

## My Recovery

Peer education programs that empower people in their recovery

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### Introduction

Wellways is widely known for its peer education programs. These have been and continue to be developed by Wellways through a process of co-production, based on evidence and best practice. My Recovery is a term that represents a suite of programs designed for diverse groups of people experiencing mental health challenges. The programs are facilitated by people with lived experience, who are required to attend specialised training, and are paid for their work.

The original My Recovery program was developed in 2006, and was designed to provide support, hope, education and skills in the spirit of 'recovery'. The program has been revised four times, to reflect emerging research and best practice, and has been university evaluated. Five adapted versions of the program have more recently been designed including a brief 2-day program, a one-to-one peer worker/client adaptation, and versions targeting young people, Chinese speaking adults, and adults returning to work.

The programs are delivered by Wellways and partners throughout Australia and in Hong Kong. My Recovery has supported and empowered thousands of people in their ability to maintain personal wellbeing, and live meaningful lives within their communities.

Wellways has also produced successful evidence-based programs for carers of people with mental health issues.

### How does My Recovery conceptualise 'recovery'?

My Recovery takes a non-clinical, holistic approach to mental health recovery. The program offers a community focused approach as a complement to existing clinical

support that people might be engaged with. The program acknowledges the conceptualisation of recovery by the 'consumer survivor movement' of the 1950s, and aligns with the principle of recovery as a human rights imperative, that must derive from choice, empowerment and self-determination (Chamberlin; 1977).

William Anthony describes recovery as:

**"A deeply personal, unique process of changing one's attitudes, values, feelings, and goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with the limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life (1993).**

Recovery is recognised by the World Health Organization as:

*"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..." (2010).*

The Intentional Peer Support model demonstrates the centrality of supportive peer relationships in recovery (Mead, 2008). Peers are known to be immensely influential in assisting people to understand what's happened to them, supporting them to get out of 'stuck patterns', and allowing them to explore identity, values and purpose - in service of a recovered future (Mead, 2008). Theories of recovery and peer support underpin the design of My Recovery.

My Recovery values diversity of experience, identity, background and culture, and differing cultural perspectives about wellbeing - expecting that participants, regardless of world view, will connect as a peer group.

# My Recovery evaluation

## Program development and design

The original version of My Recovery was co-produced in 2006, by a researcher and a project worker, both with lived experience, and by people in three Victorian based peer support groups. It was informed by theory and evidence which revealed the benefits and value of peer delivered services (Yanos et al. 2001; Solomon, 2004) and peer support (Mead & Copeland, 2000; Salzer & Shear, 2002). 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, et al, 2001), choice, responsibility, control, and empowerment (Chamberlin, 1997; Deegan, 1993), education, (Lukens & McFarlane, 2004), valued roles and meaningful activity (Bond, 2004), and self-advocacy (Mead & Copeland, 2000).

Ten sessions were facilitated with three peer support groups, focussing on the conditions and factors that contributors knew to be essential enablers of their recovery. The lived experience perspectives were thematically analysed. Themes from the literature and lived experience were combined to inform the program content of 10 three-hour program sessions, as well as facilitation style and delivery structure.

## Evaluative research

In 2011-2012, a Masters of Psychology student at Swinburne University evaluated My Recovery, finding statistically significant recovery outcomes for program participants.

The research 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' (Porter, 2012). One hundred and twenty-three My 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.

The results demonstrate meaningful 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.

## Empirical research

Time-test points revealed that Time 4 (T4) scores were significantly improved compared to Time 2 (T2) scores. Illness management scores significantly increased between T2 and T4, ( $t(26) = -3.31, p < .01$ ). Participants had higher mean Empowerment scores at T4 follow up compared to T2 ( $t(26) = -3.48, p < .01$ ). Internalised Stigma scores significantly decreased between T2 and T4 ( $t(26) = 4.64, p < .01$ ). Participants had higher mean Connectedness scores at T4 follow up compared to T2 ( $t(26) = -3.20, p < .01$ ).

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 research

In 2011 Wellways invited former My Recovery participants and facilitators to contribute to our understanding of subjective experiences of participating in the program. We also sought to gain further insight into the key learnings for individuals, and ongoing benefits derived from the program. At that time very few studies had evaluated such experiences (Corrigan, 2006; Holter et al., 2004; Segal et al, 1995; Yanos et al, 2001). Two peer facilitators and four recent program participants were interviewed. Interview transcripts were thematically analysed.

### Themes and key phrases

#### 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.'

#### 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.'

'My 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/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 revealed the complexity of experience derived in the peer education environment. Interview themes support and add a greater depth of understanding to the Swinburne research. 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.

## Program revisions and additional versions

Since 2006, several revised editions and new versions of the program were developed. These required inclusions of more recent evidence and thus included new information about outcomes of peer support, and approaches to challenging stigma and discrimination. Trauma informed practise, theories and evidence for community inclusion, the CHIME model, and target group specific research and practice principles have also become embedded in program design.

### Peer support

More recent research has found peer services are generally just as effective as services provided by non-peer professionals (Chinman, 2014). To date, multiple studies have found that peer support increases hope, empowerment, self-efficacy, social skills, quality of and satisfaction with life, and activation for self-care (Davidson et. al., 2018). Intentional Peer Support has an international reputation for effectiveness (<https://www.intentionalpeersupport.org/>).

### Empowerment against stigma and discrimination

Stigma and discrimination remain as significant obstacles to recovery, preventing people from being understood and valued, from accessing necessary resources and public facilities, and fully participating in society. Internalised stigma leads reduced self-esteem, self-exclusion and isolation. Knowledge about human rights, and new skills can assist people in feeling empowered to stand up to stigma and discrimination and to access the resources needed for recovery (Corrigan, 2015; Michaels et. al., 2012).

### CHIME

In 2014, British researchers undertook a systematic review of the literature on personal recovery. From this they developed a conceptual framework for recovery (Leamy et. al). The findings included an understanding of the key processes of recovery, which are Connectedness, Hope, Identity, Meaning and Empowerment (CHIME).

### Community inclusion and belonging

Community inclusion in multiple domains of mainstream life is essential to recovery and people entering and returning to mainstream roles such as family and community roles, as well as working, studying, training and volunteering (Salzer and Baron, 2016).

### Trauma informed practice

Multiple studies indicate that childhood trauma, including family violence, childhood physical and sexual abuse, and experiences of extreme events such as war or serious illness put people at the highest risk of developing mental health conditions (Kendler, et al, 2000; Najman, Nguyen, & Boyle, 2007; Shevlin, et al, 2010; Moore, Gaskin & Indig, 2012). Recovery focussed programs have a duty to train practitioners in trauma awareness and trauma sensitive practices.

## Conclusion

My Recovery is currently delivered nationally by Wellways staff and external partners, including a partner in Hong Kong.

## References

Chinman, M. et. al. (2014) Peer Support Services for Individuals with Serious Mental Illnesses: Assessing the Evidence. *Psychiatric Services*, 64(4).

Commonwealth of Australia. (2010) *Working Together: Mental Health and Wellbeing Principles and Practice*. Ed: Purdie, N., Dudgeon, P., & Walker. [https://research.acer.edu.au/indigenous\\_education/24/](https://research.acer.edu.au/indigenous_education/24/)

Chamberlin, J., 1997, A Working Definition of Empowerment. *Psychiatric Rehabilitation Journal* 20(4), 43-46.

Corrigan, P.W., 2006, Impact of consumer-operated services on empowerment and recovery of people with psychiatric disabilities. *Psychiatric Services* 57(10), 1493-1496.

Corrigan, P., (2015). What is the impact of self-stigma? Loss of self-respect and the "why try" effect, *Journal of Mental Health*. Vol. 25(1).

Corrigan, P., Penn, D. (2015) Lessons from Social Psychology on Discrediting Psychiatric Stigma. *Stigma and Health*. 1(5), 2-17.

Davidson, L. et. al. (2018). Revisiting the Rationale and Evidence for Peer Support, *Psychiatric Times*, Vol 35(6).

Davidson, L., 2005, Recovery, self-management and expert patient – changing the culture of mental health from a UK perspective. *Journal of Mental Health*, 14(1), 25-35.

Deegan, P., 1998, Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*, 11(4), 11-19.

Dye, H. (2018). The impact and long-term effects of childhood trauma. *Journal of Human Behavior in the Social Environment*. 28(11), 1-12.

Holter, M.C., Mowbray, C.T., Bellamy, C.D., MacFarlane, P. & Dukarski, J. (2004). Critical Ingredients of consumer run services: Results of a national survey. *Community Mental Health Journal* 40(1), 47-63.

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual Framework for Personal Recovery in Mental Health: Systematic Review and Narrative Synthesis. *The British Journal Of Psychiatry*, 199(6), 445-452. <http://dx.doi.org/10.1192/bjpp.bp.110.083733>

Michaels, P. et. al. (2012). Constructs and Concepts Comprising the Stigma of Mental Illness. *Psychology, Society and Education*. Vol. 4(2).

Mead, S. (2008) Intentional Peer Support: An alternative approach.

Mead, S. & Copeland, M.E., 2000, What Recovery Means To Us: Consumer perspectives. *Community Mental Health Journal*, 36(3), 315-328.

Peers For Progress, available at <http://peersforprogress.org/learn-about-peer-support/science-behind-peer-support/>. Retrieved on 3/01/2019.

Porter, C., (2011). 'Psychosocial Models of Recovery from Mental Illness in a Consumer Delivered Service'. Masters of Psychology thesis. La Trobe University.

Salzer, M.S. & Baron, R.C. (2016). *Well Together – A blueprint for community inclusion: fundamental concepts, theoretical frameworks and evidence*. Published by Wellways Australia Limited, Melbourne, Australia.

"Salzer, M.S. & Shear, S., 2002, Identifying consumer-provided benefits in evaluations of consumer-delivered services. *Psychiatric Rehabilitation Journal*, 25(3), 281-288.

Segal, S.P., Silverman, C. & Temkin, T., 1995, Measuring empowerment in client-run self-help agencies. *Community Mental Health Journal*, 31(3), 215-227.

Shevlin, M., Murphy, J., Read, J., Mallett, J., Adamson, G., & Houston, J. (2010). Childhood Adversity and Hallucinations: A Community-based Study using the National Comorbidity Survey Replication. *Social Psychiatry and Psychiatric Epidemiology*, 46(12), 1203-1210. <http://dx.doi.org/10.1007/s00127-010-0296-x>

Solomon, P. (2004). Peer Support/Peer Provided Services Underlying Processes, Benefits, and Critical Ingredients. *Psychiatric Rehabilitation Journal*, 27(4), 392-401. <http://dx.doi.org/10.2975/27.2004.392.401>

Turner, G., & Shepherd, J., (1999). A method in search of a theory: peer education and health promotion. *Health Education Research*. 14(2), 235-47.

Yanos, P.T., Primavera, L.H. & Knight, E.L., 2001, Consumerrun service participation, recovery of social functioning and the mediating role of psychological factors. *Psychiatric Services*, 52(4), 493-500.

World Health Organization, 2010, *Community-Based Rehabilitation CBR Guidelines*. <[http://whqlibdoc.who.int/publications/2010/9789241548052\\_supplement\\_eng.pdf](http://whqlibdoc.who.int/publications/2010/9789241548052_supplement_eng.pdf)>"

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