Independent Evaluation of the European Union's Education, Audiovisual & Cultural Executive Agency-funded project to develop a Master Programme in Mental Health Recovery and Social Inclusion

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Background

The vision of "recovery" in and from serious mental illnesses that was developed by the mental health consumer/survivor/ex-patient movement in the late 1980s, and which is supported by a body of longitudinal research dating back to the 1970s, is now in the process of becoming a global phenomenon. In the recent past, elements of the recovery process have been identified by persons in recovery and a growing body of qualitative research, and the training and deployment of persons in recovery as providers of mental health peer support has expanded rapidly. As one example, an international charter on mental health peer support is currently in development, and has at this time signatory countries from six continents. So, there is much to learn about recovery but presently few ways to get this knowledge into the classroom, even in the developed world.

Despite efforts by both the American and British governments, for instance, professional organizations and academic institutions have been slow to integrate the recovery vision into existing curricula and training programmes, not to mention their criteria for licensure or certification. One reason for this reluctance has been that the concrete implications of the recovery vision for transforming clinical practice have yet to be determined in any clear or definitive way. Systems that are transforming to a recovery-orientation typically understand this process to include introducing peer support and self-help tools such as Wellness Recovery Action Planning (WRAP) into their existing array of services and supports without changing the fundamental way in which services and supports are conceptualized, designed, delivered, and evaluated. Much work thus remains to be done in articulating and implementing more substantive reforms to clinical care as well as in developing new supports that enable self-care.

What will be crucial for the recovery vision to be actualized in care is for current and future system leaders to be educated in what is already known about processes of recovery and to be engaged in bottom up approaches to translating this knowledge into practices that are consistent with indigenous values. Many, if not most, of these leaders will need to have the lived expertise that comes with personal experiences of recovery (either their own and/or that of a loved one); people who, in the past, may not have had access to, or the resources required for, advanced educational opportunities. It is within this context that the European Union's Education, Audiovisual, and Cultural Executive Agency-funded project to develop a Master Programme in Mental Health Recovery and Social Inclusion was awarded. This programme has the potential to fill a real and pressing need in providing advanced training on-line to persons who are in, or who

wish to take on, leadership roles in systems of care around the world. It is unique in this respect, being both the first on-line training to be provided on recovery and social inclusion and the first Master of Science degree to focus on this emerging area of practice.

In this respect, the development of this programme is very timely and likely to attract a large number of potentially interested people, should the programme prove to be accessible, affordable, and of high quality. The level of interest is especially likely to be high among persons in recovery, family members, and non-credentialed ("paraprofessional") staff in mental health settings, who will see this programme and the credential it offers as an attractive path for career development as well as a way to exert more influence within their own local systems of care. Anticipating that the programme will be especially appealing to this population, it will be important for the curriculum to include information, resources, and skills needed for such persons to obtain and effectively exercise leadership roles in transforming existing systems of care or in developing services and supports from the bottom up in communities where they are lacking.

Scope of Evaluation

This programme evaluation is intended to be complementary to, rather than duplicative of, the formal programme evaluation conducted by Dr. Charles Simpson. As Dr. Simpson's evaluation focused primarily on the programme itself and its functioning—what we might consider the "micro" level—this evaluation will focus on the role of this programme in the broader mental health field, especially related to mental health training and education—what I am suggesting be considered the "macro" level. As a result, I will be considering the programme's course content, student composition, and educational processes within the context of global efforts to disseminate recovery-oriented practices.

Programme Strengths

With respect to the context referred to above, this Master of Science in Mental Health Recovery and Social Inclusion Programme has several considerable strengths. Foremost among these is the fact that this is the first on-line programme to attempt to disseminate information about the transformation of mental health care required by the adoption of the recovery paradigm. As noted in the Background section, the vision of recovery developed and advocated for by persons with serious mental illnesses is rapidly becoming a global phenomenon. While it may have originated primarily in English-speaking countries (e.g., the US, UK, Canada, and Australia/New Zealand), it has now spread throughout most of Europe and is in the early stages of adoption in South America, Asia, and Africa. While there certainly will be substantial differences in how recovery and recovery-oriented practice look across continents and cultures, there is a pressing need for accessible and low cost, but nonetheless high quality, educational and informational

resources to enable leaders, and potential leaders, in all countries to grasp the basics of the recovery vision and to receive some guidance as to its implementation at the local system level. An on-line Master of Science programme can be an ideal vehicle for disseminating this information on a broad basis and at a sufficient level of sophistication to prepare current and future system leaders with the tools and resources needed to tailor this vision to their own circumstances.

It is an obvious benefit, in this regard, that the developers and faculty for this programme come from several different countries and represent a variety of disciplines. It also has been important that persons with lived experience of recovery have been involved from the start, in the roles both of advisors and as faculty. As I will note below, it is fairly common for the most important and innovative, and thereby challenging, elements of the recovery vision to be lost in the absence of the lived expertise such people bring to the table. Faculty for this programme have prevented this from happening through the inclusion of persons in recovery and relevant content experts; it will be important in ensuring the high quality of the programme content for this practice to continue, especially as new implications of the recovery vision continue to emerge as practice changes are introduced. We are still very early in the transformation process, and so we should expect the content to continue to evolve and become more refined over the coming decades.

Another important, if perhaps unanticipated, strength of the Masters Programme is its appeal to persons in recovery who may have had limited opportunities to pursue advanced degrees earlier in their lives or in their local communities. The fact that students can be eligible to apply to this programme without stringent academic prerequisites offers a rare and much appreciated opportunity for such individuals to obtain the academic credentials they need to have broader credibility and to exert more influential within their local systems of care. The same can be said for persons who do not have lived experience of recovery but who have yet to be able to work their way up the career ladder due to their limited academic credentials. Being able to pursue an advanced degree via the internet is sure to appeal to many experienced providers who have felt hampered in their careers due to the lack of financial resources, time, or relevant academic programmes in their vicinity. I imagine a sizable percentage of future students will be drawn from these two groups.

For the programme to be most relevant and useful to these target groups, it should continue to focus concretely on the practice implications of recovery. As noted in student feedback, however, it may also need to include more content on the development and exercise of leadership skills to equip graduates with the knowledge and tools they will need to make the systemic changes in practice needed to implement recovery-oriented care. This brings us to the next section of this report.

<u>Areas for Possible Improvement</u>

As noted above, there is a need to include more content in the curriculum in terms of leadership and policy and programme development. If the graduates of this programme are to become recovery champions in their local systems of care, they will need to know how to elicit, conceptualize, implement, and evaluate the input and feedback of their local recovery community. It is important to note, in this regard, that "leadership" within a recovery framework may be somewhat different from leadership in other contexts, such as business or personal development.

Within a recovery framework, empowerment and leadership are understood to be more political in nature than therapeutic or managerial per se. While people may need to become empowered and develop skills to exert leadership, this is not because of skill deficits or because of their lack of self-confidence. It is more a matter of being offered opportunities to speak and to have their voice matter. In this case, people are empowered by being asked for their goals, asked to sit in on their team meetings, asked for feedback about and how to improve the services they receive, asked to sit on work groups, quality improvement teams, boards of directors, advisory councils, etc. One motto of the recovery movement is especially relevant here. It is the motto of: "Nothing about us, without us." With that understanding of leadership in mind, it is not clear to me at least how the approaches of systemic, cognitive behavioral, or solution-focused therapy that the faculty have proposed to add to the curriculum will lead to this kind of empowerment as much or as directly as policy and practice changes in the ways services are designed, delivered, and evaluated. Briefly stated, preparing for leadership in this context may be more a matter of becoming an advocate rather than of becoming (self-)actualized.

Within the context of this more political sense of leadership, the skills that students will need to learn will include participatory and collaborative strategies that may be borrowed more from the community organizing field than the clinical one. As in the examples above (i.e., of various therapies), clinicians tend to try to subsume recovery into their conventional practices, viewing these as tools to promote the person's individual "journey." Doing so, however, overlooks the social determinants of health that play an equally, if not more, important role in recovery than individual efforts toward self-care. More so than effective therapies, actualizing recovery requires ending the discrimination and stigma that continues to be associated with mental illness in virtually every country on the globe. As a result, students need to be educated about the skills required to push the recovery agenda forward as a civil rights and social justice issue first, with clinical and rehabilitative skills taking second place. The current curriculum appears to have these priorities reversed.

In somewhat of a related vein, both students and faculty have been dissatisfied with the level of peer-to-peer interaction among the students. Especially given the mix of students that the programme has attracted thus far—including practitioners and persons with lived experience

who are not yet employed as staff—peer interactions could be an important source of learning that is currently under-developed. The faculty are urged to consider ways to allow for and promote more peer-to-peer interaction, both in small groups and as a collective, in order to balance the course content with the sharing of real life challenges and successes. It is very much the case with adopting recovery-oriented practices that the proof is in the tasting. Should students not have direct access to experiencing the power of recovery-oriented care in their own locale, they will be very limited in the extent to which they can envision care being any different from what it has always been. Cross-cultural discussions among peers are one useful way to go beyond such limitations.

Finally, for the programme to have more universal appeal, it is recommended that the faculty be expanded to include both academics and persons with lived experience from Asia, South America, and Africa. The programme may very well thrive solely within the European context, and would be a very valuable resource in such a case. The addition of faculty from other continents, however, would not only attract additional students, but would also help to challenge what is currently a highly Westernized and individualistic view of recovery, extending the promise of recovery to persons living with mental illnesses in more collectivist, less industrial cultures.

Conclusion

This programme is unique in the world at this time and has numerous considerable strengths. It promises to open up and expand opportunities for current and future leaders, including persons in recovery, to take up central roles in the global transformation of mental health care to a recovery orientation. To live up to its promise, it will be important for the faculty to continue to value and encourage the involvement of persons in recovery and carers in all aspects of programme design and operation and to enhance the current curricula content related to empowerment, leadership, and the bottom up articulation of what recovery-oriented care looks like in practice in different cultural contexts. In addition, it would be extremely valuable to find ways to increase student-to-student interaction, both formal and informal, and to recruit additional faculty from diverse cultural backgrounds to ensure an appropriate amount of cultural humility as recovery makes its way south and east.

Biographical Information of Evaluator

Larry Davidson, Ph.D., is a Professor of Psychology and Director of the Program for Recovery and Community Health at the School of Medicine and Institution for Social and Policy Studies of Yale University. In addition to his academic roles, he has served as Clinical Director of the Connecticut Mental Health Center, Mental Health Policy Director and Senior Policy Advisor for the Connecticut Department of Mental Health and Addiction Services, and Project Director for

the U.S. Substance Abuse and Mental Health Services Administration's Recovery to Practice initiative, in which role he oversaw the development of training curricula in recovery-oriented practice for six of the major behavioral health disciplines in the U.S. (psychiatry, psychology, nursing, social work, addiction counseling, and peer support).

Dr. Davidson's own research has focused on processes of recovery in serious mental illnesses and addictions, the development and evaluation of innovative recovery-oriented practices, including peer-delivered supports, and designing and evaluating policies to promote the transformation of behavioral health systems to the provision of recovery-oriented, person-centered, and culturally-responsive care. In addition to being a recipient of psychiatric care, Dr. Davidson has produced over 300 publications, including *A Practical Guide to Recovery-Oriented Practice: Tools for Transforming Mental Health Care* and *The Roots of the Recovery Movement in Psychiatry: Lessons Learned*. His work has been influential internationally in shaping the recovery agenda and in operationalizing its implications for transforming behavioral health practice.

<u>The Programme team response to Prof. Davidson's evaluation</u>

The Programme team are grateful for Prof Davidson's work on this evaluation, and assessment of strengths and further recommended work.

We will consider all points carefully, and will look to include other areas of the globe beyond Europe as suggested.

Changes had been made to the Leadership Module as Prof Davidson raised some issues about this module in particular.

We are using the University processes to change the title to Leadership and Collaborative Practice for Innovation.

The learning units have been significantly edited as well as re-ordered. The first four units have a focus on organisational issues for collaborative practice.

Learning Unit One has been replaced with an Introduction to Participation, Integration, Collaboration and Co-production where the "lollipop moment" video aims to set to the context for the module.

There is much more emphasis now in the first half of the module on promoting recovery through organisational change which incorporates the ImRoc work programme as well as examples of integrated working.

The mid module assignment has been changed to:

Critically analyse how the concept of leadership can be applied to innovative ways of working in recovery-oriented services.

The second half / 4 learning units have a focus on people.

Unit 4.5 is a new one: Multi-disciplinary perspectives for collaborative practice. This includes values for social inclusion and recovery. 4.6 continues with this theme about how staff need to work differently to embrace these values. 4.7 provides examples of New Ways of Working. I know you had some reservations about this learning unit, but it is a unit which can continually grow and change as practitioners 'catch up' with service users. The ways of working currently available to students are peer support, solution focused practice and working with voice hearers. The final learning unit reflects this and is now called Co-production in recovery-focused services - essentially about service users leading their own journeys of recovery.

Each learning unit has contributions from service users and some also have carers as active contributors.