well ways

mental illness
fellowship victoria

Well Ways MI Recovery, a peer-led education program that fosters recovery and reduces the negative impacts of mental illness

Introduction

The Well Ways Programs

Well Ways is a suite of peer-led education programs developed and offered by the Mental Illness Fellowship Victoria. In addition to MI Recovery, the suite includes: Well Ways Building a Future, Well Ways Snapshot, and Well Ways Duo, for family and friends of people who have a mental illness.

Well Ways MI Recovery

The MI Recovery program is a peer facilitated education program for people who have a mental illness diagnosis and are interested in exploring new ways to manage illness and live a fulfilling life. The program was developed in 2006 by the Mental Illness Fellowship Victoria. Six years after the program's inception a research project was undertaken in collaboration with Latrobe University and this has yielded statistically significant findings that indicate powerful recovery outcomes for participants. To add value to this, the MI Fellowship's Consumer Participation Team undertook a qualitative evaluation to ascertain the experiential benefits of the program.

At inception, the aim was to design a peer education program that would equip participants with the necessary knowledge, confidence and capabilities to be 'in recovery', as encapsulated by the following definition (WHO,2010).

"Recovery is a process of personal growth and transformation beyond suffering and exclusion – it is an empowering process emphasizing peoples' strengths and capabilities for living full and satisfying lives...enjoying the pleasures life has to offer, pursuing personal dreams and goals..."

In the current socio-cultural context, however, achieving recovery is not an easy feat. The following social constructs faced by people with mental illness, suggest that the recovery journey is impeded by formidable barriers:

- Society's negative views lead to 'internalised stigma' (Yanos et al: 2008) and discrimination, which results in exclusion from essential resources such as housing and employment (Corrigan: 2006)
- The health services system 'disables' people with mental illness and removes a person's sense of control (Barker: 2001)
- Diagnosis often results in loss of rights, status and selfhood (Solomon: 2004)

Recovering from mental illness is about so much more than illness management and the return to pursuing personal dreams and goals; it is also about recovering belief in one's identity, and a purpose within society.

Cognizance of the social reality for many people living with mental illness strongly influenced the design of MI Recovery, ensuring inclusion of approaches that would re-equip participants with the confidence and capabilities that illness and social exclusion had diminished.

The Development and Design of MI Recovery

A consumer project worker and a researcher were employed to mutually develop the program, initially conducting a literature review of international evidence, theory and best practice pertaining to mental illness management and recovery, adult education, and consumer delivered services. This process revealed the widely accepted benefits and value of peer delivered services (Yanos et al. 2001, Solomon, 2004) and peer support (Mead & Copeland, 2000; Salzer & Shear 2002), and the lived experience of mental illness. A set of essential recovery factors and conditions were identified, these being: hope (Mead & Copeland, 2000), acceptance of illness (Deegan, 1998), symptoms management (Davidson: 2005), reconstructing identity and purpose (Frese, 1993), supportive others (Jacobson & Greenly, 2001, cited by Frese, at al 2001), choice, responsibility, control, (Chamberlin, 1997), education, (Lukens & McFarlane, 2004), valued roles/meaningful activity (Bond, 2004), and advocacy (Mead & Copeland, 2000). Following this, the consumer project worker facilitated a series of focus groups with people in recovery, to mine their experience for the gold – that is, to identify the conditions and factors that they knew to be essential enablers of their recovery. The lived experience knowledge and the international literature were brought together in dialogue, to inform the program content and delivery structure.

MI Recovery was designed to be a year-long peer led education program comprised an Engagement Phase, a Development Phase and a Consolidation Phase – with a group of between eight and twelve individuals, with various mental illnesses. The content is delivered using a facilitation style rather than teaching approach, to encourage discussion, debate and mutual support.

The session modules include the following educational components, with skill building opportunities:

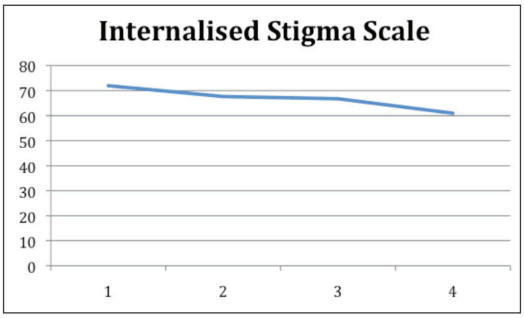
- Facts about mental illness, and models for understanding causation, symptoms and treatment
- Mental illness management using personal treatment approaches, recognising triggers and developing strategies to deal with relapse
- Reviewing selfhood, strengths and values
- Stigma, discrimination, rights and advocacy
- Recovering skills and resources for returning to work, study, etc.
- Introduction to advocacy, peer support and peer work.

For the last six years the program has undergone several developmental stages. Two pilot programs were conducted in Victoria, followed by a review of the program structure. The program was then launched in New South Wales, Queensland, Western Australia and the ACT, thanks to an injection of Commonwealth funds. This year an empirical research project, undertaken in collaboration with LaTrobe University by a Masters student in Clinical Psychology, was completed. To date, approximately 300 people have participated in the MI Recovery program nationally.

Empirical Research

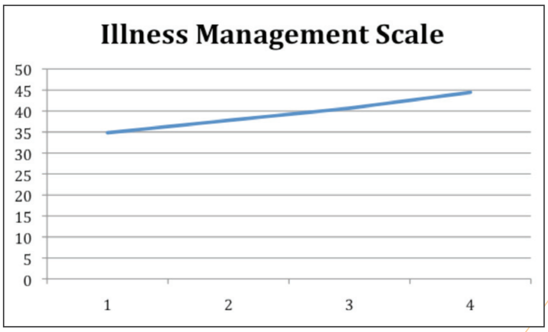
The research project sought to examine the impact of participation in a peer delivered service by exploring the psychological constructs that contribute to recovery outcomes for people living with a serious mental illness. One hundred and twenty three MI Recovery participants completed research questionnaires. These were provided on four different occasions at eight week intervals. Seven empirically validated scales were used to measure recovery: Empowerment Scale, Internalised Stigma of Mental Illness Scale, Connectedness Scale, Illness Management and Recovery Scale, Perceived Similarity to Self Scale (at 3rd time point only), Perceived Similarity to Stereotypes Scale (at 3rd time point only) and General Health Questionnaire. Participants completed the first questionnaire eight weeks prior to program commencement; this provided control data. The final questionnaire was completed eight weeks after the conclusion of the development phase, to assess if recovery dimensions had evolved during a non-contact period (Porter: 2012).

Table 1.



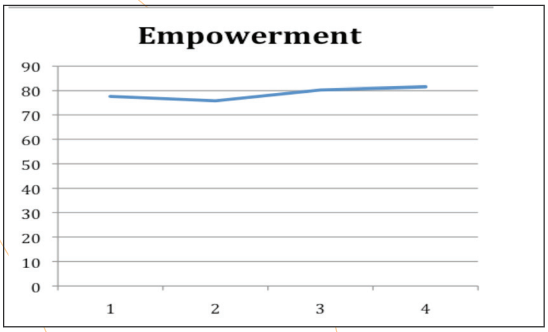
Research shows a significant reduction of internalised stigma over time, particularly from Q2 to Q3.

Table 2.



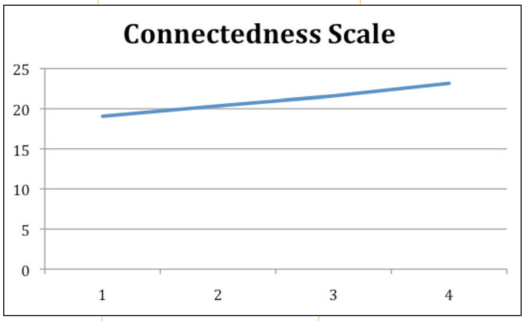
Significant improvement show from Q2 thrrough to Q4, demonstrates ongoing impacts of the program.

Table 3.



Higher scores indicate stronger endorsement of feelings of empowerment.

Table 4.



Higher scores indicate stronger endorsement of feelings of connectedness.

The results demonstrate significant outcomes for participants, from commencement of the program through to the post-contact period. These findings show major improvements in empowerment, illness management, stigma reduction and health status. Additionally, a hypothesis that improvement in empowerment would predict improved illness management, proved to be correct; "Hierarchical regressions indicated that empowerment significantly contributed as a predictor of change in illness management" (Porter: 2012). This supports Corrigan's (2006) claim that empowerment is an important factor in motivating a person to undertake recovery activities.

Qualitative Evaluation

Very few studies (Corrigan: 2006; Segal et al.,1995; Yanos et al., 2001) have evaluated the subjective experiences of participants in a peer delivered service (Holter et al., 2004). MI Fellowship decided to pursue a qualitative evaluation with the hope to build upon this evidence base, and to elucidate the empirical research findings. The aim was to gain an understanding of the subjective experience of being a participant in the MI Recovery program, and the key learnings and ongoing benefits derived from the program.

MI Fellowship's Consumer Participation Team facilitated a series of in-depth exploratory interviews, engaging two males and four females, two of whom were MI Recovery peer-facilitators and four of whom were participants. These were attendees in four different MI Recovery groups in 2011. The interview transcripts were thematically analysed and the themes were compared with the research results and the design aims of the program.

Themes and key phrases are outlined below.

Internalised stigma reduction

- "I felt like I walked around with a mental illness sign on my head, I don't have that now."
- "I've been unwell for many years and for the first time I don't feel ashamed of my illness. I don't feel that I'm less of a person."

Peer support

- "Hearing about others experiences helped me feel better about myself."
- "[facilitators] were more compassionate and empathetic towards us, because they could relate to what we're all going through."

The lived experience

- "Everyone's experience is different. It's not telling people that they 'should do' this, it's saying 'you have done this and you can do it again,' in a positive light."
- "If an experience is only learned but not lived then that downplays that respect...but if the experience is lived and learned and you've come out of it on the other side people look at you and go 'hey, you're kind of okay. I want to be like that."

Redefining identity

- "Looking at yourself as a whole person, not just this little person."
- "So the bad stuff that happened doesn't have to be a factor of who you are now."

Self esteem and confidence

- "You feel better about yourself if you make your own choices."
- "MI Recovery gave me the courage and confidence to accept it and do something about it, where before I would have stayed at home, on my own , dealing with it like 'poor me.'"

Self efficacy and empowerment

- "I'm like, 'this is what I've got, this is what I'm going to do, how to fix it or deal with it on a daily basis."
- "Having control over – instead of having everybody else tell me what I had to do for recovery. I took control back over decisions."

Information and choice

- "Education, informing myself. Before I didn't know any of it and just took everybody else's word as 'it'. Now, before making decisions and choices I research what I'm doing, or questioning before making decisions."

Citizenship/social belonging

- "I've done a complete turnaround in my life. Even just going to a restaurant or a shopping centre, I don't feel that anxiety and stress anymore. Yeah, I'm a citizen, whereas before, I didn't feel as if I was."
- ""Several people in my group were at that point where they were agoraphobic and hadn't been into society for years. It's claiming that ... 'I belong here, I have rights and I'm just as good as anyone else.'"

Illness Management

- "Tools to manage relapse"
- "Unless you take it all [what experts say] and go forward, you'll stay there. You have to do this yourself."
- "Communicating with my doctor..."

The qualitative evaluation reveals the complexity of experience derived in the peer education environment. The interview themes support and add a greater depth of understanding to the research findings. In addition, most of the themes resonate with and affirm the value of the theoretical and lived experience recovery factors and conditions that were embedded in the program design.

Citizenship/social belonging emerged as a theme that wasn't intentionally predicted by the program design. The experience of social exclusion by people with mental illness is a well researched phenomenon (as presented above). But perhaps the notion of citizenship might more broadly encapsulate the loss of not only participatory roles, but also rights, status and selfhood. An Australian government citizenship website, (http://www.citizenship.gov.au/learn/schools/citizenship.htm/) explains that citizenship is important because it "helps build our nation, unites all Australians in a shared identity". By definition, citizenship affords a nation's subjects with certain rights and responsibilities: to work, to have housing, to be recipients of democratic liberties, and to have equal opportunities and obligations as defined by law. Interviewee's comments suggest that prior to MI Recovery participation, they were aware that their identities weren't supported or valued by mainstream society. Time and again, the interviewees spoke of 'the real world' or 'out there' – this suggesting non-participation in a united or 'shared identity'.

By balancing the tension back in favour of rights, self-efficacy and valid identities, the MI Recovery peer-only environment creates a space for recovering citizenship, a space that actively fosters the reclamation of personal esteem and power, so that people with mental illness can confidently participate in society rather than feel as though they have a "second class citizen" sign looming over their heads.

Conclusion

The MI Recovery research project demonstrates that significant outcomes were achieved during and after the peer education experience, including improved sense of self and general health and better illness management. Undertaken several months following interviewees' participation in the program, the evaluation project revealed additional positive outcomes: improved sense of self and abilities, confidence to return to work and/or participate in social roles, being knowledgeable and directive about illness management, and embracing the right to be equal and to belong.

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