

Evaluation of the Mental Health Recovery and WRAP Education Programme

Executive summary to the Irish Mental Health & Recovery Education Consortium



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*For the
Irish Mental Health and Recovery Education Consortium*

Executive Summary

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Executive Summary

Background

Mental health policy in Ireland has emphasized the need for a Recovery orientation to inform all aspects of the design, development and delivery of mental health services and for the education of all staff working in these services. A Recovery-focused approach to care is one of the standards identified in the *Quality Framework for Mental Health Services in Ireland* (Mental Health Commission, 2007). The provision of high quality education in the philosophy and principles of Recovery that is relevant, accessible and evidence based is thought crucial if the vision for Recovery-oriented mental health services in Ireland is to be realized. To this end, a group of mental health service providers, called The Irish Mental Health & Recovery Education Consortium (IMHREC), came together to develop and deliver a facilitated learning programme on Mental Health Recovery, throughout the Republic of Ireland. The consortium represented stakeholders—families, carers, people with experience of using mental health services and practitioners—and comprised Eastern Vocational Enterprises (EVE), Support, Training, Education, Employment and Research Ireland (S.T.E.E.R), Sli Eile Housing Association, Mayo Mental Health Association and Ballyhoura Development. The education programme was funded by the Department of Justice, Equality and Law Reform under the Enhancing Disability Services Programme.

The education initiative involved a two-day education programme which sought to educate individuals about Recovery and WRAP (Wellness Recovery Action Planning) principles and teach participants strategies to promote mental health recovery. This was followed by a five-day education initiative for a smaller cohort of participants which was aimed at providing its participants with a greater depth of knowledge on recovery and WRAP in addition to the facilitation skills necessary to deliver the two-day WRAP recovery programmes within their own communities. Participants who had attended the two-day programmes were eligible to apply for a place on the five-day programme.

Aim of the evaluation

An independent evaluation of the education programme was commissioned, with the aim of evaluating the impact of the education programme on participants' knowledge, attitude and skills in mental health recovery.

Methods

The evaluation employed a multi-method approach using quantitative and qualitative approaches. Data on the impact of the programme were collected using pre and post programme questionnaires. Of the 197 people who attended the 2-day programme all

completed the pre course questionnaires and 195 people completed the post course questionnaires. Of the 68 participants who completed the 5-day programme, 67 completed the pre course questionnaire, and 62 completed the post course questionnaire. Overall, the highest number of participants came from the practitioner group, followed by people with self experience and family members/carers. Participants from the family member/carer group were the least well represented group on the 2-day and 5-day programmes. More than 25% of the participants on both the 2-day and 5-day programmes described themselves in more than one category. Participants from all age categories were represented, however the groups categorised as younger than 30, and over 60, were the least represented. Approximately two thirds of the participants at the 2-day (F= 126, M = 68) and 5-day (F= 38, M = 20) education programme were female.

In addition, focus group interviews were held with participants who completed the education programme. In total, 33 participants were involved in the focus group interviews. A total of 11 people who attended the two-day programme and 22 people who attended the 5-day programme were interviewed. One focus group was also held with consortium members and telephone interviews were conducted with the 3 education facilitators of the programme.

Findings from the questionnaires

The programme increased participants' knowledge of, and improved their attitudes towards, Recovery and WRAP. However, the increase in knowledge and attitudes was not statistically significant for the 5-day participants. Comparison of reported teaching and facilitation skill levels before and after the 5-day programme also showed statistically significant increases in participants' perceptions of their ability to teach and facilitate the principles underpinning Recovery and WRAP. Participants reported they had become most skilled at facilitating Wellness Recovery Action Planning, Peer Support, Self Advocacy/Self Agency and Crisis/Post Crisis Planning. Participants were highly satisfied with the content and delivery of the programme. An overwhelming majority of participants agreed or strongly agreed that they would recommend the programme to others. The age and gender of participants, and their identification as a mental health professional or someone with self-experience of mental health problems, had little impact on participants' experiences of the programme.

Findings from the focus groups

Overall, participants spoke very positively and were enthusiastic about the benefits they had achieved personally, professionally and within their broader social circle as a result of their participation in the programme. Many described their experience as inspiring, invigorating, life changing and empowering. Attending the programme exposed participants to new ways of thinking about recovery and they left the programme with a great sense of optimism about the concepts underpinning recovery

and WRAP and with clear messages of hope and personal validation. The emphasis within the programme on wellness, positive mental health and recovery were viewed as a positive move away from the dominant medical and illness paradigms. The focus on self help, self management, and taking responsibility and control was perceived by the participants to be empowering, refreshing and positive. Learning about Recovery and WRAP challenged the assumption that those with self experience of mental distress are passive recipients of mental health care. It also helped the participants to think differently about themselves and view mental distress as a normal reaction to life's challenges. Participants described how the programme shifted their mindsets and enabled them to open up a different dialogue with themselves and others, around recovery and wellness. For participants who came from a practitioner background the programme also began a process of deep questioning around the values and knowledge base which underpin their practice. One of the most valuable aspects of the programmes appeared to be the mix of people with self experience, family members/carers and practitioners. Participants attributed many of the positive outcomes to the level of interaction, engagement and personal disclosure that was fostered throughout the days. Through the facilitative process of sharing and listening to each others' experiences, participants were enabled to learn from and support each other. Many commented that the process of shared education helped to equalise relationships, normalise mental distress, and communicated a strong message of partnership. This model of education was seen as essential to all future education endeavours on recovery.

Participants reported that a major challenge to developing a recovery oriented service was overcoming the traditional biomedical approach, and shifting the philosophy of care from the present preoccupation with *illness* to one of *wellness*. They expressed concern that current practices might be re-labelled and repackaged as recovery without any fundamental change in philosophy and approach to care. Tied to these concerns were the lack of a national strategy for implementing a recovery oriented service, the uncertainty of IMHREC's future (IHMREC was perceived as the driver behind the implementation of recovery and WRAP), and the perceived lack of support from medical practitioners. Some participants expressed concern that people with self experience could be exposed to an extra burden if they were continually expected to share their experiences as a means of educating others.

Most of the participants were keen to be involved in either implementing Recovery and WRAP principles into their own practice or educating others about it. For many participants, the core principles associated with recovery and WRAP were more important than the actual action plan itself. Many offered suggestions on how recovery and WRAP could be implemented and sustained. Examples of these included having an apprenticeship model of facilitation, developing a support network for facilitators, and extending education outside traditional health services.

Conclusions

Providing mental health practitioners and people with self-experience of mental health problems with a systematic education and training in recovery principles using the Wellness Recovery Action Planning approach leads to positive changes in people's knowledge, skills and attitudes towards recovery principles, and their ability to teach and facilitate these changes in others. This education also inspires, invigorates and empowers people, and for many, it is a life changing experience. Mental Health Service Providers and Educators seeking to embed recovery principles into service delivery and education are more likely to do so if they adopt the principles and methods employed in the Recovery and WRAP education programme used in this study.

Recommendations

In light of the findings from this study, the researchers make 14 recommendations:

1. A national mental health recovery network for Ireland is developed. Consideration be given to developing the consortium that formed IMHREC as the network.
2. A national strategy for mental health recovery education be developed, with due consideration of the need to have a wider public focus and expand recovery education outside traditional mental health care environments into general health settings and the wider community, including schools and community networks.
3. Funding is made available to implement a mental health Recovery education programme for all mental health practitioners in Ireland that is inclusive of family members/carers and people with self experience.
4. An identified person/group with autonomy and authority to produce recovery education programmes is appointed.
5. The Mental Health Commission develops a national mental health recovery collaborative to put recovery at the heart of all mental health provision through Local Recovery Implementation Groups.
6. Educational accrediting bodies ensure the inclusion of recovery principles, values and practices is central to undergraduate and postgraduate education curricula that prepare mental health practitioners to work in mental health services in Ireland.
7. Funding be made available for evaluating initiatives developed to promote recovery in people living with mental health problems.

8. The network of recovery facilitators developed as a result of this programme be supported to facilitate the development of locally organised recovery education programmes.
9. Consideration be given to the development of a mentorship programme for facilitators.
10. Those who completed the 2-day programme but did not have access to the five-day facilitation be offered, as a priority, the opportunity to complete the five-day programme.
11. Similar programmes be developed and offered in areas of the country not catered for by the IMHREC project.
12. Future programmes need to address the concerns expressed by participants regarding content, facilitation and issues such as duration and room layout and recruitment of family members/carers and medical practitioners.
13. A follow-up study of participants be undertaken to examine whether the changes reported in this study were maintained over time, and to examine how participants who completed the programme used their knowledge and skills to support their own or others' mental health. It would also be important to explore what proportion of participants actually formulated a WRAP plan either for themselves or for someone else and facilitated a formal education programme. In addition, a study is required to evaluate the outcomes of education programmes delivered by the facilitators prepared through the IMHREC process.
14. Further evaluation studies are conducted using experimental approaches. In addition, international researchers with an interest in Recovery and WRAP education agree on core outcome measurement tools so that direct comparisons between future Recovery and WRAP education evaluations can be made.