MENTAL ILLNESS
FELLOWSHIP
of Australia Inc

mental illness
fellowship victoria

Peer-Led Consumer Education Program
miRecoveryJourney

Literature Review

Cassy Nunan
Consumer Education Program
Project Coordinator
Research and Development Unit
MI Fellowship Victoria
2006

Part 1: Evidence base for the program

Recovery and Peer Provider Theories

Recovery

Up until the late 20th century, people living with serious mental illness were condemned by western society and modern medicine to a life of chronic illness and incarceration. Only in the1970s was the notion of permanent disability reconsidered, and the concept of recovery initiated. During the 1970s the consumer survivor movement galvanized, establishing a unified voice for people with mental illness, and disseminated a discourse about lived experiences of recovery. Simultaneously, a number of longitudinal studies in various countries researched the life long illness trajectory of people with schizophrenia, revealing that up to two-thirds of people suffering from a serious mental illness did achieve significant improvement or recovery (Harding: 2003, 21). The coalescence of these zeitgeist activities propelled the widespread conceptual and programmatic development of the 'Recovery Paradigm'.

Definitions for recovery abound. For Lehman, it is founded on the belief that people with mental illness can move into wellness and enjoy quality of life despite the multifaceted challenges of psychiatric disability (Lehman, 2000). Recovery is defined by Anthony (1993) 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…(p. 15)

Seminal practice research conducted by Patricia Deegan in the 1990s lead to the establishment of core practice principles of recovery (1995) that guide psychiatric rehabilitation workers in how to best support people with mental illness. These have been broadly adopted internationally, and inspired further theorizing about the essential dimensions that enable recovery.

Frese, Stanley, Kress, & Vogel-Scibilia, (2001) provide an expanded review of the activities and attitudes that assist recovery, citing the body of theory and evidence that purports the importance of these. In brief these are:

> ➢ **Hope:** There must be a vision of hope that recognizes that people with psychiatric symptoms can and do in fact get well (Mead & Copeland, 2000). Rather than feeling condemned to a life of illness, people with mental illness need to feel optimistic about the future, with assistance, support, and encouragement from those around them (Ralph, 2000). Even the smallest

C:\Users\iedeson\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\6Q2I2MBC\Literature Review MI Recovery.docx

1

belief that one can heal, as others have, can fuel the recovery process. Early in the recovery process, it is important for a treatment provider, friend or family member to carry hope for the unwell person. Ultimately, the individual must develop and internalize their own sense of hope.

➢ **Acceptance of Illness:** Accepting the illness as a part of one's life is necessary to recovery. This is not about accepting the identity of a 'mental patient'. Rather as Patricia Deegan says, "in accepting what we cannot do or be, we begin to discover who we can be and what we can do" (Deegan: 1998).

➢ **Managing Symptoms:** The management of symptoms is an essential but often arduous experience. It may require a trial and error process with medications and therapies, and may require endurance over a period of time. Part of this process is the monitoring and 'self-management' of triggers and stressors. A productive and mutually respectful relationship with treating professionals is essential. With symptom management comes clarity, stability and the opportunity to reflect (Deegan, G,: 2003, p 373, Davidson: 2005, Frese, et al: 2001).

➢ **Re-constructing Identity and Purpose:** Experience of a mental illness can dissolve a person's sense of themselves and their place in the world. The cognitive impacts of mental illness can erode social skills and self-esteem. Opportunities to redefine identity and life goals, and to practice and relearn skills is a necessary part of recovery, as is acceptance of the illness. Interacting with peers can provide a safe and empathic environment for this process (Frese:1993).

> *Damien: "I had to make great changes between who I thought I was and who I actually was (and who I had become through the illness). This has been hard stuff. Wellness for me comes when I can accept the bald truth of who I am – what I do for a living, where I live, how many friends I have. Sanity is about being squarely rooted in reality!"* (Russell: 2005, p 78)

➢ **Supportive Others:** "Recovery is not a solitary process, it's a social process" (Jacobson and Greenley: 2001, cited by Frese, et al 2001). The variability of illness stages for different people means that the role of supportive others also varies. During times of acute illness others, being family, friends, medical professionals, can provide hope and containment. During the well times, encouragement and recognition enables an awareness of a person's successes. "People in recovery speak of the importance of having a person in recovery as a mentor or role model as they go through their journey". Also, supportive others help people sustain lasting connections to their communities. (Frese, et al: 2001)

C:\Users\iedeson\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\6Q2I2MBC\Literature Review MI Recovery.docx

2

- ➤ **Choice, Responsibility, Control**: Recovery is dependent on people with mental illness, themselves, taking responsibility for their change process, and becoming empowered (Mead & Copeland, 2000; Chamberlin, 1997). It is argued that overdependence can in fact prevent recovery, (Frese, Stanley, Kress, & Vogel-Scibilia, 2001). With recovery the locus of control is internal, as reflected in the following comments: "To me recovery means I try to stay in the driver's seat of my life. I don't let my illness run me" (Deegan, P: 1993, p.10).

- ➤ **Education**: There is evidence that knowledge enhances health outcomes (Lukens & McFarlane, 2004). Accessing knowledge and information about the aetiology, symptoms and treatment options for mental illness is an important aspect of recovery (Chamberlin: 1997). When the range of available knowledge is broad and accessible people with mental illness can be empowered to discover what best works for them in managing illness (Mead & Copeland, 2000). The provision of education needs to be empowering, rather than coercive (Paulson et al., 1999) and expansive rather than reductive, so that the consumer can appraise all available evidence then make decisions that best meet his or her individual needs (Lehman, 2000).

    > *Alan was mis-diagnosed for ten years. He is now vigilant about reading everything he can about his illness. He says that flyers are often similar in content and can over-generalise and be patronizing (Russell: 41). His experience in hospital was that nurses pushed him to take his medication, but did not mention that there were additional ways that would help him get well. His reading his told him that 69% of people with bi-polar disorder are initially mis-diagnosed! He warns that information should be read 'critically' as there is a lot of poor research being published. "My psychiatrist tells me that I am better informed than him about the current medical literature on manic depression" (Russell:44)*

- ➤ **Meaningful activity/Employment:** Continuing to work, with support, or returning to employment or meaningful activity (study, volunteering) early in the recovery period, leads to improved symptom control, better self esteem, and ensures faster recovery (Bond: 2004).

- ➤ **Advocacy**: Advocacy for self and others with mental illness can create an empowering 'voice', particularly when the impact of illness may have resulted in reduced self-esteem and self-worth (Mead & Copeland, 2000). Advocates can play a critical role in modelling hope to others, and in reconstructing the social meaning of mental illness. The unity of advocacy movements can influence changes in society's views of mental illness and can lead to improvements in the mental health system (Mead & Copeland, 2000).

Cautionary use of the Recovery paradigm

In a workshop presented at the TheMHS conference in 2004 Margaret Springgay provides a salient reminder that the term recovery won't sit comfortably with, or provide promise for people are severely disabled by their illness and who have multiple readmissions, co-morbidity issues, little insight and low responsiveness to medication treatment. For these people, the essential ingredients of recovery: hope, willingness and responsible action may not be achievable. Springgay asks "What are the implications for the adoption of recovery [model] for this group of severely disabled people? One of course is to adopt techniques that are available to help those with little or no insight. Another is to use a recovery oriented language with people" (2003: p. 2)

Stages of Recovery

> Andrew: *"When I was diagnosed I was outraged. 'I am not depressed' I told my doctor, 'I am just very stressed.' In a way I self-imposed stigma because I was so horrified at the thought of having an emotional imbalance. I was very, very defensive and angry. I now realize in hindsight that I was very ill indeed."* (Prendergast: 2006: p18)

> Rosemary: *"I have learnt through my own experience and through observing several other people with this illness, that the first crucial step to wellness is acceptance of the disorder…acceptance will lead you on the road of recovery…* (Russell: 37).

The Mental Health Education Resource Centre of Manitoba (MHERC) provides this following overview of the stages of recovery that most people experience. It is useful to recognize these, as part of a non-linear process of change. Knowledge of these stages can assist people in accepting the stages that they might be experiencing, and foster hope that continuing change towards healing is possible.

Shock – The experience is often confusing and disorganizing. The implications of the illness are devastating to our life, hopes, and dreams. They are too much to grasp.

Denial – It is often the first response to the onset of mental illness. Denial serves to cushion the shock of the illness. Another type of denial that is often more deliberate is the denial that comes from fear of stigma-fear of the responses of friends, society, or the helping system. This can lead to keeping the experience to themselves as a way of coping.

Depression/Despair/Grieving – Depression is a common reaction to the experience of mental illness and often leads to despair. If there is support in the despair phase by other consumers, friends, and professionals; the door to the grieving process, to the healing of the loss, and then to the development of hope, opens.

Anger – It is a necessary and important part of the process. Anger is a stimulus to recovery. It is normal and natural. Slowly, the realization that the anger comes from

C:\Users\iedeson\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\6Q2I2MBC\Literature Review MI Recovery.docx

4

strength, a sense of what is right and wrong, a sense of what needs to change, and not from the illness.

Acceptance/Hope/Helpfulness -These are outcomes from despair and grieving and is helped along by the presence of at least one person. It is a process that builds gradually, and that is often fragile.

Coping - This is learning to live with who you are and what you have to offer the world. Coping is built on acceptance. Acceptance means that there is nothing that you need to do or should do, only what you want to do and are able to do the best way you can.

Advocacy/Empowerment - This process is exciting and energizing. The illness may continue, but you have changed. You begin to think, feel, and act in your own interest with more confidence and competency. (http://www.mherc.mb.ca/)

Models of Change

Prochaska and DiClemente (1982) developed what is known as the Transtheoretical Model of Change. It is a model of intentional change that focusses on the decision making of the individual. Other approaches to health promotion focuss on social and environmental influences on behaviour or on biological influences on behaviour. The MHERC's model of recovery stages has similarities with Prochaska and Diclemente's model as it takes into account the cognitive and behavioural processes that occur and facilitate movement through a change process. The recovery stages model also takes into account the importance of empowerment and personal responsibility, as necessary for change. Dun and Fossey note that recovery is essentially an internal process of personal growth (2002: 46); whereas others claim that the individual's experience in the social environment is also critical to recovery. Jodie's comment confirms that the recovery processes (or stages) involve cognitive and behavioural changes:

> Jodie: *"this 'success story' is a result of many difficult times and choices, many home truths being ingrained, frustration, relapses, learning to set limits and boundaries, developing insight into my illness and the things that set me off.. [I} gave up smoking marijuana and moved away from people who were not good for me. I have learnt to take my pills without resentment – I take the pills in one gulp to get it over and done with quickly. I have finally realized that I can not do everything…"* (Russell: p.1-2)

The Prochaska DiClemente model of change is often used as the basis for developing effective interventions to promote behaviour change in regards to unhealthy lifestyle practices, such as drug and alcohol misuse. There are dangers in this model, if directly applied to a mental illness framework, as it can imply that mental illness is a result of cognitive and behavioural patterns, whereas the biopsychosocial model (more below) recognizes that causation and change are related to the broad context of a person's life, including biological, social, psychological and environmental effects.

C:\Users\iedeson\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\6Q2I2MBC\Literature Review MI Recovery.docx

5

The following table is an adaptation of the model of change, to reflect what people experience at stages of mental illness, and the interventions that assist a recovery-change process. (see http://www.comminit.com/changetheories/ctheories/changetheories-56.html for a different application of the change model.)

Stage of Change	Characteristics	Interventions/supports
Pre-contempla tion	Unwell Not currently considering change. May not be well enough recognize that an illness is affecting them. Shock/Denial/.	Validate lack of readiness Provide necessary support/intervention (social, biological, psychological)
Contemplation	Change seems out of reach. Depression/grief/Anger Medication might be subduing symptoms Not considering personal change within the next month	Validate lack of readiness Identify and promote new, positive outcome expectations (hopeful peer messages) Provide necessary support Encourage evaluation of pros and cons of change initiating possibilities
Preparation	Some experience with change and are trying to change: "Testing the waters" Planning to act within 1month Acceptance/hope/helpfulness	Identify and assist in identifying triggers/stressors and skills Help identify social support Verify underlying skills and strengths for personal change (lifestyle adaptations, interests, therapies, diet) Encourage small initial steps
Action	Practicing new skills and activities for 3-6 months (may be lifestyle change, taking medication, stress reduction techniques, counseling) Coping/acceptance	Focus on negotiating support roles Development of wellness and relapse plans Bolster self-efficacy for dealing with obstacles Combat feelings of loss and reiterate long-term benefits

Maintenance	Continued commitment to sustaining new behavior	Plan for follow-up support
	Post-6 months to 5 years	Reinforce internal rewards
	Return to work/study and social/community activity	Discuss coping with relapse
	Acceptance, advocacy, empowerment	
Relapse	Illness episode	Evaluate trigger for relapse
	Return to some previous thought patterns and behaviours.	Reassess motivation and barriers
		Plan stronger coping strategies
	Residual hope due to past experience of recovery.	
		Reintroduce strengths, supports, treatments that assisted in the past.

The adapted model of change, above, includes the types of 'internal' or emotional/attitudinal experiences people are likely to have at different stages of recovery (the MHREC's theory) and the necessity of external influences such as support, . Though the above model suggests that certain interventions can assist the person to recovery, an important model of change, promoted by Carl Rogers, is that "there is in every organism, at whatever level, an underlying flow of movement towards constructive fulfillment of its inherent possibilities" (1980: 117). To paraphrase this: change happens, regardless. Time, unplanned events, unconscious and conscious processes, and interventions, all influence change. The above model however, indicates that particular environments, interventions and supports can foster positive and accelerated change.

Stress Vulnerability Model

The Stress Vulnerability model recognizes that every human being has a threshold ability to cope with life's stressors, and that symptoms of mental illness occur when stressors accumulate above and beyond this threshold. The Stress Vulnerability model recognizes that individuals can take responsibility for noticing one's stress 'triggers' or risks and can develop a knowledge-base of one's 'protective factors' or lifestyle patterns that can minimize or ameliorate life's stresses. The model recognizes that all people are vulnerable and that no-one is immune from the risk of mental illness.

C:\Users\iedeson\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\6Q2I2MBC\Literature Review MI Recovery.docx

7

The Biopsychosocial Model

The Biopsychosocial model is widely used by psychosocial rehabilitation services. It purports that a person's wellbeing is influenced by biological, psychological, and socio-cultural factors. It offers as a holistic and valuable theoretical foundation for the practical aspects of recovery. David Pilgrim distils the concept developed by George Engel (Engel, 1980):

> "He argued that for psychiatry to generate a fully scientific and inclusive account of mental disorder, bio-reductionist accounts should be superseded by ones which adhere to the insights of general systems theory…" (http://www.critpsynet.freeuk.com/Pilgrim.htm),

The context and content of the body's biochemistry, a person's social environment and thought processes, set the scene for health or illness. The impacts of physical, psychological or biochemical stressors can cause mental illness; while the introduction of protective factors can reinstate wellness. The biopsychosocial model is useful for people who have mental illness, as well as mental health practitioners, as it equips people with an understanding of risk factors and provides a holistic range of recovery resources, including medication, psychological treatment, lifestyle change, social support, community and peer-group interactions, dietary changes, relaxation and exercise.

Borrell-Carrio et al (2004) describe the biopsychosocial model in the follow terms:

> "Philosophically, it is a way of understanding how suffering, disease, and illness are affected by multiple levels of organization, from the societal to the molecular. At the practical level, it is a way of understanding the patient's subjective experience as an essential contributor to accurate diagnosis, health outcomes, and humane care."

Peer-Support

There is a sizeable body of literature that claims an essential role for peer-support in the recovery process. This is not only borne out by a growing body of evidence, but more importantly, is repeatedly confirmed in lived experience accounts about recovery.

> *Maggie: "in my work with the psychiatric patients, I have found that my personal experience with mental illness has made me more sensitive and open to their needs. Despite their own illness, they in turn show understanding and empathy when I have a difficult day."* (Mowbray et al: 1997, pg 318.)

> *Rosemary: "Kay Redfield Jamison's book, an 'Unquiet Mind' has also been extremely helpful. Through some very difficult times I have read and reread*

C:\Users\iedeson\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\6Q2I2MBC\Literature Review MI Recovery.docx

8

pages from her book that have been both comforting and inspirational. Her words encouraged me when no one else could; she understood when no one else did. It is very important to know and read about others' experiences with the illness. You realize you are not the only one suffering from its cruel hand. It is so lonely when you are caught in its grip." (Russell: 2005, 39-40)

Emily: "I went through twelve or so particularly difficult years…It would have been helpful to know that others had learnt to manage this illness…Back then, I could not even find out about anyone who had gone through an illness as disruptive as mine and come out 'OK'." (Russell: 18)

In these accounts there is a resounding theme of social isolation; pointing to the difficulty people have in finding supportive peer contexts.

Peer-Led Recovery Programs

Despite there being a steadily developing body of theory and research that claims significant benefits for people participating in peer provided recovery programs, there isn't a strong culture of such programs in Australia, unlike in the USA.

Since the late 1970s, peer-led recovery focused programs and services for people who have a serious mental illness, have proliferated in the USA. A political and theoretical imperative for what are known in the USA as Consumer Delivered Services (CDS), grew out of the 'ex-patient' or 'survivor' movement (Mead, McNeil: Peer Support a Systemic Approach). In recent years, support by US government policy has enabled the expansion and integration of CDS into the formal mental health system (Salzer: 2002). [1] In Australia by contrast, there is no such movement. Finn and Bishop (www.communitybuilders.nsw.gov.au/download/mutual.doc) claim that the benefits of 'mutual support groups' are widely unrecognized by Australian professionals and that

"this omission can be explained by the dearth of research into mutual help groups in this country, and alongside this scarcity, a lack of teaching in mainstream health curricula about their potential benefits."

As the US example would suggest, government policy has a critical role, in the valuing and resourcing of a peer leadership culture. The Australian Commonwealth Government funds the Group Advocacy Program for consumer networks, to "assist and support the establishment of local consumer groups", (http://www.vmiac.com.au/), but there seems to be no other provision for the resourcing of groups or services other than mutual support groups and self-help

---

[1] A recent press release from the Mental Health Association of Southeastern Pennsylvania (16th July 2006) indicates the emergence of a nationally coordinated professional organization for 'peer specialists' – the National Alliance of Peer Specialists, indicating the wide-spread context of peer services in North America.

C:\Users\iedeson\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\6Q2I2MBC\Literature Review MI Recovery.docx

9

groups. The "Doing it with us not for us – Participation in your health service system 2006–09: Victorian consumers, carers participation policy (Department of Human Services)" demonstrates that the Victorian government is cognizant of the need for consumers and carers to be involved in their own and family members' health care, but does not go so far as to promote or support peer-led or peer-delivered services.

There are a range of typologies that have been developed to describe CDS in the USA (Salzer: 2002, Solomon: 2004). Solomon describes these categories as: "self-help groups, Internet support groups, peer delivered services, peer run or operated services, peer partnerships, and peer employees" (2004: 393). The types of programs run by these services include unstructured support groups, crisis services, structured education and training programs, drop in centres, recovery focused programs such as WRAP (Copeland), GROW and BRIDGES, and individual support.

Theorists provide clear definitions of peer provided services, as distinct from services delivered by non-consumers. Solomon states:

> "Peer delivered services are services provided by individuals who identify themselves as having a mental illness and are receiving or have received mental health services for their psychiatric illness, and deliver services for the primary purpose of helping others with a mental illness." (2004: 393)

Salzer states:

> "*Consumer-operated services* are those that are planned, managed, and provided by consumers. *Consumer partnership services* are those in which consumers deliver the services, but the control of the program is shared with non-consumers" (2002: 0)

> "It is recognized that many professionals have personal experiences with mental illnesses but choose not to identify as mental health consumers and do not share their personal experiences as consumers. Services delivered by persons who do not identify as consumers or share their personal experiences as consumers would not be considered a CDS. A program or agency where consumers serve only as advisors or on a board is also not a CDS." (2002: 2)

Hybrid self-help groups are described as groups in which professionals play a major role (Solomon: 394). The term 'prosumer' has been constructed, to describe a person who is a consumer as well as a professional, but must "self identify" as an individual with a severe psychiatric disorder (Frese and Davis: 1997 cited by Solomon: 394) Oddly, neither Solomon or Salzer spell out the rationale for making the distinction between consumer and non-consumer led services, perhaps assuming prior knowledge of the historical, ideological and social context for this distinction.

Peer-led Consumer Group Programs

Peer-led group programs are a sub-set of peer delivered services. Examples of these include the WRAP Program (Wellness Recovery Action Plan), GROW, and BRIDGES, in the USA. These programs focus on empowerment and responsibility in managing one's own recovery. These are variously titled as 'education' or 'recovery' programs: some being formal and providing self-management tools. WRAP, for example, assists people to develop a well designed and comprehensive health maintenance plan, whereas GROW provides a 12-step recovery program focusing on the development of social participation skills and the enhancement of quality of life. Other group programs are less structured and prefer to enable a context for mutual support and information sharing opportunities. WRAP has been widely implemented in various states and counties in the USA and is also being utilised in Australia (MIFSA is currently implementing a WRAP Program). GROW was established in Sydney in 1957 by Fr. Con Keogh (http://www.grow.ie/about.asp) and is probably the most active peer-group organization in Australia with over 325 groups. Overseas it is estimated that there are 200 GROW groups in Ireland, America, and New Zealand (Finn and Bishop: 2).

In addition to peer-led recovery focused group programs, similar programs are often run by service providers. In Australia, some examples include: the Collaborative Therapy Program run by the Mental Illness Research Institute in Melbourne, the Strengths Based Program for Women with Depression and Anxiety, run in central and north western Victoria by St Luke's and Loddon Mallee Womens' Health.

A search of research databases and the internet suggests that peer-led recovery/education programs are not common in Australia. Or if they are, there is not much literature available that announce their existence.

Mental Illness and the doctor/consumer power dialectic

There is strong rationale and a strident ideology that validates the construction of peer based activities as distinct and separate from provider run or controlled services. The need for this distinction arose from the 'ex-patient' or 'survivor' movement, and has earlier roots in the USA in the racial rights and women's rights movements.

Mead, Hilton and Curtis provide a rich and compelling discussion of the ideological significance of peer support for people who have a mental illness, as well as the tangible benefits of peer activities. Their article: "Peer Support: A Theoretical Perspective" (2001), tackles the cultural context of mental illness, and issues such as social justice and human rights. The authors acknowledge that mental illness is not accepted by contemporary western society, and that those who are mentally unwell are broadly labelled as abnormal and excluded from participation in society's activities and from their own health management. The 'medical model' and research methodologies collude in an 'us and them' construction whereby mentally unwell people become objects of medical knowledge and passive recipients of treatment.

This establishes unwell people as 'mental patients' dependent on external expertise. The medical model then has the final say, about a patient's relationship to illness:

> "Founded on beliefs that we won't get over having a mental illness; we are only capable of "functional" healing…defines mental illnesses as a permanent disability" (2001: 5).

Within this context arises the issue of empowerment versus power-over. The notion of empowerment is central to theories recovery[2]. Chamberlin (1997) defines empowerment for people who have a mental illness as: having an internal locus of power, whereby a person is able to be assertive, make choices and decisions, access resources, communicate and express emotions effectively, effect change and make a difference, 'come out of the closet' and overcome stigma. All of these capabilities must be expressed within society's ideological environment. To be empowered, in the way that Chamberlin describes, means to reinstate within oneself and one's behaviours and activities what society continues to undermine and oppress. Knight emphasizes this social impact in regards to recovery:

> "A person receiving a diagnosis of schizophrenia loses hope and enters a state of anguish caused by an experience of meaninglessness, hopelessness and helplessness. Much of this hopelessness is not due to the disease but to the mental health systems designed to treat it. Mental health systems are set up for maintenance and usually communicate that life is without hope of significant accomplishment once serious mental illness has set in." (Knight: 2003, 1)

Mead, Hilton and Curtis discuss the importance of peer activities as essential within a society whose dominant ideology results in the oppression of people who are not defined as normal. Peer support enables empathic understanding of the shared experience of emotional and psychological pain, within a social context that devalues and disenfranchises the expression of these experiences.

> "This connection, or affiliation, is a deep, holistic understanding based on mutual experience where people are able to "be" with each other without the constraints of traditional (expert/patient) relationships…Peer support can offer a culture of health and ability as opposed to a culture of "illness" and disability" (Mead and Curtis: 7).

The 'mental patient' culture transposes a person's power to the medical practitioner/system and too often results in chronicity and systemic dependence. Peer connection can facilitate a culture that validates the experience of mental illness, and can mutually construct a recovery culture. "Recovery lies in undoing the cultural process of developing careers as "mental patients" (Mead, Hilton, Curtis: 7).

---

[2] And indeed empowerment features as a key element in evidence about recovery. See Courtenay Harding (2003) "Changes in Schizophrenia Across Time: Paradoxes, Patterns, and Predictors, in *Schizophrenia Into Later Life*: *Treatment, Research, and Policy,* Carl I. Cohen, M.D. (ed). American Psychiatric Publishing: New York.

"Through mutually empathic relationships" peer programs can enable new ways of "making meaning and see ourselves from vantage points of personal worth and social power" rather than continue being defined by the 'mental patient' role that "keeps us feeling hidden and separated from others" (Mead et al: 8).

Mead and others discuss how peer support can become a "natural extension and expansion of community" and can play a role in restructuring the larger system (Mead et al: 8). To do this, peer cultures must contribute to the challenge by fostering new identities (Mead at al: 9).

Peer as Provider Theory

There is a broad base of theory that supports the need for peer-led services and recovery focussed groups. Similarly, there is a long history of peer program practice.

Green draws attention to historical precursors of peer-education:

> "Although it origins can be traced to Lancaster's 'monitorial system' of the early 1800's in London and further back to Aristotle, the use of peer education for health education has grown in popularity in recent years." (2001: 1)

Benefits of peer activity have long been practiced and observed by psychotherapists (Yalom: 1998), health providers, educationalists and employers (Turner and Shepherd). There is wide agreement that peer activity benefits leaders and participants as well as the broader system surrounding the program itself.

Theories about benefits of peer-led mental health recovery programs include:

1. Social Learning Theory (Bandura: 1977, cited by Salzer, Solomon, Green, Turner/Shepherd and many others), which provides opportunities for ongoing reinforcement of messages through continued social contact with peers.
2. Role Theory (Sarbin, 1968, cited by Green) recognises that communication is more difficult when there are differences in role and culture.
3. Communication of Innovations Theory (Rogers and Shoemaker, 1971 cited by Green) is applicable to a number of claims put forward for peer education including acceptability, credibility and effectiveness of peers as well as cost effectiveness and tapping into naturally existing networks which also provide opportunities for reinforcement.
4. Subculture Theories (Cohen 1955, cited by Green) are found to be of relevance and to offer explanatory power for those targeting subgroups with a strong identity.
5. Diffusion of Innovations Theory (Rogers 1995, cited by Green) suggests that the sharing of information in social groups and adoption of behaviour by some members leads to an exponential increase in adoption.

6. <u>Social Comparison Theory</u> (Festinger: 1954 cited by Solomon) suggests that individuals are drawn to "others who have commonalities…in order to establish a sense of normalcy for themselves" (Solomon: 395).

7. <u>Helper Therapy Principle:</u> (Riessman 1965, Skovholt: 1974, cited by Solomon) Benefits are derived from helping others, such as a sense of competence, mutual gain, "personalized learning" (Solomon: 395), enhanced self esteem from approval.

8. <u>Experiential Knowledge:</u> (Borkman: 1990, cited by Salzer and Solomon). This relates to "Specialized information and perspectives that people obtain from living through the experience of having a severe psychiatric disorder…through relating to others…individuals with psychiatric disorders may obtain validation of their approaches to problem resolution and gain increased confidence" (Solomon: 394)

Turner and Shepherd conducted a review of literature about peer-led education groups, and give an overview of the justifications that are commonly made for adopting peer education initiatives. These are:

- Cost effectiveness
- Peers are a "credible source of information",
- Peer education is empowering,
- Peer delivered education is more successful than professionally delivered education;
- Learning is reinforced by ongoing contact;
- Peers are positive role models;
- It utilises established channels of communication;
- It provides access to those who are hard to reach by conventional methods; (1999: 236-237)

Turner and Shepherd note that some of these claims are supported by some of the theories detailed above and that others are hopeful expectations, not supported by theory or evidence.

Evidence of outcomes

While there are compelling ideological imperatives and convincing theoretical claims for the benefits of peer delivered programs for people with mental illness, there is also a need for evidence that such programs provide positive outcomes for participants, and that benefits are equal to or outweigh the value of services provided by professionals. Salzer comments that: "CDS have emerged as a best practice, but cannot yet be considered an evidence-based practice due to insufficient systematic research" (Salzer: 2002, 3). However, in the last five or so research activity of this sort has increased considerably. Two sizeable annotated bibliographies, the first by Sommers et al (1999) and the second by Campbell (2005) demonstrate an enormous diversity of peer-led programs and research activity. If there is a concern about the existence of an evidence base for the efficacy of such programs, this could in part be

owing to the variety in program types and following this, the many measures and methods used and considered valuable, in the evaluation of these.

Salzer and Shear (2002: 281) claim that amongst this limited body of research conducted on peer-delivered services most research of this has focused on self-help groups. Campbell's bibliography (2005) supports this claim. Research to date reports "reduced symptoms, increased functioning, and enhanced sense of empowerment, recovery, hope and quality of life" and decreased service utilization (Salzer and Shear: 2002, 281). Studies of the GROW program report outcomes such as: reduced symptomatology, reduction in duration of hospitalization, reduction in the use of medication and professional support, increased coping skills, increased personal value and purpose, and development of interpersonal skills (studies cited by Finn and Bishop). A study of Recovery Inc. by Raiff in 1984, "determined that members had improved coping, greater acceptance of illness, improved medication adherence, lower levels of worry, and higher satisfaction with health" (Solomon: 2004, 395). Research by Raiff and Rappaport demonstrates that outcomes are better for participants who are involved in the group dynamic rather than just attending (Solomon: 2004, 395).

Research on Peer Provided Services seems to report less consistent findings, compared with that of self-help groups. Solomon and Draine's study of peer provided services found these to be as effective as non-peer provided services (1995), whereas Chinman, Rosenheck, Lam and Davidson found them to be more effective (cited by Solomon: 2004, 396) for clients. Two highly rigorous studies by Clarke et al in 2000 and Klein et al in 1998 (cited by Solomon) claim that recipients of peer provided services had improved social functioning, reduced substance use and improved quality of life. Another highly rigorous study by Edmunson et al, in 1982, found having a peer specialist on an intensive case management team, as compared to a non-peer, resulted in improved gains for clients in regards to problem reduction, quality of life, improved self-esteem and social support (cited by Solomon: 396). In addition to highlighting the range of studies that demonstrate outcomes for consumers, Solomon also draws attention to benefits gained by providers and the mental health service system, as a result of peer provided services. Benefits for the system and service providers include: cost savings, reduced hospitalizations and use of other services, more effective engagement in the mental health system, consumers are more likely to be involved in their health needs, improved attitudes held by mental health providers, including reduction of stigma (Solomon: 2004, 396). Solomon also points out that peer support and peer provided services "enhance the ability of the mental health service delivery system to meet the mental health needs of the community" (2004:397).

Of equal importance to benefits for clients, are the outcomes that are attained by peer providers and peer group leaders. Gene Deegan's account of his participation in the Kansas peer provider initiative is a compelling story of his own recovery from mental illness. The peer provider training program at the University of Kansas uses the strengths-based approach and the recovery paradigm to educate and empower

peer leaders in their own ability to recovery, and equipping them to enable recovery for others. Deegan's narrative of recovery parallels his professional development, ranging from trainee status to state-wide coordinator of peer-led programs. His story provides a phenomenological account of the benefits of being a peer provider that is also evidenced by research conducted by Boykin (1997) and Mowbray & Moxley, (1997): "role-identification for peer providers can increase their self-esteem and open pathways for personal development" (cited by Deegan, p 370).

Alongside the growing body of evidence that demonstrates the benefits of peer activity for people who have a mental illness, there are a few concerns and criticisms about peer provided services expressed in the literature. There are also a number of studies that have produced ambivalent results about the benefits of such services.

Research by Chesler, into concerns that professionals hold about peer-led groups, raises a number of anecdotal concerns. Amongst these is the concern that medical misinformation can be spread, that escalation of feelings could upset people and that such groups might encourage an anti-intellectual or anti-professional stance (Somers et al: 1999). Though these concerns haven't been validated, this raises the point that any group that meets in isolation and without a governing philosophy or structure can run the risk of becoming ill-equipped and potentially harmful.

Gartner and Riessman argue that a strong relationship between professionals and self-help groups is important, noting that "independence from professional intervention has been part of the self-help rhetoric from the beginning of the movement". The authors comment that professionals need specific training to become aware of the benefits of such groups, approach them with respect, and collaborate to ensure that they are included as part of the continuum of mental health services.

McDiarmid and her colleagues support this contention, citing studies that show that when consumer provided services are partnered with non-consumer providers, there are better outcomes for clients (2005: 1). A study by Surles in 1994 (cited by Sommers et al: 1999, 30) demonstrated that the addition of a recovering consumer to an ICM team (intensive case-management) resulted in enhanced service effectiveness. Another study by Klein, Cnaan and Whitecraft in 1998 (cited by Campbell: 2005) found that clients connected to both an ICM and peer support showed improved quality of life and "perceived physical and emotional well-being" compared with people who only accessed ICM (2005: 5).

A comparative investigation of consumers and non-consumer case managers, by Solomon and Draine found that both were regarded by clients as equally effective. Clients who experienced their case managers as understanding, caring were more satisfied with the service they received. "It appeared that the characteristics of individual case managers and the more general elements of the working alliance were more important in explaining the differences in overall satisfaction with mental health treatment than whether the clients were served by a team of consumers or

non-consumers" (Sommers et al: 1999, 28-29). In a consequent study, Solomon and Draine identified that while consumer case managers were more likely to maintain more interpersonal contact with clients than non-consumer case managers, they were less likely to maintain and facilitate linkages with other professionals. (Sommers et al: 29) Again the authors concluded that the "characteristics and personalities of individual case managers appeared to be at least as important as their consumer/non-consumer status" (Sommers et al: 29).

Peer Delivered Programs Alone, or in Collaboration?

Though evidence of the value of peer delivered programs and services is limited, there is no doubt that there is an ideological necessity for such programs; a peer culture generates empathy, hope, empowerment and provides an opportunity to share knowledge and to practice lost skills. These elements are significant in a society that stigmatizes, marginalises and infantalises people who have a mental illness. Peer environments can be regenerative 'safe havens'.

So far, most literature about recovery focused programs tends to discuss professional services and peer provided services as separate entities. As stated above, there is strong justification for maintaining the integrity of peer provided activities because society's 'us and them' stance insidiously perpetuates. It makes equal sense that it is not only the responsibility of the consumer movement to influence this change, but for society to become more inclusive, and service providers to play a pivotal role in bridging the 'us and them' divide. Importantly, this seems to be occurring more often at the interface of clinical services. The Colorado "Managed Care Capitation Project" has made a significant attempt to bring the best of both worlds together. The project began as a partnership between a 'managed care agency' and eight community mental health centres. Principles of recovery and recognition of the benefits of peer activities were embedded in the design of this project. Self-help activities and best practice recovery tools and techniques (as developed by the Boston Centre) were established as part of a continuum of programs, including clinical support and managed care. Research conducted by Berkeley University (Forquer and Knight: 2001), demonstrated beneficial outcomes such as an increase in numbers of people with psychiatric disability involved in the project, a reduction in the suicide rate, decrease in substance abuse, reduction in hospitalisations, increased social contacts for participants, and increased ability to carry out daily living activities. The project partners believe that success was due to combining self-help groups, theory and tools that aid recovery and a collaborative partnership between the managed care agency and clinical services. The successes of this project demonstrate that chances of improved mental health and recovery are enhanced when professional services and peer activities are combined.

Discussion

There is a compelling body of philosophical, theoretical and evidence based literature that demonstrates the benefits and necessity for peer provided programs and

services that adhere to a vision of recovery. Lived experience accounts also confirm these theories, and provide a realistic view of the journeys that people travel and what assists recovery.

MI Fellowship Victoria's vision is "of a society in which mental illness will be understood and accepted". This social change imperative requires bridging the gap that society has historically structured and maintained, between the 'well' and the 'unwell'. Indeed, it requires the dismantling of the dualism and a revisioning of the commonalities that all people share. The evidence and theories cited suggest that combining the knowledge and expertise of non-consumers and consumers alike, can be transformative. Service providers have access to a range of resources: networks, best practice experience and research, that self-help or peer-support groups may not. Organisations such as the Mental Illness Fellowship Australia, can bring resources and expertise to social change campaigns. But the people who have lived the experience of mental illness must inform, lead and participate in every activity that is undertaken to promote recovery.

C:\Users\iedeson\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\6Q2I2MBC\Literature Review MI Recovery.docx

18

Part 2 – Program Design

Models for Peer Education

The above literature demonstrates that peer education can enable people who have a mental illness to manage their illness, attain self-determination and to experience significantly enhanced quality of life. Indeed, recovery theorists purport that education about mental illness, wellness planning and managing life domains, can equip people for recovery.

The scoping study conducted by the Mental Illness Fellowship Victoria, in 2005, provides a broad overview of preferred education program content areas (or life domains) recommended by focus groups comprised of people who have mental illness. Further focus group consultations in 2006 have gathered people's lived experience of these domains that can be used as 'educational content' for the program. An equally important design consideration for the program, is how the program content is presented to participants. The purpose of the proposed 'recovery focussed' peer consumer education program is to provide a group environment for learning about mental illness, as well as an opportunity for personal and social change. An education program that simplistically provides educative content cannot meet the needs of people who are managing illness as well as issues around stigma, self-esteem and social exclusion. The program design must maximize the benefits of change processes for individuals and groups, and minimize the risks. Similarly, the program must nurture the diversity of learning needs and styles and provide opportunities for experiential skill acquisition, group learning and personal development. Further research about adult education theory and group development will ensure that the program can meet these needs.

Group Theory

There are observable processes that all groups experience at various stages of development. The Forming, Storming, Norming, Performing and Mourning (Tuckman: 1965) formula is probably the most commonly cited description for how groups operate throughout their duration. Understanding group processes is important to the design of a program, as there can be dissonance between the group's stage of development, and the content and educational style utilised. In designing a program, the content, facilitation style, and stage of group development need to be mutually considered, and aligned in a manner that enables timely learning in a trusting and cooperative group environment.

There are many theories about the phases of group development and how to maximize the potential of the group process (Yalom: 1995). Frew (1997) provides a practical framework for facilitating groups, that ensures that content and interventions are tuned into group development processes. Frew employs Gestalt therapy theory,

C:\Users\iedeson\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\6Q2I2MBC\Literature Review MI Recovery.docx

19

as this approach "attends to the relationship *between the individual and the environment*"; the group environment strongly influences the individual's thoughts, feelings and behaviours, and therefore their ability to learn (ibid, 132). According to Gestalt theory, the individual strives to maintain equilibrium within the context of their environment. In the light of this theory Frew insists that:

> "to effectively lead a group, the leader must understand how individuals experience the groups to which they belong. To effectively intervene and influence a group's process, group leaders must have a framework to guide their actions."

An environmental approach to group processes is particularly relevant and useful for a program that aims foster peer support for people who experience mental illness.

Frew's framework applies to time-limited groups, and also draws on group development theory. Frew surmises that amongst the different theories of group development, "there are striking commonalities…in relation to what issues members and groups as a whole are confronting at various points in a group's life" (ibid, p. 134). Frew's formulation combines these commonalities. This is delineated in the table below.

Phases of Development	**Key Issues that Arise**
Orientation	Safety, belonging, orientation, similarities,
Differentiation	Power, control, differences, distrust, competition, leadership, counterdependency
Affiliation	Affection, support, cooperation, interdependency

Each of the above phases are seen as necessary to the group formation process. Frew states that if the issues that arise in each phase are dealt with adequately then the group will move through the first two phases to the Affiliation stage. If the end state of a cohesive group is achieved then the group is more likely to meet its objectives.

The group leader must ensure that the expected issues can be thoroughly worked through, at each phase. Throughout the various phases members will have issues and questions around purpose (what am I doing here?), safety (will I be hurt here?), belonging (will I fit in?), differences (what if I'm not accepted for my differences?) and so on (ibid, pp. 134-135). Frew advises that "group leaders can actively facilitate that development by anticipating and attending to these issues as they emerge during early, middle and later phases of a group's life and by supporting the group's efforts to bring these issues to some resolution.

In the very early stages of formation, groups are awkward and there is a high level of anxiety and uncertainty amongst the members. During this phase, there is a natural tendency for individuals to be introspective and not outwardly motivated. During this phase members need to be oriented, included and provided with a sense of safety.

> "Orientation issues can be addressed by clarification of time lines, dates of contact, purpose of the group, expectations of members and your style of leadership. You can attend to the members' needs to be included by prompting each participant to say something during this first meeting. Usually a brief introduction that includes a statement about why the member is there is sufficient to create a preliminary sense of belonging. Leaders must also monitor and tactfully limit the more loquacious members. Inclusion of a group can be hindered if one or several members dominate…the leaders can begin to shape an atmosphere in which each member feels welcomed and valued." (ibid: pp. 135-136)

Frew goes on to provide further guidance about how to support a group to move through the challenges of the second and third phases of group formation.

Frew imparts further guidance from Gestalt theory, about the dominant relational modes that groups experience during the different phases of development. These are:

Phases	Dominant Mode
Orientation	Intrapersonal
Differentiation	Interpersonal
Affiliation	Group

During the orientation phase group members will be anxious about their place in the group. As there are no connections between members, the primary mode will be introspective and feeling-based. Members will feel anxious, apprehensive, self-conscious. During this phase group members will be more likely to work in a focussed manner on tasks "to attenuate the discomfort they are feeling" (ibid: p. 140). If the leader has addressed the key issues that present in this phase, the group will progress to the Differentiation phase, feeling safer, clearer about the group purpose, and more aware of connections with other group members. In the Differentiation phase the dominant mode is Interpersonal. Members will become "less aware of their own internal processes" (p. 141) will recognize "allies and enemies" and will be interested in what other members of the group want to say. This phase can be 'stormy', as people are still negotiating their place and purpose in the group. If opportunities are provide to move through these issues then the group will progress into the Affiliation phase. In this phase members will have achieved familiarity and the group will operate as a cohesive whole:

> "Members will begin most sentences with 'we' rather than 'I' or 'you'". During the affiliation phase the group dynamics are strong and reliable and the group

is well equipped to achieve its objectives and to provide internal leadership and vision," (p.141).

Adult Education and Learning Theory

Teaching and learning are complex topics and there is a multitude of theories about learning styles, learning processes, conditions for learning and the design of curriculum. Contemporary education theory recognises that people have multiple intelligences and learning preferences that draw from cognitive and sensory processes. Multiple intelligences have been described as "Verbal/linguistic, musical/rhythmic, mathematical/logical, visual/spatial, emotional, body/kinaesthetic, interpersonal and intrapersonal" (Consumer Focus Collaboration [CFC]: 2000, p. 12). As a result, different people learn in different ways; some people learn through experience and reflection, others by trial and error, and others still may learn best from the presentation of visual or auditory material. For adult learners there is no 'one size fits all' model. A program can be designed to employ a range of educative techniques that enable people to learn according to their natural preferences and abilities.

Adult learning theory recognizes that adult students have a broad and diverse range of prior learning and life experiences that influence how they learn and what conditions optimize and motivate learning. Current trends in adult education theory regard learning as broader than the "traditional preoccupation with knowledge and skill…so that individuals can adapt throughout life to a changing, complex and interdependent world." The UNESCO Commission on Education for the 21st Century (the Delors Report) promotes this concept, by proposing four pillars for education:

- Learning to know;
- Learning to do;
- Learning to understand others; and
- Learning to be (CFC 2000: p. 18)

These 'pillars' reflect the educative aims of the proposed peer consumer education program: to provide opportunities for knowledge attainment, skills, peer support and personal change.

Kolb's Theory of Adult Learning

Experiential learning theory purports that people best learn when content is immediately relevant, and provided in an interactive and practical manner. For Kolb, experiential learning is "a process whereby concepts are derived from, and continuously modified by, experience" (Best & Rose: 1996, p. 62).

Kolb defines experiential learning as a "Holistic integrative perspective on learning that combines experience, perception, cognition, and behaviour." He suggests that people learn in four ways:

"through immediate concrete experience (an affective way), through observation and reflection (a perceptual way) through using abstract concepts (a thinking way), through active experimentation (a behavioral way)" (ibid: p. 11).

Kolb's Learning Cycle
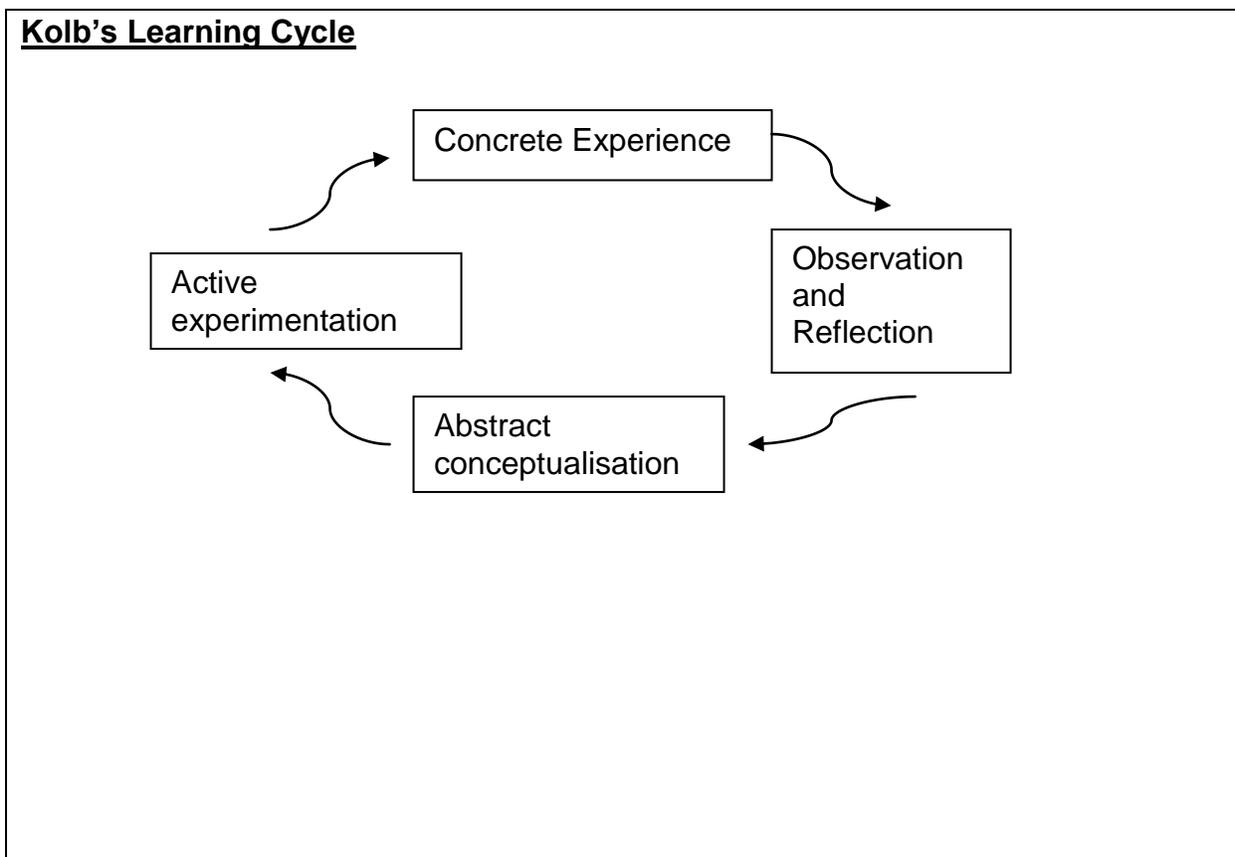
Optimum Learning Conditions

Knowles (cited by CFC: 2000, p. 11) proposes that adults are most motivated to learn when the following needs and conditions are addressed:

- Content is relevant to the individual,
- Content is related to previous experience,
- Opportunities are provided for active participation,
- Focus on problems,
- Can take responsibility for own learning,
- Immediate practical application,
- Involves a cycle of action and reflection,
- Is based on mutual respect and trust.

Optimum learning occurs when participation is willing and voluntary, there is a spirit of collaboration, there is opportunity for action and reflection and self direction is encouraged. In an effective learning environment, all participants (teacher and learners) are able to learn from each other. Adults value learning environments in which there is an exchange of information, a sharing of perspectives and collective focus on an area of mutual interest (ibid: p.13).

There are many strategies that can be applied in improving the learning skills of people so that the value of ongoing informal learning is enhanced.

These strategies and techniques include:

- The role of **mentors** in working with small groups or individuals. Volunteers can be used in this role.
- Techniques such as **active learning** can be used so that the individuals learn from each other in problem solving.
- **Workshops** can be useful in developing sensitivity to learning needs and strategies; and
- Individuals can be encouraged to keep **notebooks** or **diaries** which provide a structured way of reflecting on experience. Many of the most creative people in human history such as Leonardo de Vinci, Isaac Newton, and Thomas Edison had the habit of using notebooks or diaries to record observations and reflections. (Resource Guide for Education and Training for Consumer Participation in Health Care: p. 132)

The above theories about group development and adult education resonate strongly with the philosophy demonstrated by the Mental Illness Fellowship Victoria in developing and implementing a range of adult education and training programs, and in particular, the *Well Ways* program. The *Well Ways* program employs a three stage approach: a highly structured and supportive engagement phase, a development phase that acknowledges group development processes and establishes a supportive, structured and safe learning environment for participants, and a Consolidation phase that provides opportunities for mutual support and self-determination.

Adult Learning and Serious Mental Illness

Adults who have experienced serious and/or prolonged mental illness may be restricted in their learning abilities due to memory and 'attentional' impairments and the interference of persistent symptoms. An educational environment needs to be responsive to these factors. Liberman, Wallace et al (Spaniol et al: 1994) suggest that

> "material to be learned must be presented slowly, repetitively, and consistently. To counteract their memory impairments (Mueser et al. 1991; Oltmanns, 1987), the material must be presented in small 'chunks' punctuated with numerous reviews. To counteract their abstraction impairments, the material must be presented using words and actions that closely match their own, natural environments, supplemented by in vivo exercises that specifically help individuals practice their newly learned skills in those environments" (ibid: p. 260).

Liberman and Wallace, utilising outcomes based evidence, designed a 'social and independent living skills training program' at the UCLA Clinical Research Center for Schizophrenia and Psychiatric Rehabilitation. A pragmatic 'psychoeducation' program, the UCLA model doesn't facilitate peer support, or focus on personal experience or social issues such as stigma. Nevertheless, the skills provision and self-management aspects of the program are highly relevant to MIFA and MI Fellowship's program objectives. The program designers claim that a highly structured modular educational approach is deemed to be more effective for people who have particular learning needs, and can also ensure program replicability. The UCLA program focussed on "self-management of medication, coping with symptoms" as well as community integration. Video learning assisted the repetition of themes and 'in vivo' exercises enabled participants to practice new skills (ibid: p 262). New skills need to be reinforced and repeated. Prompting and assistance from carers or friends will facilitate experiential learning in the individuals 'natural' environment (ibid: p. 261). The program provided a holistic and replicable package with material for all those involved: a training manual for facilitators, a workbook for participants, and a demonstration materials (videos etc.). The participants' workbook included "written materials, self-monitoring forms, and homework exercises" and the modules were divided into skill areas, to be taught using the same "instructional technique" (ibid. p.

263). The skill areas contained 'competencies' that could be regarded as educational objectives.

The designers of the UCLA educational program suggest a group size of 8 participants, and claim that the program is most effective for participants if limited to a time-period of one and a half hours. They also claim that 2-3 sessions a week ensure efficiency (program term is shorter) and the most effective learning opportunity for participants.

In light of MIFA and MI Fellowship Victoria's objectives for a peer-led educational program for people who have a mental illness, these prescriptions may have limited relevance. The planned program will include a didactic educational and skills development component, which can incorporate some of UCLA's principles. However, the program will also provide peer-support opportunities, and will build on lived experience themes including the process of re-building identity, understanding how society frames mental illness (stigma), and confronting society's deficits (advocacy). Provision of opportunities to socialise and to practice 'intentional' peer interactions (more about this below), may warrant design of sessions that are longer than 1.5 hours.

Narrative Theory

Theories of change were discussed in Part 1, as recognition that recovery from mental illness requires a supportive change focussed process. The Prochaska and Di Clemente model provides a description of the stages of change. But for the purposes of developing a recovery focussed education program, a question remains: "how can this program provide a change oriented environment?" Certainly, the application of adult education theories and group development theory will create the context for learning and change. But what conditions can the program provide for personal change, given that mental illness is not only a social (interpersonal) experience, but also a personal experience?

Narrative approaches to personal development and change are broadly utilised in therapeutic contexts, as well as educational, life coaching, and professional training contexts. Theory, research and practice undertaken by Michael White and David Epston at the Dulwich Centre in South Australia, is recognized internationally as 'leading edge' work. Erik Sween (1998) attempts to answer the "one-minute question" that plagues narrative therapists: What is narrative therapy? In his snapshot answer he explains that narrative therapy provides an opportunity for refocusing on the stories that give our lives meaning in a way that enables us to revision and reshape our stories and our life. Narratives are dominant in society. They play a role in identity construction, in communicating ideas and relating to people. Narratives give our experiences meaning. Narratives can change over time: seldom does a story stay true to its origin; it depends on the perspective brought by the individual and the frame imposed by society.

For narrative theory, the process of change is owing to the individual constituting their "preferred selves" by "performing their preferred stories" (Freedman & Combs, 1996, 237). For a person's subjective experience of change to take hold, it requires validation of and participation from others in the preferred stories. Others can "bear witness" to the emergence of the preferred self. Dominant cultures aren't receptive to reconstitution of selfhood; therefore the creation of subcultures that can affirm and participate in new narratives of self are essential. Witnesses can participate in a process of "subverting the dominant culture" and creating "communities of concern" for individuals who wish to constitute a healthier self. A witness, therefore, should be a trusted person, chosen by the participant, who is able to recognise the participant within their new stories.

Shery Mead, in her extensive work on consumer peer support projects, turns to the Dulwich Centre's formulation of narrative theory, to deconstruct the 'us and them' narratives that individuals and society construct and reproduce. Mead concurs with Erik Sween's 'slogan' for narrative therapy, that "The person is never the problem; the problem is the problem". For people who are struggling with mental illness, the problem becomes much bigger than dealing with an illness. Society creates a meta-narrative about mental illness based on fear and ignorance. The person with mental illness bears the burden of a problem. Sadly and too often life stories include experiences of poverty, homelessness, ongoing illness, extended hospitalization and isolation. These devastating experiences are consequences of a blaming narrative (the person is the problem) that resorts to punitive and alienating responses.

By positioning the problem outside the core of the person, external and personal resources can brought to bear on the problem and other possibilities will emerge. With the emergence of new possibilities the story can take a different turn. Or as Alice Morgan describes it, a narrative stance enables people to "become the primary authors of their lives. Narrative questions put people's views, preferences, desires, hopes, dreams and purposes in the centre of the conversation," (2002: p. 86). So how can theories about narrative be applied in the context of a peer-led consumer education program? By externalizing 'the problem', participants can be freed up to tell their stories differently. Peer environments create a unique opportunity to take a stance that is separate from the dominant narrative imposed by society, to construct new personal narratives, deconstruct society's meta-narratives, and participate in a mutually reassuring environment that insists on full participation in society rather than exclusion.

Shery Mead met with MI Fellowship Victoria staff in October 2006 to discuss her experience with peer support and self help groups. She also presented at the Melbourne based Consumer Perspectives Conference. In working with groups Mead encourages and guides people in creating new meanings about their illness experience and their lives, so that opportunities can emerge and dreams can have a chance. In a peer group context members are encouraged to tell their stories in different ways – what is your illness story? What is your wellness story? – and through this they begin to explore how meaning is constructed in their lives. An

illness story constructs the person as the problem and as a perpetual victim of unalterable circumstances. Whereas a wellness story – with the specific problem named and externalized – provides a new frame and new possibilities. Mead also advised that peer skills need to be taught and learned. Often people who have the experience of being a 'mental patient' have learned to passively receive help. Being a peer means being able to be both the 'helper' and the 'helped'. Honest reciprocity is essential to being a supportive consumer peer. Mead suggests principles for intentional peer support: Re-defining, re-membering, re-claiming, who and how we want to be in the community. In this way peers can challenge each other out of doing what's been done to people with mental illness, in the past. Mead warns that being a peer is not about assessing the other person, as this creates one peer as the expert over the other. Rather, the peer role is about "creating rather than commiserating".

The success of a men's group program run by the "Living Skills Centre" on the Lower North Shore of Sydney also attests to the sorts of outcomes that can be achieved by using a narrative process as part of the recovery process. In their discussion of the program, O'Neill and Stockell (1991: p. 201) draw on Foucault's conceptualisation of power in the client/worker relationship. Destructive and disruptive behaviours expressed by young male participants at the Living Skills Centre suggest that the Centre wasn't meeting their needs. Establishment of a peer focussed narrative therapy oriented group provided an opportunity for the men to hear each others stories and draw strength from each others experiences. Doing this also provided alternatives to the "dominant story of schizophrenia" that for the young men perpetuated "the feeling of being trapped" (ibid: p. 201). The process of actively listening to each others stories in a group environment enabled the creation of new meanings: "meaning (understanding)… is evolved through the dynamic social process of dialogue and conversation…it is in language that we are able to maintain meaningful human contact with each other and through which we share a reality". This also enables individuals to "access self knowledge" (ibid: p. 202). An evaluation of the program's usage of a narrative theory methodology demonstrated that people experiencing mental illness can become "experts of their own experience" (ibid: p. 202), if given the opportunity to construct a meaningful view of their experience.

A narrative approach can be utilised to orient the education program's change agenda, and can support people who have a mental illness through an actively articulated change process. It can be employed as a reframing stance that frees people up to view their life in a different way and to ask questions that provide opportunity rather than constraint.

Narrative oriented peer skills can be articulated and taught in a manner consistent with personal change and group development processes – from a highly structured and directive beginning, through the phases of personal orientation and early group development, to a consolidation phase where the group is more in control and individuals have a greater sense of independence and self-determination.

C:\Users\iedeson\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\6Q2I2MBC\Literature Review MI Recovery.docx

28

Group Leadership Qualities

DeLucia-Waack and Kalodner describe a range of qualities that are necessary for effective group leadership. Group leaders must be positive, warm, enthusiastic and supportive. Any form of negativity can influence dissatisfaction. (69) Group leaders shouldn't be controlling but must be able to set clear norms for behaviours. Leaders must be able to provide protection to participants. This can be demonstrated in a variety of ways - by establishing appropriate group norms, modelling care and using the selection process to filter out people who present as vulnerable or unready for the group work environment, or preventing a person from unsafely disclosing sensitive information. The ability to 'block' is also important. Blocking is stopping people from rambling, dominating, or inappropriately probing others.

> "Research suggests that group members frequently attributed their damaging experiences to undue confrontation, criticism, and pressure to self-disclose by other members." (p. 70)

Being able to provide 'support' is also necessary. Supportive interventions include encouragement, reassurance and reinforcement to group members.

A group leader must also be able to energise the group. Techniques such as drawing people out, linking information and comments, modelling and encouraging feedback are essential to group work. Modelling requires the group leader to demonstrate desirable skills and attitudes to the group, such as honesty, openness, respect and giving and receiving feedback. A group leader must be able to providing structure, encourage feedback and facilitate continual reflection about all events and activities (ibid, pp. 70-71).

Male and female co-leadership is believed to be preferable. Weekly supervision for leaders is advised (ibid. p. 75).

Engagement Phase

Appropriate selection and preparation is necessary, particularly for people who are socially vulnerable, to ensure both personal safety and satisfaction and successful group development. The American Counselling Association *Code of Ethics and Standards of Practice* stipulates that group programs must be sure to

> "select group members whose needs and goals are compatible with the goals of the group, who will not impede the group process, and whose well-being will not be jeopardized by the group experience" (cited by DeLucia-Waack and Kalodner, in Wheelan: 2005, p. 73).

Corey et al concur with this, stating that "all groups are not appropriate for all people. Indeed, for some, group participation can be damaging or at least counterproductive to their growth (1982: p. 37).

Couch (1995, cited in DeLucia-Waack and Kalodner: pg. 74) suggests a four-step model to engage and assess participants:
- ➢ Identify clients needs, expectations and commitment;
- ➢ Challenge any myths and misconceptions;
- ➢ Convey information;
- ➢ Screen the person for the group fit.

Group leaders should meet with prospective participants individually (1982, p.37) to describe the group and ascertain benefits and suitability of the program to the individual. This process also establishes the conditions for a trusting relationship and can allay fears. Prospective participants should receive descriptions of:

- ➢ Group goals,
- ➢ Information about how groups work, (processes and development)
- ➢ Theoretical orientation,
- ➢ Member and leader roles,
- ➢ Leaders qualifications,
- ➢ Confidentiality and exceptions to confidentiality,
- ➢ Potential risks and potential value of participating in the group (Corey et al: p. 37)

A selection process can ensure whether or not the goals of the program match the goals and abilities of the potential participant. Certain interpersonal and intrapersonal characteristics are necessary for a person to participate fully in a group. One model proposes the following inclusion criteria: "a moderate amount of social ability, and frustration tolerance and a commitment to changing interpersonal behaviours". Intrapersonal variables include: psychological mindedness and expectation about the benefits of group participation. Two measures are available that could assist the selection process: The Group Psychotherapy Evaluation Scale (Kew, 1975) and the Group Therapy Survey (Carter, Mitchell, and Krautheim, 2001; Slocum, 1987).

Bowman and DeLucia (1993, cited in DeLucia-Waack and Kalodner: pg. 74) suggest three steps.

> "a cognitive component (a handout summarizing how group works, typical group topics and activities, and helpful group member behaviours), a vicarious component where potential group members view a video-tape of a working group (eg., Stockton, 1996), and an experiential component consisting of role-plays that emphasize helpful group member behaviours" (ibid: p. 74).

Corey at al also recommend a preliminary session with all potential group members. The purpose of this session is to provide an outline of the purposes and goals of the group program, as well as the processes that will be undertaken and what the participants will be doing in the group. This opportunity to meet other group members

will also provide additional information that will assist members in their decision to commit to the group. Aspects of the preliminary session include:

> "getting acquainted; clarifying personal goals and group goals; learning about the procedures to be used in the group; learning about how the group will function and how to get the most from the experience; discussing the possible dangers or risks involved in participating in the group as well as ways of minimizing these risks; discussing the essential requirement of confidentiality and any other ground rules necessary for the effective functioning of the group; exploring with members their fears, expectations, hopes, and ambivalent feelings and answering their questions," (ibid: p. 38).

Policies or ethical considerations should be discussed at this session, as well as ground rules. Corey et al suggest a set of ground rules for consideration (ibid, p. 39).

At the conclusion of this session members would be asked to think about whether or not they wish to commit to the group: those who have reservations (either group member or leader who has doubts about a group member) can reflect on this in another individual interview, if necessary.

Corey et al also suggest holding disengagement interviews, after the formal group program has concluded. This can assist the participant to evaluate the degree to which their goals were met by the program (1982: p. 38).

Appendix 1: "Change Inducing Program Methods"

Goal Setting

Participants have a lot to gain from setting their personal goals. Opportunities to reflect on goals, at the beginning of each session can maximise their learning potential. Initially goals might broad, so it's important for group leaders to encourage participants to develop specific goals. Reflective techniques such as journaling, using structured questionnaires, and constructing 'critical-turning-points' charts can be useful in thinking about the goals a person wishes to set on their recovery journey, and in imagining and pursuing a satisfying life (ibid: pp. 40-47).

Program design will provide 3 different 'working' opportunities for students. These are consistent with Gerard Egan's counselling model that articulates three processes of change.

1. The classroom environment that is the foundation for learning, exploration and processing information that's based on 'lived experience' and evidence. This stage utilises adult learning theory. Exploration is fostered through dynamic activities, journalling, a scale exercise, and homework exercises. This stage also provides opportunity for peer relationship development.
2. Recovery Kit Bag is a place where students can gather together the strategies, experiences and tools that they have arrived at, through the exploration and learning process. The Kit Bag will be a personal resource that will grow and change as their awareness of 'what works' increases. This will be where students safe keep their goals and dreams and the strategies that they use to be successful. It is also a practical place where their planning can occur for elements of their recovery like managing medication.
3. Students will be encouraged, through homework activities and the relationship with their support person, to practice and develop their 'recovery' routine. This will be based on the exploratory work that have done, and will be directed by the strategies they have set for themselves.

Recovery Factors Self-Measurement tool

A self-measurement scale has been designed for the program, based on lived experience drawn from the consultation workshops, best-practice frameworks and research about the factors that are the most important determinants for recovery (Anthony: 1993, Deegan: 1988, Onken et al: 2002). The dimensions considered most important and relevant for the miRecoveryJourney program are:

- *"Right Diagnosis: Because it assists with appropriate treatment".* This was drawn from the project consultations, and from lived experience monographs such as *A Lifelong Journey (*Russell: 2006).
- **"Medication:** can reduce symptoms, but getting it right might take time and patience." This is a necessary dimension of the biopsychosocial model, also supported by lived experience consultations.

- **"Personal medicine:** enjoyable and healthy activities can reduce symptoms as well as increase self esteem and fitness." Concept is from Patricia Deegan (2006: www.patdeegan.com), draws on notions of 'self help', and maintaining a holistic and healthy lifestyle.
- **"Emotional and psychological/spiritual support (psychologist, counsellor):** helps with confidence, self-image and dealing with traumatic aspects of having a mental illness." This is a fairly traditional rehabilitation determinant, but also links into the concept of redefining self that was reiterated in the lived experience consultations.
- **"Taking personal responsibility:** Learning skills and getting info, information for managing my wellness." This is a commonly accepted concept has been drawn from many sources including Chamberlin (1997) and Rickwood (2006).
- **"Support & Participation:** Spending time with family and friends and staying involved. Other people can help notice changes." This is a key feature of the biopsychosocial model of health, and Otawa Charter and psychosocial rehabilitation practice.
- **"Things to do:** Having a routine and doing enjoyable things". This broadly accepted theory holds that routine activity is essential to self-esteem, personal meaning and spirituality.
- **"Work/study/training:** These things provide meaning and build self-esteem. May need to do less when unwell, but keep in view." Returning to work is broadly considered a necessary aspect to recovery and social participation.
- **"Learning about my illness:** Knowledge provides options and helps with making informed choices. Learning and using new skills helps me be in charge of my wellness" This is one of Rickwood's 4 As. Knowledge and options bring about empowerment and inturn lead to taking responsibility for recovery.
- **"Hope & Courage:** Mental illness is traumatic and life-changing. Recovery is possible and change is takes courage." Hope is believed by most researchers, commentators and theorists, to be essential to recovery. Workshop participants remarked on this frequently, and also noted that courage is equally important in making changes that lead to recovery.
- **For me………………………………………………..assists in my recovery.** Participants in the program will be invited to include a recovery activity that they have found useful, as part of their self-measurement tool. This will encourage the notion that everyone's recovery journey is unique, and there is no generalisable strategy for managing mental illness.

Relapse Prevention

Research suggests that taking personal responsibility for illness management needs to occur at several levels including maintaining a holistic and healthy lifestyle, reducing the sorts of things that trigger illness, developing an understanding of early warning signs and developing a 'drill' to respond to early warning signs. Birchwood et al have developed a comprehensive tool, pertaining particularly to schizophrenia that can assist in the management of early warning signs (2000: 93-101). In identifying an

individual's early warning sign 'signature' Birchwood et al provide a list of non-specific signs that are drawn from research. For the purposes of the program, these signs have been expanded to include a set of early warning signs pertaining to other major mental illnesses including mood disorders, anxiety disorders and personality disorders. Program participants will be given an opportunity to explore and name other warning signs that have not been mentioned by those listed.

C:\Users\iedeson\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\6Q2I2MBC\Literature Review MI Recovery.docx

34

References

Anthony, W. A. (1993). "Recovery from mental illness: The guiding vision of the mental health service system in the 1990s". Psychosocial Rehabilitation Journal, 16(4), 11-23.

Best, Dawn and Rose, Miranda. (1996). *Quality Supervision: Theory and Practice for Clinical Supervisors,* WB Saunders and Company LTD: Sydney.

Birchwood, Max; Spencer, Elizabeth; McGovern, Dermot. (2000). *Advances in Psychiatric Treatment.* Volume 6, pp. 93-101.

Bond, Gary, (2004) **"**Supported employment: Evidence for an evidence-based practice", *Psychiatric Rehabilitation Journal,* Volume 27, Number 4, pp. 345 – 359.

Borrell-Carrió, Francesc, Suchman, Anthony L., and Epstein Ronald M., (2004) "The Biopsychosocial Model 25 Years Later: Principles, Practice, and Scientific Inquiry" *Annals of Family Medicine,* Volume 2, pp. 576-582. http://www.annfammed.org/cgi/content/abstract/2/6/576

Campbell, J., (2005) "Emerging Research Base of Peer-Run Support Programs" Annotated bibliography, www.power2u.org/emerging_research_base.html

Campbell, Jean, and Leaver, J., (2003) "Emerging New Practices in Organized Peer Support," prepared for National Technical Assistance Center for State Mental Health Planning (NTAC), NASMHHPD, CMHS, SAMHSA and the National Association of State Mental Health Program Directors.
Chamberlin, J. (1997) "A Working Definition of Empowerment", *Psychiatric Rehabilitation Journal*, Volume. 20, Number 4.

Consumer Focus Collaboration. (2000). *Improving Health Services through Consumer Participation: A Resource Guide for Organisations.* Produced by Department of Health, Flinders University and the South Australian Community health Research Unit. Canberra: Brown and Wilton Integrated Publishing Services.

Corey – Schneider, Marianne, and Corey, Gerald, (2001) *Groups: Process and Practice.* California: Brooks/Cole Publishing.

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

Deegan, Gene, "Discovering Recovery", *Psychiatric Rehabilitation Journal,* Volume 26, Number 4, pp 368-376.

Deegan, Patricia, "Principles of a Recovery Model Including Medications", 1995 http://www.power2u.org/downloads/MedicationMeetingPacket.pdf

Deegan, Patricia, (1998), "Recovery: The lived experience of rehabilitation". *Psychosocial Rehabilitation Journal.* Volume 11, Number 4, pp. 11-19.

DeLucia-Waack, Janice L., Kalodner, Cynthia R., (2005) "Contemporary Issues in Group Practice", *The Handbook of Group Research and Practice, Susan A Wheelan (ed). London: Sage Publications. 65-84.*

Dun, C., Fossey, E., (2002). "Promoting the process of recovery". In S Pepper (ed) Vol 1: *Towards recovery* (Series - Psychosocial rehabilitation: Working with People with a Psychiatric Disability. 45-50, North Fitzroy: New Paradigm Press.

 Egan, Gerard (2002), *The Skilled Helper - a problem management approach to helping.* USA: Wadsworth.

Engel, G.L. (1980) The clinical application of the biopsychosocial model. *American Journal of Psychiatry* 137, 535-544.

Falloon, I. And Fadden, G. (1993) *Integrated Mental Health Care* Cambridge: Cambridge University Press.

Finn, Lizzie., Bishop, Dr Brian., "Mutual Help, An Important Gateway to Wellbeing and Mental Health", School of Psychology, Curtin University, Western Australia. www.communitybuilders.nsw.gov.au/download/mutual.doc

Forquer, Sandra., Knight, Ed., (2001) "Managed Care: Managed Care: Recovery Enhancer or Inhibitor?" *Psychiatric Services,* (52), 25-26.

Freedman, Jill, & Combs, Gene, (1996) *Narrative Therapy: The Social Construction of Preferred Realities.* New York: Norton and Company.

Frese, Frederick J., (1993) "Coping with Schizophrenia", *Innovations and Research,* Volume 2, Number 3.

Frese, Stanley, Kress, & Vogel-Scibilia (2001) "Concepts of Recovery in Behavioral Helth: History, Review of the Evidence, and Critique" draft posted on the Internet http://www.dmhas.state.ct.us/recovery/concepts.pdf

Frew, Jon, (1997) "A Gestalt Therapy Theory Application to the Practice of Group Leadership" *Gestalt Review*, 1 (2), pp. 131-149.

Gartner, A., and Riessman, F., (1982). "Self Help and mental health", *Hospital and Community Psychiatry,* 33(8), 631-635*.*

Green, J. (2001) "Peer Education". *Promotion and Education.* (8)2. 65-68.

Harding, C. M. (2003). "Changes in Schizophrenia Across Time: Paradoxes, Patterns, and Predictors" in Carl Cohen (Ed). *Schizophrenia into Later Life: Treatment, Research, and Policy.* Washington, DC: American Psychiatric Publishing, Inc., 19-42.

Knight, Edward L. (2003) "Recovery", presented at *Factors that Promote Recovery: A holistic approach to service systems change.* 13th Annual Conference on State Mental Health Agency Services, Baltimore.

Lehman, A. (2000). "Putting Recovery into Practice: A commentary on 'what recovery means to us'" *Community Mental Health Journal,* Volume 36, Number 3, pp 329-331.

Liberman, Robert Paul. et. Al (1994) "Innovations in Skills Training for People With Serious Mental Illness: the UCLA Social and Independent Living Skills Modules", in *An Introduction to Psychiatric Rehabilitation* (Spaniol, et al, eds)*.* IAPSRS: Columbia.

Lukens, E, McFarlane, William, (2004) Psychoeducation as Evidence-Based Practice: Considerations for Practice, Research, and Policy *Brief Treatment and Crisis Intervention,* Volume 4, 205-225

McCallagh, Juniper. (2005). "The Road to Recovery: A Project Describing the Development of a Peer-led Support and Education program for Consumers", Sponsored by Mental Illness Fellowship Victoria.

McDiarmad, Diane; Rapp, Charles; Ratzlaff, Sarah; (2005). "Design and Initial Results from a Supported Education Initiative: The Kansas Consumer as Provider Program", *Psychiatric Rehabilitation Journal. (29)1. 1-9.*

Mead, S, Copeland, M.E. "What Recovery Means to us: consumer Perspectives", Community Mental Health Journal, Volume 36, Number 3, pp. 315-328.

Mead, S., Hilton, D., Curtis L. "Peer Support: A Theoretical Perspective", (2001) *Psychiatric Rehabilitation Journal.* Volume 5, Number 2, pp. 134 -141.

Mead, S, McNeil. (2003) "A Systematic Approach" http://www.mentalhealthpeers.com/pdfs/PeerSupportSystemicApproach.pdf

Morgan, Alice, (2002) "Beginning to Use a Narrative Approach in Therapy", *The International Journal of Narrative therapy and Community Work,* No. 1, pp. 85-90. www.dulwichcentre.com.au

Mowbray, C.T., Moxley, D.P., Jasper, C.A., Howell, L.L. (1997) *Consumers as Providers in Psychiatric Rehabilitation,* International Association of Psychosocial Rehabilitation Services: Columbia.

National Association of State Mental Health Director Sites Emerging New Practices in Organized Peer Support "Research Bibliography. www.mhcan.org/Resources/peersrc.htm

O'Neill, Marilyn, Stockell, Gaye, (1991) "Worthy of Discussion: Collaborative Group Therapy". *Australian, New Zealand Journal of Family Therapy.* Vol. 12, No. 4. pp. 201-206.

Onken, S. J. *Mental Health Recovery: What Helps and What Hinders? A National Research Project for the Development of Recovery Facilitating System Performance Indicators.* Fifth Annual International Inter-Centre Network for Evaluation of Social Work Practice Workshop, Columbia University, New York, NY, October 3-4, 2002.

Prendergast, Maria, (2006) *Understanding Depression,* Penguin: Melbourne.

Prochaska, J.O. & DiClemente, C.C. (1982) Transtheoretical therapy: Toward a more integrative model of change. Psychotherapy: theory, research and practice, 19: 276-288.

Ralph, R.S., (2000). "Recovery". *Psychiatric Rehabilitation Skills.* (4)3, 480-517*.*

Rickwood, D. (2006) "Pathways for recovery: 4A's Framework for Preventing Further Episodes of Mental Illness", http://www.auseinet.com/cnscare/relapse.php

Russell, Sarah (2005), *A Lifelong Journey: Staying Well with Manic Depression/Bipolar Disorder.* Michelle Anderson Publishing: Melbourne.

Salzer, Mark S, (2002) "Consumer-Delivered Services as a Best Practice in Mental Health Care Delivery and the Development of Practice Guidelines" *Psychiatric Rehabilitation Skills" 6 (3), 355-382.*

Salzer, & Shear, S. (2002). "Identifying consumer-provided benefits in evaluations of consumer-delivered services" *Psychiatric Rehabilitation Journal,* 27,(4), 392-401.

Schutz, W. C. (1973) *Elements of Encounter.* New York: Bantam Books.

Solomon, Phyllis. (2004)   "Peer Support/Peer Provided Services underlying Processes, Benefits and Critical Ingredients", *Psychiatric Rehabilitation Journal,* Volume 27, Number 4, pp 392, 394.

Solomon, P., and Drain, J., (2001). "The state of knowledge of the effectiveness of consumer provided services". *Psychiatric Rehabilitation Journal,* 25(1), 20-27.

Sommers, D., Campbell, J., and Rittenhouse, T. (1999). Annotated Bibliography on Consumer Operated Services, Missouri Institute of Mental Health Program in Consumer Studies and Training: St. Louis, MO.

Spaniol, Leroy, et al. (1994) *An Introduction to Psychiatric Rehabilitation,* edited by The Publications Committee of IAPSRS, International Association of Psychosocial Rehabilitation Services: Columbia

Springgay, Margaret, (2003) "Recovery Issues", presented at a Recovery Workshop.

Sween, Eric, (1998) *Gecko,* Volume 2, pp. 3-6.

Tuckman,, B.W. (1965), Developmental Sequence in Small Groups. *Psychological Bulletin,* Volume 63: 384-399.

Turner, G., Shepherd, J., (1999) *Health Education Research.* (14)3. 235-247.

Wheelen, S. (2005). *The Handbook of Group Research and Practice*. California: Sage Publications.

Yalom, I.D. (1995), *The Theory and Practice of Group Psychotherapy.* New York: Basic Books.Literature Review