Lean on me: the potential for peer support in a non-government Australian mental health service

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Lean on me: the potential for peer support in a non-government Australian mental health service

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This paper examines the challenges and opportunities for integrating peer support in mental health. After reviewing the contemporary literature, it considers how the findings of a recent qualitative case study, which examined the perspectives of mental health service users (n = 11) on service-user participation and evidence-based practice, might inform the introduction of a peer support program into a mental health service provided by a large Australian non-government organisation. While there is little empirical evidence demonstrating the effectiveness of peer support, the study revealed that service users valued the expertise of their peers and offered guidance for translating evidence into service models.

Keywords: peer support; mental health; service users; participation; evidence-based practice

The engagement of peer support workers in the delivery of mental health services is becoming increasingly common in Australia despite a lack of empirical evidence to explicate the factors that contribute to successful peer support interventions. There are myriad ways in which service users have been engaged in mental health services as advocates, mentors and trainers helping service providers better understand the needs of their clients. Peer support is a fairly new innovation occurring within the recovery-oriented mental health movement, which advocates that engaging peers is effective in improving service users' sense of connectedness to mental health services. However, there is little evidence about how the different modes and methods of peer support affect outcomes for service users and providers. This paper reviews the contemporary literature on peer support and considers how the findings of a recent study on the relationships between evidence-based practice and service-user participation for mental health service users might inform the introduction of a peer support program in an Australian non-government mental health service.

Literature review

Peer support 'has emerged as an innovative service delivery mechanism, particularly for those ill-served by traditional systems of care' (Hardiman, 2004, p. 432). It involves the exchange of mutual helping between individuals and can be viewed as an embodiment of client-centred principles since 'consumer providers may be inclined toward a naturally empathic relationship with service recipients, and may be able to better advocate for their needs based on experience with the mental health system' (Hardiman, 2004, p. 432). Peer

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support programs tend to vary in the procedures, methods and definitions they use (Bolzan, Smith, Mears, & Ansiewicz, 2001; Mohr, Burke, Beckner, & Merluzzi, 2005). Some function as complementary to mainstream mental health services, while others are entirely consumer-run (Hodges, 2007; Moran, Russinova, Gidugu, Yim, & Sprague, 2012). Some focus on providing support, while others concentrate on teaching specific self-management skills. Programs can be highly structured, following a plan, or unstructured and organic, evolving from some other activity such as an information session (Bolzan et al., 2001). They can be conducted face to face or via telephone (Mohr et al., 2005) and may involve people with mental illness, their carers or a combination of these people (Bolzan et al., 2001). Thus, peer support is a complex phenomenon with highly variable applications (Dennis, 2003).

In recent times, less than optimal outcomes and escalating costs for chronic conditions, including mental illness (Lawn et al., 2007), have prompted recognition that health professionals alone are unable to address evolving health needs (Dennis, 2003) and that mental health consumers potentially represent a key asset to this service environment (Dennis, 2003; Hodges, 2007; Moran et al., 2012). Consequently, peer support services have become increasingly prevalent in consumerist recovery-oriented mental health (Hodges, 2007). Some studies suggest peer support is cost-effective and can be implemented with few resources (Mohr et al., 2005; Young, Harrell, Jaganath, Cohen, & Shoptaw, 2013) and little training (Hardiman, 2004). However, Watson's (2012) personal experience as a peer support worker led him to conclude that the process was not that simple and peer support workers required intensive training, supervision and support. While an initial input of resources might be required to support peer support workers, an overall cost benefit might nonetheless ensue. While a recent study published by the Centre for Mental Health found some evidence to support the relationship between peer support and lower inpatient bed use (Trachtenberg, Parsonage, Shepherd, & Boardman, 2013), further research is needed to explore the benefit-to-cost ratio.

However, peer support's appeal is not merely economic rationalism. It emerged from the mental health 'consumer' or 'survivor' movement (Moran et al., 2012), which proposed more empowering notions of choice and control (Scott & Doughty, 2012) and a more active role for people with mental illness as 'experts' in service provision (Beresford, 2010; Bolzan et al., 2001). The ethos underlying user-based initiatives was service users speaking and acting for themselves; having more say over their lives and the support they receive; working together to achieve change; challenging stigma and discrimination; having access to non-medicalised interventions; valuing user-controlled organisations; focusing on people's human and civil rights; and being part of mainstream life and communities, able to take on responsibilities as well as secure entitlements (Beresford, 2010). The ultimate goal of peer support-based mental health interventions or, at least, the inclusion of peer support as a component of mainstream mental health services, is to improve the quality of life and well-being of participants.

Studies of peer support generally found it beneficial for providers and receivers of services (Davis, 2013; Hardiman, 2004; McLean, Biggs, Whitehead, Pratt, & Maxwell, 2009; Moran et al., 2012; Schon, 2010) or at least that interventions provided by peer support workers had similar outcomes to those provided by clinical staff (Slade, 2013). Additionally, social work students on field placement indicated that the best source of on-the-job professional learning they had received came from peer support workers (Beresford, 2010).

An Australian study showed that people with a mental illness who participated in peer support groups reconstructed the ways they saw themselves, suggesting that peer support

enables a transition from passive consumerism to active citizenship (Bolzan et al., 2001). Hardiman (2004) found that consumer-run mental health agencies provided a haven for people with a mental illness, promoting a sense of ownership, flexibility, expansion of social networks and an opportunity for peers to model recovery for one another. These consumer-led services were considered complementary to professional-run services, offering a personalised type of support that fulfilled a different need to conventional mental health services. Studies also identified potential for peer support interventions to contribute to enhanced functioning in activities of daily living, decreased service utilisation (Davis, 2013) and reduction in the stigma associated with mental illness (Hodges, 2007). Clayton, O'Connell, Bellamy, Benedict, and Rowe (2013) found that a citizenship-based intervention, which included peer support, as well as classes and projects related to citizenship and community values, had positive impacts on psychiatric symptoms, alcohol use, drug use and quality of life for people with serious mental illness and involvement in the criminal justice system. However, this randomised controlled trial also highlighted the importance of post-intervention follow-up and support.

Peer support may have benefits not only for the recipient of support services, but also for the individual providing peer support. Moran et al. (2012) found it transformative for the peer support workers, in line with the recovery process, whereby 'the use of one's lived experience as a source of knowledge transforms that which is most stigmatized into an asset' (p. 314). However, the positive impacts of peer support may vary for different groups. In one study, racially and ethnically diverse people with a serious mental illness expressed a preference for peer-based approaches over clinician-driven professional models (Cabassa et al., 2013). In another study, male patients recruited from a Veterans Affairs clinic were more likely than other patients in the study group to complete a telephone-based mutual peer support program for depression (Travis et al., 2010). While peer support services have been found to reduce the stigma associated with mental illness (Hodges, 2007), findings from one study showed that they only had a positive outcome among clients with few stigma experiences, as stigma itself impeded the formation of beneficial outcomes (Verhaeghe, Bracke, & Bruynooghe, 2008).

While the literature is promising in terms of peer support's potential contribution to recovery for both recipients and providers, the specific factors which contribute to the success or otherwise of peer support interventions is not so clear. Moran et al.'s (2012) study indicated that, given the potentially transformative impact for peer support workers, there must be sufficient but sensitive opportunities for the telling of personal stories; also, for the benefit of the peer support workers, there must be opportunities for networking with peers and an environment that is optimistic and encourages self-determination.

Findings also differed according to the aim and focus of the peer support programme. A study of telephone-administered peer support for people with multiple sclerosis found that programs involving skills training led to significant improvements, while those focused on support provision did not (Mohr et al., 2005). Other studies found that peer social support provided in tandem with intensive case management was associated with positive outcomes, including fewer hospitalisations and improved quality of life (Beresford, 2010; Lawn et al., 2007). These findings highlight that peer support may be one component in a multifaceted intervention in which recovery is improved through a peer support program that is part of, or complementary to, proper training and the provision of quality clinical care.

Several barriers to the implementation of peer support services were identified in the literature. Professionals continued to value professional services over user-led services (Bolzan et al., 2001). These attitudes have been strengthened by the evidence-based

practice agenda, which prioritises objectivity (Beresford, 2010) over personal experience. Like other employees, peer providers have been found to experience job satisfaction in an integrated work environment that includes role clarity, strong co-worker support, rapport with supervisors, inclusion in organisational processes, independent functioning, and respect for the expertise that peer support workers contribute (Davis, 2013), and there is a risk that peer support interventions that do not sufficiently support or train workers will not attain positive impacts.

While on the surface recognition of the potential contribution of peer support has increased, there remains a substantial gulf between rhetoric and reality in many areas of policy and practice (Beresford, 2010). Robust evidence of the effectiveness of peer support is required if this approach is to become more widely accepted and promoted by mainstream mental health services and professionals. Eysenbach, Powell, Englesakis, Rizo, and Stern's (2004) 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. Further, the small sample sizes and definitional inconsistencies of many studies of peer support limit the generalisability of results. A recent Cochrane review was able to identify only 11 randomised controlled trials and came to largely agnostic conclusions (Pitt et al., 2013). As funding becomes more contingent on evidence-based practice, it is essential that the growing concept of peer support is clearly explicated (Dennis, 2003), standards for its implementation created (MacNeil & Mead, 2005) and the role of peer support workers clearly articulated.

What service users are telling us

A recent study with users of Australian mental health services sought to identify the value of evidence-based practice to service-user decision-making and participatory practices (Davies, 2012; Davies, Gray, & Webb, forthcoming). Semi-structured interviews were conducted with 11 users of Australian mental health services, recruited through advertisements in the publications and bulletins of service-user agencies and associations. Interviews were also conducted with a sample of mental health service providers (n = 6) to test for consistencies and tensions in the understandings between users and providers. Initial findings were presented to two focus groups with service users (n = 4) to test their accuracy and workability. Participants in the original interviews were invited to focus groups and new participants were also invited through advertisements in publications and bulletins of service-user agencies. Focus group participants generally agreed with the findings of the study and reinforced the key messages. The service-user participants in the interviews and focus groups were primarily individuals who were active in roles as representatives and advocates for people with experience of mental illness. This was to be expected, given that participants were recruited through consumer representative agencies, and was considered beneficial, as the participants were able to reflect on both individual and representative experiences of participation. Of the mental health service-user participants interviewed, nine were female and two were male, and of those in focus groups three were female and one was male. Participants were not asked to reveal details of their specific psychiatric diagnoses and were only required to attest that they had used – clinical and community-based – mental health services in the past five years.

The study identified key points about potential participatory roles for service users in shaping decisions about services, policies and interventions. It highlighted that service users value the expertise of their peers and see them as a trusted source of information, and

find it easier to form relationships with peer workers than professionals. Service users who had acted in paid or voluntary peer support roles expressed concerns about tokenistic participation, which signalled a lack of real intent for change in workplace practices, and believed service-user participation that carried financial rewards meant their expertise was valued. High demands were placed on peer workers, who were expected to traverse the widely divergent realms of service users and professionals. This often required arduous reading and levels of technical knowledge that excluded many service users from taking on peer support roles. Service users experienced conflict in taking on paid or voluntary roles within organisations against which they had, as activists, sought to advocate. They experienced ambivalence about the shift from working on the outside to working from within. Further, the recurring nature of their illness meant that flexibility and compassion within service structures was needed to support their fluctuating capacity for participation.

Service-user experiences of participation

For service users, participation had a broad meaning and included a variety of activities, of which peer support was one. Most of the service users in Davies (2012) study had participated in multiple roles as consumer representatives or advocates. Nine had worked in consumer-designated, salaried roles and one had worked as a professional in the mental health sector but had not identified her status as a mental health consumer to her employer. Six had participated on at least one, but more often multiple, committees as mental health consumer representatives, in generally unpaid positions. One service user ran a local peer-supported recovery group as a volunteer. Most respondents described a type of 'informal' participation that was about individual advocacy activities, *ad hoc* contributions to peer groups or raising awareness through personal interactions. One interviewee had not participated in any activities and only received a regular newsletter from a mental health organisation, because of physical health problems and because he was not ideologically motivated to participate, as society already viewed him as a 'bludger' (a lazy person).

In this study, participation was defined at two levels, individual and representative. Individual participation considered the extent and ways in which individual service users participated in decision-making around their own treatment and the ways in which they, as individuals rather than members of peer groups, challenged stigma and discrimination in their daily lives. Representative participation considered those roles where service users acted as advocates, champions, peer leaders and so on to influence service delivery or policy regarding mental health.

In general, the respondents in this study believed themselves capable of meaningful participation in society that may have been compromised only temporarily during times of extreme illness, such as major psychosis. That society, and the human and health services system within it, did not always afford equal opportunities for participation was a motivating factor for many as consumer advocates and representatives. For example, Tara stated: 'I have empathy with the people who use the system and who don't know what I know. And I know that what I have learnt is useful and I want to share that.' Greta and Martha wanted to be role models for how recovery from mental illness could be achieved, despite the tendency for mentally ill people to be treated as incapable and dysfunctional. Greta aimed to 'make people understand what happens to people in the system'.

The experience of being a user of mental health services, trying to locate and access the most appropriate services, to maintain one's independence and confidence while a client of those services, and to understand the illness and one's options for treatment and recovery were seen as overwhelming tasks. The service users felt that the frightening nature of

serious mental illness was often exacerbated by discriminatory attitudes, a lack of compassion, gross incompetence, and complete exhaustion among some professionals within the health and human services sectors, as well as a lack of resources available to support clients and their recovery. The system had failed and so service users saw the need to step in to address this failure, using the knowledge and skills they had gained from their own experiences.

Importance of lived experience

Mental health service users saw that their unique knowledge gleaned from living the experience of mental illness was a source of special and valuable expertise. Most saw sharing their knowledge with fellow consumers as an important tool in recovery. For example, Tara said that most consumers will tell you 'well actually the best thing about being in hospital was talking to the other consumers on the verandah and that's how I got well'. In conducting their own investigations into schizophrenia by searching for information about their illnesses, Sarah and Elizabeth had been heavily influenced by other service users' personal accounts of their experiences. In her work as a consumer consultant, Tracey would tell clients immediately that she was a fellow consumer, because this was an effective way of breaking down barriers and establishing a 'connection'.

Greta saw 'lived experience' as a highly valuable but contentious source of expertise. A significant part of her work as a consumer advocate was to gain recognition for the importance of this lived experience in treatment and support decisions, but also important were training, education, and skill development. She cited examples where consumers had been placed on committees to share their experience-based knowledge but where, because they were poorly trained and lacked support in their role, they had broken down and appeared fragile, reinforcing stereotypes of the helplessness of people with mental illness. Greta was selective about sharing her story in public because of the way in which people's stories could be taken over by mental health workers and researchers and retold in contexts where individuals lost 'power' over their stories. In contrast, other interviewees made their stories publicly available, seeing them as a source of knowledge and shared expertise. One service user had written and self-published books about mental illness, which told of the personal journey through mental illness and the strategies that had worked for him in dealing with it. A number of participants had spoken publicly about their experience of mental illness at conferences, community events and professional networking meetings. For these people, sharing their stories and suggestions enabled them to support other consumers in making informed decisions, enhance workers' understandings of mental illness, build better strategies for working with people with mental illness and break down public stigma. These approaches to the dissemination of service-user expertise highlighted its personal nature and the complexities involved in working with a type of knowledge stemming from lived experience.

Challenges of participation

The historical mistreatment of people with mental illness and a sense of anger toward the system that doled out poor treatment and stigmatised the mentally ill led to a consumer movement premised on amending and ending such abuse. Therefore, the participation of service users *within* the system became important, as though from within they could stop mistreatment from happening. The paradox for the majority of the mental health consumers interviewed was that to change the system that had been the source of much

hurt, and even trauma, they needed to work with, and often within, that very system and sometimes in bounded roles that led them to feel further marginalised.

Tara and Claire described experiences as consumer representatives on committees where they had not been listened to and where their ideas and feedback had been ignored or undermined. The examples they cited of where their participation had been effective, and where they had felt listened to, were those where their involvement was long term and their roles were clear.

For Greta, the reluctance on the part of government and non-government organisations to pay consumers for their input or to provide them with adequate resources, such as computers, Internet access and telephones, was an indication of the low value placed on consumer participation and the lack of understanding regarding the challenges to meaningful participation. She found that her desire to be paid for her time had been a point of contention in many activities, where other consumers did not consider payment appropriate or where the workers involved were unwilling or unable to provide payment. This was a major barrier to participation where costs related to travel for meetings, Internet access and telephone usage were incurred.

The frustration with non-payment for services rendered as a consumer representative was indicative of the economic cost of participation and of a desire to be treated on a par with professional counterparts. It represented a conflict between enthusiasm for the opportunity to participate and anger with the manifestation of that participation and recognition that many of the opportunities were not achieving real changes in power relations. In response to the perception that their participation was tokenistic, service users strove to achieve legitimacy and a degree of parity with sector professionals.

Professionalisation of the consumer role

The professionalisation of consumer roles was indicative of the way in which service-user participation sought legitimacy and power. Increasingly, community-based mental health organisations were engaging skilled consumers as paid employees in peer support roles. People with experience of mental illness who had undertaken employment as consumer representatives felt this professionalisation of their roles was important and it allowed them to provide support to their peers in a more informed and effective way. For Tracey, this professionalisation was really crucial:

> I mean the great thing for me is that I can walk into any ward at any time and as a team member I can go and look at any of the files. I can sit in on any of the staff handover meetings or the case-planning meetings, I can question.

Other service users had found it challenging to balance their dual position as consumer and professional, noting they had often been questioned about their qualifications for the role and, mindful of the workplace hierarchy, with consumer workers at the bottom. Five service users had undertaken formal study in social science or community service disciplines, including degree-level qualifications. Tara explained:

> I remember being, trying to communicate that I wasn't happy with what they were saying … and saying well 'stuff you, you don't know what you're talking about, you will not listen to us, you don't want to hear us, so I'm going to go and get a degree and get your qualifications so that you will have to listen to me'.

Becoming formally educated in the sector in which they were service users was a means of understanding the conditions and issues affecting them, arming themselves with knowledge and skills so they could perform their function as a consumer representative

more effectively, and achieving legitimacy. The way in which service users sought to supplement lived experience skills and knowledge with academic training also reflects the expectations upon service-user representatives to fit in with professional forums, where the demands on time and intellect can be substantial.

The demands on service users to participate in large numbers of forums, especially those where they were lone service users working with groups of professionals, were enormous and often seen as disincentives to participation. In many instances, it was the service users who were required to quickly acquire new skills and knowledge and extend themselves beyond their comfort zone in order to participate in structured, professional forums such as committee meetings. The amounts of reading required were often arduous. There was little evidence that the professional sector had adjusted its structures to create more equal involvement of service users, other than to allow the service users into its existing forums. Most of the compromise was made on the part of the service users, who were often out of pocket, busy and overwhelmed. Claire suggested that to participate in the range of committees and consultancy activities with which she had been involved, 'it's not enough just to be a consumer. You also have to be like an intelligent, informed, articulate consumer.'

An optimistic outlook

Despite the significant challenges for participatory and, more specifically, peer support roles, overall the respondents expressed hope and optimism. Most were passionate in their commitment to change and were positive about their roles. The service users believed their representation had led to a number of positive consequences. They had been able to give fellow consumers information they would otherwise not have received about their rights and options for treatment and support. They had allowed clients and patients in service settings to open up and express concerns and fears they would otherwise not have expressed to professional staff. Almost all described a feeling of self-worth, or improved self-esteem, arising from the process of service-user participation, frequently using phrases such as 'having a voice', 'giving a voice to', 'empowerment' and 'connecting' when discussing the participation process (Davies, 2012). They saw participation as an intrinsic part of recovery, believing service users needed to increase their level of input and control in individual-level decision-making and also, for some, at a program and policy level.

Implementing peer support models

Australia's 'National Framework for Recovery-Oriented Mental Health Services' (Australian Health Ministers' Advisory Council, 2013) states that recovery-oriented mental health services have a responsibility to 'embrace and support the development of new models of peer-run programs and services' (p. 5). There is a growing recognition of the importance of peer-based interventions and increasing expectations on providers of mental health services to incorporate peer support into their practice.

The application of a recovery-orientated service system entails challenges for ensuring both consumer choice and protective systems (Gilburt, Slade, Bird, Oduola, & Craig, 2013). In order to conceptualise recovery-oriented practice, Le Boutillier et al. (2011) identified the four organisational pillars of promoting citizenship, organisational commitment, working relationships and support for personally defined recovery.

Mission Australia is one service provider currently contemplating the ways in which peer support might enhance its recovery-oriented approach to mental health service delivery. Mission Australia is a non-government organisation delivering a range of employment, community, early learning and housing services across the country. Of all users of Mission Australia's community services, 85% indicate mental illness as a contributing factor to presenting to services for assistance (Lynch, 2012). Mission Australia delivers a range of specialist mental health services including the Housing and Accommodation Support Initiative (HASI). HASI is a state government-funded program that supports people with mental illness to access secure housing, and clinical and rehabilitative services. Mission Australia has identified that the recruitment of peer support workers within this program could provide an important complementary service to its current clinical and community-based support mechanisms. However, the challenge faced when initiating the implementation of such an intervention was that, despite recognition of the potential benefits of peer support, there was little guidance regarding components that constitute a successful peer support initiative.

The review of literature and the findings from the above study provide some useful starting points for considering the ways in which peer support should be implemented, but also reveal important gaps for ongoing study. It is apparent that the introduction of a peer support program is part of an organisational change process. The receptivity of managers to this innovation needs to be assessed and mental health service users need to be involved in the development of the peer support intervention. In the case of Mission Australia, a reference group will be established, comprising academic, practitioner and lived experience experts, to guide the process of designing, implementing and evaluating a peer support programme. Preparatory steps will determine the nature of the peer support workers' roles, the training and support needed, remuneration, integration with the overall organisation, and monitoring and evaluation measures to determine its effectiveness. Crucially, a 'whole-of-organisation' approach will be adopted, recognising that the success of the peer support program does not rest only on the effectiveness of the relationship between the peer support worker and peer support recipient, but relies on staff at all levels engaging in a process of structural reform that formally places a higher value on the expertise of people with lived experience. It is anticipated that this will require, or lead to, changes in policy, procedure and even governance within the organisation.

Considerations relating to the implementation of a peer support programme

Organisational commitment to meaningfully engaging a peer support workforce is one of the key determinants of the successful implementation of a peer support program (Slade, 2013). Slade (2013) claimed that the greatest function of the peer workforce in mental health was to promote hope and empowerment in service users and, hence, facilitate recovery. Mission Australia's motto of *Standing together with Australians in need until they can stand for themselves* fits neatly alongside the philosophy of peer support – to support hope and recovery, and empower people into independence.

However, the stark warning from participants in the study is that tokenistic and poorly supported approaches to peer support are likely to have the opposite effect, exacerbating the frustration and alienation of people with experience of mental illness. While in Mission Australia there is already an organisation-wide recognition of the value of a peer, work is needed to ensure that managers and co-workers – whether professional, paraprofessional

or volunteer – recognise peer workers as colleagues. In its implementation of a peer support mental health programme, therefore, organisational recognition will ensue from paid employment in designated positions within the organisation, supported by supervision structures that promote inclusiveness and autonomy, meaningful opportunities for personal and professional development, and involvement in decision-making. Further, managers, supervisors and clinical caseworkers will be involved in the development of the peer support role within the mental health team, and peer support workers and service users will participate in the development of the peer support program in order to incorporate service-user perspectives.

As per the findings from the literature and the study, the peer support program will ensure that the role of peer support workers is well defined, and remunerated in accordance with relevant workplace standards. It will also provide flexible work conditions that consider the fluctuating capacities of the peer support workers and their personal recovery needs. Roles for peer support workers will include:

Providing input at a policy level in the organisation to ensure that perspectives of people with experience of mental illness are considered and that responses and frameworks are appropriate and relevant.

Providing direct, face-to-face support at regular intervals for clients of the Housing and Accommodation Support Initiative, which might entail navigating treatment and service options and providing mentoring and support in daily living skills.

Advocating within the organisation and to other stakeholders regarding key issues facing people with experience of mental illness.

Peer support workers will undertake formal training prior to being matched with peers. In Australia the Mental Health Coordinating Council (2013) is currently designing an accredited peer support work training programme, which provides an important starting point for recognising the formal qualifications sought by both the peer support workers and their employers.

An opportunity to build the evidence base

The successful design and implementation of any service innovation is a complex undertaking that frequently requires organisational change. In effect, the process has already begun with the evidence-based approach being taken to the introduction of Mission Australia's peer support programme, as this paper has described. However, this case study on the initial stages of peer support implementation has revealed a need to build the empirical evidence base regarding not only the impact and effectiveness of peer support interventions, but also the organisational requirements to making peer support interventions successful in achieving recovery-oriented goals for recipients and providers of peer support. As such, this provides the starting point for a further study which will compare and contrast the implementation of peer support programs at a number of HASI sites in urban and rural settings in Australia. These case study sites will provide an opportunity to evaluate the relevance and effectiveness of training programs for peer support workers, the changes in attitude and practice of managers and practitioners and the impact on outcomes for peer support recipients, including personalised recovery outcomes and standardised outcomes relating to housing and hospitalisation. The intervention research design will seek to produce an evidence-based model of peer support for urban and rural mental health settings in Australia.

Conclusion

In examining the challenges and opportunities inherent in integrating a peer support program into an Australian mental health service in light of a literature review and findings from an exploratory qualitative case study, this paper has highlighted the importance of gleaning organisational and service-user perspectives early in the development of such an initiative. To achieve positive impacts from a peer support intervention requires a serious organisational commitment to integrating peer support workers as valued and vital members of the team, which in this case will be achieved through workforce development and role definition. While service users, as both recipients and providers of peer support, will inevitably challenge and extend their own capacities, the organisation must match this, through its own structural reform. Further, this recent attempt at implementing a peer support program has highlighted the need to build the evidence base on the relationship between peer support and recovery and has provided the stimulus for further study.

Notes on contributors

Kate Davies (PhD) completed her PhD on 'Service-user perspectives on evidence: Shaping participatory mental health and homelessness services' through the Research Institute for Social Inclusion and Wellbeing at the University of Newcastle. She has worked extensively in social policy, welfare and community development roles in Australia and throughout the Asia-Pacific region. Kate's recent research work has analysed the relationship between social justice, evidence-based practice and service-user participation.

Mel Gray (PhD) is Professor of Social Work in the School of Humanities and Social Science at the University of Newcastle in Australia. Mel has an extensive, highly acclaimed research and publication profile focused on the relationship between social work ethics, theory, research, policy, and practice. She recently edited the Sage Handbook of Social Work (with Midgley & Webb 2012), New Politics of Social Work (with Webb, Palgrave 2013), Environmental Social Work (with Coates & Hetherington, Routledge 2013), Decolonizing Social Work (with Coates, Yellow Bird & Hetherington, Ashgate 2013) and is Book Review Editor for the Asia Pacific Journal of Social Work and Social Development.

Luke Butcher completed undergraduate qualifications in psychology through the University of Newcastle. For the past six years, Luke has been employed with Mission Australia delivering mental health recovery, family and youth justice services in rural and remote communities across New South Wales. Luke's professional and research interests include service-user involvement in the human services and collaborative service provision models in rural and remote areas.

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