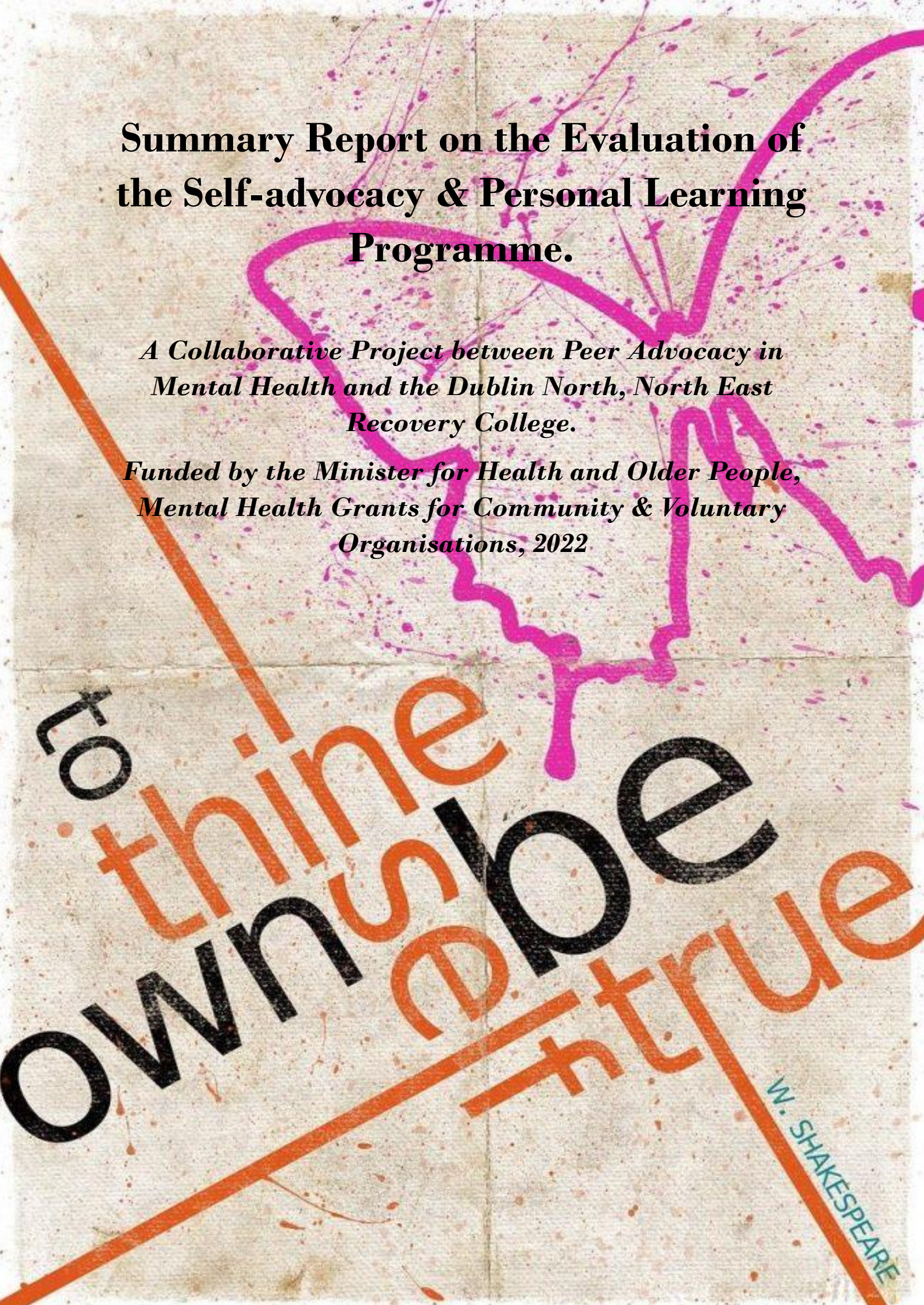
Summary Report on the Evaluation of the Self-advocacy & Personal Learning Programme.

A Collaborative Project between Peer Advocacy in Mental Health and the Dublin North, North East Recovery College.

Funded by the Minister for Health and Older People, Mental Health Grants for Community & Voluntary Organisations, 2022



Student Quotes

The Programme

"Ground making model"
"Wide variety of media with fun sessions that also helped balance the serious issues very importance, those fun sessions"
"I have a broader view of advocacy".
"Has increased my self-confidence and my opinion of myself".

Peerness and Camaraderie

"Freedom of ease to talk about where we are ourselves";
"Great unity in the room"
"Safe space"

Motivate to act – practical impact

"Honouring your right to speak up instead of staying silent. If everyone stays silent nothing changes"
"I learned how to self-advocate and become more assertive in speaking up about my mental health difficulties"
"…learned a lot of how to express myself and aids to help myself"
"I am now able to help other people about self-advocacy also"
"Now I am aware of the supports that are out there. I know that I am not alone. This gives me hope in my mental health journey"
"Have become self-aware, not only of my rights and responsibilities but also other people's."

Introduction

Peer Advocacy in Mental Health is an island-wide, independent, mental health organisation led by people with personal experience of mental health challenges. Our services promote recovery by offering peer advocacy, information and support to clients. Ultimately, we support and encourage people experiencing challenges to their mental health to self-advocate. In other words, supporting them in having their voice heard: **To speak up, speak out and take back control of their own lives!**

In line with the above undertaking Peer Advocacy in Mental Health (PAMH) delivers peer-to-peer learning programmes with a particular focus on Self-advocacy and Personal Development (SPD). The programme helps people experiencing challenges to their mental health grow in confidence and assert their human and civil rights.

The SPD learning programme comprising of 8 sessions, has been regularly modified in response to ongoing evaluation. Even though feedback has been consistently positive, PAMH has never utilised the combined knowledge and self-experience of mental health, mental health providers and family members/carers facilitated through the principles and methodology of co-production to improve the content and delivery of the SPD programme.

With this in mind, PAMH was successful in a submission to the Mental Health Grants for Community & Voluntary Agencies 2022 to include the refinement of the long-established SPD programme in collaboration with Dublin North, North East Recovery College (DNNE). The DNNE Recovery College through its networks, depth of experience and expertise enabled PAMH to enhance the SPD programme through co-production. The DNNE Recovery College administration hub is based at Dublin City University and their approach centers on "the principle of co-production, meaning people with personal experience, including people overcoming distress and supporters (family members and friends) work in respectful partnerships with professionals to co-design, co-deliver and co-evaluate all aspects of the college." (https://recoverycollege.ie/about-us/our-story/). The process engaged and findings from evaluation in accordance with co-production methodology is described below.

A Phased Approach

The SPD project included a number of pivotal phases involving action points and associated timelines to achieve successful completion of the project. Below is a brief description of each phase highlighting processes of co-production

Phases of the Project

To begin, the establishment of a Steering Group made up of Experts by Experience, carer/family member and provider of services from the DNNE Recovery College was necessary. The steering group provided guidance and advice on implementing the various phases below:

1. Review the content and delivery of the most recent SPD learning programme.
2. Design methodology to measure outcomes and agree specific timelines to complete the various phases of the project, including arrangements for co-facilitators, recruitment into the trial group (phase 2) and areas to deliver the SPD programme in community settings, phase 3.

3. Review feedback from phase 2 and revise/develop the learning programme accordingly to roll out in Phase 3.
4. Develop a recruitment strategy and identify areas in the community where the three SPD programmes of learning will be delivered as part of phase 3. Agree co-facilitators for each group.
5. Feedback from 3x SPD learning groups to be reviewed, Phase 3, with feedback from co-facilitators on their experience delivering the programme noted. Writing up of a report with findings and recommendations agreed and prepared as a draft of same.
6. A review of the draft report on the project and agreement how this might be circulated/disseminated/launched

Summary Findings

Focus group questions (Phase 2) and the paper evaluation used for the three community groups, Phase 4 was co-designed with the steering group. Questions that participants were invited to respond to in relation to their experience of the SPD learning programme were centred on: Content, Practicality and Peer to Peer hierarchy. Findings are presented below. A total of 21 (68%) out of a potential 31 participants from the 4 SPD groups provided feedback through the evaluations.

Findings, Phase 2 and Phase 4

Participants of the trial group and the three community groups were overwhelmingly complimentary toward the content of the programme stating that it was particularly relevant, appropriate and that it wasn't "mentally draining". There was a consensus that there was "nothing to add to the topics" covered throughout the programme with the various methods of engagement including videos, tasks in pairs and small groups, larger group discussions all complimented by notes disseminated following each session. Time spent at the beginning of each session summarising the previous was helpful for recall and to understand how one session logically follows and compliments the next which participants could easily follow.

There was a sense that there was a wealth of information and that "each week could have been a course" in itself. Significant to the programme was the emphasis on communication and rights. There was a request for additional time to be spent on these topics.

Practicality

Overall, participants found the SPD programme to be well organised, interactive, fun, enjoyable with an appropriate mix of "light aspects" to each session alongside meaningfulness, informative and "empowering" methods of facilitation. Materials were pronounced as "good" with the programme described as a "ground making model". Methods of facilitation and learning that included physical movement were noted.

Participants believed the programme required a fixed number of 8 sessions and that the number of participants should be capped to best ensure full and equal participation from everyone. Splitting into smaller groups and into pairs for meaningful discussions, around sometimes sensitive subjects, was appreciated.

Several comments on the real impact of the SPD programme referred to continued efforts toward acts of self-advocacy; recognition that self-improvement/personal development is a requirement to self-advocate. For example: "Need to work on assertiveness and see the bigger picture on things". Mainly, comments involved practical consequences for participants, in the here and now and into the future: "Relevant for me when communicating with doctors/medical support. Also, can be useful for me in communicating with my family, though I may need further support with that" and "In treatment at the moment. I am having to advocate for services of unmet needs and also in daily life with my family so very relevant". Several comments referred to a 'natural' connection between self-advocacy, self-care and recovery.

Peer to Peer Hierarchy

By far the greatest number of comments particularly provided by focus group participants centred on the sense of 'peerness' during sessions where a lack of hierarchy between co-facilitators and participants was experienced. This was reflected in descriptions provided which included levels of support experienced (one-to-one and collectively), honesty, authenticity, 'honourableness' and respect serving to affirm and validate the lived experience of mental health problems as a rich source of knowledge. Participants appreciated the intimate space for sharing experiences in a non-judgemental learning environment of trust and openness. "Being equal", a sense of belonging and camaraderie was expressed, for example: "freedom of ease to talk about where we are ourselves"; "We are many people together and not alone", "Great unity in the room" and "sharing struggles". There was a direct link made between the sense of collectiveness, camaraderie and recovery with sessions described as part of a "path to recovery" associated with practical, lived benefits of the SPD programme.

General

General findings from the evaluations suggested activation and motivation toward addressing challenges in personal life through self-advocacy. To self-advocate was described in terms of: "Honouring your right to speak up instead of staying silent. If everyone stays silent nothing changes" This was also described as opening "up pathways never thought about", "gets you thinking about what's out there" and "The change began for me realising so many campaigns out there". One participant was a bit more hesitant stating I: "haven't used myself so far" (course content). Facilitators were described as approachable - "worked

well with us" and attentive. Findings highlighted positive shifts in participant's acquisition of knowledge, skills and confidence, pre and post SPD programme.

Recommendations

Given the overall positive response to the SPD learning programme, there are only a small number of recommendations with regards changes to be made going forward - below.

1. The SPD programme should be delivered over 8 sessions.
2. Six to eight is the preferred number of participants for each SPD programme.
3. More information about peer advocacy (not self) should be included.
4. The SPD programme should be delivered through co-production with potential to work with local Recovery Colleges throughout the South of Ireland, similar to the collaboration between PAMH and DNNE Recovery College viz a viz, this project.
5. Training to prepare peer collaborators must be further considered and planned well in advance of delivering the SPD programme across Ireland.
6. The peer collaborator training should include the enhancement of 'soft skills'.
7. In addition to the soft skills specifically suggested by members of the steering group, incorporation of 'inner child' trauma during a session would be useful to help participant's realize other blockages to progressing recovery and activating self-advocacy in their lives.

Conclusion

The overwhelming consensus was that the SPD learning programme was appreciated, well received and advantageous for participants. Feedback from all four groups revealed that the SPD learning programme provided a space where recognition, validation and endorsement of self-experience of mental health challenges can be harnessed in a shared mutual learning environment. The content of the SPD learning programme enabled this environment to develop as did the non-hierarchical 'peerness' experienced through co-production, methods of facilitation, wealth of knowledge exchanged involving a 'relaxed', informed space. The learning experience provided a level of meaningful and potentially transformative undertakings for participants.

In addition, the SPD programme addresses the needs and recommendations as set out in Irish national policy, namely; *Sharing the Vision: A Mental Health Policy for Everyone* and *Connecting for Life* and has wider implications related to internationally recognised standards, models of recovery and general direction in mental health policy. For instance, CHIME, a widely recognised model of recovery in mental health and one that is found in Health Service Executive documents (e.g. the *National Framework for Recovery, 2017)*. The SPD programme supports, facilitates and enables tenets found in CHIME as presented in the Table below.

Tenets of CHIME, supported facilitated and enabled through the SPD learning programme

Tenets of CHIME	Corresponding outcomes of the SPD programme
Connectedness	Between peers; realizing, confirming, utilising, social networks
Hope and Optimism	Establishing self-belief that I can influence others to benefit my mental health, assert my rights and express my needs
Identity	Where I can gain a sense of who I am and reclaim my place in the world
Meaning	Where I can construct my narrative in terms of social justice, not personal failings
Empowerment	Self-mastery through the acquisition of self-advocacy skills and motivation to act

Further, a rights-based approach to mental health has been recognised by the World Health Organisation as significant in peer-to-peer support and peer-to-peer environments (https://www.who.int/publications/i/item/9789240025783). This is facilitated, practiced and supported throughout the SPD programme. By way of example, principles of the rights-based approach facilitated in the SPD programme include:

1. Encouraging and prompting *Participation*, influencing one's own health decisions is encouraged through assertive acts;
2. *Equality* is engaged and demonstrated through a non-hierarchical relationship between peers (we are equal);
3. *Dignity* of the person is upheld by respecting and validating each participant's truth and identity by listening and paying attention to the narrative and 'normalising' the self-experience through shared experiences;
4. The enhancement of *Social inclusion* is also enabled through peer-peer connection and encouraging the person to assert themselves and take up opportunities in their local community.

We believe that current emphasises on wellness (recovery) programmes fail to acknowledge the significance of challenging environments and social relations that directly impact on the ability of people to regain or reclaim their rightful place in their community and society at large. Actions toward equality, dignity and respect through social justice, participation, assertiveness, choice in care and treatment facilitated and offered to persons who find their mental health challenged should be factored in the recovery equation where assertive acts to reclamation of social status is enacted.

A full report of this Executive summary can be found using the following link:

https://www.peeradvocacyinmentalhealth.com/reports

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May we continue to learn through sharing and connecting.

Peer Advocacy in Mental Health.

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