TESI DOCTORAL

Adaptació i Aplicació a la Catalunya Central del Model de Recuperació a Persones amb Trastorn Mental Sever

Col·laboració amb la Yale University

Ivan Cano Prieto

Directores de tesi: **Dra. Gemma Prat i Vigué i Dr. Salvador Simó i Algado**

Programa de doctorat: **Cures Integrals i Serveis de Salut**

2023

UNIVERSITAT DE VIC
UNIVERSITAT CENTRAL DE CATALUNYA
Escola de Doctorat

Caminante no hay camino

Caminante, son tus huellas
el camino y nada más;
Caminante, no hay camino,
se hace camino al andar.
Al andar se hace el camino,
y al volver la vista atrás
se ve la senda que nunca
se ha de volver a pisar.
Caminante no hay camino
sino estelas en la mar.

Antonio Machado, 1912.

Agraïments

Tot i trobar-se al principi, aquestes son les darreres paraules d'aquest camí que ha durat més de cinc anys. Aquelles que heu estat al meu costat sabeu que ha estat un trajecte ple d'alts i baixos, satisfaccions i frustracions que ens hem trobat pel camí. Sens dubte, la persistència i tenir-vos al costat m'ha mantingut ferm. A totes vosaltres gràcies.

En primer lloc, vull agrair la confiança i el suport en aquest viatge de dues persones sense les quals avui no estaríem aquí, persones que amb la seva implicació en la direcció de la tesi han fet més amena la tasca. Gemma i Salva, moltíssimes gràcies, m'emporto la motxilla plena de grans aprenentatges personals.

Com he comentat anteriorment, ha estat un trajecte llarg, en molts moments de solitud. Per això, vull agrair a la Universitat de Vic i la Fundació Althaia per confiar en mi i poder gaudir d'un Doctorat Industrial. Aquesta beca d'AGAUR em va permetre incorporar a un equip excel·lent de persones de les quals, avui en dia, encara recordo els bons moments viscuts. Gràcies, Mosaic! I en especial a totes les participants d'un projecte meravellós, Tocats de Ràdio, sempre us tindré present.

A totes les persones amb les quals he compartit espais de treball, totes importants, però una menció especial a l'equip de tarda nit de Tres Pins: Álex, Jesús, Guillem, i Javi.

A les companyes de Salut Mental Catalunya per confiar i donar-me l'oportunitat a participar d'aquest projecte meravellós: gent de seu central, Activa't, Fundació i com no, ¡el despachito!

A totes aquelles persones, companys i amics, que m'heu sostingut i empès a seguir des de Vic, Tarragona, Barcelona.

A la gent del màster, Bruno i Fer, que tot i la distància i el temps m'heu acompanyat en els moments de foscor i llum.

Al Helsinki Team, aquelles dues setmanes van donar per a molt, i també per crear una amistat que perdurarà en el temps, Sergi i Carlos, seguim!

A la meva família, la de Vic i Barcelona, per l'esforç per entendre'm i acompanyar-me, i allargar la mà en els moments que més la necessitava. I també a tu, les teves converses van ser les que em van motivar a fer el màster. El teu record és el millor dels suports que puc tenir.

I finalment, a vosaltres, la casa dels guepards. Aran, Etna, Helena, us estimo.

ÍNDEX

Acrònims i Abreviacions

CAMI	Community Attitudes toward Mental Illness
CD-RISC	Connor-Davidson Resilience Scale
CHIME	Connectedness, Hope and optimism about the future, Identity, Meaning in life, and Empowerment
CMOP	Canadian Occupational Performance Measure
COPES	Careers Offering Peers early Support
CS	Club Social
EMAS	Engagement in Meaningful Activities Survey
GSE	General Self-Efficacy Scale
HHS	Heart Hope Scale
NU	Nacions Unides
OMS	Organització Mundial de la Salut
OTPF	Occupational Therapy Practice Framework
PNSM	Pacte Nacional per a la Salut Mental
PSI	Pla de Servei Individualitzat
PSW	Agent de suport entre iguals
RAS-R	Recovey Assessment Scale-revised
SPPS	Statistical Package for the Social Sciences
SRC	Servei de Rehabilitació Comunitària
SSQ	Schizophrenia Self-Estigma Questionnaire
SWLS	Satisfaction with Life Scale
TMS	Trastorn Mental Sever*

*Una malaltia mental greu fa referència a un conjunt de trastorns mentals, conductuals o emocionals diagnosticables que causen un deteriorament funcional substancial i afecten significativament la capacitat d'una persona per dur a terme les principals activitats de la vida. Aquestes condicions poden incloure trastorns com esquizofrènia, trastorn bipolar, trastorn depressiu major i trastorns d'ansietat greus.

L'impacte del TMS pot ser profund i afectar diversos aspectes de la vida d'un individu, inclosa la capacitat per treballar, estudiar, mantenir relacions i realitzar les tasques diàries. Aquest deteriorament funcional distingeix el TMS d'afeccions de salut mental menys greus.

La càrrega de les malalties mentals, en particular les malalties mentals greus, pot ser significativa no sols per als individus sinó també per a les seves famílies, comunitats i la societat en general. Pot generar desafiaments a l'ocupació, l'habitatge, l'educació i la qualitat de vida en general. A més, les persones amb TMS poden enfrontar estigma i discriminació, cosa que complica encara més la seva capacitat per accedir a atenció i suport adequats.

Els esforços per abordar la càrrega de malalties mentals greus sovint impliquen una combinació d'intervencions mèdiques, psicològiques i socials. L'accés a l'atenció de salut mental, els serveis de suport comunitari i les campanyes de conscienciació pública són components essencials d'estratègies integrals per millorar les vides de les persones afectades per TMS.

RESUM

RESUMEN

ABSTRACT

Dandelions. *Yayoi Kusama, 1985*

Resum

La recuperació en el context de la salut mental és un enfocament que posa èmfasi en la capacitat de les persones que pateixen trastorns de salut mental per restaurar i desenvolupar un sentit de vida significatiu i una identitat positiva, independentment del seu problema de salut mental. Aquest enfocament va sorgir com a resultat del "moviment de recuperació" de les dècades dels anys seixanta i va defensar els drets de les persones amb trastorns de salut mental a rebre tractament amb dignitat i a prendre decisions sobre el seu propi projecte de vida i participació comunitària.

En aquest enfocament de recuperació, es destaca la importància de l'empoderament, l'esperança, la qualitat de vida, la reducció de l'estigma internalitzat i altres factors psicosocials com a claus per aconseguir una recuperació personal. Aquesta recuperació es conceptualitza com un procés no lineal en què les persones amb trastorns de salut mental canvien les seves creences, actituds i conductes, i integren el trastorn en el seu desenvolupament funcional i inclusió social.

Els professionals de la salut mental que segueixen aquest enfocament tenen la responsabilitat de donar suport al projecte de vida de la persona atesa, fomentar un autoconcepte positiu i la identitat, i promoure l'autorresponsabilitat. També promouen la creació de suport social i xarxa, i ofereixen eines per afrontar la malaltia i lluitar contra l'estigma.

El model de recuperació a persones amb trastorns de salut mental (RECOVERY) és una estratègia que posa la persona amb un diagnòstic de salut mental al centre de la intervenció, amb un enfocament en la seva qualitat de vida i projecte de vida. Un aspecte destacat d'aquest model és la implementació de la intervenció entre iguals, on les persones amb una història de vida pròpia de trastorn de salut mental es converteixen en

coterapeutes, oferint la seva experiència i suport a les persones ateses. Aquest enfocament entre iguals ajuda a proporcionar una visió realista i esperançadora de la recuperació.

A més, es destaca la importància de la formació en recuperació per als professionals que atenen persones amb trastorns de salut mental i la capacitació de les mateixes persones amb diagnòstic de salut mental perquè puguin ser part activa del seu procés de recuperació.

Aquest enfocament de recuperació està guanyant força en l'àmbit internacional i ha demostrat ser eficaç en millorar la vida de les persones amb trastorns de salut mental, proporcionant-los un camí cap a una recuperació més significativa i satisfactòria.

Resumen

La recuperación en el contexto de la salud mental es un enfoque que pone énfasis en la capacidad de las personas que padecen trastornos de salud mental para restaurar y desarrollar un sentido de vida significativo y una identidad positiva, independientemente de su problema de salud mental. Este enfoque surgió como resultado del "movimiento de recuperación" de las décadas de los años 60 y defendió los derechos de las personas con trastornos de salud mental a recibir tratamiento con dignidad y tomar decisiones sobre su propio proyecto de vida y participación comunitària.

En este enfoque de recuperación, destaca la importancia del empoderamiento, la esperanza, la calidad de vida, la reducción del estigma internalizado y otros factores psicosociales como claves para conseguir una recuperación personal. Esta recuperación se conceptualiza como un proceso no lineal en el que las personas con trastornos de salud mental cambian sus creencias, actitudes y conductas, integrando el trastorno en su desarrollo funcional e inclusión social.

Los profesionales de la salud mental que siguen este enfoque tienen la responsabilidad de apoyar el proyecto de vida de la persona atendida, fomentar un autoconcepto positivo y la identidad, y promover la autorresponsabilidad. También promueven la creación de soporte social y red, y ofrecen herramientas para afrontar la enfermedad y luchar contra el estigma.

El modelo de recuperación a personas con trastornos de salud mental (RECOVERY) es una estrategia que pone a la persona con un diagnóstico de salud mental en el centro de la intervención, con un enfoque en su calidad de vida y proyecto de vida. Un aspecto destacado de este modelo es la implementación de la intervención entre iguales, donde las personas con una historia de vida propia de trastorno de salud mental se convierten en coterapeutas, ofreciendo su experiencia y apoyo a las personas atendidas. Este enfoque entre iguales ayuda a proporcionar una visión realista y esperanzadora de la recuperación.

Abstract

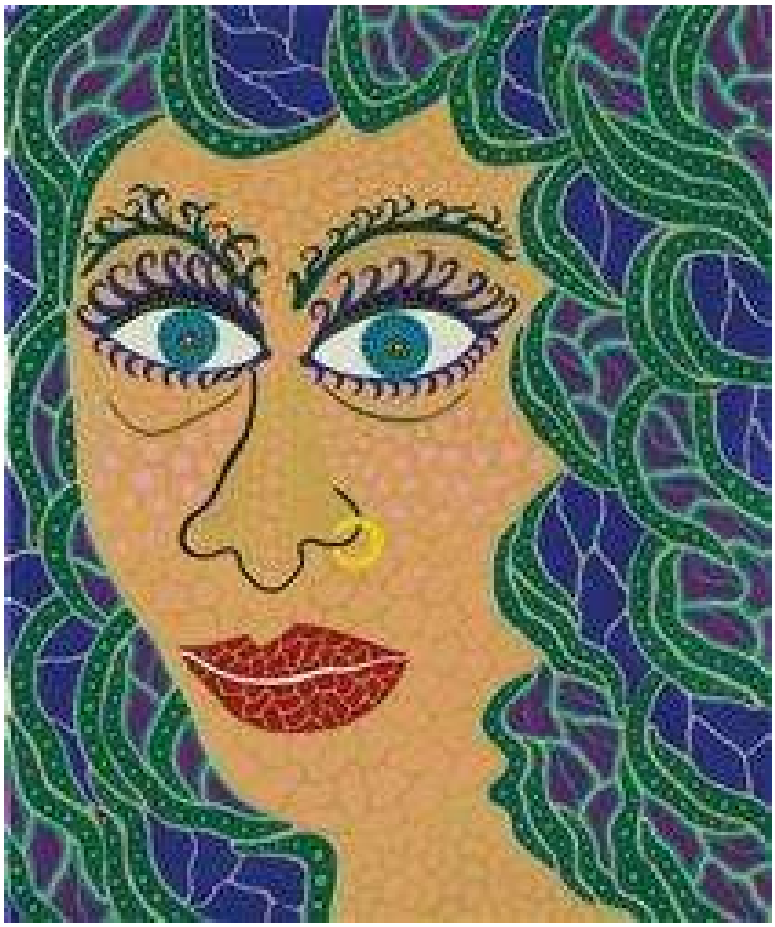
Recovery in the context of mental health is an approach that emphasizes the ability of people suffering from mental health disorders to restore and develop a meaningful meaning in life and a positive identity, regardless of their mental health problem. This approach emerged as a result of the "recovery movement" of the 1960s and defended the rights of people with mental health disorders to receive treatment with dignity and make decisions about their own life plans and community participation.

In this recovery approach, the importance of empowerment, hope, quality of life, reduction of internalized stigma and other psychosocial factors are highlighted as keys to achieving personal recovery. This recovery is conceptualized as a non-linear process in which people with mental health disorders change their beliefs, attitudes and behaviors, integrating the disorder into their functional development and social inclusion.

Mental health professionals who follow this approach have the responsibility to support the life project of the person being cared for, foster a positive self-concept and identity, and promote self-responsibility. They also promote the creation of social support and network, and offer tools to face the disease and fight stigma.

The recovery model for people with mental health disorders (RECOVERY) is a strategy that puts the person with a mental health diagnosis at the center of the intervention, with a focus on their quality of life and life project. A notable aspect of this model is the implementation of peer intervention, where people with their own life history of mental health disorder become co-therapists, offering their experience and support to the people they serve. This peer-to-peer approach helps provide a realistic and hopeful view of recovery.

MARC TEÒRIC



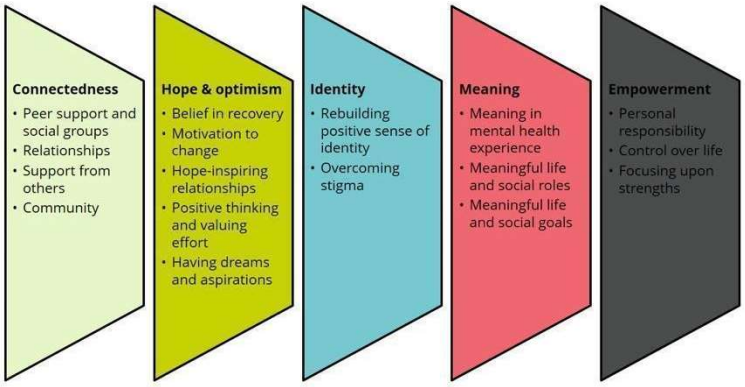
Watching the Sea. *Yayai Kusama, 1989*

Model de recuperació

Aquest moviment va tenir els seus orígens a la dècada de 1980 i va destacar la importància de reconèixer l'experiència i el coneixement dels usuaris de serveis de salut mental i els seus cuidadors en el planejament i desenvolupament d'accions en aquest àmbit (Keet et al., 2019). Un dels principis centrals d'aquest enfocament és l'orientació a la recuperació personal, que implica el canvi de les actituds, valors, sentiments, objectius, habilitats i rols d'una persona amb una malaltia mental cap una a visió de ciutadania (Rowe & Davidson, 2016). La recuperació es descriu com un procés profundament personal que va més enllà de resoldre els aspectes clínics del trastorn mental i implica el desenvolupament d'un nou sentit i propòsit a la vida de la persona, fins i tot amb les limitacions causades per la malaltia (Slade et al., 2011; Slade et al., 2012a). Segons Anthony (Anthony, 1993), "*la recuperació es descriu com un procés únic i profundament personal de canviar les actituds, els valors, els sentiments, els objectius, les habilitats i/o els rols. És una manera de viure satisfactòria, esperançadora i aportant la vida fins i tot amb les limitacions causades per la malaltia. La recuperació implica el desenvolupament d'un nou sentit i propòsit a la vida d'un mateix a mesura que es va més enllà dels efectes catastròfics de la malaltia mental*".

L'enfocament CHIME (Connectedness, Hope and optimism about the future, Identity, Meaning in life, and Empowerment) és un marc teòric que es fa servir per entendre el procés de recuperació personal en salut mental. Aquests cinc elements són considerats fonamentals per a la recuperació (Leamy et al., 2011):

Figura 1. Marc conceptual CHIME



Leamy et al. 2011

- **Connectedness** (Connexió). Aquest aspecte es refereix a la importància de les connexions i relacions socials en el procés de recuperació. Les persones amb trastorns de salut mental poden beneficiar-se de les relacions positives i de suport amb altres persones.
- **Hope and optimism about the future** (Esperança i optimisme pel futur). Mantenir l'esperança i la confiança en la possibilitat d'un futur millor és essencial per a la recuperació. Creure que les coses poden millorar és un motor important en aquest procés.
- **Identity** (Identitat). La recuperació personal implica la reafirmació i el desenvolupament de la pròpia identitat. Les persones poden recuperar el seu sentit de qui són i dels seus objectius personals.
- **Meaning in life** (Sentit de la vida). Trobar significat i propòsit a la vida és crucial per a la recuperació. Això pot incloure trobar un sentit en les pròpies experiències i actes.
- **Empowerment** (Empoderament). L'empoderament implica donar a les persones la capacitat de prendre decisions i controlar les seves vides i tractaments. Donar poder a les persones en el seu propi procés de recuperació és un element central.

Aquest enfocament de recuperació personal ha estat adoptat en molts països, especialment en els de parla anglesa, i ha canviat la forma en què s'aborden els trastorns de salut mental, posant un èmfasi més gran en la dignitat i l'autodeterminació de les persones que pateixen aquests trastorns (Slade et al., 2012b).

En l'enfocament de recuperació en el camp de la salut mental es destaca la importància dels programes d'igual a igual i el suport mutu (Mead, Hilton, and Curtis, 2001; Mead & Macneil, 2004). Aquestes estratègies es basen en la interacció i el suport entre persones que han experimentat problemes de salut mental i persones que estan en procés de recuperació. Aquí hi ha alguns punts clau que es poden destacar de la informació proporcionada:

1. **Programes d'igual a igual**. Aquests programes impliquen l'ús de treballadors de suport entre iguals (PSW) que han experimentat problemes de salut mental i han après a fer front a ells. Aquests PSW poden ser una font valuosa de suport emocional i comprensió per a aquells que estan en procés de recuperació, ja que poden compartir les seves pròpies experiències, emocions i pensaments (Repper & Carter, 2011; Solomon & Draine, 2001).
2. **Suport mutu**. La interacció entre persones amb problemes de salut mental pot ser essencial en diverses etapes del procés de recuperació, incloent la detecció primerenca de problemes, l'afrontament del diagnòstic i la millora de les habilitats socials. Aquest suport mutu pot ser especialment important durant l'hospitalització i en el procés de recuperació a llarg termini (Repper & Carter, 2011; Solomon, 2004; Fan, Ma, Ma, et al., 2018).
3. **Credibilitat i significat**. La informació compartida per companys amb experiència en salut mental pot ser percebuda com més creïble i significativa per

a la persona afectada, ja que és immediatament rellevant i comprensible. Això pot ser diferent de la informació proporcionada pels professionals de la salut mental, pel fet que es basa en experiències compartides (Davidson et al., 2012).

Aquest enfocament destaca la importància de la connexió personal i la comprensió mútua en el procés de recuperació de les persones amb problemes de salut mental. La interacció amb altres que han passat per situacions similars pot oferir suport, esperança i un sentit d'afiliació, tot contribuint a la recuperació de les persones amb problemes de salut mental.

Peer to Peer

L'ús de treballadors de suport entre iguals en l'àmbit de la salut mental és una estratègia important per a la recuperació de persones amb trastorn mentals sever (TMS) (Bellamy et al., 2017; Davidson. et al., 2012); Pickett et al., 2010); (Jewell et al., 2006). Aquesta pràctica es basa en la filosofia de la recuperació personal i l'ajuda mútua entre iguals en l'abordatge dels desafiaments de la salut mental (Repper i Carter, 2011); (Dewhurst et al., 1974) . Els PSW són individus que han experimentat problemes de salut mental i que han aconseguit estabilitzar-se i avançar en el seu procés de recuperació. Aquests PSW poden jugar diversos rols clau en el suport i la recuperació de les persones amb TMS (Davidson et al., 2012).

Els PSW de vegades formen part d'equips interdisciplinaris de salut mental, tècnicament no són membres de l'equip perquè el seu paper és el de donar suport a un igual, compartir la seva experiència personal sense fer intervencions emmarcades dins del paper de metge, psicòleg o terapeuta ocupacional (Silver i Nemec, 2016). Els PSW aborden la tasca des d'un altre paradigma que es basa en l'ajuda mútua entre iguals; en ajudar els altres, també s'ajuden a si mateixos. L'anomenada recuperació “personal”, complementària a la recuperació clínica i social, es basa en un procés d'adaptació positiva a la malaltia i la discapacitat, buscant crear les condicions per assolir un nivell adequat de benestar personal més enllà de les limitacions. que la malaltia pot causar (Kuhn et al., 2015). Els rols dels PSW en el procés de recuperació inclouen (Mead et al., 2001):

- **Capacitar a les persones amb TMS**. Els PSW poden col·laborar amb els seus iguals per ajudar-los a prendre el control del seu tractament i recuperació. Això pot implicar donar-los suport per afrontar els desafiaments de la malaltia mental,

proporcionar-los eines per millorar la seva gestió i oferir consells basats en les seves pròpies experiències.

- **Connectar amb la xarxa social**. Els PSW també poden actuar com a enllaços entre les persones amb TMS i les seves famílies, amics i la comunitat en general. Això pot ajudar a combatre l'aïllament social i promoure la inclusió i la socialització, aspectes importants en el procés de recuperació.
- **Millorar la competència en les activitats quotidianes**. Els PSW poden oferir suport pràctic per ajudar les persones amb TMS a millorar les seves habilitats i competències en les activitats de la vida quotidiana. Aquest suport pot incloure l'ensenyament de tècniques per fer front a les demandes diàries i la promoció de l'autonomia.
- **Fer que les demandes siguin audibles i visibles**. Els PSW poden actuar com a ponts entre les persones amb TMS i els equips de salut, assegurant-se que les necessitats i les preferències dels seus iguals siguin escoltades i tingudes en compte en el procés de recuperació. Això pot ajudar a millorar la qualitat de l'atenció i a fer-la més centrada en la persona.

Els treballadors de suport entre iguals exerceixen un paper crucial en el procés de recuperació de les persones amb TMS, oferint suport, esperança i empoderament des de la seva pròpia experiència. Aquest enfocament es basa en la idea que la recuperació personal va més enllà dels criteris de diagnòstic psiquiàtric i que les persones amb experiència pròpia de TMS poden fer una diferència significativa en el suport i la recuperació dels seus iguals.

Model de recuperació personal en salut mental i teràpia ocupacional

Antecedents històrics: el tractament moral de Pinel

Philippe Pinel, conegut com el pare del tractament moral en l'ajuda de persones amb problemes de salut mental, va tenir un paper fonamental en el desenvolupament de les intervencions entre iguals i va influir en la teràpia ocupacional (Pelletier et al., 2015). Les seves contribucions es remunten al segle XIX, i la seva visió holística de l'ésser humà i el seu enfocament en la participació en tasques de la vida diària i l'ocupació com a mitjà terapèutic van ser pioners en el camp de la salut mental i la rehabilitació psicosocial.

Una de les principals aportacions de Pinel va ser el concepte de "tractament moral", que es basava en un enfocament humanista de la persona i en l'atenció a les seves necessitats socials i psicològiques. Aquest enfocament implica l'estudi de la història del pacient, el restabliment de la comunicació amb ells i el respecte per les seves àrees d'interès. Això es relaciona de manera significativa amb els principis actuals de la teràpia ocupacional, que busca millorar la qualitat de vida i la funció ocupacional de les persones mitjançant la participació en activitats significatives i la consideració dels factors ambientals (Peloquin, 1989).

A més, la idea de Pinel de reclutar persones en recuperació per ajudar altres que pateixen problemes de salut mental també va ser una contribució significativa als conceptes contemporanis d'intervencions entre iguals (Davidson et al., 2012). Aquest enfocament destaca la importància de l'empoderament i el suport mutu entre persones que han experimentat els mateixos reptes.

En resum, Philippe Pinel va ser un precursor en el camp de la salut mental i la teràpia ocupacional, i les seves idees i pràctiques van influir en les intervencions entre iguals i en l'actual paradigma de la teràpia ocupacional. La seva visió holística i humanista

de l'ésser humà encara és rellevant en la pràctica actual de la salut mental i la rehabilitació psicosocial.

Ocupació significativa, pilar del model de recuperació personal

Hi ha un consens general sobre els components d'una "bona recuperació", incloent-hi la recerca d'esperança, l'optimisme sobre el futur, la restauració d'una identitat positiva sobre la identitat danyada i el desenvolupament d'un sentit d'empoderament en el context de la malaltia (Repper i Carter, 2011). Diversos investigadors i acadèmics han demostrat que l'enfocament dels PSW és ideal per desenvolupar aquestes facetes, a causa de les seves experiències directes de discapacitat (Campos et al., 2014), i fer front a l'estigma i aconseguir la restauració (Davidson et al., 2006; Flanagan et al., 2006; al., 2016). Els companys restaurats creen ràpidament una relació d'empatia que anima els pacients a recuperar l'esperança i l'optimisme i crea les condicions òptimes per assolir objectius més ambiciosos (Dahl et al., 2015; Sells et al., 2008).

Una de les persones més transcendentals dins de la disciplina de la teràpia ocupacional va ser Adolf Meyer. Va ser un dels precursors del paradigma ocupacional, ocupacions que proporcionen un sentiment d'interès, valor, assoliment i repte. Meyer va subratllar la importància de les relacions interpersonals entre professional i pacient com a element essencial en la construcció d'ocupacions significatives (Meyer, 1922), la qual cosa dona suport a la importància del concepte de programes entre iguals en salut mental.

Aquests conceptes estan íntimament lligats a la idea de significat de Vicktor Frankl (pare de la logoteràpia), on la logoteràpia mostra que la motivació fonamental de cada persona és la recerca de sentit per a la seva pròpia vida, en cada moment concret i situació particular i única, en què es troba la seva existència (Parker, 2021). Ser humà significa estar vivint "la tensió establerta entre la realitat i els ideals a materialitzar" (Frankl, 1959, p. 58). L'essència de les intervencions dels PSW està en línia amb el

paradigma actual de la teràpia ocupacional. Mary Reilly (1962) va qüestionar els principis utilitzats fins als anys seixanta i va recuperar un enfocament holístic amb l'ocupació com a centre de la intervenció, donant a l'usuari del servei un paper actiu en la seva recuperació.

Els terapeutes ocupacionals busquen millorar la salut i el benestar d'una persona des d'un punt de vista holístic, incloent-hi els aspectes físics, cognitius, psicològics i espirituals mitjançant la implicació de les persones en ocupacions significatives. L'espiritualitat de la persona es pot expressar en diferents formes i accions, que li permeten connectar amb ella mateixa i amb el seu entorn (Humbert, 2016).

Connexió de la teràpia ocupacional amb el model de recuperació personal

La teràpia ocupacional té un paper essencial en el suport entre iguals i en la millora del benestar ocupacional de les persones, ajudant-les a trobar un equilibri en les seves ocupacions i aconseguir una millor qualitat de vida.

- Valoració de l'ocupació com a part integral de la salut i el benestar. La teràpia ocupacional entén l'ocupació com una part fonamental de la salut i el benestar de les persones. Aquesta visió implica que el suport entre iguals pot ser crucial tant per a qui ofereix aquest suport com per a qui el rep (Kielhofner, 2009; Wilcock, 2006).

- Paper del terapeuta ocupacional. El terapeuta ocupacional pot defensar i promoure el valor del suport entre iguals, destacant la importància d'aquest tipus de suport en el treball i el benestar dels participants. Aquesta professió pot aportar una perspectiva única per equilibrar les ocupacions d'automanteniment, productivitat i oci en la vida de les persones (Wilcock, 2006).

- Compromís amb els PSW. El compromís del professional amb els PSW és fonamental per al seu èxit. El terapeuta ocupacional pot ajudar-los a explorar els seus interessos i rols ocupacionals, així com a trobar un equilibri entre les seves responsabilitats de cuidador i altres aspectes de la seva identitat ocupacional.

- Disseny de la intervenció. Diferent de moltes altres professions sanitàries, la teràpia ocupacional té la capacitat de dissenyar intervencions que se centrin en l'ocupació i ajudin les persones a aconseguir un equilibri ocupacional saludable, incloses les ocupacions d'automanteniment, productives i d'oci (Jones et al., 2013).

- Benestar i control de la vida. L'objectiu final de la teràpia ocupacional en aquest context és promoure el benestar en el desenvolupament ocupacional de les persones i evitar desequilibris laborals que puguin afectar la seva qualitat de vida. El control de la pròpia vida es veu com un símptoma de salut i benestar (Townsend i Polatajko, 2013); (Repper & Carter, 2011).

Així podem afirmar, la importància de la teràpia ocupacional en l'ajuda a les persones que ofereixen suport entre iguals i com a via per millorar el benestar i la salut ocupacional de totes les persones involucrades.

Exemples de programes entre iguals en salut mental des de la teràpia ocupacional

La teràpia ocupacional ha estat una part integral de programes d'igual a igual en serveis de salut mental a diverses regions del món. Aquests programes es basen en els

principis de la teràpia ocupacional per acompanyar a les persones amb problemes de salut mental a millorar la seva qualitat de vida i les seves habilitats ocupacionals.

1. **Careers Offering Peers Early Support** (COPES) a Austràlia. Programa dissenyat per a persones que proporcionen suport a altres amb problemes de salut mental (Bourke et al., 2015). La teràpia ocupacional ha tingut un paper essencial en el disseny i implementació del programa COPES. Aquest programa està basat en diversos conceptes clau de la teràpia ocupacional, com l'enfocament basat en la força centrat en la persona (Wilcock, 2006; Townsend i Polatajko, 2013), el marc basat en drets (Hammell, 2017), la col·laboració com a facilitador i l'anàlisi ocupacional detallada (Fransen et al., 2015).
2. **Programa peer-to-peer en serveis forenses d'alta seguretat** (Regne Unit). Aquest programa ha estat dissenyat per a serveis forenses d'alta seguretat i utilitza principis de teràpia ocupacional per augmentar la confiança de les persones, desenvolupar habilitats de comunicació i interacció social, augmentar els factors de protecció i realinear la voluntat cap a interessos i opcions més prosocials (Wolfendale i Musaabi, 2017). Els treballadors entre iguals (PSW) actuen com a vincle entre les persones i els seus objectius terapèutics. El terapeuta ocupacional supervisa i fa seguiment de l'evolució de la intervenció.
3. **Programa de formació a Hong Kong**. A Hong Kong, es va dur a terme una intervenció entre iguals que incloïa una formació extensa i pràctica. Aquest programa tenia com a objectius mesurar l'impacte en la consciència del progrés de la recuperació, la competència ocupacional i les habilitats de resolució de problemes (Yam et al. 2018). La teràpia ocupacional va estar present en totes les

etapes, des del disseny i la implementació del programa fins a la selecció dels participants i l'avaluació dels resultats.

Aquests exemples mostren com la teràpia ocupacional pot jugar un paper important en els programes de suport entre iguals. Aquesta integració de principis i pràctiques de teràpia ocupacional pot contribuir a millorar la qualitat de vida i el benestar de les persones que necessiten aquest suport.

Atenció integrada i integral: Mosaic, un exemple de bona praxi

L'aposta per la integració social i sanitària és una preocupació crucial per als governs en molts països, especialment en un context de crisis social i econòmica. La necessitat d'abordar aquesta integració rau en la demanda d'eficiència i millora de l'atenció a les persones, així com en la promoció de la salut i la prevenció de malalties (Baxter et al., 2018; Frost et al., 2017; Gröne & Garcia-Barbero, 2001).

La definició de Kodner i Spreeuwenberg (2002) sobre el procés d'integració ressalta la importància de la connectivitat, l'alienació i la col·laboració entre els sectors dedicats a la cura social i de la salut. Això implica coordinar els mètodes de finançament, l'administració, l'organització i la prestació de serveis per aconseguir una millor atenció a la població. Aquest enfocament posa l'èmfasi en l'atenció centrada en la persona i considera els determinants socials de la salut com un aspecte crític en l'atenció (Leutz, 1999).

Els processos d'integració no només milloren la continuïtat en l'atenció, sinó que també s'enfoquen en les necessitats individuals i es prenen en compte els factors socials que influeixen en la salut. Aquesta aproximació no només cura les persones quan estan malaltes, sinó que també es preocupa de la prevenció i promoció de la salut, abordant les arrels de les malalties i promovent un estil de vida sa (Valentijn et al., 2013).

Aquesta atenció integrada és fonamental per abordar els reptes socials i de salut que es presenten en la societat actual, i pot contribuir a millorar la qualitat de vida i el benestar de la població en situacions de crisi.

El projecte MOSAIC és una iniciativa social amb l'objectiu de millorar la qualitat de vida de les persones que pateixen problemes de salut mental i addiccions a la Catalunya Central, amb una ubicació específica a Manresa. Aquesta iniciativa és pionera a Catalunya i pot servir com a model per altres àrees del territori. És una col·laboració entre

diverses entitats: la Fundació Tomàs Canet, les Germanes Dominiques de Santa Clara, l'Orde de Sant Joan de Déu, l'Ajuntament de Manresa i la Fundació Althaia.

El Mosaic ofereix diversos serveis per millorar la qualitat de vida de les persones amb problemes de salut mental i addiccions. Aquests serveis inclouen:

- **Programa de Treball** (PT). Aquest servei proporciona suport i assessorament individualitzat per ajudar les persones a trobar, accedir i mantenir l'ocupació.
- **Club Social** (CS). Aquest servei té com a objectiu fomentar la participació i la connexió de les persones amb la comunitat.
- **Servei de Rehabilitació Comunitària** (SRC). Aquest servei se centra en la rehabilitació psicosocial de les persones amb trastorns mentals, oferint atenció individual, grupal, familiar i comunitària per abordar les seves necessitats i característiques personals.
- **Pla de Servei Individualitzat** (PSI). Aquest servei es basa en la gestió de casos i en un model d'intervenció comunitària assertiva per garantir la continuïtat assistencial i promoure la recuperació màxima possible de les persones amb trastorns de salut mental greus.

El projecte Mosaic és una mostra de com la col·laboració entre diferents entitats pot millorar el suport i l'atenció a les persones amb problemes de salut mental i addiccions. Pot ser un exemple inspirador per altres regions i comunitats que vulguin abordar aquestes qüestions de manera integral i coordinada.

Mosaic acompanyar a la persona reconeixent la diversitat en els processos de recuperació de la salut mental i posa èmfasi en l'esperança, el suport mutu i la resiliència com a factors clau en aquest procés, incloent el trauma com una part integral de la recuperació (Rowe & Davidson, 2016). S'adapta al ritme de la persona. Cada persona ha

de construir el sentit de la seva pròpia vida, ha de trobar els recursos que li serveixin per al seu benestar, ha d'enfortir o construir una identitat que no està definida per la patologia. Els serveis s'orienten a la recuperació, definit com un procés, és a dir, tot un conjunt de petites accions quotidianes que, fetes al llarg del temps, ajuden a la persona (Rubashkin, Warnock & Diamond-Smith, 2018).

L'atenció integrada pot millorar significativament la qualitat de vida de les persones amb problemes de salut mental. És un desafiament global que afecta la població mundial, especialment aquella que pateix problemes de salut mental (Baxter et al., 2018; Frost et al., 2017; Gröne & Garcia-Barbero, 2001). Hi ha dues revisions sistemàtiques recents (del 2017 i del 2022) que aborden aquest desafiament i destaquen la seva importància.

La revisió del 2017 va mostrar l'eficàcia de 172 experiències d'atenció integrada. No obstant això, va posar de manifest la necessitat d'indicadors de qualitat per millorar la seva implementació (Sunderji et al., 2017). L'equip de recerca de Chan també va destacar la precarietat dels serveis en salut mental i la importància d'equips multidisciplinaris per millorar el coneixement i l'atenció. Altrament, la revisió del 2022 d'atenció integral de salut mental basada en el model de recuperació personal, que destaca la importància d'intervencions psicosocials basades en l'evidència i la col·laboració amb organitzacions comunitàries (Frost et al., 2021).

Ambdós estudis ressalten la necessitat d'identificar indicadors de qualitat per millorar els serveis d'atenció integrada en salut mental i abordar aquest problema com una qüestió de salut pública global.

Aquesta informació suggereix que l'atenció integrada en salut mental és un camp complex i en evolució, i que es requereixen indicadors de qualitat i col·laboració multidisciplinària per millorar la seva implementació i abordar les necessitats de la

població amb problemes de salut mental. Per aquesta raó l'estudi, i el projecte Mosaic, tenen un paper essencial.

Catalunya, un context d'oportunitats per promoure el model de recuperació

La limitada implantació de la perspectiva de la recuperació a la nostra regió, tot i que està més present en altres països com els Estats Units, Nova Zelanda, Austràlia, Anglaterra i Canadà, és un punt crític (Slade et al., 2012b). Això pot ser una oportunitat per a la millora i el canvi en l'atenció a les persones amb problemes de salut mental a la vostra zona.

1. **Canvi en els dispositius de salut mental**. Aquesta perspectiva implica transformacions en els serveis i dispositius de salut mental. Això pot implicar un canvi en la cultura institucional, la formació del personal, els protocols de tractament i les polítiques de salut (Dubreucq et al., 2022; Khan & Tracy, 2022; Weaver, 2021).
2. **Mesurament dels resultats a través de la recuperació**. En lloc de mesurar l'èxit únicament en termes de reducció de símptomes, es poden establir indicadors de recuperació més amplis que tinguin en compte la qualitat de vida de les persones i el seu benestar en general.
3. **Canvis en les actituds dels professionals**. És crucial que els professionals de la salut mental abordin els seus propis prejudicis i creences sobre la salut mental i les persones amb trastorns mentals. La formació i l'educació poden ajudar a promoure una mentalitat orientada a la recuperació.
4. **Participació ciutadana**. Involucrar les persones afectades i les seves famílies en la presa de decisions sobre el seu propi tractament i en el disseny de programes i serveis pot ser clau per promoure la recuperació. Aquesta participació pot afavorir la seva autonomia i empoderament.
5. **Orientació als drets de les persones amb malaltia mental**. Reconèixer i protegir els drets de les persones amb trastorns mentals és fonamental. Això inclou

l'eliminació de l'estigma, la garantia d'accés als serveis de salut mental i el respecte de la seva dignitat (Onocko-Campos, Davidson & Desviat, 2021).

Promoure la perspectiva de la recuperació en l'atenció a les persones amb problemes de salut mental és un pas crucial cap a una atenció més holística, centrada en la persona i que busca el seu benestar i recuperació. Això implica canvis en els dispositius, les actituds dels professionals i un enfocament en els drets de les persones amb malaltia mental.

A Catalunya, com a altres regions, s'ha implementat un enfocament innovador en la prestació de serveis de salut mental, amb un èmfasi en la recuperació i la comunitat. Aquest enfocament integra diversos aspectes i programes per millorar la qualitat de vida i el benestar de les persones amb problemes de salut mental. Algunes de les característiques clau d'aquest son:

- **Model de tractament comunitari assertiu** (adaptació). Aquest model es centra en l'atenció integral de les persones amb problemes de salut mental i es basa en l'adaptació del model de tractament comunitari assertiu. Aquest enfocament implica l'atenció a diversos àmbits de la vida de la persona, com l'habitatge, la socialització, els símptomes, la formació, el treball i fins i tot la dimensió espiritual. Això proporciona una atenció completa i personalitzada.
- **Programa Activa't per la Salut Mental**. Aquest programa té com a objectius acompanyar les persones amb problemes de salut mental en la construcció d'un projecte de vida i promoure les xarxes de suport social. Això ajuda a integrar les persones afectades en la societat i a millorar la seva qualitat de vida (Rojo et al., 2019; Sampietro & Gavaldà, 2018).

- **Pacte Nacional per a la Salut Mental** (PNSM). El PNSM és un instrument interdepartamental i intersectorial de la Generalitat de Catalunya que promou la salut mental des de tots els àmbits d'actuació del govern i la societat (Generalitat de Catalunya, 2021). Aquest pacte estableix objectius importants, com l'enfocament integral i comunitari, la promoció d'un canvi de paradigma en les polítiques públiques de salut mental i l'adopció de les conclusions de la Convenció de les Nacions Unides sobre els drets de les persones amb discapacitat (Funk & Drew, 2017).

Per concloure, podem afirmar que a Catalunya s'ha desenvolupat un enfocament complet i integrador en la prestació de serveis de salut mental, amb l'objectiu de millorar la qualitat de vida de les persones afectades i promoure la seva inclusió social i la seva recuperació personal. Aquest enfocament està alineat amb les recomanacions de l'Organització Mundial de la Salut i les conclusions de la Convenció de les Nacions Unides sobre els drets de les persones amb discapacitat (UN, 2006).

JUSTIFICACIÓ

Ready to Blossom in the Morning. *Yayoi Kusama, 1989*

Justificació

El concepte de recuperació personal s'està començant a estudiar en profunditat en diferents països donada la rellevància dels primers estudis que han indicat el seu valor predictiu d'afavorir el funcionament sociocomunitàri de persones amb problemes de salut mental greu. La capacitació tant de professionals com de persones amb experiència de vida psiquiatritzada, en l'atenció centrada en la recuperació és un dels aspectes clau per tal d'afavorir la inclusió social de les persones que pateixen un problema de salut mental.

Pensem que el projecte que es presenta conté dos grans nuclis d'interès social, per una banda, la seva difusió i la implementació a la Catalunya Central, pot contribuir a la disminució de l'estigma envers la salut mental; fomentant la seva participació ciutadana, repte de la majoria de societats contemporànies d'acord també amb les recomanacions i prioritzacions de l'Organització Mundial de la Salut; en les quals roman un interès per les actituds socials cap a les persones amb problemes de salut mental i la conseqüent preocupació pels seus efectes sobre aquestes és una constant en el marc de l'atenció comunitària.

D'altra banda, el fet de treballar amb persones amb experiència pròpia en salut mental en un model d'atenció diferent de l'usual en els dispositius d'atenció a la salut mental, contribueix al foment de l'empoderament d'aquestes, i de tot l'equip de professionals, contribuint a una visió diferent de la salut mental i, proporcionant la competència personal a les persones afectades, habitualment negada. D'aquesta manera, la realització del projecte, tindrà un efecte darrer en la millora del benestar personal i de les relacions interpersonals.

El nostre projecte pretén anar més enllà i verificar científicament l'eficàcia del model de recuperació en l'atenció i tractament de persones amb problemes de salut mental, i l'efectivitat de l'aplicació d'una de les tècniques d'evidència científica, la inclusió

del grup d'iguals com a coterapeutes, fet que tindrà una rellevància científica innovadora en el nostre territori, on manquen treballs sobre l'aplicació d'aquest model. De fet, creiem que els resultats del projecte tindran una rellevància quant al seu impacte bibliomètric, ja que els resultats del projecte seran publicats en revistes internacionals amb índex d'impacte.

El nostre estudi pretén, en última instància, promoure un canvi de model en l'atenció a la Salut Mental, proposant un nou enfocament, model d'atenció i tècniques d'intervenció, tots ells basats en l'evidència científica, la qual indica que afavoreixen el funcionament sociocomunitari autònom de les persones afectades amb problemes de salut mental.

HIPÒTESIS i OBJECTIUS

Sunlight. *Yayaoi Kusama, 1998*

Hipòtesis i Objectius

En el següent apartat, es detallen les hipòtesis i objectius plantejats els quals han conduït el procés de recerca.

⇒ **Hipòtesis 1**. La implementació del model de recuperació millorarà el funcionament comunitari i afavorirà la qualitat i satisfacció amb la vida de les persones amb problemes de salut mental greu.

⇒ **Hipòtesis 2**. La incorporació de persones amb problemes de salut mental, formades, com a coterapeutes repercutirà positivament en el seu benestar propi com en el de les persones afectades a les quals donin suport.

⇒ **Hipòtesis 3.** La implementació del model de recuperació conduirà a la correlació de l'ocupació significativa amb variables orientades a la recuperació.

Objectius generals

1. Valorar l'efectivitat de la implementació del model de recuperació en una mostra de persones TMS ateses als dispositius de Salut Mental de la Catalunya Central.

Objectius específics

La tesi s'organitza en tres articles que aborden els objectius generals de la següent manera:

- **Article 1**, *Peer Interventions in Severe Mental Illnesses: A Systematic Review and its Relation to Occupational Therapy*. L'objectiu d'aquesta revisió és sistemàtica és:
    - Ampliar el coneixement de la tècnica peer-to-peer en teràpia ocupacional explorant:
        - (1) les intervencions realitzades pels agents de suport entre iguals;
        - (2) els resultats aconseguits de la intervenció;

- (3) l'impacte en els usuaris del servei, i;
- (4) la influència de la teràpia ocupacional.

- **Article 2,** *Training Peer Support Workers in Mental Health Care: A Mixed Methods Study in Central Catalonia*. L'objectiu d'aquest estudi és:
  - Avaluar l'impacte de la implementació de la tècnica peer-to-peer en els tres participants de la intervenció: agents de suport entre iguals; usuaris del servei; i professionals
- **Article 3,** *Mosaic, an Example of Comprehensive and Integrated Social and Health care: Care and Practices Oriented Towards Personal Recovery.* L'objectiu d'aquest estudi és:
  - Examinar la relació entre el nivell d'activitats significatives i altres factors associats amb el patró de recuperació de la salut mental.
  - Avaluar l'efectivitat de la implantació del model de recuperació en una mostra de persones amb problemes de salut mental greus ateses a MOSAIC.

METODOLOGIA

Mushrooms. *Yayaoi Kusama, 1995*

Metodologia

El projecte es va dur a terme a la Catalunya central en col·laboració amb dues institucions d'atenció a la salut mental: Osonament de Vic i la Divisió de Salut Mental de la Fundació Althaia de Manresa. Aquestes dues institucions ofereixen serveis importants per al benestar i la recuperació de persones amb problemes de salut mental i addiccions. Aquí tens una descripció més detallada de les seves activitats:

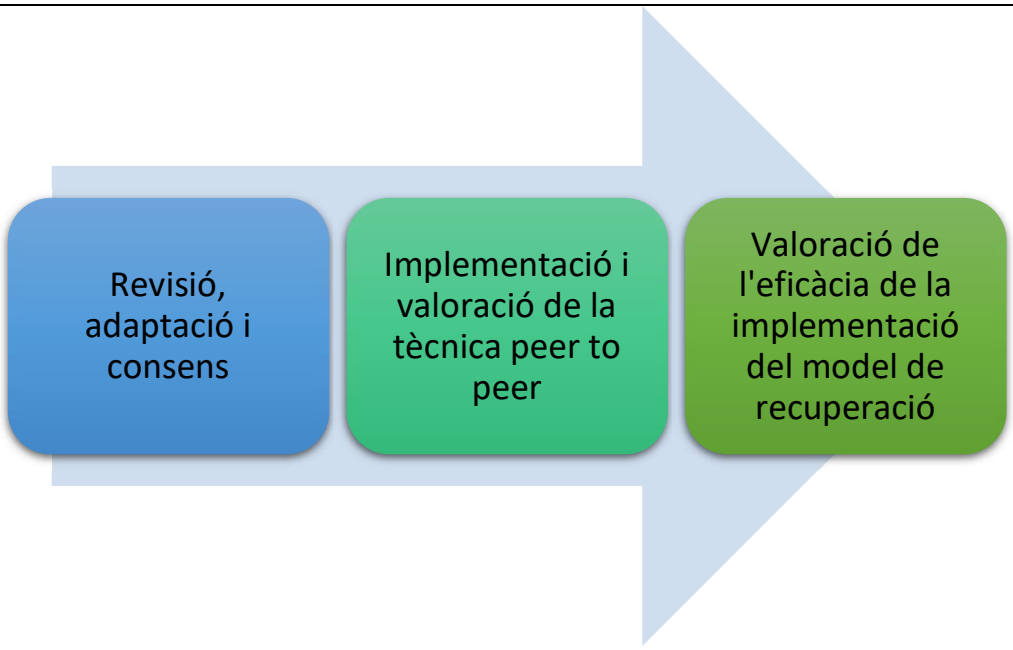
1. **Osonament** (Vic). Osonament es dedica a oferir serveis comunitaris integrats especialitzats en la prevenció i cura de la salut mental i addiccions. Aquest enfocament integral implica abordar les necessitats de salut mental i les addiccions d'una manera holística, considerant els aspectes clínics i socials de la persona. Osonament té com a objectiu promoure el desenvolupament integral de les persones i millorar la seva qualitat de vida. Això pot incloure proporcionar teràpia i suport emocional, treballar en la millora de les habilitats socials i emocionals i afavorir l'autonomia de les persones. L'organització també es dedica a lluitar contra l'estigma social associat a la salut mental i les addiccions, promovent la integració de les persones a la comunitat i fent-les sentir part activa de la societat.
2. **Fundació Althaia** (Manresa). La Fundació Althaia ofereix atenció sociosanitària integral per a persones amb problemes de salut mental i addiccions. Això significa que ofereixen una àmplia gamma de serveis per abordar les necessitats mèdiques i socials de les persones en aquesta situació. La fundació facilita l'ús comunitari dels espais, el que implica que les persones poden participar activament en activitats i programes a la comunitat, afavorint així la seva integració social i contribuint a la reducció de l'estigma que sovint es relaciona amb els problemes

de salut mental. Althaia també ajuda les persones a desenvolupar un projecte de vida significatiu. Això pot incloure l'assistència per promoure la seva inserció laboral, oferint assessorament i suport individualitzat. A més, proporcionen suport a domicili per ajudar les persones a viure de la manera més autònoma possible.

Aquestes dues institucions treballen de manera col·laborativa per ajudar les persones amb problemes de salut mental i addiccions a millorar la seva qualitat de vida, promoure la seva integració a la comunitat i ajudar-les a construir un projecte de vida significatiu i autònom. Aquest és un enfocament integral i vital per al benestar de les persones que es troben en aquestes situacions.

El projecte que es presenta consta de 3 fases diferenciades:

Figura 2. Fases del projecte de recerca



Elaboració pròpia

A. Revisió, adaptació i consens

En aquesta fase s'ha adaptat i consensuat entre els professionals de les entitats participants i col·laboradores (UY), el model de recuperació i la tècnica peer to peer a implementar en els dispositius de l'atenció a la Salut Mental de la Catalunya Central. Això

va ser possible per mitjà d'una revisió sistemàtica de la literatura científica sobre el model i la tècnica, fent-ne la difusió pertinent a aquelles associacions, institucions i la societat en general sobre les característiques i la implementació d'aquest model.

a. **Criteris d'elegibilitat**:
    i. articles des de gener de 1990 fins a juliol de 2019;
    ii. escrit en anglès;
    iii. publicat en línia i amb text complet disponible perquè això era el que estaven a disposició dels autors;
    iv. comparació entre el grup experimental (intervenció PSW) i el grup control (intervenció estàndard);
    v. Edat dels participants entre 18 i 65 anys;
    vi. diagnòstic de trastorns mentals greus;
    vii. (g) intervencions de teràpia ocupacional.
b. **Tipus de dominis de resultats**. Els resultats del procés de teràpia ocupacional analitzats a la revisió són els que figuren a l'OTPF-4, concretament els següents:
    i. Desenvolupament ocupacional
    ii. Prevenció
    iii. Salut i benestar
    iv. Qualitat de vida
    v. Participació
    vi. Benestar
    vii. Justícia ocupacional.
c. **Estratègia de cerca**. La cerca, selecció i avaluació crítica dels estudis rellevants es va dur a terme tenint en compte les directrius PRISMA (Preferred

Reporting Items for Systematic Reviews and Meta-Analyses) (Liberati et al., 2009). La cerca de dades es va dur a terme a través de les bases de dades informàtiques MEDLINE, Web of Science, Scopus i Cochrane Library. Es van utilitzar i combinar dues estratègies de cerca en l'anàlisi final:

i. ((“mental health”) OR (“mental illness”)) AND ((((“peer support”) OR (“peer to peer”)) OR (“peer led”)) OR (“consumers”));
ii. (((“mental health”) OR (“mental illness”)) AND (((“mental health”) OR (“mental illness”)) AND ((((“peer support”) OR (“peer to peer”)) OR (“peer led”)) OR (“consumers”)))) AND (“occupational therapy”).

d. **Avaluació del biaix**. El risc de biaix en cada article es va avaluar seguint el protocol establert a la guia Cochrane (Higgins et al., 2011).
e. **Gestió de dades**. El programa utilitzat va ser Microsoft Excel (v.18.11), en el qual es va desenvolupar un formulari d'extracció de dades per registrar la informació següent: disseny de l'estudi; país de mostra; mida de la mostra, edat, ètnia i criteris d'inclusió; descripció del grup d'intervenció i control experimental; Mesures de resultat; i resultats. Tres avaluadors independents, entre ells dos terapeutes ocupacionals, van extreure dades mitjançant formularis idèntics. Després de l'extracció de dades, vam comparar la informació introduïda i vam resoldre els conflictes mitjançant la discussió i el consens. De cadascun dels articles també s'ha obtingut la següent informació: any de publicació (per tal de rastrejar cronològicament l'ús de la tècnica); (2) mida de la mostra, per avaluar la representativitat; (3) Tipus de disseny de l'estudi i avaluació dels instruments i resultats.

B. Implementació i valoració de la tècnica peer to peer

En aquesta segona fase es va adaptar la formació partint dels resultats de la revisió sistemàtica, per a acreditar a persones amb problemes de salut mental per intervenir en els equips de treball. L'avaluació es va dur a terme en tres moments: pre-test (T1), post-entrenament (T2) i post-test (T3).

a. **Criteris d'elegibilitat**. El projecte va incloure tres grups de participants, amb el criteris d'inclusió següents:
    i. PSW: edat de 18 a 65 anys, diagnòstic de trastorn mental greu i procés de recuperació òptim durant l'últim any.
    ii. Usuaris del servei: edats compreses entre 18 i 65 anys, assistència regular al Serveis de Recuperació Comunitària (SRC) i diagnòstic trastorn mental greu. Els diagnòstics més freqüents van ser esquizofrènia, trastorn bipolar i depressió.
    iii. Professionals: entre 18 i 65 anys, membres del personal de SRC: psicòlegs, infermeres, treballadors socials, i terapeutes ocupacionals.
b. **Variables i mesures de resultat**. Dades sobre autoestigma, satisfacció amb la vida, participació en activitats rellevants, recuperació personal, rendiment laboral, etc. Les actituds cap a la salut mental es van registrar mitjançant els cinc qüestionaris que s'indiquen a continuació:
    i. *Self-Stigma Questionnaire* (SSQ) (alfa de Cronbach que oscil·la entre $\alpha = 0,75$ i $\omega = 0,901$) utilitza les següents categories de resposta Likert: 1 = molt d'acord, 2 = moderadament d'acord, 3 = lleugerament d'acord, 4 = ni d'acord ni en desacord, 5 = lleugerament en desacord, 6 = moderadament en desacord i 7 = molt en desacord. Les puntuacions més altes indiquen un autoestigma més baix (Ochoa et al., 2015).

ii. La versió espanyola de la *Scale of Satisfaction with Life* (SWLS) de Diener et al., adaptada per Atienza et al. (α de Cronbach = 0,88), ofereix un judici global de la satisfacció de les persones amb les seves pròpies vides. Consta de cinc ítems de tipus Likert amb puntuacions que van des d'1 "molt en desacord" fins a 5 "molt d'acord" (Atienza, Balaguer & Garcia_Merita, 2003; Diener et al., 1985).

iii. *Engagement in Meaningful Activities Survey* (EMAS) (α de Cronbach = 0,91) reflecteix múltiples propostes de teràpia ocupacional i ciència ocupacional que aborden els components d'un compromís significatiu. L'EMAS aborda l'avaluació del significat d'una ocupació reunint diferents punts de vista sobre el significat i l'ocupació (Prat et al., 2019).

iv. *Recovery Assessment Scale-revised* (RAS-R) (alfa de Cronbach que oscil·la entre α = 0,93 i ω = 0,95) és un instrument autoaplicat que mesura la recuperació personal, desenvolupat fa més de 20 anys per Gifford i col·legues dels Estats Units. El RAS-R consta de 24 ítems en una escala de cinc nivells "molt en desacord", "en desacord", "no estic segur", "d'acord" i "molt d'acord" (Saavedra et al., 2021).

v. *Canadian Occupational Performance Measure* (COPM) és una eina d'avaluació individual dissenyada per detectar canvis en l'autopercepció dels clients sobre el seu rendiment i satisfacció al llarg del temps. Es puntua amb valors d'1 (més baix) a 10 (puntuació més alta) (Law et al., 1990). La fiabilitat de la nova prova del COPM va ser r = 0,842.

vi. *Community Attitudes toward Mental Illness* (CAMI) de Taylor i et al. és una escala composta per 40 ítems, valorats en una escala Likert de 5 punts, que va des d'acord total fins a desacord total (alfa de Cronbach que oscil·la entre $\alpha = 0,861$ i $\omega = 0,909$) . L'escala consta de quatre factors anomenats: autoritarisme, benevolència, moderació social i ideologia mental de salut comunitària, cadascun dels quals conté 10 declaracions sobre opinions sobre com tractar i atendre les persones amb malalties mentals greus. Cinc d'aquests 10 ítems s'expressen positivament i els altres cinc negativament (Ochoa et al., 2016).

⇒ **Aquests mètodes es van escollir tenint en compte dos criteris: (1) mesuren els resultats d'acord amb el paradigma de recuperació personal i (2) els instruments es van validar en castellà.**

c. **Procediments de recollida de dades**. Al començament de la formació (T1), es van recollir dades sociodemogràfiques dels PSW i es van administrar mesures de resultats a tots els grups de participants. Després de 6 mesos (T2), els PSW que havien completat amb èxit la formació van respondre els mateixos qüestionaris i, addicionalment, el COPM. Finalment, 12 mesos després (T3), es va tornar a contactar amb tots els participants per completar les mesures de resultat i el COPM. Al final del programa, es van utilitzar grups focals per avaluar més l'impacte sobre els participants. Es va contactar amb tots els professionals de les dues institucions de referència on es van incloure els PSW mitjançant un qüestionari en línia amb un format d'ítem obert (Gill et al., 2008). Paral·lelament, es van realitzar grups focals (Stalmeijer et al., 2014) amb els PSW i usuaris del servei, basats en un format d'entrevistes semiestructurades i obertes i amb una durada mitjana de 90-120 min. Les

preguntes giraven al voltant de les percepcions sobre el programa i la seva pròpia execució del paper dels PSW, l'impacte percebut en el seu propi procés de recuperació i suggeriments per a la implementació de programes futurs. Es van dur a terme qüestionaris i grups focals en català i castellà, i es van elaborar transcripcions literals per a la seva anàlisi final.

d. **Anàlisi de dades**.

   i. Mesures quantitatives. Dos investigadors (PV i CP) van utilitzar el programari SPSS (versió 28.0). Es va utilitzar una anàlisi de mesures repetides de ANOVA als instruments amb tres punts de recollida de dades. Aplicant la d de Cohen, es va verificar la mida de l'efecte de les diferències mitjanes. L'anàlisi de les dades es va completar mitjançant proves no paramètriques, la prova de rang de Wilcoxon per a mesures repetides i la prova de Mann-Whitney U per a comparacions de mitjanes entre grups. En tots els casos, es va considerar un valor p <0, 05 per rebutjar la hipòtesi nul·la.

   ii. Entrevistes qualitatives. ii. Entrevistes qualitatives. Tres investigadors independents (SA, PV i CP) van fer ús de l'Atlas.ti (versió 9.1) per fer l'anàlisi de les narracions i per crear grups de categories, que van ser analitzats. S'ha fet servir la tècnica d'anàlisi de contingut. Això va començar amb una lectura exhaustiva de les transcripcions de les primeres entrevistes a cada participant, realitzada pel primer autor. Després d'aquesta lectura, es va codificar el material, i es van agrupar les cites en relació amb la seva similitud i amb l'objectiu de l'estudi, a través de diverses discussions entre els investigadors. A partir d'aquestes discussions, es van generar grups preliminars de codis, que

van ser comparats pels investigadors fins a arribar a temes més centrals. Deu PSW, que van completar el projecte de principi a fi, van participar en els grups focals. Dotze professionals van participar en els qüestionaris en línia per avaluar la seva participació en el programa. Vint-i-un usuaris del servei van participar en els grups focals.

iii. Integració de dades. El mètode mixt utilitzat va ser el *convergent parallel design* (Lee, 2019). La triangulació de les troballes qualitatives i quantitatives va facilitar la comprensió dels resultats i va mostrar la seva coherència i manca de contradiccions. Es tracta d'una metodologia que permet la convergència de diferents dades: beneficiosa per aportar confirmació de les troballes, dades més completes, major validesa i millor comprensió dels fenòmens estudiats (Shoonenboom & Johnson, 2017). Es va realitzar una triangulació metodològica amb l'objectiu és analitzar el mateix fenomen mitjançant diferents enfocaments.

C. Valoració de l'eficàcia de la implementació del model de recuperació

En aquesta darrera fase, es valorarà l'efectivitat de la implementació del model de recuperació en una mostra de persones afectades per un problema de salut mental greu que rebin tractament en els dispositius d'atenció a la Salut Mental de la Catalunya Central. Per a tal es realitzarà una recerca de tipus de disseny d'estudi observacional, on els investigadors han mesurat el resultat i les exposicions en els participants de l'estudi en el mateix moment.

a. **Criteris d'elegibilitat**. Els participants de l'estudi van ser persones d'entre 18 i 65 anys; amb un diagnòstic de trastorn mental greu (clúster d'esquizofrènia i trastorns psicòtics; clúster de trastorns bipolars i trastorns afectius majors;

trastorns de la personalitat); cap diferència de gènere; i disposats a participar voluntàriament. Criteris d'exclusió: menors de 18 anys i majors de 65 anys; nivells actuals d'alta dependència i desestabilització aguda del problema de salut mental; dificultats lingüístiques pel que fa a la comprensió i l'expressió de la llengua castellana o catalana; presència de traumatisme cranial, demència o discapacitat física greu (malalties incapacitants que causen una discapacitat superior al 80%) o discapacitat intel·lectual (QI<70); no voler participar en l'estudi de manera voluntària. Presentar comorbiditat amb trastorns per consum de substàncies, trastorns de la personalitat i trastorns orgànics no van ser motius d'exclusió.

b. **Variables i mesures de resultat**. Les variables analitzades en aquest estudi van ser la 1) participació en activitats significatives; 2) grau de resiliència percebuda; 3) autoeficàcia percebuda; 4) percepció subjectiva d'esperança; i 5) percepció subjectiva del grau de recuperació.

    i. *Engagement in Meaningful Activities Survey* (EMAS) (α de Cronbach = 0,91) reflecteix múltiples propostes de teràpia ocupacional i ciència ocupacional que aborden els components d'un compromís significatiu. L'EMAS aborda l'avaluació del significat d'una ocupació reunint diferents punts de vista sobre el significat i l'ocupació (Prat et al., 2019).

    ii. *Connor–Davidson Resilience Scale* (CD-RISC) (Connor & Davidson, 2003) consta de 25 ítems amb un format de resposta de tipus Likert amb cinc opcions de resposta ("gens", "poques vegades", "de vegades", "sovint" i "gairebé". sempre"), puntuat de 0 ("gens") a 4 ("quasi sempre"). La versió espanyola del CD-RISC de 10 ítems té un

coeficient α de Cronbach de 0,85 i el coeficient de correlació intraclasse test-retest de 0,71 (Notario-Pacheco et al., 2003).

iii. *General Self-Efficacy Scale* (GSE), en la versió de Baessler i Schwarzer (1996). Consta de 10 ítems amb respostes en escales tipus Likert de 5 punts entre 1 (totalment en desacord) a 5 (totalment d'acord). Les puntuacions entre 27 i 38 punts mostren una mitjana d'autoeficàcia general. Això és fiable amb valors d'α= .87 per a la versió espanyola (Sanjuán Suárez et al., 2000).

iv. *Herth Hope Scale* (HHS) (Herth, 1992) va ser dissenyada per mesurar el pensament dirigit a objectius en diferents situacions. Està compost per 12 ítems que mesuren vies i components d'agència mitjançant 4 ítems cadascun, i s'afegeixen 4 ítems de farciment més. En els estudis de validació, tenia una consistència interna elevada (α =.97) i una validesa divergent adequada amb desesperança de -.77 (Sánchez-Teruel et al., 2020).

v. *Recovery Assessment Scale-revised* (RAS-R) (alfa de Cronbach que oscil·la entre α = 0,93 i ω = 0,95) és un instrument autoaplicat que mesura la recuperació personal, desenvolupat fa més de 20 anys per Gifford i col·legues dels Estats Units. El RAS-R consta de 24 ítems en una escala de cinc nivells "molt en desacord", "en desacord", "no estic segur", "d'acord" i "molt d'acord" (Saavedra et al., 2021).

⇒ **Aquests mètodes es van escollir tenint en compte dos criteris: (1) mesuren els resultats d'acord amb el paradigma de recuperació personal i (2) els instruments es van validar en castellà.**

c. **Procediments de recollida de dades**. Al llarg de 12 mesos (setembre de 2019-juny de 2020) es va identificar una mostra transversal per part de professionals, amb formació prèvia per unificar els criteris de recollida de dades, de tots els participants inclosos a l'estudi. Els professionals de referència van explicar cadascuna de les mesures (autoaplicades) als participants de l'estudi, donant-los l'oportunitat d'omplir-les a casa. Un cop acabades les escales, els professionals de referència van introduir les dades en una base de dades

d. **Anàlisi de dades**. Dos investigadors (G.P. i I.C.) van utilitzar el programari SPSS (versió 28.0). Es van dur a terme proves de correlació de Pearson per estudiar la relació entre l'ocupació significativa i els diferents factors mitjançant el paquet estadístic SPSS/PC+ (v. 28.0). La correcció de Bonferroni es va fer servir per ajustar l'alfa a les múltiples correlacions.

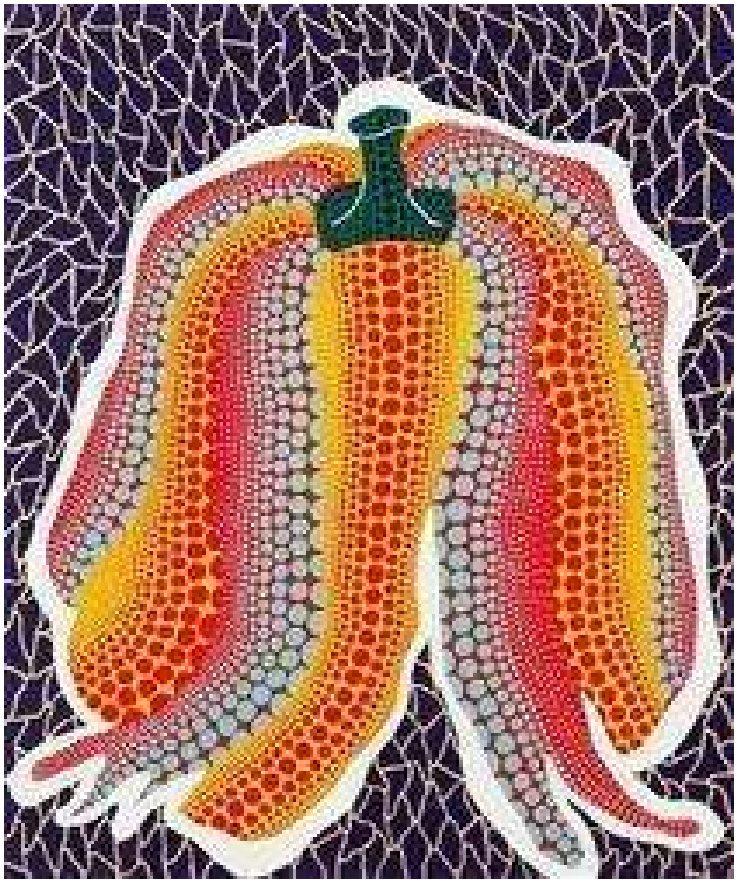
D. Consideracions ètiques

L'estudi va seguir les recomanacions de la Declaració d'Hèlsinki (WMA, 2015). Totes les persones que han participat han signat un consentiment informat per a la seva participació.

En referent a l'article 2, es informes s'han adherit a les directrius per la *Journal Article Reporting Standards for Qualitative Primary, Qualitative Meta-analytic, and Mixed Methods Research in Psychology* (Levitt, et al., 2018).

Aquest projecte ha estat avaluat pel Comitè d'Ètica de la Recerca del centre participant: (vegeu Annex 1-4).

RESULTATS



Pumpink. *Yayaoi Kusama, 1990*

RESULTATS. Presentació dels articles

Article 1

Títol: Peer Interventions in Severe Mental Illnesses: A Systematic Review and its Relation to Occupational Therapy

Autors (segons orde de publicació): Ivan Cano Prieto; Salvador Simó Algado; Gemma Prat Vigué

Revista: Occupational Therapy in Mental Health

Data de publicació: 29 de juny de 2022

Tipus: Systematic Review

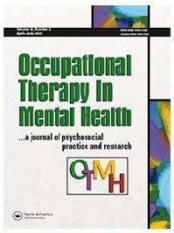
DOI: 10.1080/0164212X.2022.2085645

ISSN: 1541-3101

Base de dades d'indexació: Journal Citation Reports

Quartil i Àrea: Q4 – Applied Psychology

Impact Factor: 0.7 (2022)



Occupational Therapy in Mental Health

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/womh20

Peer Interventions in Severe Mental Illnesses: A Systematic Review and its Relation to Occupational Therapy

Ivan Cano Prieto, Salvador Simó Algado & Gemma Prat Vigué

To cite this article: Ivan Cano Prieto, Salvador Simó Algado & Gemma Prat Vigué (2022): Peer Interventions in Severe Mental Illnesses: A Systematic Review and its Relation to Occupational Therapy, Occupational Therapy in Mental Health, DOI: 10.1080/0164212X.2022.2085645

To link to this article: https://doi.org/10.1080/0164212X.2022.2085645

Peer interventions in severe mental illnesses: a systematic review and its relation to occupational therapy

Ivan Cano Prieto*. PhD Student. [1] [3]

Salvador Simó Algado. PhD. [2] [3]

Gemma Prat Vigué. PhD. [1] [3]

1. *Research group Mental Health and Social Innovation, (SaMIS). Division of Mental Health, Althaia Foundation, Carrer Joan Soler 1-3, 08243, Manresa, Barcelona, Spain*
2. *Research group Mental Health and Social Innovation, (SaMIS), University of Vic – Central University of Catalonia (UVIC-UCC), C. Miquel Martí i Pol, 1, 08500 Vic, Spain.*
3. *Center for Health and Social Studies, (CEES), University of Vic – Central University of Catalonia (UVIC-UCC), C. Miquel Martí i Pol, 1, 08500 Vic, Spain.*

Name, postal address and email address of the corresponding author

Ivan Cano Prieto

Althaia Foundation. Division of Mental Health. Carrer Joan Soler 1-3, 08243, Manresa, Barcelona, Spain

icanop@althaia.cat

Peer interventions in severe mental illnesses: a systematic review and its relation to occupational therapy

Abstract

Background. The incorporation of peer support workers in care teams is one of the pillars of the recovery model in mental health care. **Purpose**. To specify the interventions carried out by peer support workers (PSW) and to identify the outcome domains they used to measure the impact of the intervention. **Methods**. A systematic review was conducted using PRISMA guidelines and performing searches in MEDLINE, Web of Science and Cochrane Library. **Findings**. Significant positive results were found in Occupational performance; Prevention; Health and wellness; Quality of life; Occupational justice. A study with implications of occupational therapy has been included. Implications. The interventions carried out by peer workers were effective and can be compared to standard care. It demonstrates that PSWs can be essential partners in achieving the goals of the occupational therapy program.

KEYWORDS. Peer support, Mental health recovery, Systematic review, Severe mental illnesses, Occupational therapy research

Introduction

What is peer to peer? Essential Personal Recovery Model Tool

Peer-to-peer interventions with people with severe mental health illness (SMI) are an essential tool in the recovery process. Peer support was gradually introduced in the 1990s as part of the move to increase the engagement of users of mental health services (Repper & Carter, 2011)

that began in the 1970s, influenced by the philosophy of the Oxford Group (Dewhurst and Leopoldt, 1974). People who have experienced mental health problems but are now stable are in a privileged position to help the recovery of others who are trying to overcome the same problems (Davidson, Bellamy, Guy, & Miller, 2012). Peer support is based on the personal recovery model rather than on psychiatric diagnostic criteria (Jewell, Falzer, Davidson, Rowe, & Sells, 2014). In fact, although peer support workers (henceforth, PSWs) are sometimes part of interdisciplinary mental health teams, they are not technically team members because their role is that of "a peer supporting a peer", sharing their personal experience without making interventions framed inside the role of physician, psychologist, therapeutic companion, or nurse (Silver & Nemec, 2016). PSWs approach the task from another paradigm that is based on mutual help between peers; by helping others, they also help themselves. The so-called "personal" recovery, complementary to clinical and social recovery, is based on a process of positive adaptation to the disease and disability, seeking to create the conditions for attaining an adequate level of personal well-being beyond the limitations that the disease can cause (Kuhn, Bellinger, Stevens-Manser, & Kaufman, 2015). This model usually incorporates trained peers who perform various non-medical tasks seeking to promote empowerment and to generate hope and optimism – variables that have been shown to be engines of change and well-being (Bellamy, Schmutte, & Davidson, 2017; Davidson et al., 2012; Pickett et al., 2010).

Peer support workers play a number of key roles in the recovery process: a) they collaborate with their partner to empower them to direct their own treatment and recovery; b) they act as connectors with family, friends and the general population to support socialization; c) they help their partner to improve their proficiency in everyday activities; and d) they act as connectors with the health team to support their peer's recovery by making their demands more audible and visible (Mead, Hilton, & Curtis, 2001).

Historical Background: Pinel's Moral Treatment

The historical antecedents to place this work go back to the 18th - 19th century and to the figure of Philippe Pinel. Pinel is considered the father of moral treatment in treating people with mental health problems. The main goal is participation in tasks and activities of daily life with the aim of improving social functioning (Pelletier and Davidson, 2015). In turn, his figure is closely related to occupational therapy due to his interest in the occupation as a therapeutic means (Peloquin, 1989)). His holistic and strongly humanistic vision of the person, the recovery of communication with the patient, the study of his history (which today we would call "roles"), the respect for the areas of interest and the importance he gives to the environment make "its moral treatment" a close approach to the current paradigm of Occupational Therapy. In addition, we can consider Pinel as one of the pioneers in recruiting people in recovery to help others who suffer from a mental health problem (Davidson et al, 2012). This is reflected in one of Jean Baptiste Pussin's letters to Pinel: "*As far as possible, all servants are chosen category of mental patients. They are in any case better suitable for this demanding job because they tend to be more kind, honest and humane*" (Weiner, 1979).

Meaningful occupation, a pillar in the personal recovery model

There is a general consensus that the components of a "good recovery" include the search for hope, optimism in relation to the future, the restoration of a positive identity over the damaged identity, and the development of a sense of empowerment in the context of the disease (Repper & Carter, 2011). Several researchers and academics have shown that the PSW approach is ideal for developing these facets; due to their direct experiences of disability (Campos et al., 2014), stigma and restoration (Davidson, Chinman, Sells, & Rowe, 2006; Flanagan, Farina, & Davidson, 2016), restored peers quickly create a relationship of empathy that encourages patients to recover hope and optimism and creates the optimal conditions for

achieving more ambitious goals (Dahl, de Souza, Lovisi, & Cavalcanti, 2015; Sells, Black, Davidson, & Rowe, 2015).

One of the most transcendental people for the discipline of occupational therapy was Adolf Meyer. He was one of the forerunners of the occupational paradigm, occupations that provide a feeling of interest, worth, achievement, and challenge. Meyer stressed the importance of interpersonal relationships between professional and patient as an essential element in the construction of meaningful occupations (Meyer, 1922). Hence the importance of peer-to-peer programs in mental health. These concepts are closely linked to the idea of meaning of Vicktor Frankl (father of logotherapy). Logotherapy shows that the fundamental motivation of every person is the search for meaning for their own life, in each concrete moment and particular and unique situation, in which their existence is found (Parker, 2021). To be human means to be living "the tension established between reality and the ideals to be materialized" (Frankl, 1959, p. 58). The essence of peers interventions is in line with the current paradigm of Occupational Therapy, once the mechanistic paradigm that prevailed in Occupational Therapy had been overcome until the 1960s, when it was questioned by Mary Reilly (Reilly, 1963).

The occupational therapist seeks to improve the health and well-being of a person from a holistic point of view, including the physical, cognitive, psychological and spiritual aspects through the involvement of the person in meaningful occupations. The spirituality of the person can be expressed in different forms and actions, which allow him to connect with his being, with the other and with nature. And one of these is meaningful occupations (Humbert, 2016, p. 12).

Connection of occupational therapy with the personal recovery model

All the interventions reviewed focused on measuring the impact of the intervention on beneficiaries and excluded the impact on the person performing the role of PSW from their

analysis. However, the effect on the PSW may be extremely positive, among other things because interventions of this kind represent job opportunities for a group with high unemployment rates (OECD, 2015).

Occupational therapy sees employment as an indispensable, integral part of people's health and well-being. The offer of a job for the PSW may be even more important than the clinical component of the intervention (Kielhofner, 2009; Wilcock, 2006). Something indispensable for the success of the PSW system is the professional's engagement with the PSW; s/he must accompany the PSW in the search for occupational interests and roles, and must help them to design/find a balance between their caretaking occupations and the others that make up their occupational identity (Jones et al., 2013). Therefore, occupational therapy plays a fundamental role in the design of the intervention thanks to its ability to analyze the occupation and provide the other with an occupational balance between self-maintenance, productivity and leisure occupations (Wilcock, 2006). The final objective is that the PSW should find well-being in their occupational development and thus avoid occupational imbalances, with the corresponding loss of quality of life (Repper & Carter, 2011). All human beings have the need (and the right) to control their lives and make changes if necessary. All this is a symptom of health and well-being (Townsend & Polatajko, 2013).

Examples of peer programs in mental health from Occupational Therapy

An example of this is Careers Offering Peers Early Support (COPES), a program developed in Victory (Australia) in which occupational therapy has played an essential role in its design and implementation: "The COPES service employs carers, defined as people who provide personal care, support and assistance to another individual in need of support due to a mental illness." (Bourke et al., 2015, p. 300). COPES is built from 4 key concepts: 1) Person-centered strength based approach (Wilcock, 2006; Townsend & Polatajko, 2013); 2) Rights

based framework (Hammell, 2017); 3) Working in partnerships as enablers (Fransen et al., 2015); 4) Detailed occupational analysis.

Other examples of implemented peer-to-peer programs for mental health services are found in the UK and Hong Kong. Wolfendale and Musaabi (2017) designed and implemented a peer-to-peer program in high security forensic services (qualitative study). They used meaningful occupation as a means with the objective of increasing people's confidence, developing communication skills and social interaction, increasing protective factors and realigning the will towards more prosocial interests, beliefs, goals, occupations and choices. The peer worked as a link between the person and the therapist who followed the evolution. In Hong Kong, Yam et al. (2016) carried out a peer intervention, designing a training program (15 sessions) and a 50-hour practicum. Her interest was in measuring (longitudinal study without control group) the impact of the program on awareness of recovery progress, occupational competence, and problem-solving skills. The role of occupational therapy, once again, is present in the design and implementation of the program, selection of participants and evaluation.

Previous systematic reviews

Over the years and until today we have found 11 reviews published, being the first one from 1999 (Davidson et al., 1999) and the last one of them from 2016 (Stubbs et al., 2016). Among them, we have highlighted the reviews carried out by Simpson (Simpson & House, 2002) and Lloyd-Evan's (Lloyd-Evans et al., 2014), where a global review of peer support with people with severe mental illness (SMI) was conducted. In the last 6 years, there has been a growing interest in implementing peer interventions in different mental health services. For this reason, we believe a systematic review that collects the interventions carried out, the results achieved and the impact on the various participants is convenient. In addition, the

review incorporates an analysis according to the standards of evidence developed in evidence-based medicine (Sackett, 1989).

Aims of study

The objective of this review is to broaden our knowledge of the peer-to-peer technique in occupational therapy by exploring: 1) the interventions performed by the PSWs, 2) the results achieved, 3) the impact on the various participants and 4) the influence of occupational therapy. For this, the results will be grouped through the Occupational Therapy Practice Framework (OTPF): Domain and process (AOTA, 2020b), taking advantage of the discussion to reflect on said relationship. Ethical approval was not required for this study.

Methods

Eligibility criteria

The criteria for inclusion of articles were: a) published from January 1990 to July 2019; b) written in English; c) published online and with full text available; d) comparison between experimental group (PSW intervention) and control group (standard intervention); e) age of participants between 18 and 65 years old; f) diagnosis of severe mental disorders; e) occupational therapy interventions

We used the evidence standards developed in evidence-based medicine (Sackett, 1989) and the criteria used by the American Occupational Therapy Association (AOTA):

- Level I: Meta-analyses, systematic reviews, randomized controlled trials (RCTs)
- Level II: Two-group, nonrandomized studies (e.g., cohort, case-control)
- Level III: One-group, nonrandomized studies (e.g., before and after, pretest and posttest)

- Level IV: Descriptive studies (single-subject design, case series)
- Level V: Case reports and expert opinions that include narrative literature reviews and consensus statements.

Types of outcome measure

The outcome measures analysed in the review were: ***Occupational performance*** (AVDs, AVDIs, health management, social participation); ***Prevention*** (hospitalization, admission, emergency room); ***Health and wellness*** *(body functions)*; ***Quality of life*** (quality of life, hope); ***Participation*** (recovery); ***Well-being*** (self-efficacy); ***Occupational justice*** (empowerment).

Search strategy

The search, selection and critical evaluation of relevant studies were carried out considering the PRISMA (Preferred Reporting Items for Systematic reviews and Meta-Analyses) guidelines (Liberati et al., 2009).

The data search was carried out through the MEDLINE, Web of Science, Scopus and Cochrane Library computer databases. Two search strategies were used and combined in the final analysis (view Supplementary material 1):

1. (("mental health") OR ("mental illness")) AND ((((("peer support") OR ("peer to peer")) OR ("peer?led")) OR ("consumers"));
2. ((((("mental health") OR ("mental illness")) AND ((((("mental health") OR ("mental illness")) AND ((((("peer support") OR ("peer to peer")) OR ("peer?led")) OR ("consumers")))) AND ("occupational therapy").

The references included in the references of the most relevant articles were also searched.

Assessment of bias

The risk of bias in each article was assessed following the protocol set out in the Cochrane guide (Higgins et al., 2011).

Data management

Using Microsoft Excel (v.18.11), we developed a data extraction form to record the following information: study design; sample country; sample size, age, ethnicity and inclusion criteria; description of the experimental intervention and control group; outcome measures; and results. Three independent evaluators, between them 2 occupational therapists, extracted data using identical forms. After data extraction, we compared the information entered and resolved any conflicts through discussion and consensus.

From each of the articles the following information was obtained: 1) year of publication (in order to trace the use of the technique chronologically); 2) sample size, to assess the representativeness; 3) type of study design and evaluation of the instruments and results.

Analysis

The studies were carefully analysed and classified in accordance with the AOTA guidelines developed in conjunction with the US Preventive Services Task Force (AOTA, 2020) as: *strong*: the results were obtained from well-conducted studies, usually two or more RCTs; *moderate*: the results were obtained from well-designed RCTs or multiple Level II or III studies; the available evidence is sufficient to determine health outcomes, but confidence in the evidence is constrained by factors such as the number, size, or quality of individual studies or by inconsistency of findings across individual studies; *Low*: low-level studies, with defects and inconsistencies in the findings; the available evidence is insufficient to assess effects on

health and other outcomes of relevance to occupational therapy with confidence.

Results

Two search strategies were combined integrating exclusive occupational therapy articles. 7120 articles were found (search 1) and 189 (search 2).

(1) 3370 articles were reviewed after elimination of duplicates. 2228 articles were excluded after reviewing the title. 1142 abstracts were checked, of which 19 were selected for total reading. Finally, 16 articles were selected for the final analysis.

(2) 130 articles were reviewed after elimination of duplicates. 61 articles were excluded after reviewing the title. 69 articles were checked, of which 10 were selected for full reading. Finally, 1 article met the inclusion criteria and were included in the final analysis.

Finally, 17 articles were selected for their final review. A flow diagram in figure 1 shows the study selection process.

[Figure 1 here]

The review collected relevant information from each article, such as: type of study, objective, number of participants, evaluation tools used, methodology, and results/conclusions.

Characteristics of the studies included

The recognition and subsequent screening process was completed in 17 studies. All were studies with two groups (experimental and control) published between 2005 and 2018 which met the inclusion criteria described above.

All the studies but one (Weissman, Covell, Kushner, Irwin, & Essock, 2005) were RCTs.

The sample size ranged from 32 to 441, and age from 39 to 57 years.

With regard to gender, the presence of women ranged from 5.4% (Resnick & Rosenheck, 2010) to 66% (van Gestel-Timmermans, Brouwers, van Assen, & van Nieuwenhuizen, 2012). Women were represented in all studies but one (Weissman et al., 2005). One study did not provide data on age and gender (Yamaguchi et al., 2017).

With regard to the origin of the studies, in agreement with Puschner et al., (2019) most interventions between peers were found in English-speaking countries. Of the 16 studies selected for analysis, only three were carried out outside the US: one each in the UK (Johnson et al., 2018), the Netherlands (van Gestel-Timmermans et al., 2012), Canada (Wrobleski, et al., 2015) and Japan (Yamaguchi et al., 2017).

The participation of occupational therapy in the studies has been delegated. Despite carrying out a specific search, only one project (comparison of groups) with the presence of occupational therapists was detected (Wrobleski et al., 2015).

The inclusion criteria ensured that participants had a SMI, the main requirement of the review. The most common diagnoses were schizophrenia, schizoaffective disorder, psychotic disorder not otherwise specified, bipolar disorder, and major depressive disorder. The 16 studies also incorporated new disorders: for example, in the already mentioned criterion of a person with a diagnosis of mental health in the process of personal recovery, two studies (Druss et al., 2018; Muralidharan et al., 2018) added as an inclusion criterion one or more diagnoses of chronic diseases (comorbidity); drug addiction (Jewell et al., 2014); homelessness (Weissman et al., 2005); and criminal record (Rowe et al., 2007). All the studies mentioned have been added to the review.

[Table 1 here]

Risk of bias

Following the protocol established by the Cochrane guide, all the studies analysed present a correct explanation for the generation of random sequence. Eight studies presented problems of allocation concealment. In none of the interventions were differences found between groups. Regarding the blinding of the participants and the personnel involved in the studies, all studies show a risk of bias due to the need for informed consent. Eight of the 17 studies present a low risk of detection bias. Many of the articles included were deficient in attrition bias; in six of them it is not clear how the problem was solved and only in one of them was it omitted. Finally, only two cases of reporting bias were observed.

[Table 2]

Evidence grade and strengths

All the studies analysed had a level of evidence of I and II (Sackett, 1989): only one level II study was recorded (no RCTs). The study included 16 level I articles (RCTs), showing that the existing evidence is strong (AOTA, 2020).

Quantitative data synthesis

The review detected the existence of two different types of peer intervention. The first group of studies framed their intervention in a training program in which peers acted as trainers taking advantage of their experience in mental suffering and in the recovery process, accompanying the person cared for in the search for their life plan. In the second group, the peer took on the role of case manager, a community companion for the vulnerable person providing support and hope. In both interventions, future peers were trained in issues of personal recovery, bonding, communicative skills, and topics specific to each program. Below, the results are shown by type of intervention, highlighting the statistically significant

results.

Education programs

We found five articles that proposed a training intervention. Druss (2018) obtained statistically significant results in **health and wellness**, presenting improvements in Physical Component Summary ($p < 0.046$) and Mental Component Summary ($p < 0.039$) of the SF-36; and **occupational justice** (mental health recovery - $p < 0.02$).

We also found a program of support workers carried out in the Netherlands (van Gestel-Timmermans et al., 2012) which focused its peer intervention on people diagnosed with mental health problems who had gone through periods of destabilization. The only criterion for participating was being in an advanced process of personal recovery. The study found significant improvements in **occupational justice** (Dutch Empowerment Scale, ($p<0.01$), **quality of life** (HHI, ($p<0.01$), and **well-being** (MHCS, ($p<0.01$).

Similar to the Dutch study, all PSWs exercising a training role had previously participated in the BRIDGES project as trainees (Cook et al., 2012). The article presented statistically significant improvements in **occupational justice** (RAS, $p < 0.01$) and **quality of life** (SHS, $p < 0.01$).

A program developed in the US, focusing on people with a diagnosis of comorbidity (Living Well, Muralidharan et al., 2018), achieved a positive impact on the beneficiaries with significant improvements in **quality of life** (SF-12, $p<0.032$; Self-management Self-Efficacy Scale, ($p<0.001$); **occupational performance** (PAM, $p < 0.038$; MHLCS ($p < 0.045$); IMSM (physical, $p < 0.011$; relationship, 0.015).

Finally, another article presented an educational program (Resnick & Rosenheck, 2010) facilitated by PSWs. The intervention recorded statistically significant results (correlations) in **occupational performance** (Activities of Daily Living Scale, $p < 0.03$); **occupational justice** (recovery attitude scale, $p < 0.03$); and **occupational justice** ($p < 0.04$).

Case management

The review found 10 studies in which PSWs played a case manager role. The only prospective case-control study, (Weissman et al., 2005), did not present any statistically significant differences in any of the variables studied. The study by Johnson et al., (2018) reported a project developed by the National Health Service (NHS) focusing on people with SMI who had suffered a recent crisis. At the end of the project, only found a significant improvement in **prevention**, specifically in the satisfaction with respect to mental health services among the people attended had improved significantly ($p < 0.001$). Jewell et al., (2014) described a program developed by members of the Yale Program on Recovery and Community Health research team, who obtained statistically significant post-intervention improvements in **occupational performance** at 6 months (BLRI: positive regard $p < 0.05$ and unconditionality, $p < 0.05$); at 12 months (ASI, positive regard, $p < 0.01$) - empathy, $p < 0.04$ - unconditionality, $p < 0.02$).

Rogers et al., (2016) compared two interventions developed by first-person agents: an experimental individualized intervention (one-on-one), and a control group which underwent a standard peer-run-agency intervention. The program showed significant improvements in two of the outcomes studied: **quality of life** (BQOL, $p < 0.05$) and **health and wellness** (BASIS-24, $p < 0.05$). A study in Japan (Yamaguchi et al., 2017), the only one carried out in a hospital setting, assessed the impact of a 6-month peer-led intervention on shared decision making. Significant differences were found in four variables with respect to the control group: **occupational performance** (quality of the clinical decision in a medical visit, SDM-18- $p<0.001$); the patient-doctor relationship, IPC communication - $p<0.01$); patient-doctor relationship, STAR-Patient - $p < 0.02$); and **health and wellness** (medication side effects, DIEPSS - $p < 0.02$). Corrigan et al., (2017) adapted an agent support program taking into account the cultural origin of the population served. The program offered significant improvements with respect to the control group: improvements in the perception of **quality of**

life, QLS ($p<0.01$); **occupational justice** (Empowerment Scale - $p<0.05$); and **occupational justice** (perception of the recovery process, RAS - $p<0.01$).

Kelly et al., (2017) analysed a recent project based on the BRIDGES program, a peer intervention developing a case manager figure to promote healthy roles and habits. The program presented statistically significant results, greater improvements in **prevention** were observed: access and use of primary care health services - $p<0.012$; decreased preference for emergency care, $p<0.015$; increased preference for primary care clinics, $p<0.001$; increased satisfaction with care received on the Healthcare Provider Scale, $p<0.019$); improvements in **health and wellness**: improved detection of chronic health conditions (SF-12, $p<0.048$); reductions in pain (SF-12, $p<0.031$); and a greater perception of **well-being**, specifically in consumer confidence in self-management of health care (MHCS, $p<0.009$).

Mahlke et al., (2017) is a two-part support agent program developed in Germany: a 192-hour training part in which PSWs shared training with healthcare professionals (the course was taught in the first-person), and a practical part (two months) where they joined the work teams in developing the role of case manager. The program obtained statistically significant results in terms of an improved perception of **health and wellness** with respect to the control group (EQ5D, $p<0.004$). The two people who developed the role of case manager were paid € 450 per month. The last of these studies, Sledge et al., (2011) presents another project in which the PSWs had a formal contract. The program had a very positive impact, showing statistically significant differences with respect to the control group in **prevention**, with reductions in rehospitalizations ($p<0.042$) and hospital days ($p<0.03$).

Finally we present a case manager program promoted from an occupational therapy service in Canada (Wrobleski, et al., 2015). The project designed an RCT comparing a standard intervention (occupational therapy with the support of a mental health worker - MHW)) with a peer intervention (occupational therapy with the support of a peer worker -

PW). Both the MHW and PW offer individual assistance following the objectives established in the occupational therapy service. The role of the therapist in the project has been essential: design of the program, selection of participants according to the person's abilities, and monitoring of the PWs during the intervention. Wrobleski and colleagues found significant improvements in **quality of life** ($p < 0.05$).

Training program + case management

Rowe et al., (2007) tested the efficiency of peer programs by measuring their impact on crime and drug addiction. The project consisted of a training phase for project beneficiaries on issues of social inclusion, community participation, and construction of a work plan. The program presented a significant impact on the participants in the experimental group, observing improvements in **occupational performance**: low levels of alcohol consumption at follow-up periods between 6 and 12 months (ASI, $p < 0.005$), decreased non-alcohol drug use in all periods in both groups (ASI, $p < 0.05$); and a significant impact on **prevention**: reduced criminal justice charges over all periods evaluated in both groups ($p < 0.05$). The study by Chinman et al. (2015) shows us another example of training (training modules) and provision of mutual support services. The peer workers received 30-hour training in different modules: recovery, conservation skills and psychosocial rehabilitation; and intensive training (two days) in disease management. It is a training recognized by the US health system. The responsible professional supervises the intervention with the peer worker on a weekly basis. The tasks once incorporated into the teams are grouped into **occupational performance** (Health management) and **occupational justice** (recovery plans). Significant improvements in **occupational performance** were observed in the intervention between equals (PAM, $p < .005$) compared to the control group. Additional analyzes observed significant improvements in both groups in **health and wellness** measures (BASIS-R, $p < 0.02$), and **occupational justice** (MHRM, $p < 0.01$).

Discussion

This review aims to add to the body of knowledge on the participation of peer support workers in mental health work teams, with special emphasis on occupational therapy services. One important aspect that the review has highlighted is the setting in which these projects have been implemented. The presence of studies in other countries such as Japan, the Netherlands, the UK, Canada and Germany bears witness to the expansion of the practice in the wider world. People with experience in mental health can be an important asset for others who are in the midst of personal recovery.

Peer interventions and their relationship with the end result of the occupational therapy process

The results were grouped following the guidelines of Occupational Therapy Practice Framework (OTPF): Domain and process (AOTA, 2020b). The results show a positive impact in the outcome measures analysed in the review were: ***Occupational performance***; ***Prevention***; ***Health and wellness***; ***Quality of life***; ***Occupational justice*** (see table 3).

[table 3]

Occupational performance

Occupational performance is the dynamic interaction between the person, the context and the activity. This interaction has the potential to improve the skills and patterns in the occupational performance of the participants, favoring participation in meaningful occupations and activities (adapted in part from Law et al., 1996, p. 16). On the one hand, we have grouped the outcome measures with statistical impact that influence the link (therapeutic relationship) and client satisfaction. Occupational therapists know the importance of building a positive bond with the person as a necessary part of the intervention (Meyer, 1922). This

positive relationship has been identified as an essential element by clients (Cole & McLean, 2003). We found different outcome measures with statistical incidence after peer intervention in the study by Yamaguchi (2017): IPC (Stewart et al., 2007) and Star-Patient (McGuire-Snieckus et al., 2007). In turn, Johnson et al. (2018) measures the satisfaction of the participants using the Customer Satisfaction Questionnaire (Attkisson and Zwick, 1982). Kelly et al. (2017) measured the impact of the relationship between client and professional using the Healthcare Provide Scale (Bakken et al., 2020). The reason for grouping them in this category is the relationship between occupation, health and well-being (WFOT, 2012b, p. 2) and in which the link is the central element to promote changes. As can be seen, PW interventions are capable of influencing the therapeutic relationship and favoring changes.

Continuing with the outcome measures, an area of special relevance for the discipline is the activities of daily living (ADLs): Activities oriented toward taking care of one's own body and completed on a routine basis (adapted from Rogers & Holm, 1994). These activities are "fundamental to living in a social world; they enable basic survival and well-being "(Christiansen & Hammecker, 2001, p. 156. Among the studies analyzed, Resnick & Rosenheck (2010) obtained significant values in this area by means of Activities of Daily Living Scale (Cuffel et al., 1997) .Finally, three selected studies have focused their intervention on an occupation of special relevance for the well-being of clients: Health Management. Occupation focused on developing, managing, and maintaining routines for health and wellness by engaging in self-care with the goal of improving or maintaining health, including self-management, to allow for participation in other occupations (AOTAa, 2020). Yamaguchi et al. (2017) focused on client participation in their treatment (Shared Decision-Making) and obtained benefits in Scale to Assess Therapeutic Relationships in Community Mental Health Care (McGuire-Snieckus et al., 2007).

Prevention

The results measure the impact of health education or promotion efforts designed to identify, reduce or prevent the occurrence and decrease the incidence of unhealthy conditions, risk factors, diseases or injuries (AOTA, 2020c). The use and / or assistance of medical services would fall into this category (Kelly et al., 2017; Slede et al., 2011), we consider that they are a way of measuring the impact of health promotion programs within the occupational therapy services. In this grouping we have included the criminal justice charge (Rowe et al., 2007), understanding it as an opportunity for occupational therapists to promote and reduce risky behaviors.

Health & Wellness

In this section we have grouped the outcome measures that are related to client factors, bodily functions, specifically clinical symptomatology. According to the WHO (1985), health is a state of physical, mental and social well-being, as well as a positive concept that emphasizes social and personal resources and physical capacities. In our review, the instrument with the greatest presence has been the Behavior and Symptom Identification Scale (Eisen et al., 2004), which has captured statistical improvements in peer intervention in 3 studies (Chinman et al. (2015); Muralidharan et al. (2018); Rogers et al. (2016). The 24-item Behavior and Symptom Identification Scale, BASIS-24®, is a leading behavioral health assessment tool designed to assess the outcome of health treatment mental or abuse. Client's perspective. Following the line of measurement of sympathetic aspects, we found the Scale of extrapyramidal symptoms induced by drugs (Inada & Yagi, 1995) used by Yamaguchi et al. (2017). Developed in the age of the generation of second-category antipsychotics and is suitable for evaluating the low incidence of extrapyramidal symptoms that occur in the treatment of atypical antipsychotics, as well as the relationship between personal and social functioning. Finally, we have included an instrument used by Rowe et al. Alabama. (2017),

Addiction Severity Index, a measure that assesses the severity of addiction (McLellan et al., 1980). The factors of the person influence the performance of the occupation (AOTA, 2020b) and therefore must be taken into account when designing the intervention.

Quality of life

Important outcome in the day to day of occupational therapists. According to Radomski (1995) it is a dynamic appraisal of the client's life satisfaction (perceptions of progress toward goals), hope (real or perceived belief that one can move toward a goal through selected pathways), self-concept (composite of beliefs and feelings about oneself), health and functioning. "Occupational therapy practitioners develop and implement occupation-based health approaches to enhance occupational performance and participation, quality of life, and occupational justice for populations" (AOTA, 2020b, p. 3). Peer interventions have shown significant improvements in these outcomes, evaluated by different instruments (see table 3). Three studies have obtained an impact on quality of life through the Quality of Life Interview – Brief Version (Lehman, 1996) and among them one with the participation of occupational therapy (Wrobleski et al., 2015). Chinman et al. (2015) and Muralidharan et al. (2018) have shown significant improvements in the Patient Activation Measure (Green et al., 2010), scale determining patient engagement in healthcare. Another instrument that assesses the perception of self-efficacy is the Self-management Self-Efficacy Scale (Lorig et al., 1996). Another important group is in the subjective perception of the state of health, in 4 selected studies they have found significant changes (Druss et al., 2018; Kelly et al., 2017;; Mahlke et al., 2017; Muralidharan et al., 2018) with different instruments: (Salyers et al., 2000); Short-form health survey-36 (McHorney et al., 1993) EuroQol questionnaire (EuroQolGroup, 1990). In this section and following Radomski's definition of quality of life, the review has captured two studies in which the peer intervention shows a positive impact on hope. Cook and van Gestel-Timmermans using the State Hope Scale

(Snyder et al., 1996) the first, Health Hope Index (Herth, 1992). In generating hope in clients, we find an intimate relationship between the recovery model and occupational therapy. Throughout the review we have commented that hope is a very important element in the personal recovery model (Davidson et al., 2012) but also for occupational therapists. Occupational therapy practitioners use professional reasoning to help clients make sense of the information they are receiving in the intervention process, discover meaning, and build hope (Taylor, 2019; Taylor & Van Puymbrouck, 2013).

Occupational justice

If we follow the WHO definition, participating is "Involvement in a life situation" (World Health Organization, 2001, p. 10). The AOTA goes one step further: "Engagement in desired occupations in ways that are personally satisfying and congruent with expectations within the culture" (AOTA, 2020b). In this section we will group the instruments used to measure personal recovery. From an occupational perspective, the subjective feeling of recovery fits us with the development of significant occupations: access to and participation in the full range of meaningful and enriching occupations afforded to others, including opportunities for social inclusion and resources to par ticipate in occupations to satisfy personal, health, and societal needs (adapted from Townsend & Wilcock, 2004). Townsend & Wilcock's vision is complemented by the definition of personal recovery: process of positive adaptation to the disease and disability, seeking to create the conditions for attaining an adequate level of personal well-being beyond the limitations that the disease can cause (Kuhn, Bellinger, Stevens-Manser, & Kaufman, 2015). The main objective of both occupational therapy and the paradigm of personal recovery is to accompany the construction of a life project, through meaningful occupations in the search for the well-being of the person. We can find instruments to measure recovery such as Mental Health Recovery Measure (Bullock & Young, 2003), Recovery Attitudes Questionnaire (Borkin et al., 2012), and the most widely

used Recovery Assessment Scale (Corrigan et al., 1999); and personal empowerment using the Empowerment Scale (Rogers et al., 1997) and the Dutch Empowerment Scale (Boevink et al., 2009).

Peer interventions in mental health can be of great support for therapists as a link to achieve the objectives set from the service (Tse et al., 2012).

Below we discuss the different inclusion criteria observed in the studies, the setting (community vs institutional), the methodologies used and the significance of the results taking into account the control groups.

Inclusion criteria

All 17 studies included people with SMI. However, some studies highlighted other criteria that should be taken into account in future interventions. Druss et al., (2018) and Muralidharan et al., (2018) which both described training programs, used the diagnosis of one or more chronic pathologies as inclusion criteria. Two studies introduced drug consumption as a criterion (Jewell et al., 2014; Rowe et al., 2007). Rowe et al's is particularly interesting, as it focuses on peer interventions with a clear vocation to solve social problems, incorporating a criminal record as a criterion. Continuing with interventions to solve specific social problems (Weissman et al., 2005) introduced homelessness as a criterion. Finally, (Corrigan, 2017) designed a peer-to-peer cultural intervention which incorporated belonging to the same community as a criterion (a cultural approach). These results corroborate those reported in another study by the same author (Corrigan et al., 2017) which proposed a peer intervention with homeless African Americans with serious mental illness. In that study, the authors observed significant improvements in two of the areas included in the review (quality of life

and recovery) in addition to physical health.

Community vs. institutional setting

Peer intervention is mostly practiced in community settings, away from the hospital environment. In Japan, however, it has been carried out in a hospital setting. Yamaguchi and colleagues adapted a peer-to-peer intervention in a medical setting in which PSWs accompanied the person being cared for in making decisions about their treatment. PSWs received specific training from the programmer and played a case manager role. They obtained significant results with respect to the control group in the therapeutic relationship, symptomatology, and service evaluation. The results were satisfactory and opened up the possibility of incorporating this model in clinical-hospital settings. However, no significant results were obtained in recovery variables (SISR), something that community programs have achieved. Thus, given their effectiveness in community programs, peer programs need to be promoted in psychiatric units in order to quantify their impact on the personal recovery of the person being cared for. A good example of this is the studies of Wolfendale and Musaabi and Yam, both with occupational therapy foundations. The first in an institutional setting and the second in a community setting.

Clinical vs. recovery outcomes

Substantial progress has been made in new mental health intervention paradigms, and there is currently a consensus between all stakeholders that services need to be geared towards recovery.

A new paradigm of intervention with people with mental health problems is currently advancing, focused on personal recovery and on what is important to the person (Talbott, 2013). The current paradigm of occupational therapy is that of a person-centered care, understanding it as an active subject in its process which interacts with the environment

(Schell & Gillen, 2019, p. 1194). Traditionally, interventions have focused on measuring clinical aspects such as symptoms, social disability, and use of the service (Thornicroft & Slade, 2014). A common feature of the PSW system, on which all interventions (educational programs or case management) are focused, is its implementation in a climate of hope in which there is an exchange of the skills and strategies that are necessary on the path to recovery (Mead et al., 2001). We again find a connection with essential values of occupational therapy. The paradigm of personal recovery and occupational therapy focuses on aspects such as accompanying the person in a life full of meaning, in which spirituality and hope in the face of change are essential (Billock, 2005, p. 887). In our review we observed 10 studies which, in addition to considering traditional variables, have incorporated measures aimed at achieving recovery in mental health.

However, only six studies obtained significant results. Four of these studies were training programs aimed at achieving personal recovery in people with mental health problems (Cook et al., 2012; Druss et al., 2018; Resnick & Rosenheck, 2010; van Gestel-Timmermans et al., 2012). These studies incorporated variables such as quality of life, self-efficacy, symptoms, use of services and recovery-oriented variables. Van Gestel-Timmermans recorded significant results in empowerment (Dutch Empowerment Scale), hope (HHI), and in the variable of self-efficacy (MHCS); Resnick & Rosenbeck obtained significant results in functioning (activities of daily living), recovery, general empowerment and use of services; Cook, recovery (RAS) and hope (SHS); and Druss in operation (SF-36) and recovery (RAS). Two case management programs, with individual intervention, achieved a significant impact (Chinman et al., 2015; Corrigan et al., 2017). The intervention proposed by Chinman obtained significant results in symptoms (BASIS-24) and recovery (MHRM), while Corrigan's program is relevant because it incorporated peer-to-peer interventions with people with mental health issues and from the same ethnic background, and obtained positive results in all

the variables studied: quality of life (QLS), recovery (RAS) and empowerment (Empowerment Scale).

On the other hand, there is a group of four studies which despite presenting outcome domains of recovery did not obtain significant results. Two were training programs (Johnson et al., 2018; Muralidharan et al., 2018) and two case management (Rogers et al., 2016; Yamaguchi et al., 2017). Johnson recorded significant results in the use of services and Muralidharan reported significant results in functioning (SF-12, Self-management Self-Efficacy Scale, Multidimensional Health Locus of Control Scale, IMSM and MHLCS), therapeutic relationship (PAM) and symptoms (BASIS-24). As for the case management programs, (Rogers et al., 2016) found significant results for symptoms (BASIS-24) and quality of life (BQOL).

Finally, six studies proposed their interventions without any recovery domain outcome (Jewell et al., 2014; Kelly et al., 2017; Mahlke et al., 2017; Rowe et al., 2007; Sledge et al., 2011; Weissman et al., 2005), including very specific programs to solve an occupational dysfunction. The programs described are set goals with bodily functions of a psychic aspect. They assess the impact of the intervention on clinical symptomatology. On the one hand, Sledge proposed a peer-to-peer program to assess its impact on reducing hospitalizations and medical services, while Jewell's and Rowe's programs for reducing toxic substance use had a positive impact on reducing addictions. Jewell achieved significant results in the therapeutic relationship (BLRI), and Rowe significant improvements in toxic consumption (ASI). Similarly, Kelly proposed a peer intervention focused on the acquisition of habits and routines in the home, achieving significant results in the person's ability to respond to specific health problems. Kelly pursues one of the essential objectives of occupational therapy: the autonomy of people in the performance of activities of daily life (AOTA, 2020b). All these studies were designed on the basis of a case management intervention. On the other hand, the Mahlke

project focused on personal recovery in the form of a training program and only had an impact on quality of life (EQ5D). We might wonder why they did not measure the impact on recovery. There are two possible reasons. The first might be the desire to address a specific problem such as drug use (Jewell et al., 2014; Rowe et al., 2007) and health care level (Sledge et al., 2011) given the accumulated experience of peer interventions in the territory. The second might be the need to generate evidence; these authors compares the impact of peer-to-peer programs and clinical impact assessments (Kelly et al., 2017; Mahlke et al., 2017; Weissman et al., 2005).

Impact achieved vs. control group

An element to highlight in the review is the nature of the control groups. In most cases the experimental intervention has been compared with a control group with standard interventions. In Johnson et al., (2018) all participants received the same training except for peer support for the preparation of the recovery notebook, while in Rogers et al., (2016) both groups received the same content except for the case management intervention which was applied only to the experimental group. This may complicate the task of finding significant differences given the high recovery load in the two groups.

Why implement peer agent interventions? The role of the occupational therapist

Occupational therapy offers a vision of the person focused on their strengths, observes the client in their daily routine and considers their cultural, institutional and social context (Townsend & Polatajko, 2013). Occupational therapy transmits this vision of PSW in its interventions so that the person receiving care can develop its potential (Townsend, 1993). As we have mentioned previously, occupational therapy has different theoretical frameworks that offer therapists occupational tools to observe, analyze and design meaningful occupations (Polatajko et al., 2004; Townsend & Polatajko, 2013). An indispensable component of a

successful PSW program is the clear definition of the PSW's tasks and roles, which will help mitigate their fear of the system (Davidson et al., 2012; Repper & Carter, 2011). A good occupational screening will allow the creation of an environment of respect between the PSW, clients and professionals to achieve a common goal for occupational therapy: it is to enjoy a life to the fullest and that everyone can contribute to society. It is not a static process, but a dynamic one between the person, the environment and the occupations. The person is connected with the environment, from this interaction the occupation is born. The role of occupational therapy can be key to achieving a successful implementation as a discipline that: 1) Fundamental values and beliefs rooted in the occupation (Cohn, 2019); 2) Knowledge and experience in the therapeutic use of occupation (Gillen et al., 2019); 3) Professional behaviors and dispositions (AOTA, 2015d); 4) Therapeutic use of oneself (Taylor, 2020). We can group the roles of the occupational therapist in:

- Select and train program participants in interpersonal skills
- Analyze the workplace to achieve optimal occupational performance
- Accompany people in their recovery process, in the search for meaningful occupations
- Supervise the intervention, guide the peers in the objectives set with the client; and make modifications if necessary

Limitations

One of the main limitations of the study lies in the very origin of the systematic review, since the search criteria themselves eliminate papers that do not meet the inclusion criteria. The inclusion solely of papers in English means that a considerable amount of research has been

neglected, but this has been done to guarantee publications with a high impact. Regarding the articles based on occupational therapy, the fact of only including studies with a control group has led to the exclusion of interesting papers.

Comparison with earlier reviews

Recently, a systematic review (Stubbs et al., 2016) that focuses on the impact of peer interventions on physical health and lifestyle behaviours on people with SMI has been published, although there is inconsistent evidence (sample size and little clarity of the contribution of the PSW), they draw positive conclusions. However, there were no occupational therapy studies in the review. The previous systematic review (all types peer support) carried out in 2014 (Lloyd-Evans et al., 2014) carried out an in-depth analysis of peer support. Lloyd-Evan's recorded significant results, though not consistent enough to promote it to policy makers. As a complement to the Cochrane quality assessment, this review has used elements to quantify the levels of evidence and their strengths for promoting the practice. All the studies analysed present a level of evidence above II, a fact that makes it possible to classify the peer interventions as strong evidence. It is true that this evidence is defined by the inclusion criteria, but since 2014 ten level I studies have been found. Like Lloyd-Evans, the risk-of-bias analysis shows certain inconsistencies which we believe are due to the nature of the practice itself: for example, the fact that the participants and the staff cannot be blinded. For this reason, we believe that there has been an evolution in the interventions in terms of rigor and quality.

Challenges for future interventions and research

The review has provided an in-depth analysis of peer interventions with people with health issues, and has identified the domain outcomes in which there has been a significant impact.

To continue advancing in its implementation it is necessary to incorporate innovative aspects, one of which is to combine health (SMI) and origin (culture) to adjust to the new social reality of diversity. We have observed the community essence of peer-to-peer models, but programs are needed to measure its impact in hospital settings. In order to continue to demonstrate the need for peer programs in mental health intervention, RCT studies are needed in which the person is in a process of recovery marked by stability and a willingness to engage in the process. It is vitally important for future research to relate the peer interventions with the impact on the occupational competence of the participants. The need to build knowledge is a matter of social justice

Conclusions

This review aims to encourage our occupational therapists to engage in the practice of peer-to-peer support and to try to apply it to their immediate environment. The bond that is generated between the worker and the client is enveloped in an atmosphere of hope that promotes recovery. The importance of this bond has been demonstrated by the significant improvements recorded in the therapeutic relationshipPeer interventions are an example of the trend change in outcome measures following the paradigm of the mental health recovery movement, promoting empowerment, offering hope and favoring inclusion.. PWs are very important travel companions for the person in achieving the objectives set from the occupational therapy service. Its widespread use in community resources has been confirmed, but there is still room for it to be applied in hospital settings. For this, it is important to define the type of intervention (educational program, training program or case management) that PSWs will carry out among their peers. In all of them, the therapist will validate the objectives with the person and the PW will accompany the client towards the goals set. In an educational program, the professional will develop the modules and accompany the person in

achieving the objectives set. Instead, in a training program, the role of the therapist will be primarily to train in interpersonal skills. Finally, in a case management program, the main role of the occupational therapist will be to analyze the potential of the person and their motivations, with the needs of the services. This should allow a definition of their role and tasks, achieving a high level of inclusion in the services. For this last reason the presence of occupational therapy is so important.

Authorship

All authors declare that is original work and that they meet the criteria for authorship. Ivan Cano designed the study, extracted the data, conducted the analyses and wrote the manuscript. Gemma Prat and Salvador Simó conducted the analyses. All authors read and approved the final manuscript.

Funding

This work was supported by the [Catalan Agency for Management of University and Research Grants] under Grant [number 2019-DI-012]

Conflict of interest

The authors report no conflict of interest.

Acknowledgements

Thanks to the Fundació Althaia-Xarxa Assistencial i Universitària de Manresa and the University of Vic - Central University of Catalonia for offering us the time and space to write this article.

REFERENCES

American Occupational Therapy Association. (2020a). Guidelines for Systematic Reviews in American Occupational Therapy. *American Occupational Therapy*, (March), 1–11. https://doi.org/www.environmentalevidence.org/Documents/Guidelines/Guidelines4.2.pdf

American Occupational Therapy Association. (2020b). Occupational therapy practice framework: Domain and process (4th ed.). American Journal of Occupational Therapy, 74(Suppl. 2), 7412410010. https://doi. org/10.5014/ajot.2020.74S2001

American Occupational Therapy Association. (2020c). Occupational therapy in the promotion of health and well-being. American Journal of Occupational Therapy, 74, 7403420010. https://doi.org/10.5014/ajot.2020.743003

American Occupational Therapy Association. (2015d). Standards of practice for occupational therapy. American Journal of Occupational Therapy, 69 (Suppl. 3), 6913410057. https://doi.org/10.5014/ajot.2015.696S06

Attkisson, C. C., & Zwick, R. (1982). The Client Satisfaction Questionnaire: Psychometric properties and correlations with service utilization and psychotherapy outcome. *Evaluation and program planning*, *5*(3), 233-237.

Bellamy, C., Schmutte, T., & Davidson, L. (2017). An update on the growing evidence base for peer support. *Mental Health and Social Inclusion*, Vol. 21. https://doi.org/10.1108/MHSI-03-2017-0014

Barrett-Lennard GT. (1962). Dimension of therapist responses as causal factors in therapeutic change. *Psychol Monogr.* 76:1–36.

Bakken, S., Holzemer, W. L., Brown, M. A., Powell-Cope, G. M., Turner, J. G., Inouye, J., Nokes, K. M., & Corless, I. B. (2000). Relationships between perception of engagement with health care provider and demographic characteristics, health status, and adherence to therapeutic regimen in persons with HIV/AIDS. *AIDS patient care and STDs*, *14*(4), 189-197. https://doi.org/10.1089/108729100317795

Billock, C. (2005). Delving into the center: Women's lived experience of spirituality through occupation (Publication No. AAT 3219812) [Doctoral dissertation, University of Southern California]. Available from ProQuest Dissertations and Theses Global.

Boevink W, Kroon H, Giesen F (2009). Empowerment: Construction and Validation of a Questionnaire [in Dutch]. Utrecht, Netherlands, Trimbos Instituut.

Borkin, Joyce & Steffen, John & Ensfield, Lisa & Krzton, Kasia & Wishnick, Hillary & Wilder, Kelly & Yangarber, Natalia. (2012). Recovery Attitudes Questionnaire: Development and evaluation. Psychiatric Rehabilitation Journal. 24. 95-102. 10.1037/h0095112.

Bourke, C., Sanders, B., Allchin, B., Lentin, P., & Lang, S. (2015). Occupational therapy influence on a carer peer support model in a clinical mental health service. *Australian Occupational Therapy Journal*, *62*(5), 299–305. https://doi.org/10.1111/1440-1630.12235

Bullock WA, Young SL. (2003). The Mental Health Recovery Measure (MHRM). Paper presented at: 111th annual meeting of the American Psychological Association Meeting August Toronto, Canada.

Campos, F. A. L., Sousa, A. R. P. de, Rodrigues, V. P. da C., Marques, A. J. P. da S., Dores, A. A. M. da R., & Queirós, C. M. L. (2014). Peer support for people with mental illness. *Revista de Psiquiatria Clínica*, *41*(2), 49–55. https://doi.org/10.1590/0101-60830000000009

Chinman, M., Oberman, R. S., Hanusa, B. H., Cohen, A. N., Salyers, M. P., Twamley, E. W., & Young, A. S. (2015). A Cluster Randomized Trial of Adding Peer Specialists to Intensive Case Management Teams in the Veterans Health Administration. *The Journal of Behavioral Health Services & Research*, *42*(1), 109–121. https://doi.org/10.1007/s11414-013-9343-1

Christiansen, C. H., & Hammecker, C. L. (2001). Self care. In B. R. Bonder & M. B. Wagner (Eds.), Functional performance in older adults (pp. 155–175). Philadelphia: F. A. Davis.

Cole, B., &McLean, V. (2003). Therapeutic relationships redefined. Occupational Therapy in Mental Health, 19, 33–56. https://doi.org/10.1300/J004v19n02_03

Cohn, E. S. (2019). Asserting our competence and affirming the value of occupation with confidence. American Journal of Occupational Therapy,73, 7306150010. https://doi.org/10.5014/ajot.2019.736002

Cook, J. A., Steigman, P., Pickett, S., Diehl, S., Fox, A., Shipley, P., … Burke-Miller, J. K. (2012). Randomized controlled trial of peer-led recovery education using Building Recovery of Individual Dreams and Goals through Education and Support (BRIDGES). *Schizophrenia Research*, *136*(1–3), 36–42. https://doi.org/10.1016/j.schres.2011.10.016

Corrigan PW, Giffort D, Rashid F, et al. (1999). Recovery as a psycho-logical construct. Community Mental Health Journal 35:231–239.

Corrigan, P., Sheehan, L., Morris, S., Larson, J. E., Torres, A., Lara, J. L., … Doing, S. (2017). The Impact of a Peer Navigator Program in Addressing the Health Needs of Latinos With Serious Mental Illness. *Psychiatric Services*, *69*(4), 456–461. https://doi.org/10.1176/appi.ps.201700241

Corrigan, P. W., Kraus, D. J., Pickett, S. A., Schmidt, A., Stellon, E., Hantke, E., & Lara, J. L. (2017). Using peer navigators to address the integrated health care needs of homeless african americans with serious mental illness. *Psychiatric Services*, *68*(3), 264–270. https://doi.org/10.1176/appi.ps.201600134

Cuffel, B. J., Fischer, E. P., Owen, R. R., &Smith, G. R. J. (1997). An instrument formeasurement of outcomes of care forschizophrenia: Issues in development andimplementation. Evaluation and theHealth Professions, 20, 96–108.

Dahl, C. M., de Souza, F. M., Lovisi, G. M., & Cavalcanti, M. T. (2015). Stigma and recovery in the narratives of peer support workers in Rio de Janeiro, Brazil. *BJPsych. International*, *12*(4), 83–85. https://doi.org/10.1192/s2056474000000611

Davidson, L., Bellamy, C., Guy, K., & Miller, R. (2012). Peer support among persons with severe mental illnesses: A review of evidence and experience. *World Psychiatry*, *11*(2), 123–128. https://doi.org/10.1016/j.wpsyc.2012.05.009

Davidson, L., Chinman, M., Kloos, B., Weingarten, R., Stayner, D., & Tebes, J. K. (1999). Peer Support Among Individuals With Severe Mental Illness: A Review of the Evidence. In *Clin Psycho1 Sci Prac* (Vol. 6). https://doi.org/10.1016/j.wpsyc.2012.05.009

Davidson, L., Chinman, M., Sells, D., & Rowe, M. (2006). Peer support among adults with serious mental illness: A report from the field. *Schizophrenia Bulletin*, *32*(3), 443–450. https://doi.org/10.1093/schbul/sbj043

Druss, B. G., Singh, M., von Esenwein, S. A., Glick, G. E., Tapscott, S., Tucker, S. J., … Sterling, E. W. (2018). Peer-Led Self-Management of General Medical Conditions for Patients With Serious Mental Illnesses: A Randomized Trial. *Psychiatric Services*, (May), appi.ps.2017003. https://doi.org/10.1176/appi.ps.201700352

Eisen SV, Normand SL, Belanger AJ, et al. (2004). The Revised Behavior and Symptom Identification Scale (BASIS-R): Reliability and validity.Medical Care. Dec. 42(12):1230–1241.

EuroQolGroup. (1990). EuroQol–a new facility for the measurement of health related quality of life. HealthPolicy- 16:199–208.

Flanagan, E., Farina, A., & Davidson, L. (2016). Does Stigma Towards Mental Illness Affect Initial Perceptions of Peer Providers? *Psychiatric Quarterly*, *87*(1), 203–210. https://doi.org/10.1007/s11126-015-9378-y

Frankl, V. E. (1959). *Man's Search for Meaning*. Boston, MA: Beacon Press.

Fransen, H., Pollard, N., Kantartzis, S., & Viana-Moldes, I. (2015). Participatory citizenship: Critical perspectives on client-centred occupational therapy. *Scandinavian Journal of Occupational Therapy*, *22*(4), 260–266. https://doi.org/10.3109/11038128.2015.1020338

Gillen, G., Hunter, E. G., Lieberman, D., & Stutzbach, M. (2019). AOTA's top 5 Choosing Wisely® recommendations. American Journal of Occupational Therapy, 73, 7302420010. https://doi.org/10.5014/ajot.2019.732001

Green, C. A., Perrin, N. A., Polen, M. R., Leo, M. C., Hibbard, J. H., & Tusler, M. (2010). Development of the Patient Activation Measure for mental health. *Administration and policy in mental health*, *37*(4), 327–333. https://doi.org/10.1007/s10488-009-0239-6

Hammell, K. R. W. (2017). Critical reflections on occupational justice: Toward a rights-based approach to occupational opportunities. *Canadian Journal of Occupational Therapy*, *84*(1), 47–57. https://doi.org/10.1177/0008417416654501

Herth K: Abbreviated instrument to measure hope: development and psychometric evaluation. (1992) Journal of Advanced Nursing17:1251–1259.

Higgins, J. P. T., Altman, D. G., Gøtzsche, P. C., Jüni, P., Moher, D., Oxman, A. D., … Sterne, J. A. C. (2011). The Cochrane Collaboration's tool for assessing risk of bias in randomised trials. *BMJ (Online)*, *343*(7829), 1–9. https://doi.org/10.1136/bmj.d5928

Humbert, T. K. (2016). Addressing spirituality in occupational therapy. In T. K. Humbert (Ed.), Spirituality and occupational therapy: A model for practice and research. Bethesda, MD: AOTA Press.

Inada T, Yagi G. (1995). Current topics in tardive dyskinesia in Japan. Psychiatry and Clinical Neurosciences 49:239–244.

Jewell, C., Falzer, P., Davidson, L., Rowe, M., & Sells, D. (2014). The Treatment Relationship in Peer-Based and Regular Case Management for Clients With Severe Mental Illness. *Psychiatric Services*, *57*(8), 1179–1184. https://doi.org/10.1176/ps.2006.57.8.1179

Johnson, S., Lamb, D., Marston, L., Osborn, D., Mason, O., Henderson, C., … Lloyd-Evans, B. (2018). Peer-supported self-management for people discharged from a mental

health crisis team: a randomised controlled trial. *The Lancet*, *392*(10145), 409–418. https://doi.org/https://doi.org/10.1016/S0140-6736(18)31470-3

Jones, N., Corrigan, P. W., James, D., Parker, J., & Larson, N. (2013). Peer support, self-determination, and treatment engagement: A qualitative investigation. *Psychiatric Rehabilitation Journal*, *36*(3), 209–214. https://doi.org/10.1037/prj0000008

Kelly, E., Duan, L., Cohen, H., Kiger, H., Pancake, L., & Brekke, J. (2017). Integrating behavioral healthcare for individuals with serious mental illness: A randomized controlled trial of a peer health navigator intervention. *Schizophrenia Research*, *182*, 135–141. https://doi.org/10.1016/j.schres.2016.10.031

Kielhofner, G. (2009). *Conceptual Foundations of Occupational Therapy Practice* (4th ed.). Chicago: F. A. Davis Company.

Kuhn, W., Bellinger, J., Stevens-Manser, S., & Kaufman, L. (2015). Integration of Peer Specialists Working in Mental Health Service Settings. *Community Mental Health Journal*, *51*(4). https://doi.org/10.1007/s10597-015-9841-0

Lehman, A. F. (1996). Measures of quality of life among persons withsevere and persistent mental disorders.Social Psychiatry and Psy-chiatric Epidemiology,31, 78–88

Liberati, A., Altman, D. G., Tetzlaff, J., Mulrow, C., Gøtzsche, P. C., Ioannidis, J. P. A., … Moher, D. (2009). The PRISMA statement for reporting systematic reviews and meta-analyses of studies that evaluate health care interventions: explanation and elaboration. In *Journal of clinical epidemiology* (Vol. 62). https://doi.org/10.1016/j.jclinepi.2009.06.006

Lloyd-Evans, B., Brown, E., Pilling, S., Kendall, T., Johnson, S., Harrison, B., … Istead, H. (2014). A systematic review and meta-analysis of randomised controlled trials of peer support for people with severe mental illness. *BMC Psychiatry*, *14*(1), 1–12. https://doi.org/10.1186/1471-244x-14-39

Lorig K, Steward A, Ritter P, et al. (1996). Outcome Measures for Health Education and Other Health Care Interventions. Thousand Oaks,CA, Sage.

McGuire-Snieckus, Rebecca & McCabe, Rosemarie & Catty, Jocelyn & Hansson, Lars & Priebe, Stefan. (2007). A new scale to assess the therapeutic relationship in community mental health care: STAR. Psychological medicine. 37. 85-95. 10.1017/S0033291706009299.

McHorney CA, Ware JE Jr, Raczek AE. (1993). The MOS 36-Item Short-Form Health Survey (SF-36): II. psychometric and clinical tests ofvalidity in measuring physical and mental health constructs. MedicalCare 31:247–263.

McLellan AT, Luborsky L, Woody GE, et al. (1980). An improved evaluation instrument forsubstance abuse patients: the AddictionSeverity Index. Journal of Nervous andMental Disease 168:26–33.

Mahlke, C. I., Priebe, S., Heumann, K., Daubmann, A., Wegscheider, K., & Bock, T. (2017). Effectiveness of one-to-one peer support for patients with severe mental illness – a randomised controlled trial. *European Psychiatry*, *42*, 103–110. https://doi.org/10.1016/j.eurpsy.2016.12.007

Mead, S., Hilton, D., & Curtis, L. (2001). Peer support: A theoretical perspective. *Psychiatric Rehabilitation Journal*, *25*(2), 134–141. https://doi.org/10.1037/h0095032

Meyer, A. (1922). The philosophy of occupational therapy. Archives of Occupational Therapy, 1, 1–10.

Muralidharan, A., Brown, C. H., E. Peer, J., A. Klingaman, E., M. Hack, S., Li, L., … Goldberg, R. W. (2018). Living Well: An Intervention to Improve Medical Illness Self-Management Among Individuals With Serious Mental Illness. *Psychiatric Services*, *70*(1), 19–25. https://doi.org/10.1176/appi.ps.201800162

OECD. (2015). *Fit Mind, Fit Job*. https://doi.org/10.1787/9789264228283-en

Parker G. (2021). In search of logotherapy. Aust N Z J Psychiatry. Dec 7:48674211062830. doi: 10.1177/00048674211062830. Epub ahead of print.

Pickett, S. A., Diehl, S., Steigman, P. J., Prater, J. D., Fox, A., & Cook, J. A. (2010). Early outcomes and lessons learned from a study of the Building Recovery of Individual Dreams and Goals through Education and Support (BRIDGES) program in Tennessee. *Psychiatric Rehabilitation Journal*, *34*(2), 96–103. https://doi.org/10.2975/34.2.2010.96.103

Puschner, B., Repper, J., Mahlke, C., Nixdorf, R., Basangwa, D., Nakku, J., … Slade, M. (2019). Using Peer Support in Developing Empowering Mental Health Services (UPSIDES): Background, Rationale and Methodology. *Annals of Global Health*, *85*(1), 1–10. https://doi.org/10.5334/aogh.2435

Radomski, M. V. (1995). There is more to life than putting on your pants. American Journal of Occupational Therapy, 49, 487–490. https://doi.org/ 10.5014/ajot.49.6.487

Rogers, J. C., & Holm, M. B. (1994). Assessment of self-care. In B. R. Bonder & M. B. Wagner (Eds.), Functional performance in older adults (pp. 181–202). Philadelphia: F. A. Davis.

Repper, J., & Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal of Mental Health*, *20*(4), 392–411. Retrieved from https://doi.org/10.3109/09638237.2011.583947

Resnick, S. G., & Rosenheck, R. A. (2010). Who attends Vet-to-Vet? Predictors of attendance in mental health mutual support. *Psychiatric Rehabilitation Journal*, *33*(4), 262–268. https://doi.org/10.2975/33.4.2010.262.268

Rogers ES, Chamberlin J, Ellison ML, et al. (1997)A consumer-constructed scale to measure empowerment among users of mental health services. Psychiatric Services 48:1042–1047.

Rogers, E. S., Maru, M., Johnson, G., Cohee, J., Hinkel, J., & Hashemi, L. (2016). A randomized trial of individual peer support for adults with psychiatric disabilities undergoing civil commitment. *Psychiatric Rehabilitation Journal*, *39*(3), 248–255. https://doi.org/10.1037/prj0000208

Rowe, M., Bellamy, C., Baranoski, M., Wieland, M., O'Connell, M. J., Benedict, P., … Sells, D. (2007). A Peer-Support, Group Intervention to Reduce Substance Use and Criminality Among Persons With Severe Mental Illness. *Psychiatric Services*, *58*(7), 955–961. https://doi.org/10.1176/ps.2007.58.7.955

Sackett, D. L. (1989). Rules of evidence and clinical recommendations on the use of antithrombotic agents. *Chest*, *95*(2 Suppl), 2S-4S.

Salyers MP, Bosworth HB, Swanson JW, et al. (2000). Reliability andvalidity of the SF-12 Health Survey among people with severemental illness. Med Care; 38:1141–1150

Sells, D., Black, R., Davidson, L., & Rowe, M. (2015). Beyond Generic Support: Incidence and Impact of Invalidation in Peer Services for Clients With Severe Mental Illness. *Psychiatric Services*, *59*(11), 1322–1327. https://doi.org/10.1176/ps.2008.59.11.1322

Schell, B. A. B., & Gillen, G. (2019). Glossary. In B. A. B. Schell & G. Gille (Eds.), Willard and Spackman's occupational therapy (13th ed. pp.1191–1215). Philadelphia: Wolters Kluwer.

Silver, J., & Nemec, P. B. (2016). The role of the peer specialists: Unanswered questions. *Psychiatric Rehabilitation Journal*, *39*(3). https://doi.org/10.1037/prj0000216

Simpson, E. L., & House, A. O. (2002). *Involving users in the delivery and evaluation of mental health services: systematic review*. https://doi.org/10.1136/bmj.325.7375.1265

Sledge, W. H., Lawless, M., Sells, D., Wieland, M., O'Connell, M. J., & Davidson, L. (2011). Effectiveness of peer support in reducing readmissions of persons with multiple

psychiatric hospitalizations. *Psychiatric Services*, *62*(5), 541–544. https://doi.org/10.1176/ps.62.5.pss6205_0541

Snyder, C.R., Sympson, S.C., Ybasco, F.C., Borders, T.F., Babyak, M.A., Higgins, R.L. (1996). .Development and validation of the State Hope Scale. J. Pers. Soc. Psychol. 70 (2),321–335

Stewart, Anita & Nápoles, Anna & Gregorich, Steven & Santoyo-Olsson, Jasmine. (2007). Interpersonal Processes of Care Survey: Patient-Reported Measures for Diverse Groups. Health services research. 42. 1235-56. 10.1111/j.1475-6773.2006.00637.x.

Stubbs, B., Williams, J., Shannon, J., Gaughran, F., & Craig, T. (2016, December 1). Peer support interventions seeking to improve physical health and lifestyle behaviours among people with serious mental illness: A systematic review. *International Journal of Mental Health Nursing*, Vol. 25, pp. 484–495. https://doi.org/10.1111/inm.12256

Taylor, R. R. (Ed.). (2017). Kielhofner's Model of Human Occupation: Theory and application. Philadelphia: Wolters Kluwer Health.

Taylor, R. (2019). Therapeutic relationship and client collaboration: Applying the Intentional Relationship Model. In B. A. B. Schell & G. Gillen (Eds.), Willard and Spackman's occupational therapy (13th ed., pp. 527–538). Philadelphia: Lippincott Williams & Wilkins.

Taylor, R. R. (2020). The intentional relationship: Occupational therapy and use of self. Philadelphia: F. A. Davis.

Tse S, Cheung E, Kan A, Ng R, Yau S. (2012). Recovery in Hong Kong: service user participation in mental health services. International Review of Psychiatry (Abingdon, England). Feb;24(1):40-47. http://doi.org/10.3109/09540261.2011.646244

Talbott, J. A. (2013). What Does Recovery Mean in Practice? A Qualitative Analysis of International Recovery-Oriented Practice Guidance. *Yearbook of Psychiatry and Applied Mental Health*, *2013*(12), 232–235. https://doi.org/10.1016/j.ypsy.2012.07.080

Thornicroft, G., & Slade, M. (2014). New trends in assessing the outcomes of mental health interventions. *World Psychiatry*, *13*(2), 118–124. https://doi.org/10.1002/wps.20114

Townsend, E. A., & Polatajko, H. J. (2013). *Enabling occupation II : advancing an occupational therapy vision for health, well-being, & justice through occupation* (Second edi). Ottawa, Ontario: CAOT Publications ACE.

van Gestel-Timmermans, H., Brouwers, E. P. M., van Assen, M. A. L. M., & van Nieuwenhuizen, C. (2012). Effects of a Peer-Run Course on Recovery From Serious

Mental Illness: A Randomized Controlled Trial. *Psychiatric Services*, *63*(1), 54–60. https://doi.org/10.1176/appi.ps.201000450

Warner, R. (2009). Recovery from schizophrenia and the recovery model. *Current Opinion in Psychiatry*, *22*(4), 374–380. https://doi.org/10.1097/YCO.0b013e32832c920b

Weissman, E. M., Covell, N. H., Kushner, M., Irwin, J., & Essock, S. M. (2005). Implementing peer-assisted case management to help homeless veterans with mental illness transition to independent housing. *Community Mental Health Journal*, *41*(3), 267–276. https://doi.org/10.1007/s10597-005-5001-2

World Federation of Occupational Therapists. (2012b). Occupational science [Position statement]. Retrieved from https://www.wfot.org/resources/occupational-science

World Health Organization. (2001). International classification of functioning, disability and health. Geneva: Author.

Wilcock, A. A. (2006). *An occupational perspective of health* (Second edi). Thorofare, N.J. : SLACK Incorporated.

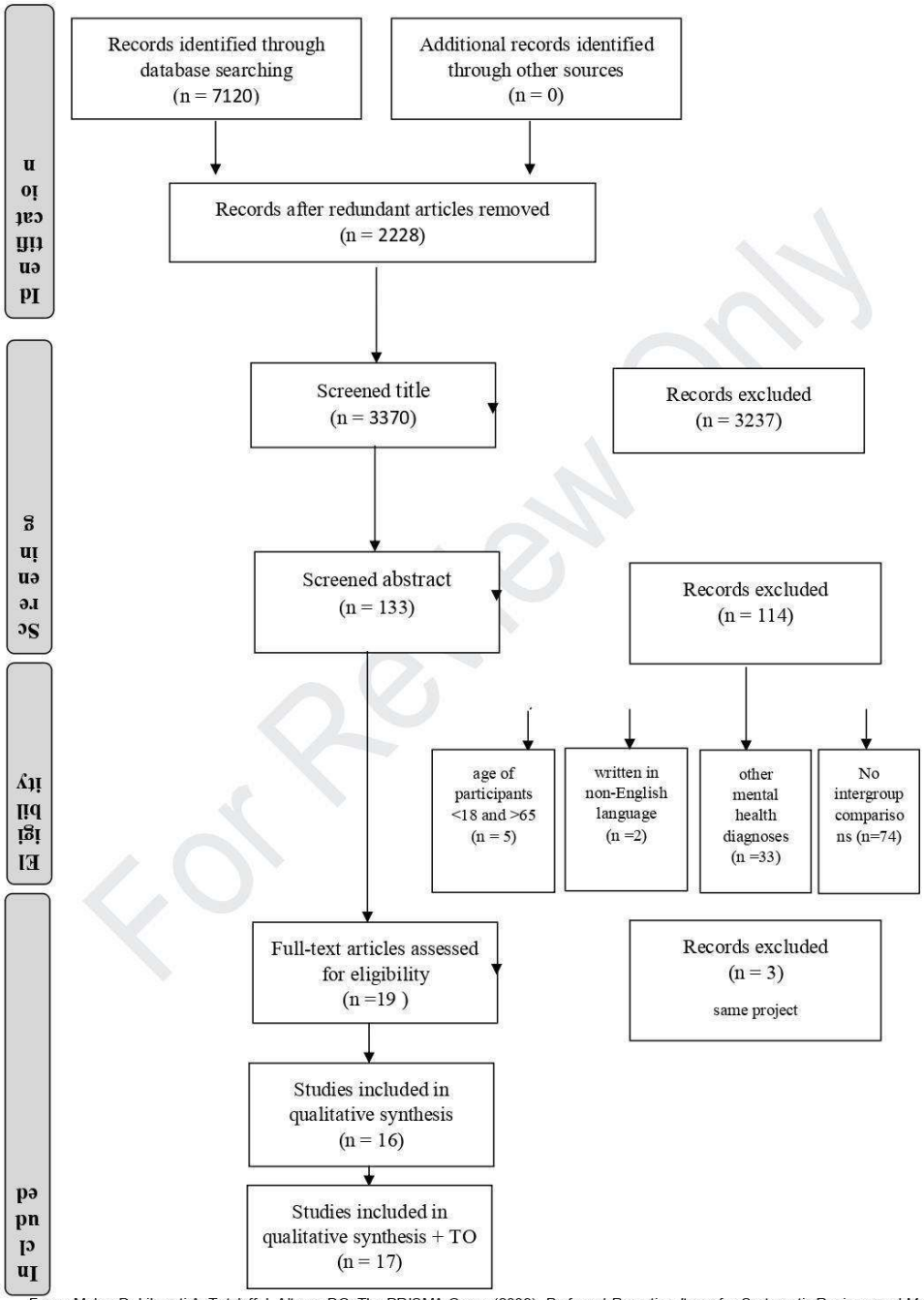
Wolfendale, T., & Musaabi, A. (2017). The implementation of a peer support scheme in an assertive rehabilitation ward in high secure forensic services. *Mental Health and Social Inclusion, 21*(4), 222-229. Retrieved from https://www.proquest.com/scholarly-journals/implementation-peer-support-scheme-assertive/docview/1925807405/se-2?accountid=133586

Wrobleski, T., Walker, G., Jarus-Hakak, A., & Suto, M. J. (2015). Peer support as a catalyst for recovery: A mixed-methods study. *Canadian Journal of Occupational Therapy*, *82*(1), 64–73. https://doi.org/10.1177/0008417414551784

Yam KKN, Lo WTL, Chiu RLP, Lau BSY, Lau CKS, Wu JKY, Wan SM. A pilot training program for people in recovery of mental illness as vocational peer support workers in Hong Kong - Job Buddies Training Program (JBTP): A preliminary finding. Asian J Psychiatr. 2018 Jun;35:132-140. doi: 10.1016/j.ajp.2016.10.002. Epub 2016 Oct 24.

Yamaguchi, S., Taneda, A., Matsunaga, A., Sasaki, N., Mizuno, M., Sawada, Y., … Ito, J. (2017). Efficacy of a Peer-Led, Recovery-Oriented Shared Decision-Making System: A Pilot Randomized Controlled Trial. *Psychiatric Services*, *68*(12), 1307–1311. https://doi.org/10.1176/appi.ps.201600544

Figure 1. Flow diagram of article inclusion and exclusion process.



From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). *P*referred *R*eporting *I*tems for *S*ystematic Reviews and *M*eta-*A*nalyses: The PRISMA Statement. PLoS Med 6(6): e1000097. doi:10.1371/journal.pmed1000097

Table 1. Summary of findings

Article	Author/Year	Level of Evidence/ Study Design / Participants / Inclusion Criteria / Country	Intervention and Control Groups	Outcome Measures	Statistically significant results
1	(Chinman et al., 2015) https://doi.org/10.1007/s11414-013-9343-1	Level I RCT N= 238 M age= not reported Female= 10% (n=28) Intervention group: 122 – M age= 54.59±9.19 yr. – Female= 10% (n=12) Control group: 116 – M age= 51.89±11.13 yr. – Female=13% (n=16) Inclusion criteria: SMI + rehospitalitations Country: US	Peer intervention: training + Case management Duration: 1 year Environment: community Control group: usual care	Baseline and 1-year follow - QOLI - BASIS-R - Patient Activation Measure (PAM) - BASIS-R - Mental health recovery: o RSA o MHRM o IIMR	1. PAM (p<0.05) 2. MHRM (p<0.01) 3. BASIS-R - (p<0.02)
2	(Cook et al., 2012) https://doi.org/10.1016/j.schres.2011.10.016	Level I RCT *N*= 428 M age= 42.8±10.9 yr. Female= 556% (n= 238) Intervention group: n=212 – M age= 42.7±9.9 yr. – Female= 53.8% (n=114) Control group: n=216 – M age= 43.0±11.8 yr. - Female= 57.4% (n= 124) Inclusion criteria: SMI Country: US	Peer intervention: Education program Duration: 8 weeks Environment: community Control: standard	Baseline - 8 weeks - 6 months (follow up) • Symptom: BSI • Recovery mental health: o RAS o SHS	1. RAS: (p <.01) 2. SHS: (p <.01)
3	(Corrigan et al., 2017) https://doi.org/10.1176/appi.ps.201700241	Level I RCT *N*=110 M age= not reported Female= 58% (n= 64) Intervention group: n=55 – M age= 48.6±9.9 yr. – Female= 51% (n=28) Control group: M age= 42.7±11.9 yr. – Female= 66% (n=36) Inclusion criteria: latinos + SMI	Peer intervention: case management. Duration: 12 months Environment: community Control group: usual care	Baseline and at four, eight, and 12 months - QLS - Mental health recovery: o Empowerment Scale o RAS	1. RAS (F=12.5, df=3 and 286, p,.01)) 2. Empowerment Scale (F=2.9, df=3 and 318, p,.05) 3. QLS (F=3.3, df=3 and 311, p,.05)

		Country: US			
4	(Druss et al., 2018) https://doi.org/10.1176/appi.ps.201700352	Level I RCT *N*= 400 M age= not reported Female= 63% (n=255) Intervention group: n=198 - *M* age= 49.74±8.72 yr. – Female= 67% (n=132) Control group: n=202 – *M* age= 49.69±9.51 yr. – Female= 61% (n=123) Inclusion criteria: SMI + comorbidity Country: US	Peer intervention: Education program Environment: community Control: usual care	Baseline, 3-month and 6- month follow-up. - SF-36: physical component summary (PCS) and mental component summary - Medical self-management: PAM - Medication adherence: MMAS - Block Fat-Sugar-Fruit-Vegetable Screener - Mental health recovery o RAS	1. Physical Component Summary (p=0.046) and Mental Component Summary (p=0.039) of the SF-36. 2. Mental Health recovery (p=0.02)
5	(Jewell, Falzer, Davidson, Rowe, & Sells, 2014) https://doi.org/10.1176/ps.2006.57.8.1179	RCT *N*= 137 M age= 41±9 yr. Female= 38.68% (n=53) Intervention group: n=68 Control group: n=69 Inclusion criteria: SMI + substance use disorder Country: US	Peer intervention: Case management Environment: community Control: usual care	Baseline - 6 months – 12 months ● Relationship: BLRI ● Addiction: ASI	1. BLRI at 6 months: Positive regard (p<.05) – Unconditionality (p<.05) 2. BLRI at 12 months: Positive regard (p<.01) - Empathy (p<.04) – Unconditionality (p<.02)
6	(Johnson et al., 2018) https://doi.org/10.1016/S0140-6736(18)31470-3	Level I RCT *N*= 441 M age= 40±12.5 yr. Female= 60% (n=263) Intervention group: n=221 – M age= 40±13 yr. – Female= 60% (n=132) Control group: n=220 – M age= 40±12 yr. – Female=60% (n=131) Inclusion criteria: SMI Country: UK	Peer intervention: education program Environment: community Remuneration: not reported Control group: usual care	Baseline, 4 months, 18 months follow-up - Symptom severity: BPRS - IMRS - Loneliness Scale - Lubben Social Network Scale - Client Satisfaction Questionnaire - readmission of participants to an acute service - Mental health recovery: o Questionnaire on the Process of Recovery	1.Satisfaction with mental health services at 4 months (p<0.001)

7	(Kelly et al., 2017) https://doi.org/10.1016/j.schres.2016.10.031	Level I RCT *N*=151 M age= 45.63±10.95 yr. Female= 53.6% (n=81) Intervention group: n=76 - M age= 44.80±11.30 yr. – Female=46.1% (n=35) Control group: n= 75 – M age= 46.47±10.59 yr. – Female= 61.3% (n=46) Inclusion criteria: SMI Country: US	Peer intervention: case management Duration: 6 months Environment: community Control: usual care	Baseline - 6 months – 12 months - Pain: SF-12 - Self-management attitudes and behaviors: Mental Health Confidence Scale - Routine health screening - Health service utilization - Satisfaction with primary care provider: Engagement with the Healthcare Provider Scale	1. Significant difference in helth service utilization: (p<.05) 2. Healthcare Provider Scale (p<0.019) 3. Improved detection of chronic health conditions (0.048) 4. Reductions in pain (p<0.031) 5. Increased confidence in consumer self-management of healthcare (p<0.009)
8	(Mahlke et al., 2017) https://doi.org/10.1016/j.eurpsy.2016.12.007	Level I RCT *N=216* M age= 41.48±12.82 yr. Female= 57% (n=124)	Peer intervention: case management Duration: 12 months Environment: community	Baseline, 6 and 12-month follow-up - GSE - EuroQol Questionnaire EQ5D - Clinical Global Impression scale	1. EQ5D, (95% CI: 0.82– 358 10.49, P = 0.04).
		Intervention group: n=114 – M age= 41.22±12.32 yr. – Female=56% (n=65) Control group: n=102 – M age= 41.79±13.43 yr. – Female= 58% (n=59) Inclusion criteria: a primary diagnosis of SMI Country: Germany	Control intervention: usual care	- GSE - number of days spent in hospital - GAF	
9	(Muralidharan et al., 2018) https://doi.org/10.1176/appi.ps.201800162	Level I RCT *N*=242 M age= 57.8±7.7 yr. Intervention group: n=124 – M age=58.5±7.6 yr. – Female= 14% Control group: n=118 – M age=57.0±7.8 yr. – Female=13% Inclusion criteria: SMI + comorbidity Country: US	Peer intervention: education program Duration: 3 months Environment: community Control intervention: usual care	Baseline, posttreatment, and 3 months follow-up - SF-12 - BASIS-24 - Self-Management Self-Efficacy scale - PAM - MHLCS - IMSM - MMAS - Recovery mental health: o MARS	1. SF-12 (t=2.15, p=.032) 2. Self-management Self-Efficacy Scale (t=4.10, p,.001) 3. PAM (t=2.08, p=.038) 4. MHLCS 5. (t=2.01, p=.045) 6. BASIS-24 (t=–2.02, p=.044); 7. IMSM - physical activity– (t=2.55, p=.011)

					8. IMSM - relationship quality- (t=22.45, p=.015)
10	(Resnick & Rosenheck, 2010) https://doi.org/10.2975/33.4.2010.262.268	Level I RCT *N*=218 M age= 48.7+/−8.9 yr. Female= 5.4% (n= 12) Intervention group: n=108 - M age= 48.9+/−8,5 yr.- Female= 8.3% (n= 9) Control group: n=110 / - M age: 48.4+/−9,3 yr. – Female= 2.7% (n= 3) Inclusion criteria: SMI + participation in CRP Country: US	Peer intervention: education program Duration: 9 months Environment: community Control: usual care	Using multiple regression analysis, baseline variables were examined as predictors of attendance in Vet-to-Vet over the 9-month study period - Employment - General life satisfaction - Functioning: GAF - Activities of Daily Living Scale - money spent on drugs or alcohol in the prior 30 days - BPRS • Recovery of mental health: - recovery attitudes - confidence - feelings of mastery over mental illness - General empowerment	The study identified significant correlations between baseline variables and acontinuous measure of program attendance: 1. Activities of daily living (r = -.21, p = .03) 2. recovery orientation (r = -.20, p = .03) 3. general empowerment (r = -.20, p = .04) 4. attendance at CRP at the one-month interview (r = .25, p = .01), 5. number of meetings attended prior to study entry (r = .30, p = .002).

11	(Rogers et al., 2016) https://doi.org/10.1037/prj0000208	Level I RCT *N*= 113 M age= not reported Female= 55% (n=63) Intervention group: n=63 – M age: 38.7±13 yr. – Female: 53.97% (n=34) Control group: n= 50 – M age: 40.9±12 yr. – Female: 58% (n=29) Inclusion criteria: SMI Country: US	Peer intervention: case management Duration: 6 months Environment: community Control group: intervention by inviting each participant to partake of all services offered by the peer-run agency	Baseline, 3-month and 6- month follow-up. - BQOL - ISEL - BASIS-24 - Recovery mental health: o RAS	1. BQOL (p<.05) 2. BASIS-24 (p<.05)
12	(Rowe et al., 2007) https://doi.org/10.1176/ps.2007.58.7.955	Level I RCT *N*= 114 M age= 39.8±8.8 yr. Female= 32% (n= 36) Intervention group: n= 73 Control group: n= 41 Inclusion criteria: SMI + criminal charges Country: US	Peer intervention: case management – education program Duration: 12 months Environment: community Control: standard services	Three interviews (baseline, six months, and 12 months). - Criminal justice data - Addiction: ASI	1. Low levels of alcohol consumption at (p<.005) 2. Decreased nonalcohol drug use (p <0.05) 3. Reduced criminal justice charges (p <0.05)

13	(Sledge et al., 2011) https:// 10.1176/ps.62.5.pss6205_0541	Level I RCT *N*=74 M age= Female= 48.64% (n=36) Intervention group: n=38 – M age= 42.16±12.0 yr. – Female=55% Control group: n=36 – M age= 38.06±9.3 yr – Female=42% Inclusion criteria: SMI + rehospitalitations Country: US	Peer intervention: case management Duration: 9 months Environment: community Control intervention: usual care	Number of hospitalizations and hospital days during the nine-month study period - number of hospitalizations - hospital days	1. Fewer rehospitalizations (p=.042) 2. fewer hospital days (p<.03)
14	(van Gestel-Timmermans, Brouwers, van Assen, & van Nieuwenhuizen, 2012) https://doi.org/10.1176/appi.ps.201000450	Level I RCT *N*=333 M age= not reported Female= 66,07% (n= 271) Intervention group: n=168 - age: 43±11 yr. - women: 68% Control group: n=165 - age: 44±10 yr. - women: 64% Inclusion criteria: SMI + rehospitalitations. Country: The Netherlands	Peer intervention. education program Duration: 12 sessions Environment: community Control group: Participants in the control group enrolled in the course at six months	Assessments took place at baseline, after three months (at the end of the course), and after six months. - Employment - Quality of life: MANSA - Self-efficacy: MHCS - BPRS • Recovery mental health: - HHI - Dutch Empowerment Scale - Loneliness Scale	Significant differences (positive results) on empowerment, hope, and self-efficacy beliefs (p<.01)

15	(Weissman, Covell, Kushner, Irwin, & Essock, 2005) https://doi.org/10.1007/s10597-005-5001-2	Level II Case control *N*= 32 M age= 48±8 yr. 100% male Intervention group: n= 17 Control group: n= 15 Inclusion criteria: Homeless + SMI Country: US	Peer intervention: case management Duration: 12 months Environment: community Control: usual case management	Interviewed participants at baseline, 4, 8, and 12 months: • Employment • Housing • General life satisfaction • Social Relationships • Functioning: GAF • Activities of Daily Living Scale • Symptoms: HSCL-25 • Addictions	without statistical significance
16	(Yamaguchi et al., 2017) https://doi.org/10.1176/appi.ps.201600544	Level I RCT *N*=56 *M* age= not reported Woman= not reported Intervention group: n=26 Control group: n=27 Inclusion criteria: SMI Country: Japan	Peer intervention: case management Duration: 6 months Environment: psychiatric hospitalization Control group: usual care	Baseline and 6- month follow-up - WHO-QOL26 - DIEPSS - BPRS - Japanese version of PAM - MMAS - IPC - STAR - SDM-18 - CSQ-8J - GAF - Mental health recovery: ○ SISR	1. SDM-18 (p=<0.001) 2. IPC (p=<0.01) 3. DIEPSS (p<0.02) 4. STAR-Patient (p<0.02)

15	(Weissman, Covell, Kushner, Irwin, & Essock, 2005) https://doi.org/10.1007/s10597-005-5001-2	Level II Case control *N*= 32 M age= 48±8 yr. 100% male Intervention group: n= 17 Control group: n= 15 Inclusion criteria: Homeless + SMI Country: US	Peer intervention: case management Duration: 12 months Environment: community Control: usual case management	Interviewed participants at baseline, 4, 8, and 12 months: • Employment • Housing • General life satisfaction • Social Relationships • Functioning: GAF • Activities of Daily Living Scale • Symptoms: HSCL-25 • Addictions	without statistical significance
16	(Yamaguchi et al., 2017) https://doi.org/10.1176/appi.ps.201600544	Level I RCT *N*=56 *M* age= not reported Woman= not reported Intervention group: n=26 Control group: n=27 Inclusion criteria: SMI Country: Japan	Peer intervention: case management Duration: 6 months Environment: psychiatric hospitalization Control group: usual care	Baseline and 6- month follow-up - WHO-QOL26 - DIEPSS - BPRS - Japanese version of PAM - MMAS - IPC - STAR - SDM-18 - CSQ-8J - GAF - Mental health recovery: o SISR	1. SDM-18 (p=<0.001) 2. IPC (p=<0.01) 3. DIEPSS (p<0.02) 4. STAR-Patient (p<0.02)
17	(Wrobleski et al., 2014) https://doi.org/10.1177/0008417414551784	Level 1 RCT N=21 M age= 53,18 Woman= 85,71% (n=18) Intervention group: n=12; age: 56,18 Control group: n=9; age: 48,65 Inclusion criteria: SMI Country: Canada	Peer intervention: training + case management Duration: 60 hr of classroom training and a 40-hr practicum Environment: community Control group: standard occupational therapy + 52 hr of MHW support	Quantitative pretest-posttest control group design and qualitative exit interviews • Quality of Life Interview–Brief Version	1. General Life Satisfaction (p=.003) 2. Satisfaction With Finances (p= .004) 3. Daily Activities (p=.05)

SMI = severe mental illness; GAF = global assessment functioning; HSCL-25 = Hopkins symptom checklist; PSW = peer supporter worker; ASI= addiction severity index; CRP= community reintegration program; BPRS = brief psychiatric rating scale; MANSA = Manchester short assessment; HHI = health hope index; MHCS = mental health confidence scale; BSI = brief symptom inventory; SHS = state hope scale; BLRI = barret-lennard relationship inventory; HARP = health and recovery peer; SF-36 = short-form health survey -36; PAM = patient activation measure; RAS = recovery assessment scale; BQOL = brief quality of life; BASIS-24 = behavior and symptom identification scale; ISEL = interpersonal support evaluations list; WHO-QOL26; world health organization quality of live; DIEPSS= drug-induced extrapyramidal symptom scale; MMAS; morisky medication adherence; IPC = interpersonal process of care; DIEPSS = Drug-Induced Extra-pyramidal Symptom Scale; STAR = scale to assess therapeutic relationship; SDM-18 = shared decision-making-18; CSQ-8J; client satisfaction questionnaire-8 japanese version; SISR = self-identified stage of recovery; QLS = quality of life scale; QOLI = quality of life instrument; MHRM = mental health recovery measure; IMR = illness management and recovery; MHC = mental health confidence; GSE = general self-efficacy; EQ5D = euroQol questionnaire; SF-12 = short form health survey-12; MHLCS = multidimensional health locus of control scale; IMSM = instrument to measure self-management; MARS = Maryland assessment of recovery scale; MHW= mental health worker

Table 2. Risk-of-Bias Table

Citation	Selection Bias			Blinding of Participants and Personnel (Performance Bias)		Blinding of Outcome Assessment (Detection Bias)		Incomplete Outcome Data (Attrition Bias)	Selective Reporting (Reporting Bias)
	Random Sequence Generation	Allocation Concealment	Baseline difference between intervention group	Blinding of Participants During the Trial	Blinding of Personnel During the Trial	Patient-Reported Outcomes	Objective Outcomes		
(Chinman et al., 2015)	+	+	+	-	-	+	+	+	+
(Cook et al., 2012)	+	+	+	-	-	+	+	?	+
(Corrigan et al., 2017)	+	+	+	-	-	?	?	+	+
(Druss et al., 2018)	+	+	+	-	-	+	+	+	+
(Jewell, Falzer, Davidson, Rowe, & Sells, 2014)	+	?	+	-	-	?	?	?	+
(Johnson et al., 2018)	+	+	+	-	-	+	+	+	+
(Kelly et al., 2017)	+	+	+	-	-	?	?	?	+
(Mahlke et al., 2017)	+	+	+	-	-	+	+	?	+
(Muralidharan et al., 2018)	+	?	+	-	-	?	?	+	+
(Resnick & Rosenheck, 2010)	+	?	+	-	-	+	+	+	+
(Rogers et al., 2016)	+	?	+	-	-	?	?	+	+
(Rowe et al., 2007)	+	?	+	-	-	+	+	+	+
(Sledge et al., 2011)	+	?	+	-	-	+	+	?	-
(van Gestel-Timmermans, Brouwers, van Assen, & van Nieuwenhuizen, 2012)	+	+	+	-	-	?	?	-	+
(Weissman, Covell, Kushner, Irwin, & Essock, 2005)	+	?	+	-	-	?	?	+	-
(Yamaguchi et al., 2017)	+	?	+	-	-	?	?	?	+

Note. Categories for risk of bias are as follows: Low risk of bias (+), unclear risk of bias (?), high risk of bias (–). Scoring for overall risk of bias assessment is as follows: 0–3 minuses, low risk of bias (L); 4–6 minuses, moderate risk of bias (M); 7–9 minuses, high risk of bias (H).

Citation. Table format adapted from Higgins, J. P. T., Sterne, J. A. C., Savović, J., Page, M. J., Hróbjartsson, A., Boutron, I., . . . Eldridge, S. (2016). A revised tool for assessing risk of bias in randomized trials. *Cochrane Database of Systematic Reviews 2016,* Issue 10 (Suppl. 1), 29–31. https://doi.org//10.1002/14651858.CD201601

Table 3. Outcome measures with statistical value grouped by outcome domains according to Occupational Therapy Practice Framework outcome domains

	Occupational performance	*Prevention*	*Health and wellness*	*Quality of life*	*Participation*	*Well-being*	*Occupational justice*
Chinman et al., 2015			BASIS-R		MHRM		
Cook et al., 2012				SHS	RAS		
Corrigan et al., 2017				QLS	RAS		Empowerment Scale
Druss et al., 2018			SF-36		Mental Health recovery		
Jewell et al., 2014	BLRI ; ASI						
Johnson et al., 2018		Client Satisfaction					
Kelly et al., (2017		acces primary care health services; emergency care; Healthcare Provider Scale	SF-12			MHCS	
Mahlke et al., 2017			EQ5D				
Muralidharan et al., 2018	PAM; MHLCS; IMSM		BASIS-24	SF-12; Self-management Self-Efficacy Scale			
Resnick & Rosenheck, 2010	Activities of Daily Living Scale				recovery attitude scale		empowerment
Rogers et al., 2016			BASIS-24	BQOL			
Rowe et al., 2007	ASI	criminal justice charge					
Sledge et al., 2011		rehospitalizations; hospital days					
van Gestel-Timmermans et al., 2012				HHI		MHCS	Dutch Empowerment Scale
Weissman et al., 2005							
Wrobleski et al., 2015				Quality of Life Interview–Brief Version			
Yamaguchi et al., 2017	SDM-18; IPC; STAR-Patient		DIEPSS				

Article 2

Títol: Training Peer Support Workers in Mental Health Care: A Mixed Methods Study in Central Catalonia

Autors (segons orde de publicació): Gemma Prat Vigué; Ivan Cano Prieto; Ruben del Río Sáez; Rut Vilanova Masana; Salvador Simó Algado

Revista: Frontiers Psychiatry. Sec. Social Psychiatry and Psychiatry Rehabilitation

Data de publicació: 8 d'abril de 2022

Tipus: Original Research article

DOI: 10.3389/fpsyt.2022.791724

ISSN: 16640640

Base de dades d'indexació: Journal Citation Reports

Quartil i Àrea: Q1 – Psychiatry and Mental Health

Impact Factor: 5.435 (2022)

frontiers | Frontiers in Psychiatry

ORIGINAL RESEARCH
published: 08 April 2022
doi: 10.3389/fpsyt.2022.791724

Training Peer Support Workers in Mental Health Care: A Mixed Methods Study in Central Catalonia

*Gemma Prat Vigué[1], Ivan Cano Prieto[1], Ruben del Río Sáez[2], Rut Vilanova Masana[1] and Salvador Simó Algado[3]**

[1] Althaia Xarxa Assistencial Universitària de Manresa, Manresa, Spain, [2] Fundació Osonament, Vic, Spain, [3] Universitat de Vic - Universitat Central de Catalunya, Barcelona, Spain

Introduction: A mental health peer support program was implemented at two reference institutions in Central Catalonia. The program culturally and contextually adapted successful international projects by training people with experience of mental health problems and ensuring their employment in multidisciplinary health care teams. This study explores the influence of peer interventions in mental health on the three groups of participants: peer support workers, service users, and mental health professionals.

Methods: A mixed observational method design included pre-, inter-, and post-experimental components and a qualitative description of the impact. The triangulation of the qualitative and quantitative findings showed its coherence and facilitated the understanding of the results. Outcomes and measures were as follows: self-stigma (Self-Stigma Questionnaire); life satisfaction (Scale of Satisfaction with Life); participation in relevant activities (Engagement in Meaningful Activities Survey); personal recovery (Scale-revised Recovery Assessment); occupational performance (Canadian Occupational Performance Measure); and attitudes toward mental illness (Community Attitudes toward Mental Illness).

Results: The program showed beneficial effects on peer support workers' (PSW) perceptions of occupational performance, specifically on the ability to find work ($p = 0.038$), work as a peer support worker ($p = 0.016$), give to the community ($p = 0.011$), and satisfaction in the ability to find work ($p = 0.031$). The assessment made by the three groups of participants was very positive: the PSWs showed an increase in self-esteem and a feeling of usefulness; users of the service described the experience as a source of hope and optimism in their recovery process; and professionals described the program as a positive step in their professional growth.

Discussion: The peer-to-peer strategy is a source of hope in the personal recovery process, providing meaning to life for the PSWs while providing an extra source of support to service users in their process of personal recovery. The results offer us lines of improvement for future implementations. PSW's final emphasis has us reflecting on improvements to enhance their own wellness in mental health care services. The findings show the importance of working on life projects and their impact on the recovery process.

Keywords: peer support (PS), mental health, personal recovery, social innovation, mixed method approach

OPEN ACCESS

Edited by:
Karen Machin,
University of Hertfordshire, United Kingdom

Reviewed by:
Karen Wright,
University of Central Lancashire, United Kingdom
Ernest Marek Tyburski,
Pomeranian Medical University in Szczecin, Poland

****Correspondence:***
Salvador Simó Algado
salvador.simo@uvic.cat

Specialty section:
This article was submitted to Social Psychiatry and Psychiatric Rehabilitation, a section of the journal Frontiers in Psychiatry

Received: *09 October 2021*
Accepted: *25 February 2022*
Published: *08 April 2022*

Citation:
Prat Vigué G, Cano Prieto I, del Río Sáez R, Vilanova Masana R and Simó Algado S (2022) Training Peer Support Workers in Mental Health Care: A Mixed Methods Study in Central Catalonia. Front. Psychiatry 13:791724. doi: 10.3389/fpsyt.2022.791724

INTRODUCTION

One of the principles of community-based mental health care is personal recovery orientation (1). According to Anthony (2), "recovery is described as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of a new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness". Until now, recovery has been understood exclusively as the resolution of the clinical aspects of mental disorder (3, 4); however, it also involves a process of personal change, as the person resumes their life project and recovers their maximum abilities and identity (4) as an individual and as a citizen (5). The interest in understanding the personal recovery process is growing, especially in English-speaking countries (6). One of the most widely accepted theoretical frameworks within the paradigm of personal recovery is CHIME: Connectedness, Hope and optimism about the future, Identity, Meaning in life and Empowerment (7).

The strategies in the recovery approach include peer-to-peer programs implemented in mental health services. The support of peers is often critical to recovery, since it encourages the sharing of experiences, emotions, and thoughts (8, 9). Given their experience of mental suffering, peer support workers (PSWs) can help others to deal with situations of disorientation and can apply their experience to favor recovery (10, 11). Among people with mental health problems, mutual support can be useful in detecting mental health problems at early stages, in coping with diagnosis, and in promoting social coexistence with mental suffering, both during hospitalization and especially in the recovery process (9, 12, 13). The information shared is often more credible and meaningful to the person than that provided by mental health professionals, because it is immediately relevant and comprehensible (14).

In general, peer support promotes a model of well-being that focuses on capabilities and recovery rather than one that centers on symptoms of the disease (8). People who have had similar experiences can provide genuine empathy and validation. In the context in which the peer-to-peer technique is developed, users with mental health issues from two institutions received training to enable them to develop a professional role in the mental health care teams. In this way, the role of the PSW is someone with direct experience of the mental health issues and meets a set of specific requirements to become part of the organization.

Purpose

The fact of being able to adapt the training and materials of other experiences of international success will allow to launch a whole series of actions to improve the attention to mental health in our territory. Likewise, the fact of carrying out an adaptation of training activities validated in other countries could generate the start of a regulated training structure that would contribute to improving the quality of care for people with mental health problems. The project follows objective 2.4 of strategic line 2 of the Mental Health and Addictions Master Plan (MHAMPS). Strategies 2017–2020 of Catalonia (15) "Guarantee the participation of people with mental health problems and the organizations that represent them." The study raises the following hypotheses:

1) The incorporation of people with mental health problems will improve community functioning and promote the quality and satisfaction of life of people with severe mental health problems.
2) The incorporation of people with mental health problems, trained, as PWS will have a positive impact on their own well-being as well as that of the affected people they support.
3) The incorporation of people with mental health problems will help to decrease the perception of social stigma toward the people affected.

MATERIALS AND METHODS

Study Design

This study evaluated the impact of the implementation of the peer-to-peer technique using a mixed methods approach. The evaluation was carried out at three time points: pre-test (T1), post-training (T2), and post-test (T3).

The study protocol was assessed by an independent clinical research ethic committee. Reporting adhered to the guidelines for Journal Article Reporting Standards for Qualitative Primary, Qualitative Meta-analytic, and Mixed Methods Research in Psychology (16).

Participants

The project included three groups of participants, with the following inclusion criteria:

(1) PSWs: age 18–65, diagnosis of severe mental disorder, and optimal recovery process in the last year.
(2) Service users: age 18–65, regular attendance at the Community Recovery Services (CRS), and diagnosis of severe mental disorder. The most frequent diagnoses were schizophrenia, bipolar disorder, and depression.
(3) Professionals: age 18–65, CRS staff members, and with a range of profiles: psychologists, nurses, social workers, and occupational therapists.

Participants as PSWs ($n = 16$) were selected by their reference professionals, who contacted the candidates and explained the project to them. They were people in care follow-up and without any experience as PWSs. At all times, participants were informed of their rights, duties, and obligations: What does the treatment consist of? What is it for? How it is performed? What effects can it produce? What are its benefits? What risks does it have? The key element was their willingness to participate; it was made clear that participation was voluntary and that they could leave the program at any time. The climate was one of continuous dialogue, with the aim of finding a balance between personal needs and the proper functioning of the project. The PWS received financial compensation through a salary scholarship.

Intervention

The project was carried out in central Catalonia, at two institutions providing mental health care—Osonament of Vic and the Division of Mental Health of the Althaia Foundation of Manresa. Osonament offers CRS: integrated community services specializing in the prevention and care of mental health and addictions, promoting comprehensive development, autonomy, and improvement of the person's quality of life. They accompany people to create a significant life project, favoring community integration; promote job placement through individualized job counseling; and offer home support so that the person can develop their life project in the most autonomous way. Althaia Foundation carries out a comprehensive social and health care plan for people with mental health problems and addictions. The community use of the spaces is facilitated, which favors integration and contributes to fighting against social stigma.

The main objective is to train, accredit, and integrate people with mental health problems in the mental health care teams. It is necessary to say that the participating professionals from each of the entities have held periodic coordination meetings throughout the development and implementation of the project, agreeing at all times on the actions to be carried out. In addition, the project has a collaboration with the first-person movement in mental health, ActivaMent Catalunya, which has a presence in the training block: a support in the preparation and writing of teaching materials and teaching tasks.

The process of adapting the peer-to-peer technique had three different phases: (1) theoretical training, (2) incorporation in the mental health teams, and (3) work as PSWs.

Theoretical Training

In order to adapt the peer-to-peer technique, different experiences of international success were sought, which could be suitable for the territory in which they were to be implemented. The theoretical contents of the training were elaborated from the previous selection of materials: (1) introduction (work environment, definitions, and objectives; (2) concept of recovery; (3) resilience; (4) ethics and rights; (5) communication skills; (6) mental health and addictions and social and health care network; (7) risks and limits of the intervention; (8) stigma, social participation, and citizenship; (9) troubleshooting; and (10) evaluation. Writing of the materials was carried out by the professionals of the participating entities (Osonament—Althaia Foundation—University of Vic-Universitat Central de Catalunya) and the first-person movement (ActivaMent). The contents of the theoretical training for the adaptation of the peer-to-peer technique were agreed upon by all the agents participating in their design and were configured as follows: 10 weekly sessions of 4-h duration. The sessions were held alternately in Manresa and Vic. It was attended by 16 students (equal percentage between Osonament and Fundación Althaia). To access work practices, 80% attendance was required as a requirement. It took place at the University of Vic-University of Central Catalonia, and all the PSWs received an accreditation by the university.

TABLE 1 | List of tasks executed by the PWS.

Review and preparation of documentation
Support for the Harm Reduction Program (aimed at people with substance use disorders)
Support for the Abstinence Support Program (aimed at people with substance use disorders)
Support for the Emotional Support and Activation Program
Support for the organization of Sports Days
Walking group
Relaxation workshop through meditation
Communications at conferences and congresses
Individual accompaniments
Supervisions with reference in the entity
Organizational meetings
Individual support through music of home residence
Home-residence music workshop
Support for the Functionality Support Program
Support for the Functional Rehabilitation Program
Support for the time occupation support program
Anti-stigma project design
Support for sports activities
Group Support Activities of Daily Living
Community accompaniment
Support for the home autonomy program
Support for the inpatient rehabilitation program
Individualized accompaniment to the community in hospitalizations
Support in the reception of the center
Support in the reception and dynamization of the social club
Support in the preparation and implementation of work dynamics
Participation in meetings of the Individualized Support Program

Incorporation to the Mental Health Teams

Once the theoretical training was completed, the people who met the specified criteria joined the mental health care teams as peer support agents of the two care provider entities: the Althaia Foundation's Mental Health Division and Osonament. Although most of the insertion occurred in CRS, insertion also occurred in an inpatient unit. We understand CRS as a free public rehabilitation community service that offers care to adults (between 18 and 65 years old) with serious mental disorders in which the personal, family, and social rehabilitation of the person is worked on. The CRS is that space located within the community, which allows the person to develop life projects in their environment.

Work as PSWs

People joined the care teams and worked over a 6-month period for an average of 10 h per week. PSWs joined a variety of services or intervention programs (case manager—therapeutic group management—hospitalization), and their participation was closely supervised by reference professionals at each site. In **Table 1**, we offer the list of tasks executed by the PWS. A weekly follow-up of 1 h is established between the reference professional and the PWSs.

Outcome Variables and Measures

Data on self-stigma, life satisfaction, participation in relevant activities, personal recovery, occupational performance, and attitudes toward mental health were recorded using the five questionnaires listed below:

The Self-Stigma Questionnaire (SSQ) (Cronbach's alpha ranging between $\alpha = 0.75$ and $\omega = 0.901$) uses the following Likert response categories: 1 = strongly agree, 2 = moderately agree, 3 = slightly agree, 4 = neither agree nor disagree, 5 = slightly disagree, 6 = moderately disagree, and 7 = strongly disagree. Higher scores indicate lower self-stigma (17).

The Spanish version of the Scale of Satisfaction with Life (SWLS) by Dieneret al., adapted by Atienza et al. (Cronbach's $\alpha = 0.88$), offers an overall judgment of people's satisfaction with their own lives. It consists of five Likert-type items with scores ranging from 1 "strongly disagree" to 5 "strongly agree" (18, 19).

The Engagement in Meaningful Activities Survey (EMAS) (Cronbach's $\alpha = 0.91$) reflects multiple proposals for occupational therapy and occupational science that address constituents of meaningful engagement. The EMAS addresses the assessment of the meaning of an occupation by bringing together diverse viewpoints on meaning and employment (20).

The Recovery Assessment Scale-revised (RAS-R) (Cronbach's alpha ranging between $\alpha = 0.93$ and $\omega = 0.95$) is a self-applied instrument that measures personal recovery, developed over 20 years ago by Gifford and colleagues in the United States. The RAS-R consists of 24 items on a five-level scale "strongly disagree," "disagree," "not sure," "agree," and "strongly agree" (21).

The Canadian Occupational Performance Measure (COPM) is an individual assessment tool designed to detect changes in clients' self-perceptions of their performance and satisfaction over time. It is scored with values from 1 (lowest) to 10 (highest score) (22). Test–retest reliability of the COPM was $r = 0.842$.

The Community Attitudes toward Mental Illness (CAMI) by Taylor and Dear is a scale composed of 40 items, rated on a 5-point Likert scale, ranging from total agreement to total disagreement (Cronbach's alpha ranging between $\alpha = 0.861$ and $\omega = 0.909$). The scale consists of four named factors: authoritarianism, benevolence, social restraint, and community health mental ideology, each of which contains 10 statements regarding opinions on how to treat and care for people with severe mental illness. Five of these 10 items are expressed positively and the other five negatively (23).

These methods were chosen considering two criteria: (1) they measure results in accordance with the personal recovery paradigm and (2) instruments were validated into Spanish.

Data Collection Procedures

At the beginning of the training (T1), sociodemographic data were collected from the PSWs, and outcome measures were administered to all participant groups. After 6 months (T2), the PSWs who had successfully completed the training answered the same questionnaires and additionally the COPM. Finally, at 12 months (T3), all participants were contacted again to complete the outcome measures and the COPM. At the end of the program, focus groups were used to further assess the impact on the participants. All the professionals at the two reference institutions where PSWs were included were contacted *via* an online questionnaire with an open-ended item format (24). At the same time, focus groups (25) were held with the PSWs and service users, based on a format of semi-structured, open-ended interviews and lasting an average of 90–120 min. The questions revolved around perceptions about the program and their own execution of the PSWs' role, the perceived impact on their own recovery process, and suggestions for the implementation of future programs.

Questionnaire and focus groups were carried out in Catalan and Spanish, and literal transcriptions were produced for their final analysis. Only the quotations selected for this manuscript have been translated into English (**Table 2** shows the assessment levels and the data collection measures).

TABLE 2 | Outline of the mechanisms used for analysis.

	Time 1			Time 2			Time 3		
	PWS	SU	MHP	PWS	SU	MHP	PWS	SU	MHP
SSQ	X	X		X			X	X	
SWLS	X	X		X			X	X	
EMAS	X	X		X			X	X	
RASR	X	X		X			X	X	
COPM	X						X		
CAMI			X						X
FG							X	X	
Q									X

PSW, peer supporter worker; SU, service user; MHP, mental health professional; SSQ, Self-Stigma Questionnaire; SWLS, Satisfactions With Life Scale; EMAS, Engagement in Meaningful Activities Survey; RAS-R, Recovery Assessment Scale-revised; COPM, Canadian Occupational Performance Measure; CAMI, Community Attitudes toward Mental Illness; FG, focus group; Q, questionnaire.

Data Analysis

Quantitative Measures

Two researchers (PV and CP) used the SPSS software (version 28.0). A repeated measures analysis of ANOVA was used on the instruments with three data collection points. Using Cohen's *d*, the effect size of the mean differences was verified. The analysis of the data was completed using non-parametric tests, the Wilcoxon rank test for repeated measurements and the Mann–Whitney *U* test for mean comparisons between groups. In all cases, a p-value <0.05 was considered to reject the null hypothesis.

Qualitative Interviews

Three independent researchers (SA, PV, and CP) used the Atlas.ti (version 9.1) to make the analysis of the narratives and to create category groups, which were analyzed. The content analysis technique was used. This began with an exhaustive reading of the transcripts of the first interviews with each participant, carried out by the first author. After this reading, the material was coded, and the quotations were grouped in relation to their similarity and in relation to the objective of the study, through several discussions between the researchers. Based on these discussions, preliminary groups of codes were

generated, which were compared by the researchers until reaching more central themes. Ten PSWs, who completed the project from start to finish, participated in the focus groups. Twelve professionals participated in the online questionnaires evaluating their participation in the program. Twenty-one service users participated in the focus groups.

Data Integration

The mixed method used was the convergent parallel design (26). The triangulation of the qualitative and quantitative findings facilitated the understanding of the results and showed its coherence and lack of contradictions. It is a methodology that allows the convergence of different data: beneficial to provide confirmation of findings, more complete data, greater validity, and better understanding of the studied phenomena (27). A methodological triangulation was carried out. When using different methods in triangulation, the aim is to analyze the same phenomenon through different approaches.

RESULTS

Initially, there were 16 PSWs, divided equally between the two institutions. Ten PSWs eventually completed the whole project, from the training phase to the placement in the work teams (see **Figure 1**).

These 10 people were the only ones who completed the entire project.

Participants and Intervention

The study population comprised 162 participants (professionals, $n = 69$ (47%); PSW, $n = 16$ (19%); service users, $n = 77$ (43%); **Table 3**). Women accounted for 52% of the sample. Most participants were aged between 36 and 55, and 5% were under 25.

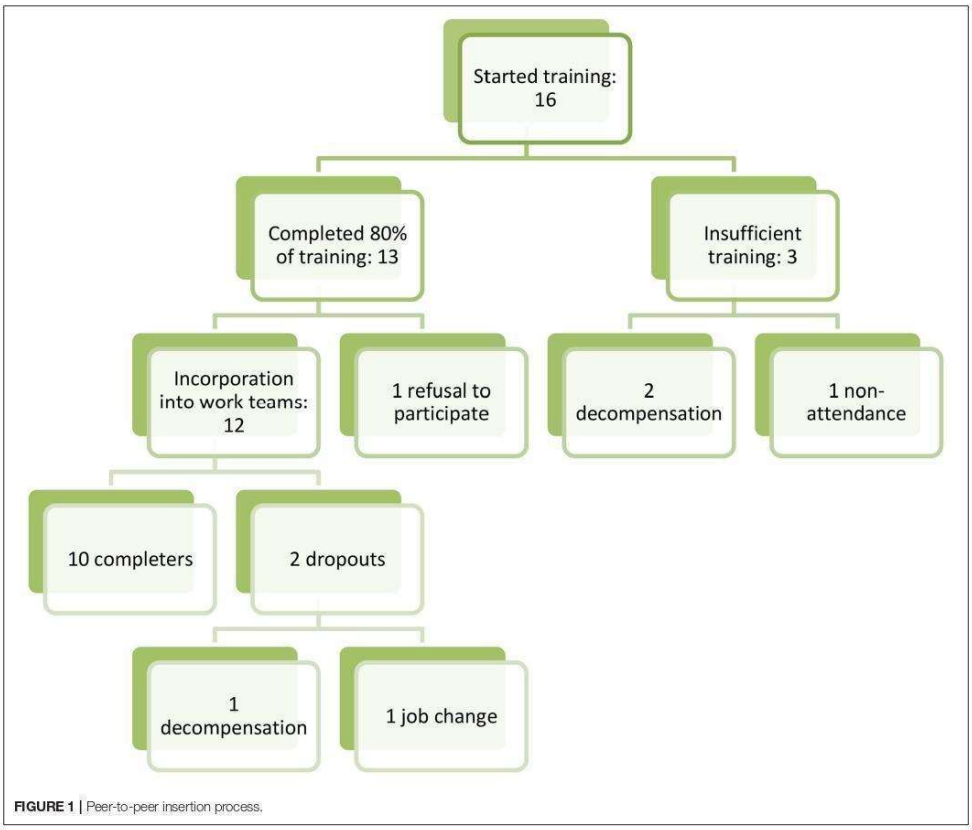


FIGURE 1 | Peer-to-peer insertion process.

TABLE 3 | Baseline demographics.

		PSW 16	SU 77	MHP 69
Female		9 (56%)	52 (68%)	52 (75%)
Age				
	<25	–	/	6 (6%)
	26–35	–	/	20 (20%)
	36–45	2 (12%)	/	14 (39%)
	46–55	7 (44%)	/	14 (20%)
	>56	7 (44%)	/	15 (15%)

PSW, peer supporter worker; SU, service user; MHP, mental health professional.

Qualitative Results

There were 583 quotations explored, which were grouped into 68 codes, and these were under the umbrella of four groups of codes. Four groups of categories have been created considering the content of the story, i.e., the first level of categorization has been created under the premise "Who or what are you talking about?" Therefore, the first group refers to the task of ACCOMPANY (A), followed by PEERS (P), all those stories that focus on the practice of PSWs; below, we find the group MENTAL HEALTH PROFESSIONALS (MHP), all those stories that focus on the professionals of the teams); and finally, the PROJECT group (PRO), all those stories that focus on the phases of the project (proposals for improvement have been collected here). In all the categorical groups, we find stories of all the participants (see **Table 4**).

Group A (212 quotations) is made up of 34 codes. It is observed that the categories Stigma and Comprehension–Empathy are the ones that include more stories, 24 and 23 quotations, respectively. Below, we find the Hope category with 18. Next, we find how Support and Values, with 14 each, and Complement, with 13, are the most references. The remaining 23 codes are in a range between eight and one quotation.

Group P (206 quotations) is made up of 18 codes. There are three categories above the rest: Impact by peer (28), Functions (29), and Example (30). In a step below is the code Lived Experience and Empowerment, with 27 and 17 quotations, respectively. The rest is in a fork between 12 (Meaning) and one story (Self-realization).

The MHP group (22 quotations) is made up of five codes. It has been a little referenced group, and we would highlight Impact for the professional with eight quotations. It is followed by Concerns, Reality Theory Discrepancy, Medication, and Breaking Barriers in order of quotations.

The PRO group (143 quotations) is made up of 11 codes. The category Improvements has been the most referenced with 30 quotations, followed by Positive evaluation with 28 quotations, and Challenge with 23. Behind, we would find a second group between the fork of 16 and one quotation in which the categories Training and Innovation with 16 and 14 quotations, respectively, stand out.

TABLE 4 | Qualitative analysis: codes, group of codes, and quotations.

Code group	Codes	Quotations
Accompany		212
	Stigma	24
	Understanding empathy	23
	Hope	18
	Support	14
	Values	14
	Complement	13
	Recovery	8
	Opening	7
	Confidence	7
	Misunderstanding	7
	Motivation	7
	Proximity	7
	Learning	5
	Listen	5
	Equal accompaniment	4
	Self-stigma	4
	Self esteem	4
	Identification	4
	Inclusion	4
	Relationship	4
	Acceptance	3
	Social impact	3
	Life quality	3
	Taboo	3
	Training	2
	Tip	2
	Previous experience	2
	Individuality	2
	Investment	2
	Normalization	2
	Suffering	2
	Inspiration	1
	Resources	1
	Resilience	1
PEERS		206
	Impact by peer	34
	Functions	31
	Example	30
	Lived experience	27
	Empowerment	17
	Feeling useful	13
	Meaning	12
	Meaningful employment	10
	Fortress	6
	Nervous	5
	Employment	5
	Be like professionals	5
	Substitution	3
	Wellness	2

(Continued)

TABLE 4 | Continued

Code group	Codes	Quotations
	Stress	2
	Previous experience	2
	Self-realization	1
	Satisfaction	1
Mental health professionals		22
	Impact for the professional	8
	Concerns	5
	Reality theory discrepancy	4
	Medication	3
	Break down barriers	2
Project		143
	Improvements	30
	Positive assessment	28
	Challenge	23
	Concern	18
	Training	16
	Innovation	14
	Ambiguity	6
	Task planning	4
	Uncertainty	2
	Information	1
	Remuneration	1

Contribution of the Project to the Personal Recovery Process

Data on the project's impact come from the quantitative measures and qualitative interviews (see **Tables 5**, **6**).

PSWs

T1–T2

The training had a positive impact on the participants.

Self-Stigma

The results of the questionnaire showed a decrease of 2.1 (T1 = 80.60–T2 = 78.50) in the perception of perceived stigma ($p = 0.344$). In turn, the changes were detailed on the Satisfaction with Life Scale ($p = 0.586$) with an increase of 2.84 points between the two periods (T1 = 23.73–T2 = 26.57). Regarding the survey on participation in significant activities, an increase of 4.72 (T1 = 48.53–T2 = 53.25) was observed at the end of training ($p = 0.753$). The greatest differences observed occurred in the revised Recovery Assessment Scale (T1 = 96.2–T2 = 101.50) with an increase of 5.3 in the perception of personal recovery ($p = 0.446$). However, the collected changes did not show statistically valuable differences ($p < 0.05$).

T2–T3

The data collected at the end of the project show us a decrease in all the measures used in the three times with the exception of SSQ. A statistically significant decrease ($p = 0.042$) was observed in the Satisfaction with Life Scale with a reduction of 4.35 (T3 = 22.22). An increase in the perception of stigma ($p = 0.893$) of 1.61 (T3 = 80.11) is observed. With respect to EMAS ($p = 0.750$) and RASR ($p = 0.528$), decreases of 2.37 (T3 = 50.88) and 4.17 (T3 = 97.33) were registered, respectively.

The effect of the commented differences has a small effect. All of them are less than $d = 0.50$.

Canadian Measure of Occupational Performance

Three performance parameters were analyzed in which significant improvements were obtained: ability to find work ($p = 0.038$), work as a support agent ($p = 0.016$), and give to the community ($p = 0.011$). Regarding satisfaction, three parameters were registered, obtaining significant improvements in the ability to find work ($p = 0.031$). There were improvements in the remaining parameters but without significant values: working as a support agent ($p = 0.018$) and give to the community ($p = 0.063$).

With the exception of the perception in the performance of give to the community ($d = 0.06$), the subtraction of items presents an effect above $d = 0.50$, so we can affirm a medium effect in the differences.

- *PSW: "[...] it made me feel very good. In fact, at the weekend I missed it [...]*
- *PSW: [...] it's an important help in our professional goal of improving [...].*

Two categories that might explain this decrease in the subjective perception of life satisfaction were nerves and stress. This decrease in the perception of life satisfaction can be observed in the results obtained in the qualitative analysis:

- *PSW: [...] At the beginning I felt a bit nervous [. . .]*
- *PSW: [...] I felt a bit of pressure but for myself [...]*
- *PSW: [...] Right now I want to finish because it is making me feel a little [...]*
- *PSW: [...] Yes, there are days when I get stressed [...].*

The perception of occupational performance improved in all the roles analyzed: ability to find work, work as a PSW, and giving to the community, which can relate directly to job placement. The PSWs experienced a sense of empowerment:

- *PSW: [...] at the same time you discover skills that you didn't know you had [...]"*
- *PSW: [...] I came out strengthened and it gave me a lot of confidence [...]*
- *PSW: [...] but it has opened up my mind and showed that I can work on something [...]*
- *PSW: [...] It is a very good way to make the peer feel motivated, and empowered [...]*
- *PSW: [...] It's made me feel more confident of myself / and not see myself as" sick "[...].*

Also, in the field of occupational performance, PSWs presented an increase in satisfaction in the ability to find work, relating to their own practice as a peer agent. They saw it as a truly meaningful occupation. The qualitative results reveal three categories that exemplify this perception of fulfillment:

TABLE 5 | Quotations used for mixed analysis.

	Label	Narrative
PWS	Perception of life satisfaction	*"[...] it made me feel very good. In fact, at the weekend I missed it [...]*
		[...] It's an important help in our professional goal of improving [...]
	Nerves and stress	*[...] At the beginning I felt a bit nervous [...]*
		[...] I felt a bit of pressure but for myself [...]
		Right now I want to finish because it is making me feel a little [...]
		Yes, there are days when I get stressed [...]
	Ability to find work, work as a PSW, and giving to the community	*at the same time you discover skills that you didn't know you had [...]"*
		I came out strengthened and it gave me a lot of confidence [...]
		but it has opened up my mind and showed that I can work on something [...]
		It is a very good way to make the peer feel motivated, and empowered [...]
		It's made me feel more confident of myself / and not see myself as" sick "[...]
	Employment	*"[...] Sometimes a job is so hard you just say "I'm not interested [...]*
		[...] having an occupation, not just a job... very often [...]
		[...] I've been in jobs where I was very busy but what I was doing was pointless
		[...] With peer2peer I feel that I've got a direction [...]
		[...] When I come to Mosaic I enjoy myself, it's very rewarding [...]
	Meaningful occupation	*[...] having an occupation, not just a job... very often [...]*
		[...] I've been in jobs where I was very busy but what I was doing was pointless [...]
		[...] With peer2peer I feel that I've got a direction [...]
		[...] When I come to Mosaic I enjoy myself, it's very rewarding [...]
	Sense of being useful	*[...] I use my most personal skills for the good of the group. And this [...]*
		[...] all this is what gives it meaning. These moments when you see that it is [...]
		[...] participating in peer2peer comes to my mind that I can make a contribution [...]
		[...] It sounds obvious... but we felt useful [...]
		[...] I think it provides a sense of usefulness and involvement [...]
	Self-esteem	*[...] Very often doing an occupation that suits you creates self-esteem [...]*
		[...] when you find a reason for doing something then you can do it [...].
SU	Hope and optimism	*First of all optimism, because you see that they're dealing very well with the situation, they're happy [...]*
		I know that you can have a disorder but still be happy.
	Understanding and empathy	*[...] when you go to the professional, you think "I don't know if he will understand me" [...]*
		And there's an empathy that is difficult to find with other people.
		I believe that people like us feel more trust for a person who has gone through the same thing [...]
		You have to go through it (share it) if you don't, you don't see anything in your heart.
		[..] it is easier to talk about these things with PSWs [...]
		Being with a person with a mental difficulty like you makes you feel safer
	Inspiration and example	*I feel positive...seeing that you can suffer from a disorder but still be ok afterwards [...]*
		He accepted the challenges and overcame them. And I just want to do the same [...]
		He comes from the real world is and is positive, he can motivate people [...]
		I also think that being able to be a support agent helps. [...]
		Because you are helping other people and that for me multiplies the recovery [...]
		Feeling useful is essential in life.
		[...] It must help a lot to feel useful and alson [...]

(Continued)

TABLE 5 | Continued

	Label	Narrative
MHP	Acceptance	*"I didn't regard the PSW like an intern or a user of the program, just another team member providing support on a day-to-day basis"*
		"Personally it has been enriching, I have learned from seeing other views of the same problem and the opportunity for change from a particular person"
		"It has been very positive, I have felt very comfortable at all times. A member of the team"
	Personal and professional growth	*"A synergistic learning process"*
		"I think it is very positive for professionals to see that there are people with a disorder who can later help others on their journey; they provide a vision and a way of working based on details and proximity, constancy."
		"It greatly enriches professional work; they help us to provide better service and are a source of satisfaction for the majority of users"
	Power of change	*"Being able to break the barriers of professional–patient [...]"*
		"[...] working on stigma, admitting the shortcomings of the system, not overvaluing professional decisions, respecting the decisions of the patients and, above all, recognizing that society is diverse"
		"[...] accept that mental health problems are another characteristic of the people with whom we share spaces. Work, life, etc. [...]"

- *Employment: "[...] Sometimes a job is so hard you just say "I'm not interested [...]"*
- *A meaningful occupation: "[...] having an occupation, not just a job... very often [...] ..... / "[...] I've been in jobs where I was very busy but what I was doing was pointless [...]" / "[...] With peer2peer I feel that I've got a direction [...]"/ "[...] When I come to Mosaic I enjoy myself, it's very rewarding [...]"*
- *Sense of being useful: "[...] I use my most personal skills for the good of the group. And this [...]"/ "[...] all this is what gives it meaning. These moments when you see that it is [...] / "[...] participating in peer2peer comes to my mind that I can make a contribution [...] / "[...] It sounds obvious... but we felt useful [...] / "[...] I think it provides a sense of usefulness and involvement [...].*

Peer-to-peer practice was particularly meaningful for participants, and they themselves related it directly to an increase in self-esteem:

- *PSW: [...] Very often doing an occupation that suits you creates self-esteem [. . .]*
- *PSW: [. . .] when you find a reason for doing something then you can do it [...].*

Service Users

Improvements were obtained in all the measures used with the exception of the RAS. In the Self-Stigma Questionnaire, the improvement was 2.33 points higher than the baseline level ($p = 0.702$); the instrument that measures satisfaction with life (SWLS) registered a change of 1.47 ($p = 0.954$); and the EMAS detected an improvement of 2.8 ($p = 0.810$) compared to the start. The personal recovery variable suffered a setback compared to the initial one of 0.77 ($p = 0.648$), giving practically the same results. However, despite the aforementioned changes, none were of statistical value. The analysis shows a small-difference effect ($d = 0.20$).

Service users stated that the presence of PSW had been a source of hope and optimism:

- *SU: First of all optimism, because you see that they're dealing very well with the situation, they're happy [. . .]*
- *SU: [. . .] I know that you can have a disorder but still be happy.*

Service users also reported feeling closer to the PSWs and opened up more quickly. They expressed a greater degree of understanding:

- *SU: [. . .] when you go to the professional, you think "I don't know if he will understand me" [. . .]*
- *SU: And there's an empathy that is difficult to find with other people*
- *SU: I believe that people like us feel more trust for a person who has gone through the same thing [. . .]*
- *SU: You have to go through it (share it) if you don't you don't see anything in your heart*
- *SU: [..] it is easier to talk about these things with PSWs [. . .]*
- *SU: Being with a person with a mental difficulty like you makes you feel safer.*

PSWs were a source of inspiration and an example:

- *SU: I feel positive...seeing that you can suffer from a disorder but still be ok afterwards [. . .]*
- *SU: He accepted the challenges and overcame them. And I just want to do the same [. . .]*
- *SU: He comes from the real world is and is positive, he can motivate people [. . .].*

And, a model for recovery:

- *SU: I also think that being able to be a support agent helps. [...]*
- *SU: Because you are helping other people and that for me multiplies the recovery [...]*
- *SU: Feeling useful is essential in life*

TABLE 6 | Results grouped according to levels of participation.

	Assessment	Time 1, mean (SD)	Time 2, mean (SD)	Time 3, mean (SD)	*p*-value	Effect size *d* (Cohen's) T1–T3
PWS						
	SSQ	80.60 (12.59)	78.50 (11.64)	80.11 (16.49)	0.294	−0.03
	SWLS	23.73 (5.70)	26.57 (6.07)	22.22 (4.99)	0.748	−0.30
	EMAS	48.53 (7.52)	53.25 (4.36)	50.88 (6.41)	0.162	0.37
	RASR	96.42 (8.98)	101.50 (9.31)	97.33 (7.46)	0.093	0.12
	Occupational development: ability to find work	6.92 (1.97)		7.08 (2.50)	0.038	1.00
	Occupational development: working as a support agent	7.19 (1.68)		8.38 (1.19)	0.016	1.08
	Occupational development: giving to the community	7.50 (1.63)		8.54 (0.96)	0.011	0.06
	Satisfaction: ability to find work	7.43 (2.10)		8.42 (1.44)	0.031	0.69
	Satisfaction: working as a support agent	8.56 (1.89)		9.23 (1.01)	0.180	0.66
	Satisfaction: giving to the community	8.75 (1.57)		9.31 (0.75)	0.063	0.75
SU						
	SSQ	57.15 (18.03)		59.48 (17.89)	0.702	0.13
	SWLS	16.71 (7.35)		18.18 (7.09)	0.954	0.21
	EMAS	41.33 (10.07)		44.13 (10.49)	0.810	0.27
	RASR	80.47 (12.09)		79.70 (17.97)	0.648	−0.04
MHP						
	CAMI	21.62 (2.02)		21.67 (2.55)	0.676	0.02
	Authoritarianism pro					
	CAMI	9.74 (2,58)		9.61 (2,32)	0.343	−0.38
	Authoritarianism anti					
	CAMI	8.45 (2.12)		8.76 (2.48)	0.750	0.13
	Benevolence pro					
	CAMI	22.46 (1.55)		22.05 (2.23)	0.277	−0.18
	Benevolence anti					
	CAMI	23.04 (1.90)		22.28 (2.16)	0.124	−0.35
	Social restrictiveness pro					
	CAMI	8.82 (2.23)		9.30 (2.72)	0.648	−0.15
	Social restrictiveness anti					
	CAMI	10.10 (1.80)		10.56 (1.99)	0.247	0.23
	Community mental health ideology pro					
	CAMI	22.57 (1.97)		22.81 (2.41)	0.435	0.10
	Community mental health ideology anti					
	CAMI Total	124.25 (4.94)		124.71 (5.50)	0.628	0.08

PSW, peer supporter worker; SU, service user; MHP, mental health professional; SSQ, Self-Stigma Questionnaire; SWLS, Satisfactions With Life Scale; EMAS, Engagement in Meaningful Activities Survey; RAS-R, Recovery Assessment Scale-revised; COPM, Canadian Occupational Performance Measure; CAMI, Community Attitudes toward Mental Illness; $p < 0.05$.

- *SU: [...] It must help a lot to feel useful and alson [...].*

Mental Health Professionals

The results between the two-time units show stability over time. Globally, there has been an increase in the Community Attitudes toward Mental Illness scale of 0.46 (T1 = 124.25–T2 = 124.71) without statistical value ($p = 0.628$). The changes in the four factors (authoritarianism, benevolence, social restraint, and community health mental ideology) and the differences are below one point and without statistical value ($p < 0.05$). The analysis shows a small difference effect ($d = 0.20$).

The qualitative evaluation indicated that professionals fully accepted the PSWs and regarded them as colleagues:

- *MHP: "I didn't regard the PSW like an intern or a user of the program, just another team member providing support on a day-to-day basis"*
- *MHP: "Personally it has been enriching, I have learned from seeing other views of the same problem and the opportunity for change from a particular* person"
- *MHP: "It has been very positive, I have felt very comfortable at all times. A member of the team".*

They also stated that the process of sharing workspace with a PSW has been a journey of personal and professional growth:

- *MHP: "A synergistic learning process"*
- *MHP: "I think it is very positive for professionals to see that there are people with a disorder who can later help others on their*

journey; they provide a vision and a way of working based on details and proximity, constancy."

- *MHP: "It greatly enriches professional work; they help us to provide better service and are a source of satisfaction for the majority of users*".

Finally, they were well aware of the stigma suffered by people with mental health problems, and believed in the potential of PSWs to break down barriers:

- *MHP: "Being able to break the barriers of professional–patient* [...]"
- *MHP:* "[...] *working on stigma, admitting the shortcomings of the system, not overvaluing professional decisions, respecting the decisions of the patients and, above all, recognizing that society is diverse*"
- *MHP:* "[...] *accept that mental health problems are another characteristic of the people with whom we share spaces. Work, life, etc.* [...]".

DISCUSSION

This pilot study explored the influence that peer interventions at mental health institutions had with the PSWs, the clients, and the professionals. On the one hand, it analyzed the effect of the program on PSWs and service users, quantifying the impact on life satisfaction, social participation, self-stigma, and occupational development. On the other hand, data from the professionals were collected about their attitudes toward people with mental health problems. The use of qualitative techniques facilitated a greater understanding of the impact of the program. This triangulation of results enabled the research questions to be addressed from different perspectives, thus providing a fuller picture than could be gained using a single method (31). Triangulation refers to the use of multiple methods or data sources in qualitative research to develop a comprehensive understanding of phenomena (30). It is a methodology that seeks to ensure that the results are consistent and not contradictory (29).

PSWs

PSWs presented changes in the perception of satisfaction with life (SWLS), the development of occupational roles (COPM), and satisfaction in the ability to find work (COPM), between the start and the end of the study. The SWLS results reflect a reduction in the perception of satisfaction with life that we can attribute to the challenge of new roles and the obligation to modify a well-established routine. As Ibrahim et al. (32) noted in their systematic review, the failure to implement measures that promote the well-being of PSWs can be a barrier for future programs. Relapse in PSWs is one of the main concerns of mental health providers (33) and may be an obstacle to the implementation of programs of this kind. Indeed, one PSW dropped out due to a relapse in the recovery process. This same situation was observed in a pilot study in Scotland (28) in which 11 PSWs were rehospitalized. These findings suggest the need to develop strategies for promoting a healthy working role and ensuring a positive environment.

With reference to occupational performance, there were improvements in all the roles analyzed: ability to find work, work as a support agent, and giving to the community, which can be related directly to the job placement. This situation was already noted by Hutchinson et al. (34) and may reflect the PSW's perception of becoming a socially valuable citizen. In the focus groups, PSWs noted the enormous benefit the practice has brought to their lives: it gave them a reason to continue the process of personal recovery and a sense of usefulness. They were keen to work as PSWs in the future and considered it to be an attractive and meaningful job option. Similarly, in their interviews with PSWs, Salzer (35) recorded that the participants felt a greater sense of self-esteem and personal growth due to the opportunity to do something useful. Simó and Guzman (36) emphasized the importance of an intervention through the construction of life projects and the possibility to engage in meaningful occupations. Many people do not know it, but everyone wants to be excited about something. Significant occupations have an impact on self-concept of self-efficacy (37, 38).

Service Users

Service users attended by PWSs did not show significant changes in the different measures of life satisfaction, meaningful activities, and level of recovery or social self-stigma. However, in the discussion groups, they described the presence of the new figure in the teams as very positive. They noted that it helped them to resolve doubts, increased their motivation, and encouraged them to express their suffering and to develop a more positive attitude. They felt more empowered and increased their social relationships. Other studies that have explored the figure of PSW recorded significant changes. Corrigan et al. (39) adapted an agent support program taking into account the cultural origin of the population served and obtained significant results in empowerment. Similarly, in a program deployed in Germany, Mahlke et al. (40) observed significant improvements in the quality of life, and Cook et al. (41) obtained significant changes in personal recovery and hope. Our project observed improvements in three of the explored areas (SSQ–SWLS–EMAS) and a slight decrease in RAS. However, the effect of the differences is very low. This makes us think about the design of future projects, considering the time linked to the service and comparing the data with a larger sample.

Professionals

The quantitative data did not indicate changes in the level of stigma toward mental health; in fact, the values obtained showed the level of stigma to be very low compared to other population groups (42). The professionals at the two institutions have extensive experience, which is also likely to keep stigma at a low level. Professionals highlighted the fluidity in the incorporation of PSWs into the teams and the acceptance of their new role in mental health care. This situation draws attention to a key element in the program's implementation, namely, the professionals' acceptance of the new figure (32). In addition, there is a professional enrichment that translates into an improvement in praxis. PWSs in mental health is one of the

central strategies within the recovery model (43). Their insertion in work teams has a catalytic role in the implementation of the new paradigm (10). PWSs can detect stigmatizing attitudes on the part of professionals. The study of Mancini (44) shows how, despite the fact that PWSs were members of the staff, they suffered stigmatizing behavior from the MHPs. Interventions must empower PWSs with autonomy and power in order to raise their voices and transform the system (45).

LIMITATIONS

The small sample size may have limited the scale of the changes obtained. Furthermore, the time elapsed between the initial and final evaluations was not the same in all participants; the resources are dynamic, and the patients come and go at different stages in their process and, in fact, are seen at different levels of care (some in the hospital setting, others during the recovery phase in the community). This means that not everyone is in the same recovery process and social situation.

RECOMMENDATIONS FOR PRACTICE

The incorporation of people with mental health experience is one of the objectives of the MHAMPS. This project has been an innovative experience in the incorporation of PWS mental health teams in Catalonia. The study's findings suggest that one of the key factors is support in employment. The results have shown us a decline in the perception of quality of life. It will be very important in future projects to be able to detect this burnout and accompany the PWS in building strengthening strategies.

The combination of quantitative instruments with qualitative data collection strategies allows a greater understanding of reality. At the same time, the creation of spaces for exchange serves participants to reflect on the impact on their lives.

The project lays the groundwork for an RCT at the territorial level, taking advantage of the design of the study and the outcome measures. This would make it possible to generate stronger territorial evidence and greater pressure on political authorities to implement these programs.

CONCLUSION

The present study has involved a whole series of reflections and considerations that may have a bearing on the development of peer-to-peer programs, offering new employment opportunities for people with mental health. Despite the difficulties that have arisen in the implementation of this pilot project, the experience was satisfactory for all participants, and the impact on the PSWs and on service users was highly meaningful.

Peer-to-peer project opens up an employment opportunity for people with mental health problems and appears as a meaningful occupation for them. The practice of PSWs can play a key role in the recovery process: it offers a feeling of usefulness for the PSWs and brings hope to the clients showing that recovery is possible. This strategy collaborates in the implementation of the recovery model in mental health institutions. Further analyses are now needed to study ways of encouraging the incorporation of PSWs in mental health care.

This is an example of the importance of accompanying recovery processes through the construction of life projects.

DATA AVAILABILITY STATEMENT

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

ETHICS STATEMENT

The study protocol was assessed by an Independent Clinical Research Ethics Committee. The patients/participants provided their written informed consent to participate in this study. Written informed consent was obtained from the individual(s) for the publication of any potentially identifiable images or data included in this article.

AUTHOR CONTRIBUTIONS

All authors listed have made a substantial, direct, and intellectual contribution to the work and approved it for publication.

FUNDING

This work was supported by the [Catalan Agency for Management of University and Research Grants] under Grant [2019-DI-012] and [La Caixa Fundation] under Grant [IS18-00323].

SUPPLEMENTARY MATERIAL

The Supplementary Material for this article can be found online at: https://www.frontiersin.org/articles/10.3389/fpsyt.2022.791724/full#supplementary-material

REFERENCES

1. Keet R, de Vetten-Mc Mahon M, Shields-Zeeman L, Ruud T, van Weeghel J, Bahler M, et al. Recovery for all in the community) position paper on principles and key elements of community-based mental health care. *BMC Psychiatry*. (2019) 19:174. doi: 10.1186/s12888-019-2162-z
2. Anthony WA. Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabil J.* (1993) 16:11–23. doi: 10.1037/h0095655
3. Slade M, Bird V, Le Boutillier C, Williams J, McCrone P, Leamy M. REFOCUS Trial: protocol for a cluster randomised controlled trial of a pro-recovery intervention within community based mental health teams. *BMC Psychiatry*. (2011) 11:185. doi: 10.1186/1471-244X-11-185
4. Slade M, Leamy M, Bacon F, Janosik M, Le Boutillier C, Williams J, et al. International differences in understanding recovery: Systematic review. *Epidemiol Psychiatr Sci*. (2012) 21:353–64. doi: 10.1017/S2045796012000133
5. Rowe M, Davidson L. Recovering Citizenship. *Isr J Psychiatry Relat Sci*. (2016) 53:14–20.

6. Slade M, Williams J, Bird V, Leamy M, Le Boutillier C. Recovery grows up. *J Mental Health (Abingdon, England).* (2012) 21:99–103. doi: 10.3109/09638237.2012.670888
7. Leamy M, Bird V, Boutillier C, Williams J, Slade M. Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *Br J Psychiatry.* (2011) 199:445–52. doi: 10.1192/bjp.bp.110.083733
8. Mead S, Hilton D, Curtis L. Peer support: a theoretical perspective. *Psychiatr Rehabil J.* (2001) 25:134–41. doi: 10.1037/h0095032
9. Mead S, Macneil C. Peer Support: What Makes It Unique?. *Int J Psychosoc Rehab.* (2004). 10:29–37.
10. Repper J, Carter T. A review of the literature on peer support in mental health services. *J Mental Health (Abingdon, England).* (2011) 20:392–411. doi: 10.3109/09638237.2011.583947
11. Solomon P, Draine J. The state of knowledge of the effectiveness of consumer provided services. *Psychiatr Rehabil J.* (2001) 25:20–7. doi: 10.1037/h0095054
12. Solomon P. Peer support/peer provided services underlying processes, benefits, and critical ingredients. *Psychiatr Rehabil J.* (2004) 27:392–401. doi: 10.2975/27.2004.392.401
13. Fan Y, Ma N, Ma L, et al. A community-based peer support service for persons with severe mental illness in China. *BMC Psychiatry.* (2018) 18:170. doi: 10.1186/s12888-018-1763-2
14. Davidson L, Bellamy C, Guy K, Miller R. Peer support among persons with severe mental illnesses: a review of evidence and experience. *World Psychiatry.* (2012) 11:123–8. doi: 10.1016/j.wpsyc.2012.05.009
15. Generalitat de Catalunya. *Estratègies 2017-2020. Pla director de salut mental i addiccions [Strategies 2017-2020. Mental health and addictions master plan].* (2017). Dir Gen Planif en Salut. Availabe at: http://salutweb.gencat.cat/ca/ambits_tematics/linies_dactuacio/estrategies_salut/salut_mental_i_addiccions/
16. Levitt HM, Bamberg M, Creswell JW, Frost DM, Josselson R, Suárez-Orozco C. Journal article reporting standards for qualitative primary, qualitative meta-analytic, and mixed methods research in psychology: the APA Publications and Communications Board task force report. *Am Psychol.* (2018) 73:26–46. doi: 10.1037/amp0000151
17. Ochoa S, Martínez-Zambrano F, Garcia-Franco M, Vilamala S, Ribas M, Arenas O, et al. Development and validation of the Self-Stigma Questionnaire (SSQ) for people with schizophrenia and its relation to social functioning. *Compr Psychiatry.* (2015) 62:93–9. doi: 10.1016/j.comppsych.2015.06.011
18. Diener E, Emmons RA, Larsen RJ, Griffin S. The satisfaction with life scale. *J Pers Assess.* (1985) 49:71–5. doi: 10.1207/s15327752jpa4901_13
19. Atienza FL, Balaguer I, Garcia-Merita ML. Satisfaction with Life Scale: analysis of factorial invariance across sexes. *Pers Individ Dif.* (2003) 35:1255–60. doi: 10.1016/S0191-8869(02)00332-X
20. Prat G, Ribot A, Recoder S, Muñoz F. Psychometric properties of the Spanish version of the engagement in meaningful activities survey in people with serious mental illness. *Br J Occup Ther.* (2019) 82:743–9. doi: 10.1177/0308022619856557
21. Saavedra J, Vázquez-Morejón AJ, Vázquez-Morejón R, Arias-Sánchez S, González-álvarez S, Corrigan P. Spanish validation of the recovery assessment scale. *Psicothema.* (2021) 33:500–8. doi: 10.7334/psicothema2021.52
22. Law M, Baptiste S, McColl M, Opzoomer A, Polatajko H, Pollock N. The Canadian occupational performance measure: an outcome measure for occupational therapy. *Can J Occup Ther.* (1990) 57:82–7. doi: 10.1177/000841749005700207
23. Ochoa S, Martínez-Zambrano F, Vila-Badia R, Arenas O, Casas-Anguera E, García-Morales E, et al. Validación al castellano de la escala de estigma social: Community Attitudes towards Mental Illness en población adolescente [Spanish validation of the social stigma scale: Community Attitudes towards Mental Illness]. *Rev Psiquiatr Salud Ment.* (2016) 9:150–7. doi: 10.1016/j.rpsm.2015.02.002
24. Gill P, Stewart K, Treasure E, Chadwick B. Methods of data collection in qualitative research: interviews and focus groups. *Br Dent J.* (2008) 204:291–5. doi: 10.1038/bdj.2008.192
25. Stalmeijer RE, Mcnaughton N, Van Mook WN. Using focus groups in medical education research: AMEE Guide No. 91. *Med Teacher.* 36:923–39. doi: 10.3109/0142159X.2014.917165
26. Lee J-T. Book review: designing and conducting mixed methods research. *HERD: Health Environ Res Des J.* (2019) 12:164–6. doi: 10.1177/1937586719832223
27. Schoonenboom J, Johnson RB. How to construct a mixed methods research design. *Kolner Z Soz Sozpsychol.* (2017) 69:107–31. doi: 10.1007/s11577-017-0454-1
28. McLean J, Biggs H, Whitehead I, Pratt R, Maxwell M. Evaluation of the delivering for mental health peer support worker pilotscheme. Edinburgh, UK: The Scottish Government
29. Santos KDS, Ribeiro MC, Queiroga DEU, Silva IAPD, Ferreira SMS. The use of multiple triangulations as a validation strategy in a qualitative study. *Cien Saude Colet.* (2020) 25:655–64. doi: 10.1590/1413-81232020252.12302018
30. Patton MQ. Enhancing the quality and credibility of qualitative analysis. *Health Serv Res.* (1999) 34:1189–208.
31. Carter N, Bryant-Lukosius D, DiCenso A, Blythe J, Neville AJ. The use of triangulation in qualitative research. *Oncol Nurs Forum.* (2014) 41:545–7. doi: 10.1188/14.ONF.545-547
32. Ibrahim N, Thompson D, Nixdorf R, Kalha J, Mpango R, Moran G, et al. A systematic review of influences on implementation of peer support work for adults with mental health problems. *Soc Psychiatry Psychiatr Epidemiol.* (2020) 55:285–93. doi: 10.1007/s00127-019-01739-1
33. Davidson L, Chinman M, Sells D, Rowe M. Peer support among adults with serious mental illness: a report from the field. *Schizophr Bull.* (2006) 32:443–50. doi: 10.1093/schbul/sbj043
34. Lauckner H, Hutchinson SL. Peer support for people with chronic conditions in rural areas: a scoping review. *Rural Remote Health.* (2016) 16:3601. doi: 10.22605/RRH3601
35. Salzer MS, Darr N, Calhoun G, Boyer W, Loss RE, Goessel J, et al. Benefits of working as a certified peer specialist: results from a statewide survey. *Psychiatr Rehabil J.* (2013) 36:219–21. doi: 10.1037/prj0000016
36. Algado S, Guzmán S. Construyendo proyectos de vida significativos con personas supervivientes de enfermedad mental [Building life projects with those living with mental illness]. *Terapia Ocupational TOG.* (2014). 11:1–25. http://www.revistatog.com/num19pdfs/maestros.pdf
37. Strong S. Meaningful work in supportive environments: experiences with the recovery process. *Am J Occup Ther.* (1998) 52:31–8. doi: 10.5014/ajot.52.1.31
38. Provencher HL, Gregg R, Mead S, Mueser KT. The role of work in the recovery of persons with psychiatric disabilities. *Psychiatr Rehabil J.* (2002) 26:132–44. doi: 10.2975/26.2002.132.144
39. Corrigan P, Sheehan L, Morris S, Larson JE, Torres A, Lara JL, et al. The impact of a peer navigator program in addressing the health needs of Latinos with serious mental illness. *Psychiatric Serv (Washington, DC).* (2018) 69:456–61. doi: 10.1176/appi.ps.201700241
40. Mahlke C, Priebe S, Heumann K, Daubmann A, Wegscheider K, Bock T. Effectiveness of one-to-one peer support for patients with severe mental illness – a randomised controlled trial. *Eur Psychiatry.* (2017). 42:103–10. doi: 10.1016/j.eurpsy.2016.12.007
41. Cook JA, Steigman P, Pickett S, Diehl S, Fox A, Shipley P, et al. Randomized controlled trial of peer-led recovery education using Building Recovery of Individual Dreams and Goals through Education and Support (BRIDGES). *Schizophr Res.* (2012) 136:36–42. doi: 10.1016/j.schres.2011.10.016
42. Grover S, Sharma N, Mehra A. Stigma for Mental Disorders among Nursing Staff in a Tertiary Care Hospital. *J Neurosci Rural Pract.* (2020) 11:237–44. doi: 10.1055/s-0040-1702916
43. Corrigan PW, Larson JE, Smelson D, Andra M. Recovery, peer support and confrontation in services for people with mental illness and/or substance use disorder. *Br J Psychiatry.* (2019) 214:130–2. doi: 10.1192/bjp.2018.242

44. Mancini MA. An exploration of factors that effect the implementation of peer support services in community mental health settings. *Community Ment Health J.* (2018) 54:127–37. doi: 10.1007/s10597-017-0145-4
45. Schmutte T, Davidson L, O'Connell, M. Improved sleep, diet, and exercise in adults with serious mental illness: results from a pilot self-management intervention. *Psychiatr Q.* (2018) 89:61–71. doi: 10.1007/s11126-017-9516-9

Conflict of Interest: The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Publisher's Note: All claims expressed in this article are solely those of the authors and do not necessarily represent those of their affiliated organizations, or those of the publisher, the editors and the reviewers. Any product that may be evaluated in this article, or claim that may be made by its manufacturer, is not guaranteed or endorsed by the publisher.

Article 3

Títol: Mosaic, an Example of Comprehensive and Integrated Social and Health care: Care and Practices Oriented Towards Personal Recovery

Autors (segons ordre de publicació): Ivan Cano Prieto; Gemma Prat Vigué; Rut Vilanova Masana; Aida Guillaumet Cornet; Rosa Giralt Palou; Gemma Lana Francos; Salvador Simó Algado

Revista: Frontiers in Health Services. Sec. Mental Health Services

Data de publicació: 04 d'agost de 2023

Tipus: Original research

DOI: 10.3389/frhs.2023.1174594

ISSN: 2813-0146

Base de dades d'indexació: Directory of Open Access Journals

Àrea: Health Policy

frontiers | Frontiers in Health Services

TYPE Original Research
PUBLISHED 04 August 2023
DOI 10.3389/frhs.2023.1174594

OPEN ACCESS

EDITED BY
Nelson Shen,
Centre for Addiction and Mental Health, Canada

REVIEWED BY
Mats Brommels,
Karolinska Institutet (KI), Sweden
Theresa Van Lith,
La Trobe University, Australia

*CORRESPONDENCE
Ivan Cano-Prieto
ivan.cano@uvic.cat

RECEIVED 26 February 2023
ACCEPTED 17 July 2023
PUBLISHED 04 August 2023

CITATION
Cano-Prieto I, Prat-Vigué G, Vilanova-Masana R, Guillaume-Cornet A, Giralt Palou R, Lana-Francos G and Simó-Algado S (2023) MOSAIC, an example of comprehensive and integrated social and health care: care and practices oriented towards personal recovery. Front. Health Serv. 3:1174594. doi: 10.3389/frhs.2023.1174594

MOSAIC, an example of comprehensive and integrated social and health care: care and practices oriented towards personal recovery

Ivan Cano-Prieto[1]*, Gemma Prat-Vigué[1,2,3], Rut Vilanova-Masana[2], Aida Guillaume-Cornet[2], Rosa Giralt Palou[2], Gemma Lana-Francos[2] and Salvador Simó-Algado[1]

[1]Grup de Recerca en Innovació en Salut Mental i Benestar Emocional (ISaMBeS), Institut de Recerca i Innovació en Ciències de la Vida i de la Salut a la Catalunya Central (IRIS-CC), Vic, Spain, [2]Divisió de Salut Mental, Althaia, Xarxa Assistencial Universitària de Manresa, Manresa, Spain, [3]Facultat de Medicina. Universitat de Vic-Central de Catalunya (UVIC-UCC), Vic, Spain

Background: The Mosaic project is a socio-health integration model that promotes the personal recovery of people with severe mental illness in a territory of Central Catalonia: the Bages region. The recovery approach in mental health care promotes meaningful activities and social inclusion for people with mental health disorders. The aim of this study is to examine the relationship between the level of meaningful activities and other factors associated with the mental health recovery model.
Methods: A cross-sectional design was used. Participants ($n = 59$) signed an informed consent and completed the following standardized instruments: Engagement in Meaningful Activities Survey; The Connor-Davidson Resilience Scale; Hert Hope Scale; and Recovery Assessment Scale.
Results: A Pearson correlation test was performed between the level of meaningful activities and life satisfaction, resilience, hope, and recovery. These data indicate that the amount of meaningful activities are strongly associated with variables related to the personal recovery process from mental health problems.
Conclusions: The integration process of MOSAIC confirms the need to accompany the recovery processes through significant occupations.

KEYWORDS
mental health recovery, personal recovery, integrated care, meaningful occupations, life project

1. Introduction

Social and health integration is a growing concern for governments, in a context of social and economic crises that demands efficiency (1–3).

Kodner and Spreeuwenberg defined the integration process as "a set of methods and models of financing, administration, organization, provision of services and clinical care designed to create connectivity, alignment and collaboration within and between the sector dedicated to caring [the social] and the sector dedicated to curing [health]" (4). Leutz (5) also emphasized this dimension of integrated care as a process, defining it as "the search to connect the health system".

Integration processes between health and social services facilitate a continuum in the care of the population, focusing the intervention on the person's needs (person-centered care). In addition, it demonstrates a special interest in accompanying the person from a paradigm of the social determinants of health (relationships between the environment, habits and routines, and personal health). Finally, a basic preventive and promotional care has been promoted (6).

1.1. Recovery model: a new approach to mental health

Personal recovery refers to the ways in which a person manages a mental health problem trying to restore or develop a meaningful life project, as well as a sense of belonging and a positive perception of identity that is independent of a mental health problem (7, 8). Recovery is a process of change by which individuals improve their health and well-being, lead their lives autonomously and strive to achieve their full potential. This approach has its origins in the historic "recovery movement", which promoted, in the 1960s, the rights of people with mental health problems to receive decent therapeutic care as well as the consideration of the person with mental health problems as a competent individual that can make decisions about their life project and community functioning (9). At first, the initiatives focused on mental health laws, especially those that sanctioned involuntary and coercive interventions, but later changes were also proposed in the practice of mental health, especially from the appearance of new therapeutics, which would allow people with mental health problems to live in the community, and started the creation of rehabilitative resources in the community in order to cover the psychosocial needs of the affected people. Unfortunately, this historical context has often been overlooked in the transformation of services towards a recovery orientation, and thus that the concept has begun to lose its inspiration and ultimate goal, which is simply to restore people with severe mental disorders their sense of dignity, respect, self-esteem and citizenship (10). However, in recent decades, the concept of initial recovery has grown strongly in the treatment of people with mental health problems, mainly due to two pieces of scientific evidence: (a) 33% of people who show a severe mental health problem, such as schizophrenia, can recover without suffering any negative consequences and 67% show significant improvements over time; and (b) different studies have indicated that care focused on recovery (mainly, the positive expectation of having a meaningful life) predicts clinical improvement and adequate community functioning (11). In this way, in the first definitions of recovery, developed by Patricia Deegan and William Anthony, recovery implies the development of a new meaning and purpose in life, regardless of the limitations derived from the mental health problem (9).

Although this definition of recovery, due to its subjective nature, has usually been measured qualitatively, in recent years, objective instruments have emerged that assess this level of recovery (12), with an increasing number of studies that have identified the factors underlying this conceptualization. Factors, including sociodemographic (gender and age) or clinical (level of symptomatology) factors or more rehabilitative aspects, such as social functioning or cognition, would not be sufficient, although would, to a certain degree, be necessary, to achieve subjective or personal recovery, having identified the psychosocial variables that would have a main role in explaining recovery, such as empowerment, hope, quality of life, internalized stigma, perceived social support, social satisfaction, degree of recognition, loneliness and self-esteem (12, 13).

In the recovery model, the care provided by mental health professionals is characterized by a main function of supporting the affected person's life project in such a way that they provide integrated care, aimed at promoting personal (2, 14) recovery through techniques based on the evidence of shared decision making, advance directives in mental health, the peer strategy, and training and self-care in the physical, mental and social spheres. It is a model that promotes active citizenship in the defense and is aimed at claiming the rights of people with mental illness.

1.2. MOSAIC: care and practices oriented towards personal recovery

MOSAIC is a social initiative, coordinated with health, that promotes the quality of life of people who suffer from mental health problems and addictions in Central Catalonia. Specifically, the project is located in Manresa, capital of the Bages region, with its own idiosyncrasy: a semi-urban area dependent on the capital in a territorially dispersed territory. It is a pioneering initiative in Catalonia, and although the project has impacted a small number of people (due to the very capacity of the services), we believe that it can promote similar experiences in Catalan territory and generate more evidence.

The Mosaic legally depends on the Tomàs Canet Foundation and is managed with the participation of four other entities: the Germanes Dominiques de Santa Clara, the Order of Sant Joan de Déu, Manresa City Council and the Althaia Foundation.In the Convent of Santa Clara, the headquarters of the project, different social and health services come together with the aim of improving people's quality of life: (1) Work Program (WP), specialized social service that offers support and individualized advice in the search, access and maintenance of work; (2) Social Club (SC), a specialized social service that aims to increase participation and connection with the community; (3) Community Rehabilitation Service (CRS) is a specialized health service that develops different actions aimed at the psychosocial rehabilitation of people with mental disorders, which integrate the individual, group, family and community care levels to respond to their needs and personal characteristics; And (4) Individualized Service Plan (ISP) is a specialized health service that works according to an organizational model of case management and an assertive community intervention model, in order to guarantee the continuity of care and the maximum

possible recovery in relation to people with a severe mental health disorders.

The fact that we can all recover does not mean that we will all do so at the same pace or following the same path (15). Mosaic adapts to the rhythm of the person. Each person must construct the meaning of his own life, he must find the resources that serve him for his well-being, he must strengthen or build an identity that is not defined by the pathology. The services are oriented towards recovery, defined as a process, that is to say, a whole set of small everyday actions that, done over time, help the person.

To better understand what Mosaic is and what its distinctive characteristics are, we can follow the US Substance Abuse and Mental Health Services Administration (SAMHSA), which proposes 10 Basic Principles of Recovery (16):

1. It comes from hope.
2. It is person-centered.
3. It occurs through many pathways.
4. It goes beyond professional care.
5. It is enriched with mutual support.
6. It assumes community.
7. It requires a comprehensive approach.
8. It is sensitive to diversity.
9. It is based on respect.
10. It requires addressing the trauma.

The last point is a very important one. Throughout our lives, people can experience painful situations that lead to a personal process that can be difficult to navigate (17, 18). A possible path towards acceptance of situations that have caused us suffering consists of facing some challenges. First of all, we need to become aware of our own experience and the possible changes that may arise in the social and relational sphere. Secondly, it is very important to have a space for the expression and management of the different emotions that can appear and overwhelm us such as sadness, anger, frustration, etc. Thirdly, we will often need to reset ourselves and not cling to the past. It is about adopting a hopeful vision of the new situation, of the present and the future, of strengthening the capacity for resilience to emerge strengthened and transformed from adversity.

1.3. Integrated care, a necessary challenge to address in mental health

As already mentioned, integrated care is a challenge for the world population (1–3) of which care for people with mental health problems is very present. There are two recent systematic reviews (2017 and 2022) that address the challenge. The first one (19) highlighted the efficacy demonstrated in the 172 experiences analyzed. However, it concluded with the need to obtain quality indicators, aimed at improving implementation.

In this line, Chan and his research team (20) exposed the precariousness of existing services in all health care for people with mental health problems. A very important detail of his research is the need for multidisciplinary teams with the aim of promoting transversal knowledge in the team. Finally, there is an Australian experience of integrated mental health care, designed on the personal recovery model (21). The need to promote evidence-based psychosocial interventions is highlighted, and to collaborate permanently with community organizations.

In this context, of the need to generate evidence on integration processes, in the paradigm of the personal recovery model, our study and the Mosaic project are of great importance. The need to identify quality indicators is vital to implement improvements in services and to be able to respond to a global public health problem.

1.4. Current context: a window of opportunity

The implementation of the perspective of recovery in the care of people with mental health problems is limited in our environment, but it is strongly considered in other countries, receiving the support of governments and public administrations, such as in the United States, New Zealand, Australia, England or Canada (22). This fact is mainly due to the fact that transformations must take place in mental health devices, and this implies that not only must the results be measured through recovery, but also that changes must be produced that promote recovery in the attitudes of professionals and in those of the people affected, so that resistance to change is softened (23–25). It is important to encourage citizen participation and orientation to the rights of people with mental illness (26).

In Catalonia, the community psychiatry resources that are using recovery-focused care characteristics, such as the Individualized Service Plan teams, use a modification of the assertive community treatment model, which provides comprehensive care (housing, socialization, symptoms, training, work, spirituality, among others); however, all Community Rehabilitation Services are prepared to provide it. On the other hand, programs, such as Activa't per la Salut Mental, promote the personal recovery model in the social and professional fabric of the country (26, 27). The objective of this program is to (1) accompany people with mental health problems in the construction of a life project and (2) promote social support networks.

At present, in Catalonia, there is a very propitious context to promote mental health interventions using the personal recovery model: the National Pact for Mental Health (PNSM). The PNSM (28) is the interdepartmental and intersectoral instrument of the Generalitat de Catalunya that, in line with the recommendations of the World Health Organization (29), promotes mental health from all spheres of action by the government and society. Among the objectives of the PNSM, we highlight that it (1) guarantees a comprehensive, responsible and community approach, placing people and their families at the center; (2) promotes a paradigm shift in public policies related to mental health so that it is concerned with the mental health of people at different stages of life and guarantees the right of affected people to full citizenship, community inclusion and job placement; and (3) includes the conclusions of the United Nations Convention on the Rights of Persons with Disabilities (30).

10.3389/frhs.2023.1174594

This article culminates the implementation project of the personal recovery model in Central Catalonia. The result of the project was three articles aimed at promoting practice and intervention models centered on the will of the people.

2. Materials and methods

2.1. Study design

A cross-sectional non-controlled follow-up study with ex post outcomes measurements was used. This is the third study of a 5-year investigation into the recovery model. This article was preceded by a (1) systematic review and (2) mixed methods approach. In this paper we focus on a quantitative approach.

This study examined the relationship between the level of meaningful activities and other factors associated with the mental health recovery pattern. The objective this study was to assess the effectiveness of the implementation of the recovery model in a sample of people with serious mental health problems treated at MOSAIC. Our hypothesis is that the implementation of the recovery model will lead to the correlation of meaningful occupation with recovery-oriented variables. The recommendations of the Declaration of Helsinki (WMA, 2015) were followed. All persons participating in the trial signed an informed consent for their participation. This project was evaluated by the Research Ethics Committee of the participating center: Fundació Unio Catalana Hospitals, CEI 19/09.

2.2. Participants

The study participants were people between 18 and 65 years of age; with a diagnosis of severe mental disorder (Schizophrenia and Psychotic Disorders Cluster; Bipolar Disorder and Major Affective Disorders Cluster; Personality Disorders); no gender difference; it is linked in the 4 services of Mosaic simultaneously; and willing to participate voluntarily. Exclusion criteria: ages under 18 years and over 65 years of age; present levels of high dependency and acute destabilization of the mental health problem; language difficulties in terms of understanding and expression of the Spanish or Catalan language; presence of head trauma, dementia or severe physical disability (disabling diseases that cause a disability greater than 80%) or intellectual disability (IQ < 70); not wanting to participate in the study voluntarily. Presenting comorbidity with substance use disorders, personality disorders and organic disorders were not reasons for exclusion.

A reference professional from each device assessed the suitability to participate of the people who meet the inclusion criteria and invited them to do so. This person also facilitated the documentation of the study and had the affected person sign the informed consent. Once the person signed the informed consent, they were entered into a database, where another professional outside the study carried out the coding.

2.2.1. Creation of a new structure

Integration processes require joint and coordinated work, in which professionals feel that they are part of the reorganization process. Therefore, three levels of coordination were defined in which all services were represented. (1) Driving group: Its role in the process is that of the design, start up and evaluation of the process. It is a multidisciplinary space, free for reflection, which is marked by a horizontal work dynamic. Its role, especially in the design and the first steps, was to define and mark the phases of the process. The participants in this group were: coordination project; WP; SC; CRS and ISP. Monthly meetings were held (2) Case management: Space in which all the referrals that reach MOSAIC are shared. It is a place where the first interview is reflected on based on the needs detected by the colleagues at the mental health center. It is a coordination space in which all the professionals who can potentially accompany the person are present: from professionals from the mental health center to colleagues from the social club. The frequency of the meetings was weekly. (3) Activities Commission: Place from where the joint activities of MOSAIC are designed. It follows the same multidisciplinary dynamic and the objective is to offer a range of occupations to the person from a broad perspective of recovery: health and healthy habits; work and active life; community; functioning. The existence of an internal management commission is responsible for optimizing communication channels. A periodicity of bimonthly meetings was maintained.

2.3. Intervention

The MOSAIC intervention is an example of support for people in the construction of their life project. The project's strategy focuses on comprehensive and integrated care, which revolves around a single entry mechanism for 4 services. Below we detail the actions of each service and how they integrate with each other.

- Work program. Resources that are available to users with the will and ability to work. It is important for job placement and training. The labor technical offices work to reduce the obstacles that hinder the insertion and permanence in the labor market of people diagnosed with a mental health disorder. The work methodology is based on individualized monitoring and support, and group work actions.
- Social Club. Self-managed voluntary resources for users with commissions, where different activities (workshops, outings …) are carried out according to their own will to promote social and community inclusion. The word "club" refers to a group of people who are organized collectively with common rules and objectives (sporting, recreational, cultural, etc.) in relation to shared hobbies. In the case of clubs for people with mental illness, there is a care aspect that is shaped by the work of a professional team and the rehabilitative orientation of their activity. The social club service is a program of support for integration and community insertion through leisure aimed at people with mental illness in a situation of dependency. It is based on the creation and

stimulation of relational links to improve the sense of belonging of the collective in the fight against social stigmatization.

- Community Rehabilitation Service. The community rehabilitation service is a public and free community rehabilitation service that offers care to older people with severe mental disorders where the personal, family and social rehabilitation and normalization of the user is worked on. The service is that therapeutic space, located at the heart of the community, which allows the user to remain integrated in their environment. It is aimed at the psychosocial rehabilitation of those people with a certain degree of autonomy and stability, and who do not present situations of acute decompensation. Different areas of the person served are worked on: social skills; the body; cognitive skills; occupational skills; the organization of leisure and free time; work skills; the family sphere; health education. Individualized service plan.
- Individualized care program aimed at the community of people who have a severe mental disorder. The professionals who make up these teams help the user connect to the health and social services he needs in his place of residence. Thus, the affected person learns to use existing resources of all kinds in an appropriate way to have their needs covered. Each professional will take about fifteen cases and will do so until the person has their deficiencies resolved.

In addition, a training program was designed based on the principles of the recovery model (11), specifically including recovery education training sessions (31, 32): emotional and material well-being of the participants; skills for the search and maintenance of meaningful occupations: work and leisure; promotion of social support networks and the care environment; and perspective of rights in the exercise of their citizenship (see Table 1).

In the recovery model, a basic premise is the participation of people with psychiatric life experience, as active agents in the process (11). At Mosaic they play an active role as facilitators of activities in the community rehabilitation service and in the social club: healthy habits, leisure and free time, culture. They are self-managed spaces where the presence of the professional is very reduced or absent and where the professional remains in the background.

2.3.1. Design of a single referral process

As has been commented, the existence of a motor group centralized the design of the project. However, a horizontal work environment was generated in which all decisions were agreed upon (equal power relations). The number of participants, between 6 and 8 people, represented all MOSAIC services. The function of the group, in addition to designing and structuring the implementation phase, was in charge of ensuring the correct implementation. The group as a whole has a long experience and connection to the project, which made it easier to adhere to the new proposed changes. The team is oriented in a perspective of accompanying recovery processes based on respect for the rights of the person.

Traditionally, to access MOSAIC services, mental health center professionals, mostly psychiatrists, activate a referral. With this model, it may be the case that a person has different references with the corresponding access interviews. The model we propose is to create a single referral channel to MOSAIC, reflecting personal needs (Figure 1). To achieve this, a new referral sheet (single) was designed in which the needs of the person in all their personal and social spheres were reflected. Once the referral reaches MOSAIC, it is the professionals who, based on a motivational interview, explore the person's needs. It will be at this time when, by mutual agreement, the inclusion of the person in one of the programs becomes effective. A single database is created, accessible to all workers, where the singularities of the person and their environment are widely collected (see Supplementary Material S1).

TABLE 1 Education training sessions.

Health	
Emotional well-being	Material well-being
Satisfaction	Housing
Self-concept	Work placement
Absence of stress	Income
	Physical well-being
	Health care
	Sleep
	Health and its alterations
	Activities of daily life
Work and active life	
Personal development	Leisure
Limitations/capabilities	Relational
Access to new technologies	Cultural
Learning opportunities	Digital play
Work skills	
Functional skills	
Community	
Interpersonal relationships	Social inclusion
Social relations	Integration
Have clearly identified friends	Participation
Positive social relationships	Accessibility
Partner relationships and sexuality	Support
Family relationships	
Autonomous development	
Self-determination	Rights
Personal goals and preferences	Privacy
Autonomy	Knowledge and exercise of rights
Decisions	Respect
Elections	

2.4. Outcome variables and measures

The objectives of this study were: Engagement in Meaningful Activities Survey; The Connor–Davidson resilience scale; Hope; Recovery. The measuring instruments were selected according to variables of the recovery model. A fact of great significance is that all instruments are self-applied.

(1) The Engagement in Meaningful Activities Survey (EMAS) (Cronbach's $\alpha = 0.91$) reflects multiple proposals for occupational therapy and occupational science that address

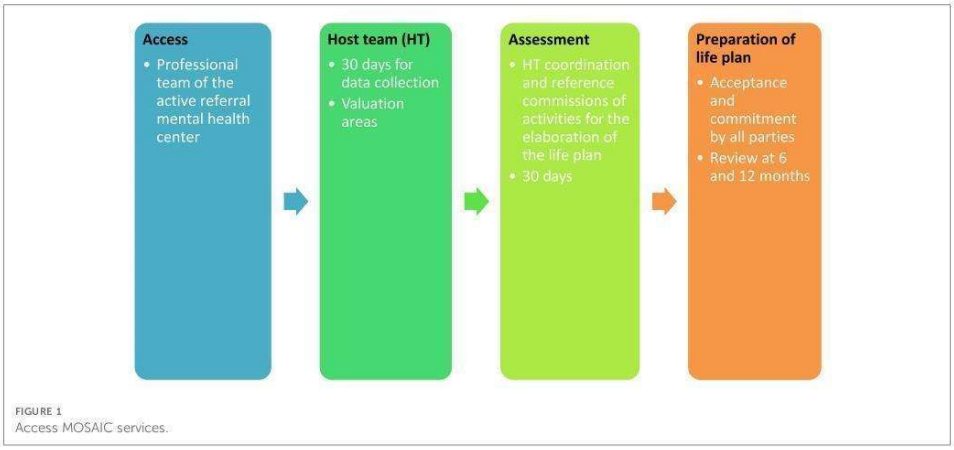


FIGURE 1
Access MOSAIC services.

constituents of meaningful engagement. The EMAS addresses the assessment of the meaning of an occupation by bringing together diverse viewpoints on meaning and employment (33).

(2) The Connor–Davidson Resilience Scale (CD-RISC) (34) consists of 25 items with a Likert-type response format with five response options ("not at all", "rarely", "sometimes", "often" and "almost always"), scored from 0 ("not at all") to 4 ("almost always"). The Spanish version of the 10-item CD-RISC has a Cronbach α coefficient of 0.85 and the test–retest intraclass correlation coefficient of 0.71 (35).

(3) General Self-Efficacy Scale (GAS) (Schwarzer, 1993), in the Baessler and Schwarzer (1996) version. It consists of 10 items with responses on Likert-type scales of 5 points between 1 (totally disagree) to 5 (totally agree). Scores between 27 and 38 points show an average of general self-efficacy. This is reliable with values of $\alpha = .87$ for the Spanish version (36).

(4) The Herth Hope Scale (37) was designed to measure goal-directed thinking across different situations. It is composed of 12 items that measure pathways and agency components by means of 4 items each, and 4 more filler items are added. In the validation studies, it had a high internal consistency ($\alpha = .97$) and adequate divergent validity with hopelessness of −.77 (38).

(5) The Recovery Assessment Scale-revised (RAS-R) (Cronbach's alpha ranging between $\alpha = 0.93$ and $\omega = 0.95$) is a self-applied instrument that measures personal recovery, developed over 20 years ago by Gifford and colleagues in the United States. The RAS-R consists of 24 items on a five-level scale "strongly disagree," "disagree," "not sure," "agree," and "strongly agree" (39).

2.5. Data collection procedures

Over the course of 12 months (September 2019–June 2020) a cross-sectional sample was identified by professionals, with prior training to unify data collection criteria, from all the participants included in the study. The team of researchers explained the research project to all the participants of Mosaic, a meeting where the inclusion criteria and the different phases of the research were detailed. Next, the reference professionals will explain again only to those people who met the inclusion criteria. Finally, their consent was collected in case of expressing a will to continue with the investigation. The reference professionals explained each of the measures (self-applied) to the study participants, giving them the opportunity to fill them in at home. Once the study participants had the measurements, the reference professional followed closely, where he accompanied the person in any doubts. Once the scales were completed, they handed them to their referral professional. The measures were shielded in order to maintain the anonymity of the responses. Finally, these were delivered to the research team and were entered into the database.

2.6. Data analysis

Two researchers (G.P. and I.C.) used the SPSS software (version 28.0). Pearson correlation tests were carried out to study the relationship between significant employment and the different factors using the statistical package SPSS/PC + (v. 28.0). Bonferroni correction was used to adjust the alpha to the multiple correlations.

3. Results

3.1. Demographic characteristics of the participants

The basic characteristics of the participants are shown in Table 2. A total of 59 participants were included, with a mean

TABLE 2 Sociodemographic and clinical profile.

Characteristics	Participants ($N = 59$)
Age (mean, SD)	49.0 (±11.0)
Gender (% women)	47
Diagnosis (% psychosis)	42
Civil status (% single)	67.3
Family unit (% alone)	36
Income (% disability benefit)	40
Education (% basic)	60

age of 49.0 ± 11.0 years. Of these, 47% were women, 67.3% were single, 42% had a diagnosis of psychosis, 60% had a basic level of education and 40% received income from disability benefits. Despite having a small sample, responses were collected from 80% of people who met inclusion criteria.

3.2. Correlation analysis

The correlation matrix for the key variables is presented in Table 3.

The scores obtained from EMAS reflect a perception of the meaning of their activities as moderate (39.76). Meaningful activities was significantly correlated with self-efficacy ($r = 0{,}112$, $p < 0{,}05$); recovery ($r = 0{,}414$, $p < 0{,}01$); hope ($r = 0{,}400$, $p < 0{,}01$); resilience ($r = 0{,}360$, $p < 0{,}01$).

On the other hand, the GSE results place the perception of self-efficacy at an intermediate point (24.25), on a scale from 10 to 40, which indicates more self-efficacy. Self-Efficacy was significantly correlated with meaningful activities ($r = 0{,}349$, $p < 0{,}01$); empowerment ($r = 0{,}437$, $p < 0{,}05$); hope ($r = 0{,}480$, $p < 0{,}01$); resilience ($r = 0{,}384$, $p < 0{,}01$); and self-stigma ($r = 0{,}396$, $p < 0{,}01$).

Continuing with the description of the results, a RASR score of 76.90 is observed. Recovery was significantly correlated with meaningful activities ($r = 0{,}014$, $p < 0{,}01$); hope ($r = 0{,}439$, $p < 0{,}01$); resilience ($r = 0{,}294$, $p < 0{,}05$.

Continuing with the analysis, HHS stood at a score of 21.21 out of 48, with higher scores indicating greater hopefulness. Hope was significantly correlated with self-efficacy ($r = 0{,}480$, $p < 0{,}01$); meaningful activities ($r = 0{,}400$, $p < 0{,}01$); recovery ($r = 0{,}439$, $p < 0{,}01$); resilience ($r = 0{,}333$, $p < 0{,}01$).

Finally, a CD-RISC score of 50.55 out of 100 can be observed, with higher scores corresponding to higher levels of resilience. Resilience was significantly correlated with self-efficacy ($r = 0{,}384$, $p < 0{,}01$); meaningful activities ($r = 0{,}360$, $p < 0{,}01$); recovery ($r = 0{,}294$, $p < 0{,}01$); and hope ($r = 0{,}333$, $p < 0{,}05$).

After applying the Bonferroni correction ($p < 0{,}005$), significant positive relationships were observed between meaningful employment and the personal recovery scale ($p = 0{,}003$); hope ($p = 0{,}004$); life satisfaction ($p = 0{,}002$); perceived social support ($p = 0{,}005$); and empowerment ($p = 0{,}001$). The correlation coefficients with meaningful activities are presented in Table 4.

TABLE 4 Correlation coefficients with meaningful activities ($n = 59$).

Variable	r	p	B	t	95% CI
1. Self-efficacy	0.349	0.012	−0.012	0.134	(0.049, 0.584)
2. Personal recovery	0.414	0.003*	−0.010	0.128	(0.140, 0.628)
3. Hope	0.400	0.004*	−0.001	0.109	(0.175, 0.605)
4. Resilience	0.360	0.009	−0.011	0.150	(0.038, 0.605)

R, Pearson correlation; B, Bias; t, standard error; CI, confidence interval.
*Correlation is significant at the 0.005 level.

4. Discussion

The work addresses a topic of special relevance in the context of Catalonia (28), given a problem of global interest: the care of the person in an integral and holistic way (1–3, 19, 20). The document has identified quality indicators aimed at personal recovery (21). We believe that despite the small sample in which the project has impacted, the study facilitates the promotion of health and social integration experiences. Especially in semi-urban and rural environments, which are the usual norm except for the metropolitan area of Barcelona.

Our article contributes to the construction of evidence and to consolidate the paradigm of personal recovery in comprehensive care in Catalonia. There is evidence of the recovery model that is in tune with the results obtained (40, 41). People in recovery must be involved in all aspects and phases of the process. Thus, recovery-oriented care is characterized by:

(1) Contemplating the promotion of a positive self-concept and identity;
(2) The development of a life project beyond the mental health problem;
(3) With the hope of being able to carry it out;
(4) The promotion of self-responsibility regarding both the life project and its therapeutic process;

TABLE 3 Descriptive statistics and correlations among the key variables ($n = 59$).

Variable	Mean (SD)	1	2	3	4	5	6	7	8	9
1. Self-efficacy	24.25 (4.53)		0.349*	0.222	0.437*	0.480**	0.228	0.384**	0.396**	0.152
2. Meaningful activities	39.76 (7.03)	0.112*		0.414**	0.489**	0.400**	0.368**	0.360**	0.415**	0.385**
3. Personal recovery	76.90 (13.50)	0.117	0.014**		0.465**	0.439**	0.231	0.294*	0.272	0.438**
4. Hope	21.21 (3.53)	0.480**	0.400**	0.439**	0.440**		0.082	0.333*	0.126	0.106
5. Resilience	50.55 (11.71)	0.384**	0.360**	0.294*	0.419**	0.333*	0.407**		0.054	0.189

SD, standard desviation.
*Correlation is significant at the 0.05 level.
**Correlation is significant at the 0.01 level.

(5) Facilitating the creation of support and a social network;
(6) Providing tools and fostering skills to manage the disease; and
(7) Increase resilience to stressful life situations and the stigma associated with the disease (42).

All human beings are occupational beings who interact in an environment. One of the objectives of all humans is to develop occupations that are interesting to us and afford value to our existence. The results obtained in this study are in line with those of Meyer (precursor of occupational therapy), who noted the need to accompany the person through meaningful occupations (43). Contemporary authors, such as Simó-Algado and Guzmán (44), have emphasized the need to weave a life project through meaningful occupations.

4.1. In search of meaningful activities

Hope in moments of fragility is a transformative mechanism that promotes change and recovery, and is a pillar of the personal recovery model. Many individuals with mental health problems show confusion in the initial phases, families lack tools and the associated stigma in our communities has an impact on the recovery process (45).

Studies such as the one by Nuslang commented on the need to incorporate hope as a central element of the intervention (46), and in the pilot peer to peer test, the participants' narratives highlighted the importance of having a meaningful occupation (47).

However, how do we promote it in our services? In the study by Hayes (48), the levels of hope between the community population and people with mental health problems were compared, obtaining significantly lower results in the study group. The conclusions they reached is that it is difficult to foster hope if the person with mental health problems has serious symptoms.

Next, we reflected on how we can generate a feeling of hope in people. As we observed in our systematic review, mutual support networks, sharing with an equal weight, are a cross element (49). MOSAIC promotes an occupational environment in which to share and forge bonds and increase social support networks. Another important aspect that the research has shown is the impact of meaningful occupations on the perception of quality of life and resilience of the participants. Both aspects have a great impact on the recovery process and are interrelated. In a study carried out in Canada (50), a direct relationship was observed: the higher the quality of life, the higher the levels of resilience. In addition, Hadebe and Ramakumba noted the importance of social networks, which influence a greater resilience in people (51).

Participation in meaningful occupations affords meaning to the recovery process and promotes resilience strategies in the face of a possible traumatic situation (52). Additionally, we found studies that support the results regarding the existing correlation between EMAS and the perception of self-efficacy (53).

This is fully consistent with the MOSAIC project and the need to establish integration processes between health and social services. It is also an opportunity to generate multidisciplinary projects and interventions, with professionals who carry in their essence a critical reflection on their praxis. These new figures are essential, as we showed, to promote an atmosphere of hope in the recovery process (54).

In addition, the construction of a meaningful life process based on meaningful occupations is key, not only because it gives hope (the basis of recovery), but also because it is essential for the person to develop full citizenship and contribute to their society as a citizen of law (55). The exercise of citizenship entails the freedom to participate in society and to be able to decide one's life. A dignified life for each person and that corresponds to the possibilities of personal fulfillment and access to opportunities to live in health. It is a process of construction of identity and belonging (13, 26, 29).

A transcendental factor to promote full citizenship, and personal recovery, is to co-create together with the community. Studies such as the systematic review of Chan et al. (20) strongly recommend generating synergies with community assets. For this, it is essential to co-create community mental health interventions (26, 27) with the objective that people become health assets. Participating in the community and having a meaningful life project is a human right (25, 30).

4.2. Limitations

The present study has, of course, some limitations. The first of these is the small sample size. Mosaic's target population is a small *n* (compared to the studies cited), and the number of participants with inclusion criteria is low. This is related to the reference population of the different services that participate in Mosaic. Another situation that marked (and surely conditioned the study) was the COVID19 pandemic. The data collection process was inactive for a few weeks due to the impossibility of monitoring. This means that not all participants are in the same recovery process.

4.3. Recommendations for practice and research

In the midst of a debate on the reformulation of the mental health care system for citizens, this study shows a case of success in the territory. The results obtained are a weighty argument to replicate and generate more integration experiences. The potentiality of relevant activities (significant occupations) with the personal recovery process indicates the need to plan interventions from a holistic and comprehensive perspective.

Future research needs to quantify the impact of the intervention on the outcomes described. The project lays the foundations for an RCT, which will make it possible to build evidence around integration processes from a perspective of personal recovery in mental health. RCTs of mixed methods are recommended that allow the triangulation of the results and a better understanding of the reality analyzed. Finally, it is crucial to incorporate the perspective of territorial equity and propose projects in urban areas with high population density.

5. Conclusions

These data indicate that the number of meaningful activities is strongly associated with variables related to the process of personal recovery from mental health problems. Subsequent studies should determine the functional weight of these variables in the performance of significant occupations.

The integration process of MOSAIC confirms the need to accompany the recovery processes through significant occupations. Variables, such as hope and resilience, are pillars in the personal recovery model, both closely related to the performance of meaningful occupations.

Finally, we highlighted the processes of social and health integration as an opportunity to include professionals with a critical vision (occupational therapists and social workers) and complement the prevailing clinical view of the health system.

The study has connected significant occupation as a human right to exercise full citizenship, in which hope is the pillar of personal recovery.

Data availability statement

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

Ethics statement

The study was conducted in accordance with the Declaration of Helsinki, and approved by the Ethics Committee of Fundació Unio Catalana Hospitals (CEI 19/09, 03/04/2019). The patients/participants provided their written informed consent to participate in this study.

Author contributions

Conceptualization, IC-P, GP-V, and SS-A; methodology, IC-P and GP-V; software, IC-P and GP-V; validation, IC-P, GP-V, and SS-A; formal analysis, IC-P and GP-V; investigation, IC-P; resources, IC-P, GP-V, RV-M, GL-F, AG-C, and RGP; data curation, IC-P, GP-V, RV-M, GL-F, AG-C, and RGP; writing—original draft preparation, IC-P; writing—review and editing, IC-P, GP-V, and SS-A; visualization, IC-P, GP-V, SS-A, RV-M, GL-F, AG-C, and RGP; supervision, GP-V and SS-A. All authors contributed to the article and approved the submitted version.

Funding

This work was supported by the Catalan Agency for Management of University and Research Grants under grant number 2019-DI-012.

Acknowledgments

Thanks are owed to the Fundació Althaia-Xarxa Assistencial i Universitària de Manresa, Tomàs Canet Foundation, Dominiques de Santa Clara, the Order of Sant Joan de Déu, the Manresa City Council and the University of Vic—Central University of Catalonia for offering us the time and space to write this article.

Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Publisher's note

All claims expressed in this article are solely those of the authors and do not necessarily represent those of their affiliated organizations, or those of the publisher, the editors and the reviewers. Any product that may be evaluated in this article, or claim that may be made by its manufacturer, is not guaranteed or endorsed by the publisher.

Supplementary material

The Supplementary Material for this article can be found online at: https://www.frontiersin.org/articles/10.3389/frhs.2023.1174594/full#supplementary-material

References

1. Gröne O, Garcia-Barbero M, WHO European office for integrated health care services. Integrated care: a position paper of the WHO European office for integrated health care services. *Int J Integr Care*. (2001) 1:e21. doi: 10.5334/ijic.28

2. Frost BG, Tirupati S, Johnston S, Turrell M, Lewin TJ, Sly KA, et al. An integrated recovery-oriented model (IRM) for mental health services: evolution and challenges. *BMC Psychiatry*. (2017) 17:1. doi: 10.1186/s12888-016-1164-3

3. Baxter S, Johnson M, Chambers D, Sutton A, Goyder E, Booth A. The effects of integrated care: a systematic review of UK and international evidence. *BMC Health Serv Res*. (2018) 18:1. doi: 10.1186/s12913-018-3161-3

4. Kodner DL, Spreeuwenberg C. Integrated care: meaning, logic, applications, and implications–a discussion paper. *Int J Integr Care*. (2002) 2:e12. doi: 10.5334/ijic.67

5. Leutz WN. Five laws for integrating medical and social services: lessons from the United States and the United Kingdom. *Milbank Q*. (1999) 77:77-v. doi: 10.1111/1468-0009.00125

6. Valentijn PP, van Es Institute J, Opheij W, Gudde T, Bruijnzeels MA. Understanding integrated care: a comprehensive conceptual framework based on the integrative functions of primary care. *Int J Integr Care*. (2013) 13:e010. doi: 10.5334/ijic.886

7. Davidson L. Recovery, self management and the expert patient—changing the culture of mental health from a UK perspective. *J Ment Health*. (2005) 14:25–35. doi: 10.1080/09638230500047968

8. Slade M, Williams J, Bird V, Leamy M, Le Boutillier C. Recovery grows up. *J Ment Health*. (2012) 21:99–103. doi: 10.3109/09638237.2012.670888

9. Anthony WA. Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. *Psychosoc Rehabil J*. (1993) 16:11–23. doi: 10.1037/h0095655

10. Rowe M, Davidson L. Recovering citizenship. *Isr J Psychiatry Relat Sci*. (2016) 53:14–20. https://cdn.doctorsonly.co.il/2016/08/04_Rowe_Recovering-Citizenship.pdf

11. Slade M, Amering M, Farkas M, Hamilton B, O'Hagan M, Panther G, et al. Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry*. (2014) 13:12–20. doi: 10.1002/wps.20084

12. Slade M. Measuring recovery in mental health services. *Isr J Psychiatry Relat Sci*. (2010) 47:206–12. https://doctorsonly.co.il/wp-content/uploads/2011/12/2010_3_6.pdf

13. Slade M. Mental illness and well-being: the central importance of positive psychology and recovery approaches. *BMC Health Serv Res*. (2010) 10:26. doi: 10.1186/1472-6963-10-26

14. Davidson L, White W. The concept of recovery as an organizing principle for integrating mental health and addiction services. *J Behav Health Serv Res*. (2007) 34:109–20. doi. 10.1007/s11414-007-9053-7

15. Rubashkin N, Warnock R, Diamond-Smith N. A systematic review of person-centered care interventions to improve quality of facility-based delivery. *Reprod Health*. (2018) 15(1):169. doi: 10.1186/s12978-018-0588-2

16. Substance Abuse and Mental Health Services Administration (USA). SAMHSA's working definition of recovery. 10. Guiding principles of recovery. (2012).

17. Fenwick-Smith A, Dahlberg EE, Thompson SC. Systematic review of resilience-enhancing, universal, primary school-based mental health promotion programs. *BMC Psychol*. (2018) 6(1):30. doi: 10.1186/s40359-018-0242-3

18. Chuang SP, Wu JYW, Wang CS. Resilience and quality of life in people with mental illness: a systematic review and meta-analysis. *Neuropsychiatr Dis Treat*. (2023) 19:507–14. doi: 10.2147/NDT.S392332

19. Sunderji N, Ion A, Ghavam-Rassoul A, Abate A. Evaluating the implementation of integrated mental health care: a systematic review to guide the development of quality measures. *Psychiatr Serv*. (2017) 68(9):891–8. doi: 10.1176/appi.ps.201600464

20. Chan V, Toccalino D, Omar S, Shah R, Colantonio A. A systematic review on integrated care for traumatic brain injury, mental health, and substance use. *PLoS One*. (2022) 17(3):e0264116. doi: 10.1371/journal.pone.0264116

21. Frost BG, Tirupati S, Johnston S, Turrell M, Lewin TJ, Sly KA, et al. An integrated recovery-oriented model (IRM) for mental health services: evolution and challenges. *BMC Psychiatry*. (2017) 17(1):22. doi: 10.1186/s12888-016-1164-3

22. Weaver N. Recovery and care continuity experiences of people in mental health care: a conciliatory approach to the challenge of implementing recovery-based services. *Sociol Health Illn*. (2021) 43:1996–2014. doi: 10.1111/1467-9566.13373

23. Khan N, Tracy D. The challenges and necessity of situating "illness narratives" in recovery and mental health treatment. *BJPsych Bull*. (2022) 46:77–82. doi: 10.1192/bjb.2021.4

24. Dubreucq J, Plasse J, Gabayet F, Faraldo M, Blanc O, Chereau I, et al. Stigma resistance is associated with advanced stages of personal recovery in serious mental illness patients enrolled in psychiatric rehabilitation. *Psychol Med*. (2022) 52:2155 65. doi: 10.1017/S0033291720004055

25. Onocko-Campos R, Davidson L, Desviat M. Salud mental y derechos humanos: desafíos para servicios de salud y comunidades mental health and human rights: challenges for health services and communities. *Salud Colect*. (2021) 17:e3488. doi: 10.18294/sc.2021.3488

26. Sampietro HM, Gavaldà Castet C. Manual per a la recuperació i l'autogestio del benestar [Manual for recovery and self-management of well-being]. Activa't per la Salut Mental (2018). Available at: https://activatperlasalutmental.org/wp-content/uploads/2023/06/salut_mental_cat_LF_web-1.pdf

27. Rojo Rodés E, San Pío Tendero MJ, Eiroa Orosa F, Marcet G. Get active for mental health: a project evaluated for active involvement of families and users. *Int J Integr Care*. (2019) 19:419. doi: 10.5334/ijic.s3419

28. Generalitat de Catalunya. *ACORD GOV/176/2021, de 9 de novembre, pel qual es crea el Programa per a l'elaboració del Pacte Nacional de Salut Mental [AGREEMENT GOV/176/2021, of November 9, which creates the program for the preparation of the national mental health pact]*. Barcelona: Departament de la Presidència (2021). https://portaldogc.gencat.cat/utilsEADOP/PDF/8540/1877946.pdf

29. Funk M, Drew N. WHO QualityRights: transforming mental health services. *Lancet Psychiatry*. (2017) 4:826–7. doi: 10.1016/S2215-0366(17)30271-7

30. United Nations. Convention on the rights of persons with disabilities (2006). Available at: http://www.un.org/esa/socdev/enable/rights/convtexte.htm

31. Hutchinson DS, Gagne C, Bowers A, Russinova Z, Skrinar GS, Anthony WA. A framework for health promotion services for people with psychiatric disabilities. *Psychiatr Rehabil J*. (2006) 29(4):241–50. doi: 10.2975/29.2006.241.250

32. Foster G, Taylor SJ, Eldridge SE, Ramsay J, Griffiths CJ. Self-management education programmes by lay leaders for people with chronic conditions. *Cochrane Database Syst Rev*. (2007) 4:CD005108. doi: 10.1002/14651858.CD005108.pub2

33. Prat G, Ribot A, Recoder S, Muñoz F. Psychometric properties of the Spanish version of the engagement in meaningful activities survey in people with serious mental illness. *Br J Occup Ther*. (2019) 82:743–9. doi: 10.1177/0308022619856557

34. Connor KM, Davidson JR. Development of a new resilience scale: the connor-davidson resilience scale (CD-RISC). *Depress Anxiety*. (2003) 18:76–82. doi: 10.1002/da.10113

35. Notario-Pacheco B, Solera-Martínez M, Serrano-Parra MD, Bartolomé-Gutiérrez R, García-Campayo J, Martínez-Vizcaíno V. Reliability and validity of the Spanish version of the 10-item connor-davidson resilience scale (10-item CD-RISC) in young adults. *Health Qual Life Outcomes*. (2011) 9:63. doi: 10.1186/1477-7525-9-63

36. Sanjuán Suárez P, Pérez García AM, Bermúdez Moreno J. Escala de autoeficacia general: datos psicométricos de la adaptación para población española the general self-efficacy scale: psychometric data from the Spanish adaptation. *Psicothema*. (2000) 12:509–13. https://www.psicothema.com/pdf/615.pdf

37. Herth K. Abbreviated instrument to measure hope: development and psychometric evaluation. *J Adv Nurs*. (1992) 17:1251–9. doi: 10.1111/j.1365-2648.1992.tb01843.x

38. Sánchez-Teruel D, Robles-Bello MA, Camacho-Conde JA. Validity of the spanish version of the herth hope index and the beck hopelessness scale in people who have attempted suicide. *Actas Esp Psiquiatr*. (2020) 48:163–8. https://www.actaspsiquiatria.es/repositorio//22/126/ENG/22-126-ENG-163-8-562420.pdf

39. Saavedra J, Vázquez-Morejón AJ, Vázquez-Morejón R, Arias-Sánchez S, González-Álvarez S, Corrigan P. Spanish validation of the recovery assessment scale. *Psicothema*. (2021) 33:500–8. doi: 10.7334/psicothema2021.52

40. Pérez-Corrales J, Huertas-Hoyas E, García-Bravo C, Güeita-Rodríguez J, Palacios-Ceña D. Volunteering as a meaningful occupation in the process of recovery from serious mental illness: a qualitative study. *Am J Occup Ther*. (2022) 76(2):7602205090. doi: 10.5014/ajot.2022.045104

41. Leamy M, Bird V, Le Boutillier C, Williams J, Slade M. Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *Br J Psychiatry*. (2011) 199:445–52. doi: 10.1192/bjp.bp.110.083733

42. Lipskaya-Velikovsky L, Krupa T, Silvan-Kosovich I, Kotler M. Occupation-focused intervention for in-patient mental health settings: pilot study of effectiveness. *J Psychiatr Res*. (2020) 125:45–51. doi: 10.1016/j.jpsychires.2020.03.004

43. Meyer A. The philosophy of occupational therapy. *Arch Occup Ther*. (1922) 1:1–10.

44. Simó-Algado S, Guzman S. Construyendo proyectos de vida con personas supervivientes de enfermedad mental [Building life projects with survivors of mental illness.] *RevistaTOG*. (2014) 11:1–25. http://www.revistatog.com/num19pdfs/maestros.pdf

45. Boehnlein JK, Kinzie JM. Experiencing mental illness: suffering, hope, and healing. *Narrat Inq Bioeth*. (2021) 11:189–94. doi: 10.1353/nib.2021.0070

46. Naslund JA, Aschbrenner KA, Marsch LA, Bartels SJ. The future of mental health care: peer-to-peer support and social media. *Epidemiol Psychiatr Sci*. (2016) 25(2):113–22. doi: 10.1017/S2045796015001067

47. Prat Vigué G, Cano Prieto I, Del Río Sáez R, Vilanova Masana R, Simó Algado S. Training peer support workers in mental health care: a mixed methods study in central catalonia. *Front Psychiatry*. (2022) 13:791724. doi: 10.3389/fpsyt.2022.791724

48. Hayes L, Herrman H, Castle D, Harvey C. Hope, recovery and symptoms: the importance of hope for people living with severe mental illness. *Australas Psychiatry*. (2017) 25:583–7. doi: 10.1177/1039856217726693

49. Cano-Prieto I, Simó-Algado S, Prat-Vigué G. Peer interventions in severe mental illnesses: a systematic review and its relation to occupational therapy. *Occup Ther Ment Health*. (2022) 39(2):99–136. doi: 10.1080/0164212X.2022.2085645

50. Mejia-Lancheros C, Woodhall-Melnik J, Wang R, Hwang SW, Stergiopoulos V, Durbin A. Associations of resilience with quality of life levels in adults experiencing homelessness and mental illness: a longitudinal study. *Health Qual Life Outcomes*. (2021) 19:74. doi: 10.1186/s12955-021-01713-z

51. Hadebe NF, Ramukumba TS. Resilience and social support of young adults living with mental illness in the city of Tshwane, Gauteng province, South Africa. *Curationis*. (2020) 43:e1–e7. doi: 10.4102/curationis.v43i1.2084

52. Frankl VE. *Man's search for meaning*. Boston, MA: United States: Beacon Press (1959).

53. Strong S. Meaningful work in supportive environments: experiences with the recovery process. *Am J Occup Ther*. (1998) 52:31–8. doi: 10.5014/ajot.52.1.31

54. Kovic M, Algado SS. Hope. *Interinst Braz J Occup Ther*. (2020) 4:131–6. doi: 10.47222/2526-3544.rbto32876

55. Eiroa-Orosa FJ, Rowe M. Taking the concept of citizenship in mental health across countries. Reflections on transferring principles and practice to different sociocultural contexts. *Front Psychol*. (2017) 8:1020. doi: 10.3389/fpsyg.2017.01020

Resum dels principals resultats

⇒ **Article 1:** *Peer Interventions in Severe Mental Illnesses: A Systematic Review and its Relation to Occupational Therapy*

- Es van utilitzar dues estratègies de cerca per combinar estudis de teràpia ocupacional amb una cerca anterior que no incloïa la teràpia ocupacional com a variable. S'han trobat 7120 articles (cerca 1) i 189 (cerca 2).
- Es van revisar 3370 articles després de l'eliminació dels duplicats. 2228 articles van ser exclosos després de revisar el títol. Es van revisar 1142 resums, dels quals 19 van ser seleccionats per a la lectura total. Finalment, es van seleccionar 16 articles per a l'anàlisi final.
- Es van revisar 130 articles després de l'eliminació dels duplicats. 61 articles van ser exclosos després de revisar el títol. Es van revisar 69 articles, 10 dels quals van ser seleccionats per a una lectura completa. Finalment, 1 article va complir els criteris d'inclusió i es va incloure en l'anàlisi final.
- Es van seleccionar 17 articles per a la seva revisió final.
    - Estudis amb dos grups (experimental i control) publicats entre 2005 i 2018.
    - La mida de la mostra oscil·lava entre 32 i 441, i les edats entre 39 i 57 anys.
    - La presència de dones oscil·la entre el 5,4% i el 66%
    - Es va detectar un projecte amb presència de terapeutes ocupacionals.
    - Existència de dos tipus diferents d'intervenció entre igual: 1) intervenció com un programa d'educació/formació en què els companys actuaven com a formadors aprofitant la seva experiència en el patiment mental i en el procés de recuperació, acompanyant la persona atesa en la recerca del seu pla de vida; 2) rol de gestor de casos, un acompanyant comunitari per a la persona vulnerable donant suport i esperança.

- Continguts formatius: recuperació personal, vincle, habilitats comunicatives i temes específics de cada programa.
- S'han trobat resultats positius amb incidència estadística en 7 de les 10 categories de resultats: **Occupational performance**; **Prevention**; **Health and wellness**; **Quality of life**; **Participation**; **Wellbeing**; **Occupational justice**.
- Els 17 estudis van incloure persones amb SMI. Tanmateix, alguns estudis van destacar altres criteris que caldria tenir en compte en futures intervencions (comorbilitat, aspectes culturals)
- La intervenció entre iguals es desenvolupa principalment en entorns comunitaris, lluny de l'entorn hospitalari.
- 10 estudis han incorporat mesures destinades a mesurar la recuperació personal.

⇒ **Article 2**. *Training Peer Support Workers in Mental Health Care: A Mixed Methods Study in Central Catalonia*

- **Agents de suport entre iguals**
  - Augment en la percepció subjectiva en el COPM en el desenvolupament ocupacional i la satisfacción de troba feina
  - Disminució de la percepció de qualitat de vida (SWLS)
    - *"[...] alhora descobreixes habilitats que no saps que tenies [...]"*
    - *"Tenir més seguretat en si mateix/a no veure's com "malalt"*
    - *M'ha donat molt de benestar. Fins al punt que el cap de setmana el trobava a faltar [...] "/*
    - *"[...] Jo crec que diré una obvietat ... que ens Hem sentit útils [...] /*

- *" [...] Crec que proporciona sentiment d'utilitat i implicació [...]*

- **Usuaris de servei**
  - No es van detectar canvis significatius en les variables analiztades.
  - Valoració molt positiva envers la implementació: espai per canalitzar el patiment, tenir un punt de vista més positiu, i augmentar la motivació envers el procés de recuperació
    - *"En primer lloc optimisme, perquè veus que estan portant molt bé amb la situació, estan contents […]"*
    - *"[…] Sé que pots tenir un trastorn però tot i així ser feliç"*
    - *"Has de viure'l si no, no veus res al teu cor"*
    - *"Estar amb una persona amb una dificultat mental com tu et fa sentir més segur"*
    - *"Va acceptar els desafiaments i els va superar. I jo només vull fer el mateix […]"*
    - *" [...] Ha d'ajudar molt sentir-se útil i també [...]"*
- **Professionals**
  - Nivell d'estigma molt baix comparat amb altres grups poblacionals
  - Experiència positiva per a la majoria de professionals
  - Fluïdesa en la incorporació de persones als equips i l'acceptació del nou rol en l'atenció a la salut mental
    - *"No considerava el PSW com un pacient o un usuari del programa, només un altre membre de l'equip que brinda suport al dia a dia"*
    - *"Crec que és molt positiu per als professionals veure que hi ha persones amb un trastorn que després poden ajudar altres en el seu*

camí; aporten una visió i una forma de treballar basada en el detall i la proximitat, la constància"

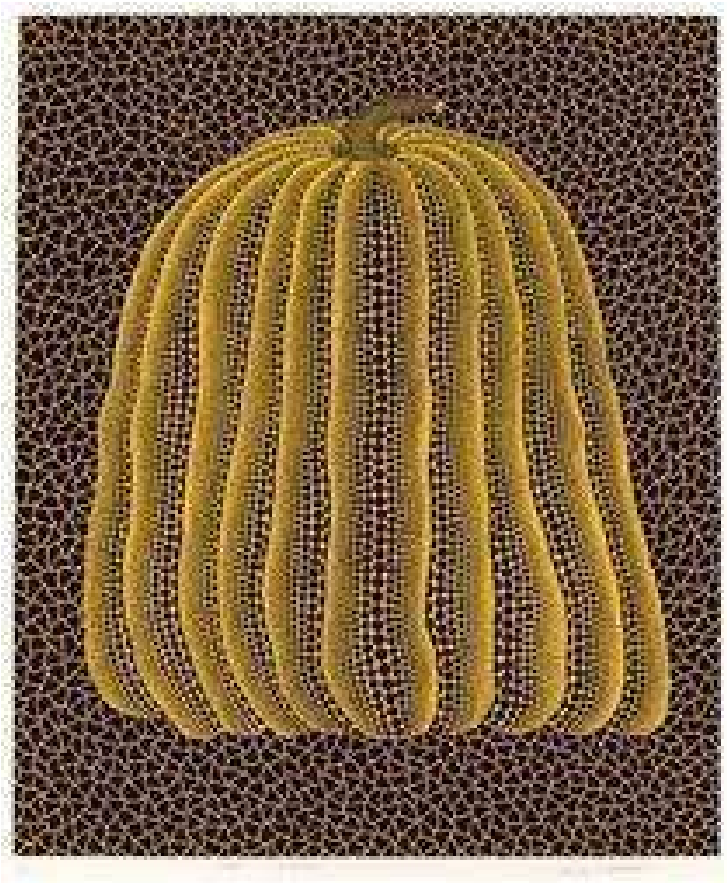
- *"Enriqueix enormement la feina professional; ens ajuden a brindar un millor servei i són font de satisfacció per a la majoria dels usuaris"*

⇒ **Article 3**. *Mosaic, an Example of Comprehensive and Integrated Social and Health care: Care and Practices Oriented Towards Personal Recovery*

- Es van incloure un total de 59 participants, amb una edat mitjana de 49,0 ± 11,0 anys. D'aquestes, el 47% eren dones, el 67,3% eren solteres, el 42% tenien un diagnòstic de psicosi, el 60% tenien estudis bàsics i el 40% cobraven ingressos per invalidesa.
- EMAS, reflecteixen una percepció del significat de les seves activitats com a moderada (39,76). Les activitats significatives es van correlacionar significativament amb l'autoeficàcia ($r = 0,112$, $p < 0,05$); recuperació ($r = 0,414$, $p < 0,01$); esperança ($r = 0,400$, $p < 0,01$); resiliència ($r = 0,360$, $p < 0,01$).
- GSE, situen la percepció d'autoeficàcia en un punt intermedi (24,25), en una escala del 10 al 40, la qual cosa indica més autoeficàcia. L'autoeficàcia es va correlacionar significativament amb activitats significatives ($r = 0,349$, $p < 0,01$); empoderament ($r = 0,437$, $p < 0,05$); esperança ($r= 0,480$, $p < 0,01$); resiliència ($r = 0,384$, $p < 0,01$); i l'autoestigma ($r = 0,396$, $p < 0,01$).
- RASR, s'observa una puntuació de 76,90. La recuperació es va correlacionar significativament amb activitats significatives ($r = 0,014$, $p < 0,01$); esperança ($r = 0,439$, $p < 0,01$); resiliència ($r = 0,294$, $p < 0,05$.

- HHS, es va situar en una puntuació de 21,21 sobre 48, amb puntuacions més altes que indiquen una major esperança. L'esperança es va correlacionar significativament amb l'autoeficàcia ($r = 0,480$, $p < 0,01$); activitats significatives ($r = 0,400$, $p < 0,01$); recuperació ($r = 0,439$, $p < 0,01$); resiliència ($r = 0,333$, $p < 0,01$).
- CD-RISC, es va observar una puntuació de 50,55 sobre 100, amb puntuacions més altes corresponents a nivells més alts de resiliència. La resiliència es va correlacionar significativament amb l'autoeficàcia ($r = 0,384$, $p < 0,01$); activitats significatives ($r = 0,360$, $p < 0,01$); recuperació ($r = 0,294$, $p < 0,01$); i esperança ($r = 0,333$, $p < 0,05$).
- Després d'aplicar la correcció de Bonferroni ($p < 0,005$), es van observar relacions positives significatives entre l'ocupació significativa i l'escala de recuperació personal ($p = 0,003$); esperança ($p = 0,004$); satisfacció amb la vida ($p = 0,002$); suport social percebut ($p = 0,005$); i empoderament ($p=0,001$).

DISCUSIÓ CONJUNTA



Yellow Punpkin. *Yayoi Kusama, 1992*

Discussió conjunta

El nostre article contribueix a la construcció d'evidències i a consolidar el paradigma de la recuperació personal i l'agent de suport entre iguals en l'assistència sanitària a Catalunya. Hi ha evidència del model de recuperació que està en sintonia amb els resultats obtinguts. Les persones en recuperació han d'implicar-se en tots els aspectes i fases del procés. D'aquesta manera, l'atenció orientada a la recuperació es caracteritza per: 1) contemplar la promoció d'un autoconcepte i identitat positius; 2) el desenvolupament d'un projecte de vida més enllà del problema de salut mental; 3) amb l'esperança de poder-ho dur a terme; 4) la promoció de l'autoresponsabilitat tant pel que fa al projecte de vida com al seu procés terapèutic; 5) facilitar la creació de suport i una xarxa social; 6) proporcionar eines i fomentar les habilitats per gestionar la malaltia; i 7) augmentar la resiliència a situacions de vida estressants i l'estigma associat a la malaltia (Davidson et al., 2006).

Altrament, tots els éssers humans són éssers ocupacionals que interactuen en un entorn. Un dels objectius de tots els humans és desenvolupar ocupacions que ens siguin interessants i que donin valor a la nostra existència. Els resultats obtinguts en aquest estudi estan en línia amb els de Meyer (precursor de la teràpia ocupacional), que va assenyalar la necessitat d'acompanyar la persona en ocupacions significatives (Meyer, 1992). Autors contemporanis, com Simo i Guzmán (Algado & Guzmán, 2014) han posat èmfasi en la necessitat de teixir un projecte de vida mitjançant ocupacions significatives.

Respecte a la revisió sistemàtica, pretén afegir el coneixement sobre la participació dels treballadors de suport entre iguals en els equips de treball de salut mental, amb especial èmfasi en els serveis de teràpia ocupacional. Els resultats es van organitzar seguint les directrius del marc de pràctica de teràpia ocupacional-4 (OTPF-4): domini i procés (AOTA, 2020). Els resultats mostren un impacte positiu en les mesures

de resultats següents: Rendiment ocupacional; Prevenció; Salut i benestar; Qualitat de vida; Justícia ocupacional.

La teràpia ocupacional ofereix una visió de la persona centrada en els seus punts forts, observa el client en la seva rutina diària i considera el seu context cultural, institucional i social (Townsend & Polatajko, 2013). La teràpia ocupacional transmet aquesta visió dels PSW en les seves intervencions perquè la persona que rep l'atenció pugui desenvolupar el seu propi potencial (Townsend, 1993). Com hem esmentat anteriorment, la teràpia ocupacional té diferents marcs teòrics que ofereixen als terapeutes eines ocupacionals per observar, analitzar i dissenyar ocupacions significatives (Polatajko et al., 2004; Townsend i Polatajko, 2013). Un component indispensable d'un programa de PSW amb èxit és la definició clara de les tasques i els rols dels PSW, que ajudarà a mitigar la seva por i incapacitat per gestionar el sistema (Davidson et al., 2012; Repper i Carter, 2011). Un bon cribratge ocupacional permetrà crear un entorn de respecte entre els PSW, clients i professionals per aconseguir un objectiu comú de la teràpia ocupacional: és gaudir d'una vida al màxim i que tothom pugui aportar a la societat. No és un procés estàtic, sinó dinàmic entre la persona, l'entorn i les ocupacions. La persona està connectada amb l'entorn, i d'aquesta interacció neix l'ocupació. El paper de la teràpia ocupacional pot ser clau per assolir una implementació exitosa dels programes de suport entre iguals com a disciplina que: (1) valora fonamentalment i manté les creences arrelades en l'ocupació (Cohn, 2019); (2) coneixements i experiència en l'ús terapèutic de l'ocupació (Gillen et al., 2019); (3) comportaments i disposicions professionals (AOTA, 2015); (4) ús terapèutic d'un mateix (Taylor, 2020).

A la recerca d'activitats significatives

L'esperança en els moments de fragilitat és un mecanisme transformador que promou el canvi i la recuperació, i és un pilar del model de recuperació personal. Moltes

persones amb problemes de salut mental mostren confusió en les fases inicials, les famílies no tenen eines i l'estigma associat a les nostres comunitats té un impacte en el procés de recuperació (Flanagan, farina & Davidson, 2016). Estudis com el de Nuslang et al., (2016) van comentar la necessitat d'incorporar l'esperança com a element central de la intervenció (Boehnlein & Kinzie, 2021), i en la prova pilot peer to peer, les narracions dels participants van destacar la importància de tenir una ocupació significativa (Prat et al., 2022). Tanmateix, com el promocionem als nostres serveis? En l'estudi de Hayes (Hayes et al., 2017), es van comparar els nivells d'esperança entre la població comunitària i les persones amb problemes de salut mental, obtenint resultats significativament més baixos en el grup d'estudi. Les conclusions a les quals van arribar és que és difícil fomentar l'esperança si la persona amb problemes de salut mental presenta símptomes greus.

Alhora, vam reflexionar sobre com podem generar un sentiment d'esperança en les persones. Com vam observar en la nostra revisió sistemàtica, les xarxes de suport mutu, que comparteixen amb un pes igual, són un element transversal (Cano-Prieto, Simó-Algado, Prat-Vigué, 2022). MOSAIC promou un entorn laboral on compartir i forjar vincles i augmentar les xarxes de suport social. Un altre aspecte important que ha mostrat la investigació és l'impacte de les ocupacions significatives en la percepció de la qualitat de vida i la resiliència dels participants. Tots dos aspectes tenen un gran impacte en el procés de recuperació i estan interrelacionats. En un estudi realitzat al Canadà (Mejia-Lancheros et al., 2021), es va observar una relació directa: com més alta és la qualitat de vida, més alts són els nivells de resiliència. A més, Hadebe i Ramakumba (2020) van assenyalar la importància de les xarxes socials, que influeixen en una major resiliència de les persones.

La participació en ocupacions significatives dona sentit al procés de recuperació i promou estratègies de resiliència davant d'una possible situació traumàtica (Frankl, 1959). A més, hem trobat estudis que donen suport als resultats sobre la correlació existent entre EMAS i la percepció d'autoeficàcia (Strong, 1998).

La construcció d'un procés de vida significatiu basat en ocupacions significatives és clau, no només perquè dona esperança (la base de la recuperació), sinó perquè és essencial perquè la persona desenvolupi una ciutadania plena i contribueixi a la seva societat com a ciutadà de dret (Eiroa-Orosa & Rowe, 2017). L'exercici de la ciutadania implica la llibertat de participar en la societat i de poder decidir la pròpia vida. Una vida digna per a cada persona i que correspongui a les possibilitats de realització personal i d'accés a oportunitats per viure en salut. És un procés de construcció d'identitat i de pertinença (Sampietro & Gavaldà, 2018; Funk & Drew, 2017; Slade, 2010).

Això és totalment coherent amb el projecte MOSAIC i la necessitat d'establir processos d'integració entre els serveis sanitaris i socials, i promoure el suport entre iguals. També és una oportunitat per generar projectes i intervencions multidisciplinàries, amb professionals que portin en la seva essència una reflexió crítica sobre la seva praxi. Aquestes noves professions són essencials, com es va demostrar, per promoure un ambient d'esperança en el procés de recuperació (Kovic & Algado, 2020).

LIMITACIONS

Butterfly. *Yayoi Kusama, 1988*

Limitacions

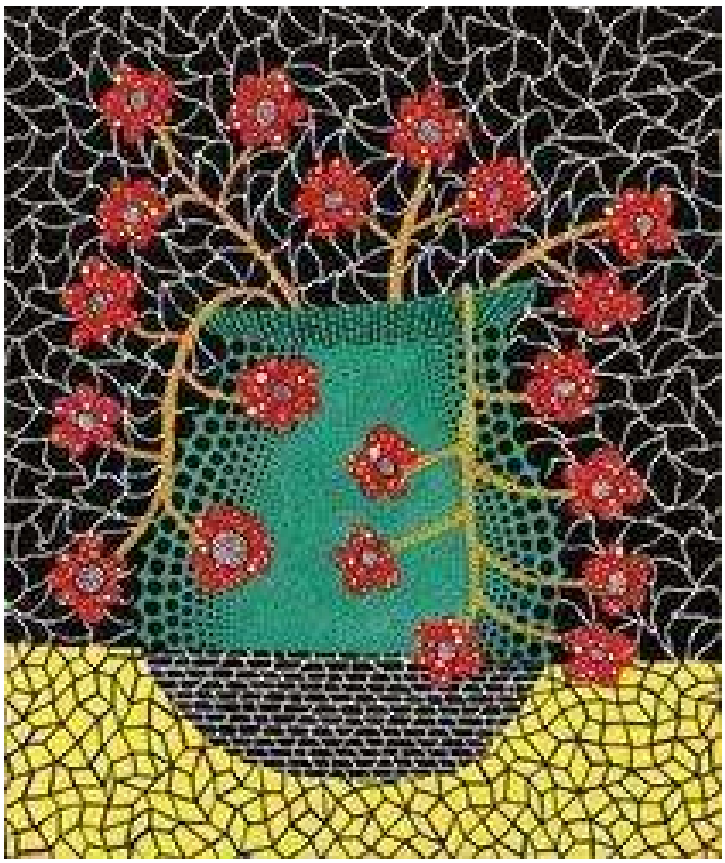
A continuació es presenten les limitacions detectades en relació amb l'elaboració d'aquesta tesi.

Primerament, farem referència a la revisió sistemàtica, article que ha guiat el projecte d'investigació. Una de les principals limitacions de l'estudi rau en l'origen mateix de la revisió sistemàtica, ja que els mateixos criteris de cerca eliminen els articles que no compleixen els criteris d'inclusió. La inclusió únicament de treballs en anglès fa que s'hagi deixat de banda una quantitat considerable de recerca, però això s'ha fet per garantir publicacions d'alt impacte. Pel que fa als articles basats en teràpia ocupacional, el fet d'incloure només estudis amb grup control ha portat a l'exclusió de treballs interessants.

Una qüestió a tenir en compte és la impossibilitat de protegir els participants de la intervenció. Tots coneixen el seu paper en el projecte, i això pot influir en els resultats. Seguidament, els articles 2 i 3 presenten limitacions compartides en els dos estudis, la petita mida de la mostra pot haver limitat l'escala dels canvis obtinguts. A més, el temps transcorregut entre l'avaluació inicial i la final no va ser el mateix en tots els participants; els recursos són dinàmics, i els pacients van i venen en diferents etapes del seu procés i, de fet, es veuen a diferents nivells assistencials (alguns en l'àmbit hospitalari, altres durant la fase de recuperació a la comunitat). Això vol dir que no tothom es troba en el mateix procés de recuperació i situació social.

Per altra banda, el tercer article presenta una limitació concreta derivada de la pandèmia. El procés de recollida de dades va estar inactiu durant unes setmanes per la impossibilitat del seguiment. Això vol dir que no tots els participants estan en el mateix procés de recuperació.

IMPLICACIONS PER A LA PRÀCTICA ASSISTENCIAL i RECERCA



Flowers. Yayaoi Kusama, 1983

Implicacions per a la pràctica assistencial i recerca

Es considera que aquesta investigació pot ser de gran rellevància i promoure la implantació del model de recuperació personal en salut mental a Catalunya. Creiem que hem contribuït a generar una evidència contextualitzada en el territori, i les experiències d'èxit poden ser replicades i incorporades a la política pública.

1. **La revisió sistemàtica ha proporcionat una anàlisi en profunditat de les intervencions entre iguals amb persones amb problemes de salut i ha identificat els resultats del domini de la teràpia ocupacional en què hi ha hagut un impacte significatiu.**

1.1 Per continuar avançant en la seva implantació, cal incorporar aspectes innovadors, un dels quals és combinar la salut (SMI) i la interseccionalitat per ajustar-se a la nova realitat social de la diversitat.

1.2 Hem observat l'essència comunitària dels models peer-to-peer, però calen programes per mesurar-ne l'impacte en els entorns hospitalaris. Per continuar demostrant la necessitat de programes entre iguals en la intervenció en salut mental, calen estudis de RCT en què la persona es trobi en un procés de recuperació marcat per l'estabilitat i la voluntat de participar en el procés.

1.3 És de vital importància per a futures investigacions relacionar les intervencions entre iguals amb l'impacte en el desenvolupament ocupacional dels PSW.

1.4 És important definir el tipus d'intervenció (programa educatiu, programa de formació o gestió de casos) que els PSW realitzaran entre els seus companys. En tots ells, el terapeuta validarà els objectius amb la persona, i els PSW acompanyaran el client cap als objectius marcats. En un programa educatiu, el professional desenvoluparà els mòduls i acompanyarà la persona en l'assoliment dels objectius marcats. En canvi, en un programa de formació, el paper del terapeuta serà

principalment entrenar en habilitats interpersonals. Finalment, en un programa de gestió de casos, la funció principal del terapeuta ocupacional serà analitzar el potencial de la persona i les seves motivacions, alinear-les amb les necessitats dels serveis. Això ha de permetre definir el seu rol i les seves tasques, aconseguint un alt nivell d'inclusió en els serveis. Per tots aquests motius la presència de la teràpia ocupacional és tan important.

2. **La incorporació de persones amb experiència en salut mental és un dels objectius del Pla Director de Salut Mental i Addicions**.

2.1 Les conclusions de l'estudi suggereixen que un dels factors clau és el suport a l'ocupació.

2.2 Els resultats ens han mostrat una disminució de la percepció de la qualitat de vida. Serà molt rellevant en futurs projectes poder detectar aquest *burnout* i acompanyar el PWS en la construcció d'estratègies de reforç.

2.3 La combinació d'instruments quantitatius amb estratègies de recollida de dades qualitatives permet una major comprensió de la realitat. Al mateix temps, la creació d'espais d'intercanvi serveix als participants per reflexionar sobre l'impacte en les seves vides.

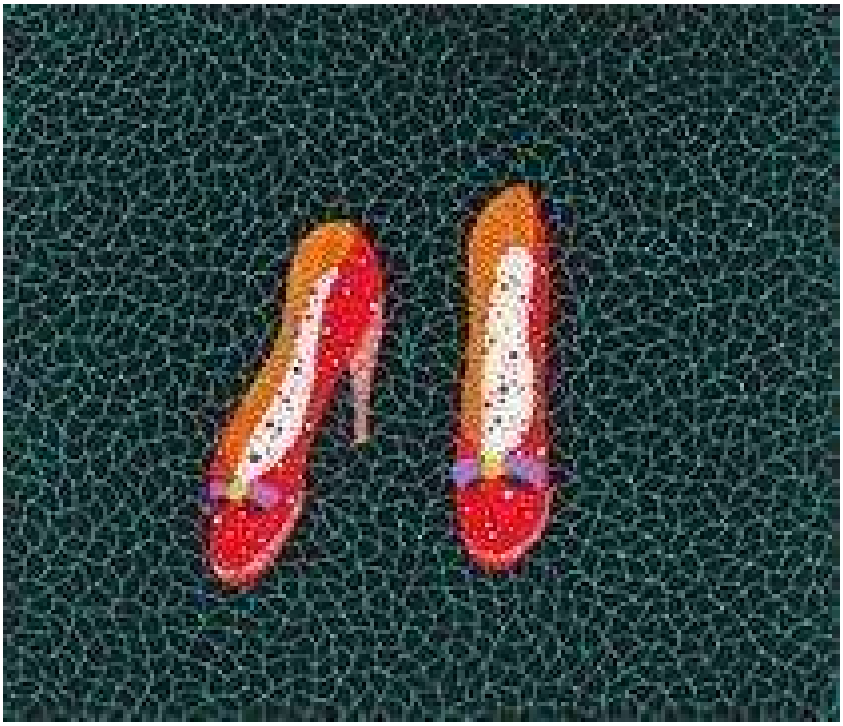
2.4 El projecte posa les bases per a un ECA a escala territorial, aprofitant el disseny de l'estudi i les mesures de resultats. Això permetria generar una evidència territorial més forta i una pressió més gran sobre les autoritats polítiques per implementar aquests programes.

3. **Els resultats obtinguts són un argument de pes per transformar i completar la integració i promoure l'atenció integral i holística**.

3.1 El potencial de les activitats rellevants (ocupacions significatives) amb el procés de recuperació personal indica la necessitat de planificar les intervencions des d'una perspectiva holística i integral.

3.2 La investigació futura ha de quantificar l'impacte de la intervenció en les mesures de resultats descrites.

CONCLUSIONS



Shoes. *Yayoi Kusama, 1985*

Conclusions

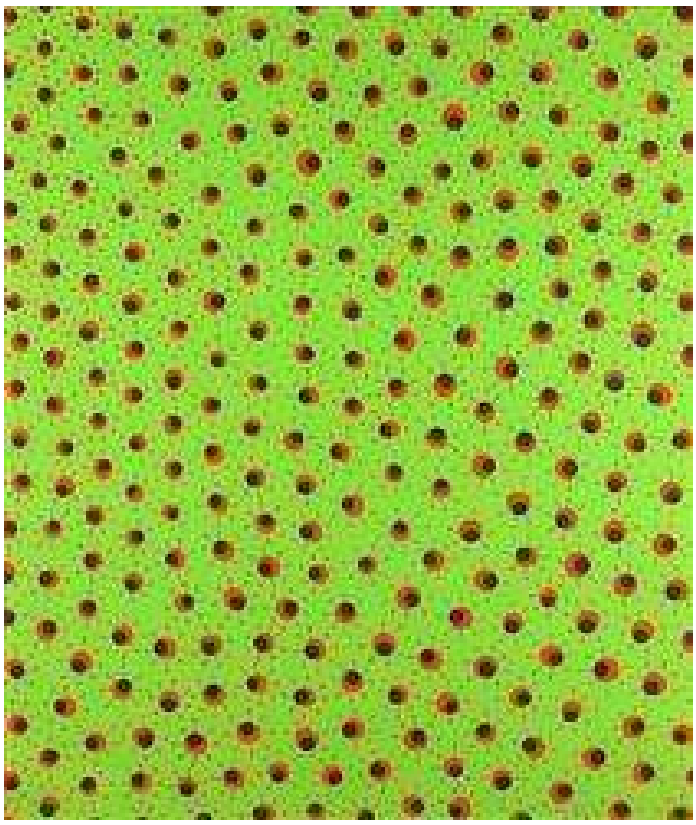
Com a conclusions generals respecte la implementació del model de recuperació i la tècnica peer to peer es podria dir que:

1. El projecte peer-to-peer obre una oportunitat laboral per a persones amb problemes de salut mental i apareix com una ocupació significativa per a ells. La pràctica dels PSW pot tenir un paper clau en el procés de recuperació: ofereix una sensació d'utilitat per als PSW i aporta esperança als clients demostrant que la recuperació és possible. Col·labora en la implantació del model de recuperació a les institucions de salut mental.
2. Les intervencions entre iguals són un exemple del canvi de tendència en les mesures de resultats que segueixen el paradigma del moviment de recuperació de la salut mental, promovent l'apoderament, oferint esperança i afavorint la inclusió. Els PSW són acompanyants de viatge molt importants per a la persona en la consecució dels objectius marcats des del servei de teràpia ocupacional. S'ha confirmat el seu ús generalitzat en recursos comunitaris, però encara hi ha marge per aplicar-lo en entorns hospitalaris.
3. Els terapeutes ocupacionals esdevén un paper cabdal a participar en la pràctica del suport entre iguals i intentar aplicar-lo al seu entorn immediat. El vincle que es genera entre el treballador i el client està embolicat en un ambient d'esperança que afavoreix la recuperació. La importància d'aquest vincle ha quedat demostrada per les destacades millores registrades en la relació terapèutica.
4. El procés d'integració de MOSAIC confirma la necessitat d'acompanyar els processos de recuperació per ocupacions significatives. Les variables, com

l'esperança i la resiliència, són pilars en el model de recuperació personal, ambdues estretament relacionades amb l'acompliment d'ocupacions significatives.

5. Els processos d'integració sociosanitària són una oportunitat per incloure professionals amb visió crítica (terapeutes ocupacionals i treballadors socials) i complementar la visió clínica imperant del sistema sanitari.

REFERÈNCIES



Fields in Spring. *Yayoi Kusama, 1988*

Referències

Algado. S, Guzmán, S. (2014). Construyendo proyectos de vida significativos con personas supervivientes de enfermedad mental [Building life projects with those living with mental illness]. *Terapia Ocupational TOG*, 11:1–25. http://www.revistatog.com/num19pdfs/maestros.pdf

American Occupational Therapy Association. (2015). Standards of practice for occupational therapy. *American Journal of Occupational Therapy*, 69 (Suppl. 3), 6913410057. https://doi.org/10.5014/ajot.2015.696S06

American Occupational Therapy Association. (2020). Occupational therapy practice framework: Domain and process. *American Journal of Occupational Therapy*, 74(Suppl.2), 7412410010. https://doi.org/10.5014/ajot.2020.74S2001

Anthony, W.A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabil J*, 16:11–23. https://doi: 10.1037/h0095655

Atienza, F.L., Balaguer, I., Garcia-Merita, M.L. (2003). Satisfaction with Life Scale: analysis of factorial invariance across sexes. *Pers Individ Dif*, 35:1255–60. https://doi: 10.1016/S0191-8869(02)00332-X

Baxter, S., Johnson, M., Chambers, D., Sutton, A., Goyder, E., Booth, A. (2018). The effects of integrated care: A systematic review of UK and international evidence. *BMC Health Services Research*,18, 1.

Bellamy, C., Schmutte, T., & Davidson, L. (2017). An update on the growing evidence base for peer support. *Mental Health and Social Inclusion*, 21(3), 161–167. https://doi.org/10. 1108/MHSI-03-2017-0014

Boehnlein, J.K., Kinzie, J.M. (2021). Experiencing mental illness: suffering, hope, and healing. *Narrat Inq Bioeth*, 11:189–94.

http://doi: 10.1353/nib.2021.0070

Bourke, C., Sanders, B., Allchin, B., Lentin, P., & Lang, S. (2015). Occupational therapy influence on a carer peer support model in a clinical mental health service. *Australian Occupational Therapy Journal*, 62(5), 299–305. https://doi.org/10.1111/1440-1630.12235

Campos, F. A. L., de Sousa, A. R. P., Rodrigues, V. P. da C., Marques, A. J. P. da S., Dores, A. A. M. da R., & Queiro´s, C. M. L. (2014). Peer support for people with mental illness. *Revista de Psiquiatria Clínica*, 41(2), 49–55. https://doi.org/10.1590/0101- 60830000000009

Cano-Prieto I, Simó-Algado S, Prat-Vigué G. (2022). Peer interventions in severe mental illnesses: a systematic review and its relation to occupational therapy. *Occup Ther Ment Health*, 39(2):99–136.

https://doi: 10.1080/0164212X.2022.2085645

Cohn, E. S. (2019). Asserting our competence and affirming the value of occupation with confidence. *American Journal of Occupational Therapy*, 73, 7306150010. https://doi.org/10.5014/ajot.2019.736002

Connor, K. M. & Davidson, J. R (2003). Development of a new resilience scale: the Connor-Davidson Resilience Scale (CD-RISC). *Depression and anxiety*, 18, 76–82.

Dahl, C. M., de Souza, F. M., Lovisi, G. M., & Cavalcanti, M. T. (2015). Stigma and recovery in the narratives of peer support workers in Rio de Janeiro, Brazil. *BJPsych International*, 12(4), 83–85. https://doi.org/10.1192/s2056474000000611

Davidson, L., Bellamy, C., Guy, K., Miller, R. (2012). Peer support among persons with severe mental illnesses: a review of evidence and experience. *World Psychiatry*, 11:123–8.
https://doi: 10.1016/j.wpsyc.2012.05.009

Davidson, L., Chinman, M., Sells, D., & Rowe, M. (2006). Peer support among adults with serious mental illness: A report from the field. *Schizophrenia Bulletin*, 32(3), 443–450.
https://doi.org/10.1093/schbul/sbj043

Dewhurst, K., McKnight, A. L., & Leopoldt, H. (1974). The Oxford group-home scheme for psychiatric patients. *The Practitioner*, 213(1274), 195–204.

Diener, E., Emmons, R.A., Larsen, R.J., Griffin, S. (1985). The satisfaction with life scale. *J Pers Assess*, 49:71–5.
https://doi: 10.1207/s15327752jpa4901_13

Dubreucq, J. Plasse, J. Gabayet, F. Faraldo, M. Blanc, O. Chereau, I. Franck, N (2022). Stigma resistance is associated with advanced stages of personal recovery in serious mental illness patients enrolled in psychiatric rehabilitation. *Psychological Medicine,* 52, 2155-2165.

Eiroa-Orosa, F.J., Rowe, M. (2017). Taking the concept of citizenship in mental health across countries. Reflections on transferring principles and practice to different sociocultural contexts. *Front Psychol*. 8:1020.
https://doi: 10.3389/fpsyg.2017.01020

Fan, Y., Ma, N., Ma, L., et al. (2018). A community-based peer support service for persons with severe mental illness in China. *BMC Psychiatry*, 18:170.
https://doi: 10.1186/s12888-018-1763-2

Flanagan, E., Farina, A., & Davidson, L. (2016). Does stigma towards mental illness affect initial perceptions of peer providers? *The Psychiatric Quarterly*, 87(1), 203–210.
https:// doi.org/10.1007/s11126-015-9378-y

Frankl, V. E. (1959). *Man's Search for Meaning*. Beacon Press.

Fransen, H., Pollard, N., Kantartzis, S., & Viana-Moldes, I. (2015). Participatory citizenship: Critical perspectives on client-centred occupational therapy. *Scandinavian Journal of Occupational Therapy,* 22(4), 260–266. https://doi.org/10.3109/11038128.2015.1020338

Frost, B.G., Tirupati, S., Johnston, S., Turrell, M., Lewin, T.J., Sly, K.A., et al. (2017). An integrated recovery-oriented model (IRM) for mental health services: evolution and challenges. *BMC Psychiatry*, 17(1):22.
https://doi: 10.1186/s12888-016-1164-3

Funk, M.; Drew, N. (2017). WHO QualityRights: transforming mental health services. *The Lancet Psychiatry*, 4, 826–827.
https://doi.org/10.1016/S2215-0366(17)30271-7

Generalitat de Catalunya. (2021). ACORD GOV/176/2021, de 9 de novembre, pel qual es crea el Programa per a l'elaboració del Pacte Nacional de Salut Mental [AGREEMENT GOV/176/2021, of November 9, which creates the Program for the preparation of the National Mental Health Pact]. *Departament de la Presidència*.

Gill, P., Stewart, K., Treasure, E., Chadwick, B. (2008). Methods of data collection in qualitative research: interviews and focus groups. *Br Dent J*, 204:291–5. https://doi: 10.1038/bdj.2008.192

Gillen, G., Hunter, E. G., Lieberman, D., & Stutzbach, M. (2019). AOTA's top 5 Choosing WiselyVR recommendations. *American Journal of Occupational Therapy*, 73, 7302420010.
https://doi.org/10.5014/ajot.2019.732001

Gröne, O., Garcia-Barbero, M. (2001). WHO European Office for Integrated Health Care Services. Integrated care: a position paper of the WHO European Office for Integrated Health Care Services. *Int J Integr Care*. 1, e21.

Hadebe, N.F., Ramukumba, T.S. (2020). Resilience and social support of young adults living with mental illness in the city of Tshwane, Gauteng province, South Africa. *Curationis*, 43:e1–e7.
https://doi: 10.4102/curationis.v43i1.2084

Hammell, K. R. W. (2017). Critical reflections on occupational justice: Toward a rightsbased approach to occupational opportunities. *Canadian Journal of Occupational Therapy*, 84(1), 47–57.
https://doi.org/10.1177/0008417416654501

Hayes, L., Herrman, H., Castle, D., Harvey, C. (2017). Hope, recovery and symptoms: the importance of hope for people living with severe mental illness. *Australas Psychiatry*, 25:583–7.
https://doi: 10.1177/1039856217726693

Herth, K. (1992). Abbreviated instrument to measure hope: development and psychometric evaluation. *Journal of advanced nursing*, 17, 1251–1259.

Higgins, J. P., Altman, D. G., Gøtzsche, P. C., Juni, P., Moher, D., Oxman, A. D., Savovic, J., Schulz, K. F., Weeks, L., Sterne, J. A., Cochrane B., & Methods Group, Cochrane Statistical Methods Group (2011). The Cochrane collaboration's

tool for assessing risk of bias in randomised trials. *British Medical Journal*, 343(7829), d5928–9.
https://doi.org/10.1136/bmj.d5928

Humbert, T. K. (2016). Addressing spirituality in occupational therapy. In T. K. Humbert (Ed.), *Spirituality and occupational therapy: A model for practice and research.* AOTA Press.

Jewell, C., Falzer, P., Davidson, L., Rowe, M., & Sells, D. (2006). The treatment relationship in peer-based and regular case management for clients with severe mental illness. *Psychiatric Services*, 57(8), 1179–1184. https://doi.org/10.1176/ps.2006.57.8.1179

Jones, N., Corrigan, P. W., James, D., Parker, J., & Larson, N. (2013). Peer support, self-determination, and treatment engagement: A qualitative investigation. *Psychiatric Rehabilitation Journal*, 36(3), 209–214.
https://doi.org/10.1037/prj0000008

Keet, R., de Vetten-Mc Mahon, M., Shields-Zeeman, L., Ruud, T., van Weeghel, J., Bahler, M., et al. (2019). Recovery for all in the community) position paper on principles and key elements of community-based mental health care. *BMC Psychiatry*, 19:174.
https://doi: 10.1186/s12888-019-2162-z

Khan, N., & Tracy, D. (2022). The challenges and necessity of situating 'illness narratives' in recovery and mental health treatment. *BJPsych Bulletin,* 46, 77-82.

Kielhofner, G. (2009). *Conceptual foundations of occupational therapy practice* (4th ed.). F.A. Davis Company.Wilcock, 2006

Kodner, D.L. & Spreeuwenberg, C. (2002). Integrated care: meaning, logic, applications, and implications a discussion paper. *International Journal of Integrated Care*. 2, e12.

Kovic, M., Algado, S.S. Hope. (2020). *Interinst Braz J Occup Ther*. 4:131–6. https://doi: 10.47222/2526-3544.rbto32876

Kuhn, W., Bellinger, J., Stevens-Manser, S., & Kaufman, L. (2015). Integration of peer spe- cialists working in mental health service settings. *Community Mental Health Journal*, 51(4), 453–458. https://doi.org/10.1007/s10597-015-9841-0/

Law, M., Baptiste, S., McColl, M., Opzoomer, A., Polatajko, H., Pollock, N. (1990). The Canadian occupational performance measure: an outcome measure for occupational therapy. *Can J Occup Ther*. 57:82–7. https://doi: 10.1177/000841749005700207

Leamy, M., Bird, V., Boutillier, C., Williams, J., Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *Br J Psychiatry*, 199:445–52. https://doi: 10.1192/bjp.bp.110.083733

Lee, J-T. (2019). Book review: designing and conducting mixed methods research. *HERD: Health Environ Res Des,* 12:164–6. https://doi: 10.1177/1937586719832223

Leutz, W.N. (1999). *Five laws for integrating medical and social services: lessons from the United States and the United Kingdom*. Milbank Q. 77, 77-v.

Levitt, H.M., Bamberg, M., Creswell, J.W., Frost, D.M., Josselson, R., Suárez-Orozco, C. (2018). Journal article reporting standards for qualitative primary, qualitative

meta-analytic, and mixed methods research in psychology: the APA Publications and Communications Board task force report. *Am Psychol*, 73:26–46. https://doi: 10.1037/amp0000151

Liberati, A., Altman, D. G., Tetzlaff, J., Mulrow, C., Gøtzsche, P. C., Ioannidis, J. P., Clarke, M., Devereaux, P. J., Kleijnen, J., & Moher, D. (2009). The PRISMA statement for reporting systematic reviews and meta-analyses of studies that evaluate health care interventions: Explanation and elaboration. *Journal of Clinical Epidemiology*, 62(10), e1–e34. https://doi.org/10.1016/j.jclinepi.2009.06.006

Sampietro, H.M. & Gavaldà Castet, C. (2018). Manual per a la recuperació i l'autogestio del benestar [Manual for recovery and self-management of well-being]. *Activa't per la Salut Mental*.

Mead, S., Hilton, D., Curtis, L. (2001). Peer support: a theoretical perspective. Psychiatr Rehabil J. 25:134–41. https://doi: 10.1037/h0095032

Mead, S., Macneil, C. (2004). Peer Support: What Makes It Unique?. Int J *Psychosoc Rehab*, 10:29–37.

Mejia-Lancheros, C., Woodhall-Melnik, J., Wang, R., Hwang, S.W, Stergiopoulos, V., Durbin, A. (2021). Associations of resilience with quality of life levels in adults experiencing homelessness and mental illness: a longitudinal study. *Health Qual Life Outcomes*, 19:74. https://doi: 10.1186/s12955-021-01713-z

Meyer, A. (1922). The philosophy of occupational therapy. *Archives of Occupational*

Naslund, J.A., Aschbrenner, K.A., Marsch, L.A., Bartels, S.J. (2016). The future of mental health care: peer-to-peer support and social media. *Epidemiol Psychiatr Sci*. 25(2):113–22.
https://doi: 10.1017/S2045796015001067

Notario-Pacheco, B., Solera-Martínez, M., Serrano-Parra, M. D., Bartolomé-Gutiérrez, R., García-Campayo, J. & Martínez-Vizcaíno, V. (2011). Reliability and validity of the Spanish version of the 10-item Connor-Davidson Resilience Scale (10-item CD-RISC) in young adults. *Health and quality of life outcomes*., 9, 63.

Ochoa, S., Martínez-Zambrano, F., Garcia-Franco, M., Vilamala, S., Ribas, M., Arenas, O., et al. (2015). Development and validation of the Self-Stigma Questionnaire (SSQ) for people with schizophrenia and its relation to social functioning. *Compr Psychiatry*. 62:93–9.
https://doi: 10.1016/j.comppsych.2015.06.011

Ochoa, S., Martínez-Zambrano, F., Vila-Badia, R., Arenas, O., Casas-Anguera, E., García-Morales, E., et al. (2016). Validación al castellano de la escala de estigma social: Community Attitudes towards Mental Illness en población adolescente [Spanish validation of the social stigma scale: Community Attitudes towards Mental Illness]. *Rev Psiquiatr Salud Ment*, 9:150–7.
https://doi: 10.1016/j.rpsm.2015.02.002

Onocko-Campos, R. Davidson, L. & Desviat, M (2021). Salud mental y derechos humanos: desafíos para servicios de salud y comunidades [Mental health and human rights: Challenges for health services and communities]. *Salud colectiva*, 17, e3488.

Parker, G. (2021). In search of logotherapy. *Australian & New Zealand Journal of Psychiatry*, 7, 000486742110628.

https://doi.org/10.1177/00048674211062830

Pelletier, J.-F., Corbière, M., Lecomte, T., Briand, C., Corrigan, P., Davidson, L., & Rowe, M. (2015). Citizenship and recovery: two intertwined concepts for civic-recovery. *BMC Psychiatry*, 15, 37. https://doi.org/10.1186/s12888-015-0420-2

Peloquin, S. M. (1989). Sustaining the art of practice in occupational therapy. *The American Journal of Occupational Therapy*, 43(4), 219–226. https://doi.org/10.5014/ajot. 43.4.219

Pickett, S. A., Diehl, S., Steigman, P. J., Prater, J. D., Fox, A., & Cook, J. A. (2010). Early outcomes and lessons learned from a study of the Building Recovery of Individual Dreams and Goals through Education and Support (BRIDGES) program in Tennessee. *Psychiatric Rehabilitation Journal*, 34(2), 96–103. https://doi.org/10.2975/34.2.2010.96.103/

Polatajko, H. J., Davis, J. A., Hobson, S. J. G., Landry, J. E., Mandich, A., Street, S. L., Whippey, E., & Yee, S. (2004). Meeting the responsibility that comes with the privilege: Introducing a taxonomic code for understanding occupation. *Canadian Journal of Occupational Therapy*, 71(5), 261–268. https://doi.org/10.1177/000841740407100503

Prat Vigué, G., Cano Prieto, I., del Río Sáez, R. ,Vilanova Masana, R. and Simó Algado, S. (2022) Training Peer Support Workers in Mental Health Care: A Mixed Methods Study in Central Catalonia. *Front. Psychiatry* 13:791724. https://doi: 10.3389/fpsyt.2022.791724

Prat, G., Ribot, A., Recoder, S., Muñoz, F. (2019). Psychometric properties of the Spanish version of the engagement in meaningful activities survey in people with serious mental illness. *Br J Occup Ther,* 82:743–9.

https://doi: 10.1177/0308022619856557

Reilly, M. (1962). Occupational therapy can be one of the great ideas of 20th century medi- cine. *The American Journal of Occupational Therapy: Official Publication of the American Occupational Therapy Association*, 16, 1–9.

Repper, J., Carter, T. (2011). A review of the literature on peer support in mental health services. *J Mental Health*, 20:392–411. doi: 10.3109/09638237.2011.583947

Rojo Rodés, E., San Pío Tendero, M., J. Eiroa Orosa, F. & Marcet, G. (2019). Get active for mental health: a project evaluated for active involvement of families and users. *International Journal of Integrated Care*, 19, 419.

Rowe, M., Davidson, L. (2016). Recovering Citizenship. *Isr J Psychiatry Relat Sci*, 53:14–20.

Rubashkin, N., Warnock, R., Diamond-Smith, N. (2018). A systematic review of person-centered care interventions to improve quality of facility-based delivery. *Reprod Health*, 15(1):169.

https://doi: 10.1186/s12978-018-0588-2

Saavedra, J., Vázquez-Morejón, A.J., Vázquez-Morejón, R., Arias-Sánchez, S., González-Álvarez, S. & Corrigan, P. (2021). Spanish validation of the recovery assessment scale. *Psicothema*, 33, 500–508.

Sánchez-Teruel, D., Robles-Bello, M. A. & Camacho-Conde, J. A.(2020). Validity of the spanish version of the Herth Hope Index and The Beck Hopelessness Scale in people who have attempted suicide. *Actas espanolas de psiquiatria*,48, 163–168.

Sanjuán Suárez, P., Pérez García, A. M. & Bermúdez Moreno, J. (2000). Escala de autoeficacia general: Datos psicométricos de la adaptación para población española [The general self-efficacy scale: Psychometric data from the Spanish adaptation]. *Psicothema*, 12, 509–513.

Schoonenboom, J, Johnson RB. (2017). How to construct a mixed methods research design. *Kolner Z Soz Sozpsychol*, 69:107–31. https://doi: 10.1007/s11577-017-0454-1

Schwarzer, R. (2016). *General Self-Efficacy Scale*. http://userpage.fu-berlin.de/~health/selfscal.htm.

Sells, D., Black, R., Davidson, L., & Rowe, M. (2008). Beyond generic support: Incidence and impact of invalidation in peer services for clients with severe mental illness. *Psychiatric Services*, 59(11), 1322–1327. https://doi.org/10.1176/ps.2008.59.11.1322

Silver, J., & Nemec, P. B. (2016). The role of the peer specialists: Unanswered questions. *Psychiatric Rehabilitation Journal*, 39(3), 289–291. https://doi.org/10.1037/prj0000216

Slade, M. (2010). Mental illness and well-being: the central importance of positive psychology and recovery approaches. *BMC Health Serv Res*, 10:26. https://doi: 10.1186/1472-6963-10-26

Slade, M., Bird, V., Le Boutillier, C., Williams, J., McCrone, P., Leamy, M.. (2011). REFOCUS Trial: protocol for a cluster randomised controlled trial of a pro-recovery intervention within community based mental health teams. *BMC Psychiatry*, 11:185. https://doi: 10.1186/1471-244X-11-185

Slade, M., Williams, J., Bird, V., Leamy, M., Le Boutillier, C. Recovery grows up. (2012a). *J Mental Health*. 21:99–103. https://doi: 10.3109/09638237.2012.670888

Slade, M., Leamy, M., Bacon, F., Janosik, M., Le Boutillier, C., Williams, J. & Bird, V. (2012b). International differences in understanding recovery: systematic review. *Epidemiology and psychiatric sciences*. 21, 353–364.

Solomon, P. Peer support/peer provided services underlying processes, benefits, and critical ingredients. (2004). *Psychiatr Rehabil J*, 27:392–401. https://doi: 10.2975/27.2004.392.401

Solomon, P., Draine, J. (2001). The state of knowledge of the effectiveness of consumer provided services. *Psychiatr Rehabil J*, 25:20–7. https://doi: 10.1037/h0095054

Stalmeijer, R.E., Mcnaughton, N., Van Mook, W.N. (2014). Using focus groups in medical education research: AMEE Guide No. 91. *Med Teache,* 36:923–39. https://doi: 10.3109/0142159X.2014.917165

Strong S. (1998). Meaningful work in supportive environments: experiences with the recovery process. *Am J Occup Ther*, 52:31–8. https://doi: 10.5014/ajot.52.1.31

Sunderji, N., Ion, A., Ghavam-Rassoul, A., Abate, A. (2017). Evaluating the implementation of integrated mental health care: a systematic review to guide the development of quality measures. *Psychiatr Serv*. 68(9):891–8. https://doi: 10.1176/appi.ps.201600464

Taylor, R. (2019). *Therapeutic relationship and client collaboration: Applying the Intentional Relationship Model*. In B. A. B. Schell & G. Gillen (Eds.), Willard and Spackman's occupational therapy (13th ed., pp. 527–538). Lippincott Williams & Wilkins.

Townsend, E. (1993). Occupational therapy's social vision. *Canadian Journal of Occupational Therapy*, 60(4), 174–184. https://doi.org/10.1177/000841749306000403

Townsend, E. A., & Polatajko, H. J. (2013). Enabling occupation II: Advancing an occupational therapy vision for health, well-being, & justice through occupation (Second edition). *CAOT Publications ACE. Therapy*, 1, 1–10.

United Nations (2006). *Convention on the Rights of Persons with Disabilities*.

Valentijn, P.P. van Es Institute, J. Opheij, W. Gudde, T.; Bruijnzeels, M.A. (2013). Understanding integrated care: a comprehensive conceptual framework based on the integrative functions of primary care. *Int J Integr Care*, 13, e010.

Weaver, N. (2021). Recovery and care continuity experiences of people in mental health care: A conciliatory approach to the challenge of implementing recovery-based services. *Sociology of health & illness*, 43, 1996–2014.

Wilcock, A. A. (2006). *An occupational perspective of health* (Second edition). SLACK Incorporated.

Wolfendale, T., & Musaabi, A. (2017). The implementation of a peer support scheme in an assertive rehabilitation ward in high secure forensic services. *Mental Health and Social Inclusion*, 21(4), 222–229. https://www.proquest.com/scholarly-journals/implementation-peer-support-scheme-assertive/docview/1925807405/se-2?accountid=133586

World Medical Association. (2013). World Medical Association Declaration of Helsinki: ethical principles for medical research involving human subjects. JAMA, 310(20), 2191–2194. https://doi.org/10.1001/jama.2013.281053

Yam, K., Lo, W., Chiu, R., Lau, B., Lau, C., Wu, J., & Wan, S. M. (2018). A pilot training program for people in recovery of mental illness as vocational peer support workers in Hong Kong – Job Buddies Training Program (JBTP): A preliminary finding. Asian Journal of Psychiatry, 35, 132–140. https://doi.org/10.1016/j.ajp.2016.10.002

TAULA D'ANNEXES

Sea. *Yayoi Kusama, 2005*

Annex 1. Informe del comitè ètic d'investigació Agent de suport entre iguals

FUNDACIÓ LA UNIÓ
Fundació Unió Catalana d'Hospitals

INFORME DEL COMITÈ ÈTIC D'INVESTIGACIÓ

Dr. Miquel Nolla, com a President del Comitè Ètic d'Investigació/ Comitè Ètic d'Investigació amb medicaments (CEI/CEIm) de la Fundació Unió Catalana d'Hospitals

ASSABENTAT:

Que aquest Comitè té coneixement que Althaia Xarxa Assistencial Universitària de Manresa, ha participat a la investigació:

Títol: **Inserció Sociolaboral De Persones Amb Malaltia Mental: Projecte Peer To Peer**

Que el programa va rebre el finançament de la Obra Social La Caixa (IS18-00323)

Que el programa es va desenvolupar entre els octubres de 2018-19 de manera conjunta entre tres entitats de referencia de la Catalunya Central (Fundació Althaia, Osonament, Universitat De Vic-Universitat Central De Catalunya).

Que la Direcció General d'Althaia va donar la conformitat per participar a l'estudi.

La capacitat de la investigadora Gemma Prat Vigué, i els seus col.laboradors són apropiats per portar a terme l'estudi.

Les instal·lacions i els mitjans disponibles són apropiats per portar a terme l'estudi i considera que es van respectar els requisits ètics i de confidencialitat vigents.

Miquel Nolla
President CEI/CEIm
Barcelona, 1 de setembre 2021

Annex 2. Consentiment informat Agent de suport entre iguals

Informació per als participants

Els membres de l'equip d'investigació SAMIS dirigit per Salvador Simó Algado – IP, portem a terme el projecte d'investigació: INSERCIÓ SOCIOLABORAL DE PERSONES AMB MALALTIA MENTAL: PROJECTE PEER TO PEER

El projecte pretén adaptar la tècnica peer-to-peer (suport pels iguals), com a tècnica basada en l'evidència. Aquesta tècnica consisteix a proporcionar formació i acreditació a persones afectades d'un problema de salut mental, per a tal que puguin exercir com a coterapetues en els equips de salut mental que treballin amb el model de recuperació. Per a tal, s'adaptaran les formacions que realitza el Program for Recovery and Community Health (PRCH) de la Yale University i, s'aplicaran en el nostre entorn. Així, es formaran a persones afectades d'un problema de salut mental, un cop acreditades s'incorporaran als equips de salut mental dels dispositius de la Catalunya Central (Osonament i Fundació Althaia) com a coterapetues. El projecte també valorarà l'impacte que suposa aquesta estratègia, tant en les persones ateses, com en les persones que actuen com a coterapeutes i en els professionals. La intervenció es reforçarà amb la tècnica del career design counselling, desenvolupant un procés de coaching laboral i creant itineraris d'inclusió laboral individualitzats.

En el context d'aquesta investigació li demanem la seva col·laboració per tal d'avaluar l'impacte del programa en la millora de la qualitat de vida i satisfacció amb la vida de les persones que s'han inserit laboralment i de les que han rebut l'atenció de les persones amb problemes de salut mental en els equips de recuperació de la Salut Mental ja que vostè compleix els següents criteris d'inclusió:
Edat compresa entre 18 i 65 anys d'edat
Diagnòstic de TMS
Presentar limitacions en el funcionament comunitari degut al seu problema de salut mental
Voluntat de participar

Aquesta col·laboració implica participar en la fase d'avaluació del programa, concretament en la recollida de dades per mitja d'entrevista directa.

Tots els participants tindran assignat un codi per el qual es impossible identificar al participant amb les respostes donades, garantint totalment la confidencialitat. Les dades que s'obtindran de la seva participació no s'utilitzaran amb un altre fi diferent de l'explicitat en aquesta investigació i passaran a formar part d'un fitxer de dades del que serà màxim responsable l'investigador principal.

El fitxer de dades de l'estudi estarà sota la responsabilitat de l'IP davant del qual podrà exercir en tot moment els drets que estableix la Llei orgànica 15/1999, de 13 de desembre, de protecció de dades de caràcter personal i el Reglament general (UE) 2016/679, de 27 d'abril de 2016, de protecció de dades i normativa complementària.

Ens posem a la seva disposició per resoldre qualsevol dubte que la mateixa hagi suscitat. Pot contactar amb nosaltres a través del següent correu electrònic: salvador.simo@uvic.cat

Consentiment informat

JO, _____ ,
major d'edat, amb DNI _____, actuant en nom i interès propi.

DECLARO QUE:
He rebut informació sobre el projecte INSERCIÓ SOCIOLABORAL DE PERSONES AMB MALALTIA MENTAL: PROJECTE PEER TO PEER del que se m'ha lliurat el full informatiu annex a aquest consentiment i pel qual es sol·licita la meva participació. He entès el seu significat, se m'han aclarit els dubtes i m'han estat exposades les accions que es deriven del mateix. Se m'ha informat de tots els aspectes relacionats amb la confidencialitat i protecció de dades pel que fa a la gestió de dades personals que comporta el projecte i les garanties donades en compliment de la Llei orgànica 15/1999, de 13 de desembre, de protecció de dades de caràcter personal i el Reglament general (UE) 2016/679, de 27 d'abril de 2016, de protecció de dades i normativa complementària.

La meva col·laboració en el projecte és totalment voluntària i tinc dret a retirar-me'n en qualsevol moment, revocant aquest consentiment, sense que aquesta retirada pugui influir negativament en la meva persona en cap cas. En cas de retirada, tinc dret a què les meves dades siguin cancel·lades del fitxer de l'estudi.

[QUAN PROCEDEIXI:] Així mateix, renuncio a qualsevol benefici econòmic, acadèmic o de qualsevol altra naturalesa que pogués derivar-se del projecte o dels seus resultats.

Per tot això,

DONO EL MEU CONSENTIMENT A:

Participar en el projecte INSERCIÓ SOCIOLABORAL DE PERSONES AMB MALALTIA MENTAL: PROJECTE PEER TO PEER

Que l'equip d'investigació SAMIS i el Dr./Dra. [NOMBRE DEL IP] com investigador principal, puguin gestionar les meves dades personals i difondre la informació que el projecte generi. És garantitzi que es preservarà en tot moment la meva identitat i intimitat, amb les garanties establertes a la Llei orgànica 15/1999, de 13 de desembre, de protecció de dades de caràcter personal i el Reglament general (UE) 2016/679, de 27 d'abril de 2016, de protecció de dades i normativa complementària.

Entenc que es recolliran dades d'àudio i/o de vídeo en les quals participo, i dono el meu consentiment perquè (marqueu les opcions):

L'investigador/a sotasignat, el/la supervisor/a i altres membres del projecte de recerca mostrin les dades d'àudio i/o de vídeo en l'àmbit acadèmic (reunions del grup de recerca, conferències, etc.).

Altres membres del grup de recerca SAMIS mostrin les dades d'àudio i/o de vídeo en l'àmbit acadèmic (reunions del grup de recerca, conferències, etc.).

L'investigador/a sotasignat, el/la supervisor/a i altres membres del projecte de recerca reprodueixin imatges de les gravacions de vídeo en publicacions acadèmiques (revistes especialitzades, llibres, etc.).

Altres membres del grup de recerca SAMIS reprodueixin imatges de les gravacions de vídeo en publicacions acadèmiques (revistes especialitzades, llibres, etc.).

L'investigador/a sotasignat, el/la supervisor/a i altres membres del projecte de recerca mostrin fragments d'àudio, de vídeo i/o imatges en les seves activitats de docència a la universitat.

Altres membres del grup de recerca SAMIS mostrin fragments d'àudio, de vídeo i/o imatges en les seves activitats de docència a la universitat.

També entenc que podré retirar el meu consentiment per a l'ús de la meva imatge en esdeveniments o produccions acadèmiques que es realitzessin des del moment que comunico la meva retirada en endavant.

Que l'equip SAMIS conservi tots els registres efectuats sobre la meva persona en suport electrònic, amb les garanties i els terminis legalment previstos, si estiguessin establerts, i a falta de previsió legal, pel temps que fos necessari per complir les funcions del projecte per les que les dades fossin recaptades.

[CIUTAT], a [DIA/MES/ANY]
[SIGNATURA PARTICIPANT] [SIGNATURA IP]

Annex 3. Informe del comitè ètic d'investigació: "Variables personals, clíniques i de funcionament social implicades en la percepció de recuperació dels usuaris/es en procés de rehabilitació i la seva relació amb la inserció comunitària

FUNDACIÓ UNIÓ Fundació Unió Catalana d'Hospitals

INFORME DEL COMITÉ ÉTIC D'INVESTIGACIÓ

Dr. Miquel Nolla, com a President del Comitè d'Ètica d'Investigació de la FUNDACIÓ UNIO CATALANA HOSPITALS

C E R T I F I C A:

Que aquest Comitè en la seva reunió del dimarts 29 de gener, ha avaluat la proposta per que es realitzi l'estudi que porta per títol "Variables personals, clíniques i de funcionament social implicades en la percepció de recuperació dels usuaris/es en procés de rehabilitació i la seva relació amb la inserció comunitària." amb codi CEI 19/09 i considera que:

Es compleixen els requisits necessaris d'idoneïtat del protocol en relació amb els objectius de l'estudi i que estan justificats els riscos i les molèsties previsibles per al subjecte. La capacitat de l'investigador i els mitjans disponibles són apropiats per portar a terme l'estudi. Són adequats tant el procediment per obtenir el consentiment informat com la compensació prevista per als subjectes per danys que es puguin derivar de la seva participació a l'estudi.

Que aquest Comité decideix emetre **INFORME FAVORABLE**, en la reunió celebrada el dia 26 de febrer de 2019

Que aquest comitè accepta que aquest estudi es digui a terme a **Althaia, Xarxa Assistencial Universitària de Manresa** amb **Gemma Prat** com a investigadora principal. I que la investigadora principal no ha estat present en les deliberacions i aprovació d'aquest estudi.

En aquesta reunió s'han complert els requisits establerts en la legislació vigent – Orden SAS/347/2009, RD 1090/2015. El CEI tant en la seva composició, com en els PNT compleix amb les normes de BPC (CPMP/ICH/135/95).

MEMBRES DEL CEI DE LA FUNDACIÓ UNIÓ CATALANA D'HOSPITALS

Dr. Miquel Nolla	President	Metge
Dra. Anna Altés	Secretari	Metge
Dra. Encarna Martinez	Vocal	Metge
Dr. Ernesto Mònaco	Vocal	Metge
Dr. Jesús Montesinos	Vocal	Metge
Dr. Josep M Tormos	Vocal	Metge
Dra. Rosa Morros	Vocal	Farmacòloga Clínica
Dra. Concha Antolin	Vocal	Farmacèutica primària
Dra. Virginia Martinez	Vocal	Farmacèutica
Dr. Jaume Trapé	Vocal	Farmacèutic
Sra. Conxita Malo	Vocal	Infermera
Sra. Ana Barajas	Vocal	Psicòloga
Sra. Itziar Aliri	Vocal	Advocat
Sra. Anna Guijarro	Vocal	Filosofia
Sra. Vanessa Massó	Vocal	C. Empresarials

Barcelona, 3 de maig de 2019

www.fundaciounio.cat CEIm

Dr. Miquel Nolla
President del CEI

Annex 4. Consentiment informat: "Variables personals, clíniques i de funcionament social implicades en la percepció de recuperació dels usuaris/es en procés de rehabilitació i la seva relació amb la inserció comunitària

Consentiment informat per a estudi científic d'investigació

Títol del

Nom *Fes clic aquí per escriure el nom* Cognoms *Fes clic aquí per escriure els cognoms*

Núm. HC *Número història clínica* Edat _____ *anys* DNI *número DNI*

Nom *Fes clic aquí per escriure el nom* Cognoms *Fes clic aquí per escriure els cognoms*

Edat _____ *anys* DNI *número DNI*

En qualitat de* *escriure familiar del/de la pacient o representant legal*

***Familiar o persona propera del/de la pacient, representant legal.**
***L'ordre de la relació per a l'autorització és el següent: pacient, cònjuge, pares, fills/es, germans/es, familiars o persones properes i tutors/ores.**

DECLARO: *que el doctor/la doctora - fes clic aquí per escriure el nom* col·legiat/ada número *fes clic aquí per escriure el número* m'ha proposat participar en l'estudi d'investigació Haga clic aquí para escribir texto. i després de rebre la informació corresponent, manifesto que:

1. He rebut el full informatiu sobre l'estudi en el que participaré i he comprès la informació continguda.
2. He estat informat/da de les implicacions derivades de la participació.
3. Sóc conscient que la meva participació és voluntaria i em puc retirar en el moment que decideixi sense haver de donar explicacions i sense que repercuteixi en la meva atenció.
4. He estat informat/a del tractament de dades de la Fundació Althaia, dels seus terminis de conservació i de la seva utilització per a recerca per part de l'investigador/a principal del projecte i que en qualsevol moment puc exercir els meus drets d'Accés, Rectificació, Supressió/Cancel·lació i Oposició en els termes i condicions establerts per la normativa vigent en matèria de Protecció de Dades (LOPD vigent, RGPD-UE 679/2016), com per exemple sol.licitar les meves dades personals, rectificar-les si fos necessari, així com revocar en qualsevol moment l'autorització d'inclusió en l'estudi. Per exercir aquests drets cal adreçar-se, personalment o per escrit, a l'Investigador/a principal o a la Unitat de Atenció a l'Usuari del centre, indicant clarament la petició, referint-se a aquest estudi i adjuntant còpia de document identificador (DNI/NIE). Adreça del Centre: Fundació Althaia c/ Dr. Joan Soler 1-3, 08243-Manresa Barcelona. . Responsable de Tractament: Fundació Althaia. En cas de disconformitat amb el tractament de les dades o amb l'exercici del drets corresponents puc adreçar-me per escrit al Delegat de Protecció de Dades de Fundació Althiaa a l'adreça indicada abans o reclamar directament davant de les Autoritats de Control (Autoritat Catalana de Protecció de Dades o la Agencia Española de Protección de Datos). Aquest document i les dades recollides en el estudi es conservaran sota la custòdia de Fundació Althaia per un període no inferior a10 anys.

He entès les explicacions que m'han facilitat en un llenguatge clar i senzill, i el/la investigador/a que m'ha atès m'ha permès realitzar totes les observacions i m'ha aclarit tots els dubtes que he plantejat.

I en tals condicions, SI ☐ NO ☐

DONO EL MEU CONSENTIMENT per participar en l'estudi d'investigació
Manresa a, a *Fes clic aquí per escriure la data*

Signatura del/de la pacient DNI	Signatura del/de la representant/tutor/a DNI	Signatura de l'investigador/a i núm. col·legiat/ada

Soy vertical

Pero preferiría ser horizontal. Yo
No soy un árbol enrizado en la tierra,
Absorbiendo minerales y amor materno
Para rebrotar esplendoroso cada mes de marzo,
Ni tampoco la belleza del arriate del jardín
Que deja boquiabierto a todo el mundo y a la que
Todo el mundo quiere pintar maravillosamente,
Ignorando que muy pronto se deshojará.
Comparados conmigo, un árbol es inmortal,
Una cabezuela, no muy alta, aunque más llamativa,
Y yo anhelo la longevidad del uno y la osadía de la otra.

Esta noche, bajo la luz infinitesimal de los astros,
Los árboles y las flores han estado esparciendo sus aromas frescos.
Yo paseo entre ellos, aunque no se percaten de mi presencia.
A veces pienso que cuando duermo
Es cuando más me parezco a ellos –
Desvanecidos ya los pensamientos.
En mí, el estar tendida es algo connatural.
Entonces el cielo y yo conversamos abiertamente.
Y seguro que seré más útil cuando al fin me tienda para siempre:
Entonces quizás los árboles me toquen por una vez,
Y las flores, finalmente, tengan tiempo para mí.

From *Crossing the water*. Sylvia Path, 1971