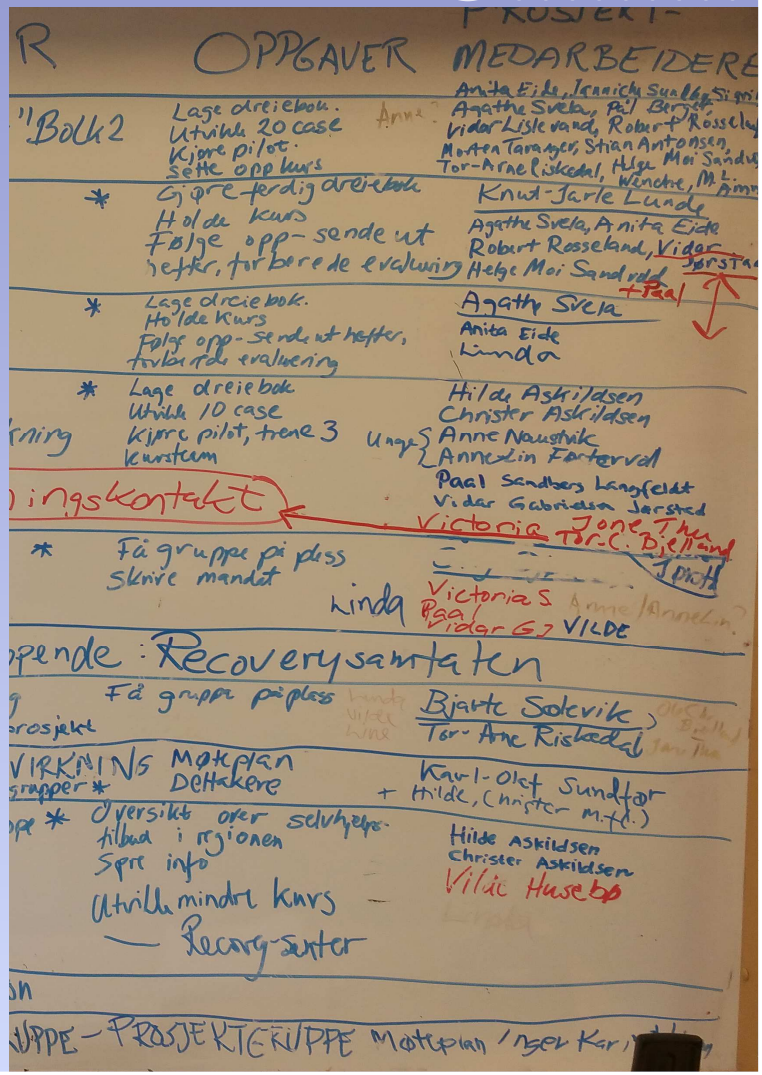
Knut-Jarle, two weeks later: Is it ok if I bring a friend of mine? He has full disability but thinks this is important.

First one, then two men, then two couples, then three women, then we had workshops twice a week with ten people, who chose projects, teaching themes for the Peer training, and generated new ideas

A grand design with grand resources

10-14 project team workers at any time. Volunteers lining up to join. Long and short term plans on the whiteboard.

Project tool:Trello



116 people have completed level 1 in the Peer Support course, 52 have completed level 2.

It has become a requirement for hiring in the commuity services. Having the diploma is important to people.

All 27 teachers from the first team in 2016 till the last in October 2018 are or have been volunteers from our project team. 1/3 have new jobs

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Continuing plan for the Peer Training Project:

- Sum up the feedback from the participants: Our evaluation coach, Post doc Eva Biringer and a master student
- Write a book with the content of the course, plus an exercise/work book.
- Write a complete teacher's manual
- Create an exam and a certification test.
- The volunteer teachers and course developers are working as we speak.

- Peer supporters are on their way
- Self help has three important tools in our area
- We are developing a program to teach recovery thinking to staff and users/patients
- We have a self-help course for patients and ex-substance abusers in several communities – our peer supports are teachers
- We are planning suicide prevention with a recovery focus
- «No Force first»: we are learning from UK and US projects changing deescalation thinking about risk into a traumasensitive mode
- Human rights in our services: a new outlook on our very core –CRPD working groups under planning

Recovery support: it is an I who meets a you. Both parties receive, both parties give. The humanness in mental health and addiction services – is this how we can save it?