# Examining the potential for peer support work to enhance recovery-oriented practice

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**ABSTRACT:** *Peer support workers hold potential to contribute to recovery-oriented practice, aiding recovery for the worker and recipient. Peer support workers potentially offer empathy, role modelling and a unique 'lived experience' expertise that can connect strongly with users of mental health services and help shape more relevant, cost-effective services. There may also be real benefits for the peer support worker's own recovery through increased confidence, feelings of self-worth, improved work skills and employability. As yet, however, there is limited evidence demonstrating the impact of peer support worker programs and little empirical understanding of how different models of peer support aid or inhibit recovery. Further, peer support worker programs have tended to place the impetus to adjust on the peer support worker themselves, with little recognition of the structural and organisational changes required to successfully implement effective peer support worker models. Peer support work is not just about a relationship between the peer support worker and service user. It is an opportunity for collaborative, participatory models of work within mental health services more broadly. This presentation reports on preliminary findings from a study of Mission Australia's efforts to introduce peer support within its Orange and Dubbo mental health services, a study undertaken as a collaborative research project with the University of Newcastle. It introduces the organisational challenges for implementing effective peer support work programs and makes recommendations about the workplace policy and practice innovations necessary to enhance this type of program. Further, the presentation reflects on the ways in which peer support might be more clearly articulated within a recovery-oriented practice framework.*

**Keywords:** *community-based mental health, peer support, recovery, mental health policy*

## Introduction

The national framework for recovery-oriented practice states that:

> The lived experience and insights of people with mental health issues and their families are at the heart of recovery-oriented culture. The concept of recovery was conceived by, and for, people living with mental health issues to describe their own experiences and journeys and to affirm personal identity beyond the constraints of their diagnoses (Australian Health Ministers' Advisory Council, 2013, p. 3).

This reflects an individualised approach to recovery that respects lived-experience expertise and is, in many ways, testimony to the advocacy of the mental health consumer movement. Similarly, there is an emerging policy and practice-level emphasis on the importance of peer support as a component of effective and respectful mental health services. Recovery-oriented practice and peer support seem to be well-aligned approaches to enhance the power and choice of people with experience of mental illness. However, the implementation of peer support models within a recovery-oriented framework is challenging, with little evidence to support translation of the conceptual models of recovery and peer support into meaningful practice. The literature on peer support has also failed to give adequate recognition to the importance of the organisational environment. Well-integrated peer support models subvert conventional hierarchical knowledge and power relationships and, as such, require a large shift in the ways an organisation and its people operate. This paper examines the ways in which recovery and peer support are theorised in key federal and state policies. It then explores the challenges for implementing the policy aspirations for recovery and peer support at the service level, highlighting the need for structural and organisational reform. Finally, the paper discusses how an innovative research collaboration between the University of Newcastle and Mission Australia seeks to address these challenges by trialling an organisational learning approach to peer support.

**Recovery and peer support in policy**

Historically, recovery has been framed in either medical terms, as the recovery from clinical symptoms, or in personalised terms as the empowerment of an individual to live meaningfully *with* their symptoms, the latter model reflecting the aspirations of the service-user movement (Davidson et al., 2005; Gwinner, Knox and Brough, 2013). Slade and Davidson (2011) describe these two meanings as "clinical recovery" and "personal recovery" (p. 26). The Australian national policy framework recognises the interconnectedness of clinical and personal outcomes, stating that "personal recovery is defined within this framework as being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues" (Australian Health Ministers' Advisory Council, 2013, p. 17). Intrinsic to this model of recovery is the positioning of individuals with lived experience of mental illness, and their carers, in key decision-making roles and as part of the mental health workforce, noting that it is one of the key responsibilities of recovery-oriented mental health services to "embrace and support the development of new models of peer-run programs and services" (Australian Health

Ministers' Advisory Council, 2013, p. 5). The strength of the relationship between recovery-oriented practice and peer support models was also a feature of the Fourth National Mental Health Plan, which similarly adopted a personal recovery orientation and emphasised peer workers as a key component of workforce development (Australian Government, 2009). Recently, the National Mental Health Commission (2013) reinforced the dual emphasis on personal recovery and peer support, identifying lived experience as a crucial component of recovery and recommending the development of a "National Mental Health Peer Workforce Development Framework" (p. 56). The National Mental Health Commission (2013) suggests that the peer workforce must be a central component of any mental health support team, with remuneration, support and training that reflect the importance of the role.

The New South Wales Government is currently considering a draft strategic plan submitted by the Mental Health Commission of New South Wales and, as such, current policy documents are somewhat outdated. However, the recommendations put forward by the Commission for the new strategic plan are likely to reflect the perspective that:

> Peer workers promote empathetic services and are known to improve health outcomes for clients, but Australia and NSW have been conspicuously slow to build a peer workforce, leaving potentially valuable experiences and expertise untapped. This must change (Mental Health Commission of NSW, 2013, p. 7).

Certainly earlier state-level policy documents reflected an individual, personal recovery framework that accorded with national policy and identified peer support groups as important in supporting individuals, families and carers (NSW Health, 2008). However, there has been little detail as to how this might be implemented. There is, therefore, clear support at a policy level for mental health services to adopt a recovery-oriented framework, working under the assumption that such a framework would be enhanced through the adoption of peer support mechanisms.

This policy-level support manifests in funding arrangements for non-government service providers, such as the Personal Helpers and Mentors (PHAMS) program, which has been funded by the Australian Government's Department of Social Services since 2008. Since the program's onset, it has been a requirement of the funding to employ at least one peer support worker. Other funding models encourage agencies to consider the employment of peer support workers, but do not necessarily mandate this as a requirement of the funding. While encouraged, there is little detail as to how the implementation of such peer support worker engagement might look.

At a regional policy level, there is also a growing interest in the uptake of peer support models. A recent review of the Western New South Wales Local Health District identified that the lack of employment of peer support workers within the regional health service failed to take advantage of associated cost benefits and improved client outcomes. The reviewers recommended peer support as an integral part of the mental health team structure, noting the importance of "developing a peer support specialist workforce, including investing in peer support specialist training and the infrastructure necessary to support the development of this discipline" (Hallwright & Chiplin, 2014, p. 24). Importantly, this recommendation highlights the structural change required to enable peer support models.

**Recovery and peer support in practice**

For community-based mental health services seeking to implement this policy intent, there are a number of challenges, including structural barriers to recovery-oriented practice, a paucity of evidence to guide the adoption of effective recovery-oriented peer support models and the pitfalls of tokenism.

While Australian mental health policy consistently outlines a personal recovery-oriented framework, the actual operation of the mental health 'system' is often at odds with this theoretical approach. The recovery approach espoused in the policy, based on models such as those of Andresen, Caputi, and Oades (2006) and Glover (2012), is highly individualised, which means that notions of what it means to be healthy, unwell or achieve good 'outcomes' rest on highly personal interpretations. However, federal and state funding models require that service users and providers meet stringent ideals of health and illness – assessed in terms of standard diagnostic criteria – to be eligible for services and benefits. Programs need to conform to these criteria and evaluations of program effectiveness hinge on their meeting government requirements. So even though the policy surrounding service delivery adopts a personal recovery approach, for a service user to access welfare payments and services to support their recovery, they must be clinically diagnosed, i.e., they must conform to protocols couched within a medical model contra to the social model of recovery, which rests on a lived-experience approach and service-user participation and choice.

Models such as that on which the National Disability Insurance Scheme rests seek to address the shortfalls of traditional funding models, which gave service providers the power to make decisions about services and programs, shifting the decision-making power to service users. However, service-users cannot establish their eligibility for services and

benefits without complying with psychiatric assessment procedures that determine that their mental illness is so severe that they are unable to meet the participation requirements, i.e., they are unable to work to support themselves (Department of Social Services, 2014). These welfare-to-work requirements are premised on assessable definitions of capacity that may, in fact, contradict the highly personal aspirations of the individual service user. This leaves community-based mental health service providers in the invidious position of having to balance individual service-user values and recovery goals with prescribed eligibility criteria and program outcomes.

While there are clear theoretical commonalities in recovery and peer support, in that both highlight the value of lived experience, there is not, as yet, clear evidence to indicate whether one has an effect on the other. Peer support models are increasingly being adopted within Australian mental health services on the premise that they will aid recovery outcomes for service users (Hodges, 2006). While studies of peer support have generally found positive impacts, including improved self-perceptions for people with a mental illness, increased involvement of service-users in the treatment and management of their mental illness, a client-centred focus, expansion of social networks, access to peer role models and service flexibility, decreased service utilisation and reduced stigma for people experiencing mental illness (Bolzan et al., 2001; Davis, 2013; Hardiman, 2004; Hodges, 2006; McLean, Biggs, Whitehead, Pratt, & Maxwell, 2009; Moran et al., 2012; Schon, 2010), there is, as yet, no clear evidence demonstrating whether or not peer support improves recovery outcomes. A recent systematic review and meta-analysis of randomised controlled trials of peer support for people with severe mental illness found little evidence to support the effectiveness of peer support interventions with this target group and recommended ongoing rigorous evaluation to determine their impact on service-user outcomes (Lloyd-Evans, et al., 2014). A systematic review of the impact of peer support identified no robust evidence emerging from consumer-led peer-to-peer communities, with most interventions evaluated in conjunction with a professional service (Eysenbach et al., 2004). A recent Cochrane review examining the impact of employing consumers to provide statutory mental health services found only 11 randomised controlled trials and suggested that overall there was little difference between those services delivered by professionals and consumers (Pitt et al., 2013). There was some indication of a correlation between peer-provided services and slightly reduced use of emergency crisis services as well as notable differences in the way services were delivered by professional and consumer workers, with consumer workers likely to spend more face-to-face time with service users (Pitt et al., 2013).

Peer support can take numerous forms, with peer support workers in paid or unpaid roles as team leaders, team members, advisors, advocates, committee representatives, caseworkers or mentors. Service users and organisations seeking to implement peer support within a recovery-oriented framework are challenged by the lack of clear evidence on which to base their peer support practices. This, in part, leads to the potential for tokenism, whereby the practice of peer support is adopted because it is seen as the 'right thing to do' rather than as an evidence-based model of practice. Service users are particularly astute at identifying tokenistic practices that offer the promise of genuine participation without actually devolving power and decision making and have expressed their frustration with participatory approaches that are unlikely to lead to real structural change (Davies, Gray, & Webb, 2014).

Peer support tends to rest on organisations 'extending an invitation' to service users to take on paid or unpaid consumer roles. Here the service user – the person who has experienced mental illness – is invited into a space – dominated by managers and practitioners – to take on a peer support role and, in so doing, adapting to the environment of the organisation, a task which demands the quick adoption of new skills in communication, use of technology, understanding of professional jargon and engagement in workplace relations (Davies, 2012; Davies, Gray, & Butcher, 2014). This would be a big ask even for a professional practitioner, but for peer support workers on their own recovery journey, albeit in many different stages and guises, this is a daunting prospect. Importantly, this approach does little to change power dynamics or address structural inequalities, hence ongoing critiques of tokenistic service-user participation persist (Beresford & Croft, 2004; Carr, 2007; Cruikshank, 1999; Davies, 2012).

## Researching the way forward for recovery and peer support in community-based mental health practice

The organisational environment that absorbs innovation exerts a strong influence on consequent professional cultures and practices. Implementation research focuses not only on systems to support innovation, but also the end-user context, that is the organisations and practitioners that ultimately apply the innovation in their day-to-day engagement with service users. It is not merely a matter of individual practitioners introducing new interventions, as it is increasingly evident that the organisational environment plays a major role in moulding and shaping new practices. Hence, the introduction of peer support does not rest only on the subjective judgements of individual managers but is also a function of engagement with service users and the broader policy environment prompting the use of recovery-oriented peer

support. As such, organisational change results from socially determined and dynamic patterns of collective sense making and decision taking (Gabbay et al., 2003). A collaborative research project between the University of Newcastle and Mission Australia will seek to examine the opportunities and challenges for incorporating peer support into community-based mental health service delivery, emphasising the importance of organisational change.

In piloting the employment of peer support workers at two of its New South Wales sites, Mission Australia confronted the lack of evidence-informed guidance to shape an effective peer-based approach and decided to undertake the work to fill this evidence gap. Unlike the add-on model described above, Mission Australia realised that the effective engagement of peer support workers would require organisational change. Following a review of the literature on peer support and recovery, it became increasingly clear that structural changes would be needed and ways of working adopted that would fundamentally shift power relationships and perceptions of 'expertise' within the organisation. The starting point was not to find peer support workers who would 'fit' into the organisation, but to shape the organisational culture to fit the requirements of people with experience of mental illness.

Increasingly, practitioners are required to do more with less and in such an environment "it is easier to guide an organisation in the direction in which it is already going than to do things differently" (Martinez-Brawley, 1995, p. 677). New ideas that are consistent with organisational beliefs have a better chance of successful implementation. Hence a process of innovation must grapple with perspectives that oscillate between resistance to change and excitement about opportunities to better maximise outcomes with limited resources. This is why the first step in the process of introducing peer support in Mission Australia's work involves interviews with community-based mental health service staff in order to assess the organisational climate and anticipate barriers and facilitators to the further embedding of peer support in its operations. The resultant program that develops to support the introduction of this innovation will ultimately be shaped by managers, practitioners, service users and peer support workers, that is, by an organisation learning to adapt to a practice innovation. From an organisational learning perspective, change or no change is determined by a collective process, though often the forces determining innovation come from outside the organisation – from funders and policy makers, in which case organisations are forced to learn to adapt to change often not of their own choosing. Organisations with flexible and responsive cultures have a far higher chance of embracing change of this nature than those that do not

The first phase of research will examine the current organisational context and explore the barriers and facilitators to employing peer support workers within the organisation's recovery-oriented approach. The early stages of this research have already revealed the difficulties involved in translating a recovery-oriented framework into practice, suggesting the need for the organisation to consult with its service users in establishing a service-delivery framework that truly reflects this approach.

The current organisational context will be examined through an analysis of existing organisational policies to determine the extent to which processes, such as recruitment, employment and supervision, might support or impede the employment of peer support workers. The barriers and facilitators will be explored through in-depth interviews with team leaders and caseworkers (n=16) and peer support workers already employed (n=2) in order to make some preliminary recommendations as to the definition and role of a peer support worker within the organisation and the training and support required, to implement an effective peer support program. Adopting an organisational learning model, the peer support workers, along with the staff members involved in the management, administration and delivery of the organisation's mental health services, will be involved in the process of 'embedding' peer support and developing the organisational culture necessary to support peer support workers and managers in negotiating this service innovation.

**Conclusion**

The current policy and practice emphasis on peer support as a tool to support mental health recovery is an opportunity to challenge traditional hierarchies and structures which have made it difficult for people with experience of mental illness to have their expertise and preferences valued. However, without an emphasis on organisational reform and a better understanding of the complex relationship with recovery, peer support models may perpetuate tokenistic and poorly evidenced approaches to practice. By examining the implementation of peer support from an organisational learning perspective and seeking to embed peer support within the culture and operations of Mission Australia, important evidence will be garnered to support *effective* models of peer support. The ultimate outcome sought is an evidence-based approach to improving recovery outcomes for clients.

**References**


Andresen, R., Caputi, P. and Oades, L. (2006). Stages of recovery instrument: Development of a measure of recovery from serious mental illness. *Australian and New Zealand Journal of Psychiatry, 40*(11-12), 972–980.

Australian Government (2009). *Fourth national mental health plan: An agenda for collaborative government action in mental health 2009-2014*, Canberra: Commonwealth of Australia.

Australian Health Ministers' Advisory Council (2013). *A national framework for recovery-oriented mental health services: Policy and theory,* Canberra: Commonwealth of Australia.

Beresford, P. and Croft, S. (2004). Service users and practitioners reunited: The key component for social work reform. *British Journal of Social Work, 34*(1), 53–68.

Bolzan, N., Smith, M., Mears, J., and Ansiewicz, R. (2001). Creating identities: Mental health consumer or citizen? *Journal of Social Work, 1*(3), 317–328.

Carr, S. (2007). Participation, power, conflict and change: Theorizing dynamics of service user participation in the social care system of England and Wales. *Critical Social Policy, 27*(2), 266–276.

Cruikshank, B. (1999). *The will to empower*. New York: Cornell University Press.

Davidson, L., O'Connell, M.J., Tondora, J. and Lawless, M. (2005) 'Recovery in serious mental illness: A new wine or just a new bottle?', *Professional Psychology: Research and Practice, 36*(5), pp. 480–487.

Davies, K. (2012). *Service-user perspectives on evidence: shaping participatory mental health and homelessness services* (Unpublished doctoral thesis). University of Newcastle, Newcastle, Australia. Retrieved from http://hdl.handle.net/1959.13/932175

Davies, K., Gray, M., and Butcher, L. (2014). Lean on me: The potential for peer support in a non-government Australian mental health service. *Asia Pacific Journal of Social Work and Development. 24*(1-2), 109–121.

Davies, K., Gray, M., and Webb, S.A. (2014). Putting the parity back into participation: An integrated model of social justice. *International Journal of Social Welfare. 23*(2), 119–127.

Davis, J.K. (2013). Predictors of job satisfaction among peer providers on professional treatment teams in community-based agencies. *Psychiatric Services, 64*(2), 181–184.

Department of Social Services (2014). *A new system for better employment and social outcomes: Interim report of the reference group of welfare reform to the Minister for Social Services.* Canberra: Commonwealth of Australia.

Eysenbach, G., Powell, J., Englesakis, M., Rizo, C., and Stern, A. (2004). Health related virtual communities and electronic support groups: Systematic review of the effects of online peer to peer interactions. *Primary Care, 328*(1), 1–6.

Gabbay, J., le May, A., Jefferson, H., Webb, D., Lovelock, R., Powell, J. and Lathlean, J. (2003). A case study of knowledge management in multi-agency consumer-informed "communities of practice": implications for evidence-based policy development in health and social services. *Health: An interdisciplinary Journal for the Social Study of Health, Illness and Medicine, 7*(3), 283–310.

Glover, H. (2012). Recovery, Life Long Learning, Social Inclusion and Empowerment: Is a new paradigm emerging? in P Ryan, S Ramon and T Greacen (eds). *Empowerment, lifelong learning and recovery in mental health: towards a new paradigm*, New York: Palgrave Macmillan.

Gwinner, K., Knox, M. and Brough, M. (2013) 'Making sense of mental illness as a full human experience: Perspective of illness and recovery held by people with a mental illness living in the community', *Social Work in Mental Health, 11*(2), pp. 99–117.

Hallwright, S. and Chiplin, J. (2014). *Mental health review – key service-related findings and recommendations.* Western NSW: Western New South Wales Local Health District.

Hardiman, E.R. (2004). Networks of caring: A qualitative study of social support in consumer-run mental health agencies. *Qualitative Social Work, 3*(4), 431–448.

Hodges, J.Q. (2006). Peer support among consumers of professional mental health services: Implications for practice, policy and research. *Journal of Human Behavior in the Social Environment, 14*(3), 81–92.

Lloyd-Evans, B., Mayo-Wilson, E., Harrison, B., Istead, H., Brown, E., Pilling, S., Johnson, S., Kendall, T. (2014). A systematic review and meta-analysis of randomised controlled trials of peer support for people with severe mental illness. *BMC Psychiatry, 14*(39), doi:10.1186/1471-244X-14-39.

Martinez-Brawley, E. E. *(*1995*).* Knowledge diffusion and transfer of technology: Conceptual premises and concrete steps for human services innovators. *Social Work, 40(*5*),* 670–682.

Mental Health Commission of New South Wales (2013). *Living well in our community: Towards a strategic plan for mental health in NSW.* Paper 1 – May 2013. Gladesville, NSW.

McLean, J., Biggs, H., Whitehead, I., Pratt, R., and Maxwell, M. (2009). *Evaluation of the Delivering for Mental Health peer support worker pilot scheme* (Report No. 87). Retrieved from http://www.scotland.gov.uk/Publications/2009/11/13112054/0

Moran, G.S., Russinova, Z., Gidugu, V., Yim, J.Y., and Sprague, C. (2012). Benefits and mechanisms of recovery among peer providers with psychiatric illness. *Qualitative Health Research, 22*(3), 304–319.

National Mental Health Commission (2013). A Contributing Life, the 2013 National Report Card on Mental Health and Suicide Prevention. Sydney: NMHC

NSW Health (2008). NSW community mental health strategy 2007 – 2012: From prevention and early intervention to recovery. Sydney: NSW Government.

Pitt, V., Lowe, D., Hill, S., Prictor, M., Hetrick, S.E., Ryan, R., and Berends, L. (2013). Consumer providers of care for adult clients of statutory mental health services. Cochrane Database of Systematic Reviews, 3 doi: 10.1002/14651858.CD004807.pub2.

Schon, U. (2010). The power of identification: Peer support in recovery from mental illness. *Scandinavian Journal of Disability Research, 12*(2), 83–90.

Slade, M. and Davidson, L. (2011) 'Recovery as an integrative paradigm in mental health', in Thornicroft, G., Szmukler, G., Mueser, K.T. and Drake, R.E. (eds), *Oxford textbook of community mental health*, Oxford: Oxford University Press.