PAID PEER SUPPORT IN MENTAL HEALTH

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Griffith University 2015

Acknowledgements

The researchers acknowledge the time and contribution of consumers, peer support workers, families and other stakeholders who participated in this research for the purpose of knowledge sharing and quality practice development.

This research was funded by a grant from Queensland Alliance for Mental Health.

Preferred citation:

Walsh, P., Stewart, V., Crozier, M., Roennfeldt, H. & Wheeler, A.J. (2015). *Paid Peer Support in Mental Health.* Griffith University: Brisbane.

CRICOS: 00233E

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EXECUTIVE SUMMARY

Introduction

The purpose of this report is to outline the findings of the peer support project, research undertaken by Griffith University and funded by the Queensland Alliance for Mental Health. The project aimed to explore, articulate and expand on existing concepts of recovery and peer support when working alongside people with a mental illness.

The project was conducted in three stages. Stage 1 involved the establishment of a Reference Group for the project, ethics approval and a literature review to develop a conceptual framework for peer support. Stage 2 involved data collection, data analysis and findings. Stage 3 consisted of feedback on findings to participants and Reference Group and the preparation of this final report.

Methodology

This was an exploratory, qualitative study. Data were collected through a series of focus group discussions and interviews with a broad range of stakeholders. Two organisations using paid peer support models were involved in the study. Peer participants were approached from each organisation to participate in a focus group held at each organisation's premises (n=21). Peer support workers and managers from each organisation were invited to participate in a face-to-face interview (n=7) and key stakeholders (n=4) were identified through recommendations from the Reference Group, and approached to participate in a faceto-face or telephone interview. Overall, there were a total of 32 participants. All interviews and focus groups were recorded and transcribed verbatim prior to analysis.

Initial data was coded using a framework developed from the literature review (Appendix 1). A second round of data analysis involved the use of a grounded theory approach to identify the dominant themes or categories and form linkages and relationships through constant comparative techniques.

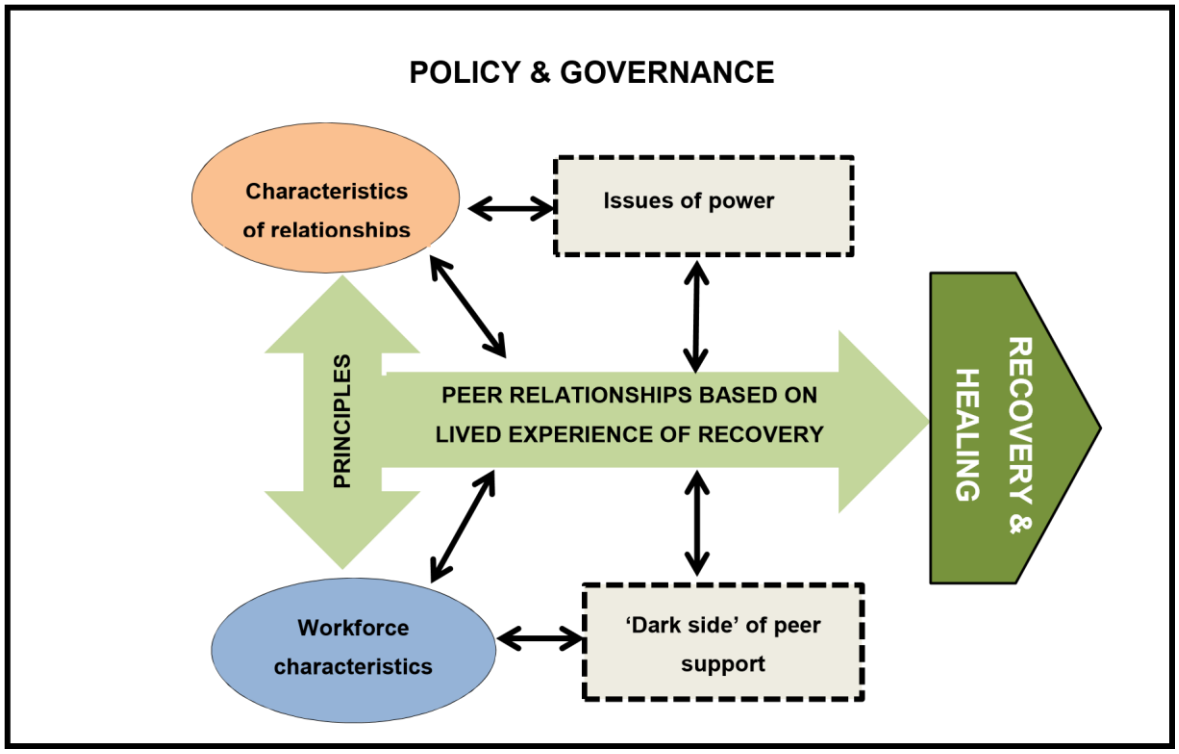
Results

Eight categories emerged from this analysis:

- Peer relationships based on a lived experience of recovery;
- The overall goal of peer support to facilitate recovery and healing;

- The characteristics of the relationships between paid peer support workers and peers;
- Workforce characteristics of the paid peer support workers including knowledge, skills and personal characteristics;
- The importance of clear principles to underpin peer support work;
- The context of policy and governance within which peer support takes place;
- Issues of power within the peer support relationship; and
- The potential 'dark side' of peer support work.

The relationship between the eight categories is shown in the figure below. Each category contributes towards understanding the key elements of effective paid peer support.



The first six of these categories align well with the conceptual framework derived from the literature review (Appendix 1). However, the last two categories (issues of power and the 'dark side' of peer support) arose from the data analysis for the study.

Peer relationships based on a lived experience of recovery

The process of building peer relationships on the part of paid peer support workers, based on a lived experience of mental illness and recovery, emerged as the central category in this

analysis. It incorporates elements of most of the other categories, in particular the characteristics of the relationships and the workforce characteristics of the peer support workers. The lived experience with recovery was a central characteristic that underpinned much of how peer work was enacted, using the lived experience of mental health recovery as a part of a tool kit for working with people. It was clear that rather than having a lived experience of mental illness, it was important for peer workers to have a lived experience of recovery. It is important to understand how lived experience is actually used in the relationship. Some workers described using it as a way to set people at ease, particularly during initial contacts. Others described employing their stories when similar experiences are described by a peer. Lived experience was certainly identified as a key tool to rapidly developing rapport.

The overall goal of peer support to facilitate recovery and healing

Facilitating recovery and healing was a central element of peer work. Concepts such as hope and the notion that everyone can learn, change and grow were explored in some detail by participants. Whist hope is an important element in the recovery paradigm and it was directly raised by more than half of the respondents. The notion of working towards recovery was important, not just from the perspective of the peer consumers, but also for the peer support workers themselves. It is an essential component of peer support work and is seen as an ongoing process.

Characteristics of the peer relationships

The literature review of paid peer work identified that the peer relationship was built on acceptance, equality, connection, respect, trust and presence. All of these concepts emerged in the participant data; however, there was also a significant expansion on the notion of presence in terms '*holding space*' and '*honestly challenging'*. Interestingly, these aspects of the peer relationship were identified as aspects of any good relationship of support. Being present and holding space with a person was closely linked to challenging people honestly on their recovery journey. Challenging was widely identified as a key aspect of paid peer work that helped people to achieve their recovery goals.

Workforce characteristics of peer support workers

This category was closely aligned to the central category of peer relationships based on a lived experience of recovery. This category incorporates the knowledge, skills and personal

characteristics of the peer support worker. As pointed out above, it is not sufficient for a peer support worker to have a lived experience of mental illness and recovery – they must also have the requisite knowledge and skill set to perform the role, along with appropriate personal characteristics to underpin that.

Three types of knowledge were seen as important – sound theoretical knowledge, particularly around recovery-based practice, knowledge of the mental health system and an ability to help people navigate their way through it, and knowledge of how to use the lived experience of recovery in working with peers. Study participants also discussed the importance of peer workers having the skills of a professional helper such as good communication skills, being a good listener, being non-judgemental. However, for effective peer support work, three key skills identified were self-care/self-reflection, the use of disclosure, and boundary setting. Study participants described a number of personal characteristics that were important for peer support workers to possess. These included having a sense of humour, courage, openness, and having a sense of concern. However, the most important characteristic that emerged from the analysis was the trait of empathy and understanding.

The importance of clear principles to underpin peer support work

Three key principles to underpin peer support work emerged from both the study data and the conceptual framework: mutuality and shared responsibility; belonging and community inclusion; and empowerment. Mutuality and shared responsibility can be described as involving collaboration, helping one another and reciprocity. These concepts are inter-related but were all mentioned by participants. Mutuality was described as the removal of the "expert" in relationships. Additionally, a number of participants identified mutuality as a key difference between peer work and traditional services. It was acknowledged that the community provided social support, helped to develop skills, built confidence and created a sense of belonging. Empowerment was a concept explored by participants as an important process within peer work. There was identification that peers needed to have a core belief in an individual's own power.

The context of policy and governance

There were three aspects to this category: service orientation, governance structures and human resource issues. There was an understanding that peer work did not operate in a vacuum and had in recent years become a funded model of practice within Australia.

Participants were able to describe concerns that paid peer work may become similar to traditional service models, particularly those influenced by the medical model. Participants discussed at length their negative experiences with medical models with the focus on illness. In contrast, peer models were seen as person-centred. Governance was identified as more than just operational management, it was something about a commitment to important concepts, particularly recovery and this should be recognised in the governance structures of organisations. In terms of human resource issues, the recruitment, training and supervision of paid peer workers were identified as important elements in providing paid peer work.

Issues of power

A central theme identified is the tension that occurs when a model (peer support) which is built on breaking down power structures through the mutuality of experience and understanding is changed by paying one person in the relationship. One participant noted that power imbalances need to be acknowledged. Ultimately peer facilitators did recognise that being paid meant an obligation to fulfill certain responsibilities. One manager commented that the focus on mutuality failed to take into account the power imbalances that happen with a paid role. It is clear that paid peer work models and services will need to better understand and manage this tension as it moves into the future

The 'dark side' of peer support

When someone is employed as a peer worker it is explicit that they have a lived experience of mental illness. Whilst identifying as someone with a lived experience has positives, there were also concerns about what this would mean for future employment opportunities. Risks regarding how peer workers access mental health services for their own health or returning to using peer services themselves once a paid position was discontinued were articulated.

Conclusion

This project identified eight categories that articulated the key elements of effective paid peer support within a consumer-operated service environment. The first six align well with the conceptual framework derived from the literature review (relationship based on lived experience of recovery, goal to facilitate recovery and healing, relationship characteristics, workforce characteristics, clear principals, policy and governance). However, two new categories arose from the data analysis for the research (issues of power and the 'dark side' of peer support). These themes have not previously been identified in the extant literature and, hence, add a new dimension to an understanding of peer support work.

Overall it was clear that having a lived experience of, not just mental illness, but also of recovery was, by definition, the essential aspect to peer support work.

1. BACKGROUND

1.1 Introduction

The purpose of this report is to outline the findings of the peer support project, research undertaken by Griffith University and funded by the Queensland Alliance for Mental Health. The project aimed to explore, articulate and expand on existing concepts of recovery and peer support when working alongside people with a mental illness. Lead Investigator Professor Amanda Wheeler and research team Victoria Stewart, Helena Roennfeldt, Peter Walsh and Michelle Crozier have collaborated with Queensland Alliance for Mental Health, two nongovernment organisations and other stakeholders to investigate paid peer work.

1.2 Peer support in mental health

Mental illness is common in Australia, with almost one person in five experiencing a high prevalence mental health disorder in any one year and 45% during their lifetime (Australian Bureau of Statistics, 2008). Mental health and wellbeing affects every aspect of individual, family and community life. National and state policy has recognised the recovery paradigm as a fundamental principle underpinning mental health service delivery and it is acknowledged that peer models are an important element in promotion of recovery principles (Basset, Faulkner, Repper, & Stamou, 2010).

With the current focus on recovery in mental health service delivery, interest in peer support has grown (Australian Health Ministers, 2009a). Over the last decade, there has been rapid growth in the employment of peer support workers in the United States of America, Australia, New Zealand and more recently the United Kingdom. (Repper & Carter, 2011). Peer support includes support or services provided to people experiencing mental health concerns by other people who have overcome mental health concerns themselves (Davidson, Chinman, Sells, & Rowe, 2006) and assumes that people who have similar experiences can better relate and offer empathetic support (Mead, Hilton, & Curtis, 2001).

Internationally peer support has been developed in a range of settings and contexts. The consumer/patient survivor movement has been credited with the development of peer support as a service model within mental health, with deinstitutionalisation and the human rights movement providing the policy background (Adame & Leitner, 2008). Traditionally peer

support has been seen as an alternative to the medical model, but increasingly the peer support model is being utilised within mainstream mental health services.

This project has been focused on paid peer work (as opposed to self-help, mutual or volunteer peer work) and data collection was limited to peer operated services.

1.3 Project purpose and outline

This project explored how paid peer support is operationalised within a consumer-operated service environment. The objectives of the research include:

- To determine how paid peer support is currently being operationalised in two consumer-operated organisations in Queensland;
- To describe how peer support values and principals are enacted within service delivery and how users view the service and;
- To develop a framework outlining effective components of paid peer support.

In order to meet these aims, this research was conducted as a three-staged process (Figure 1).

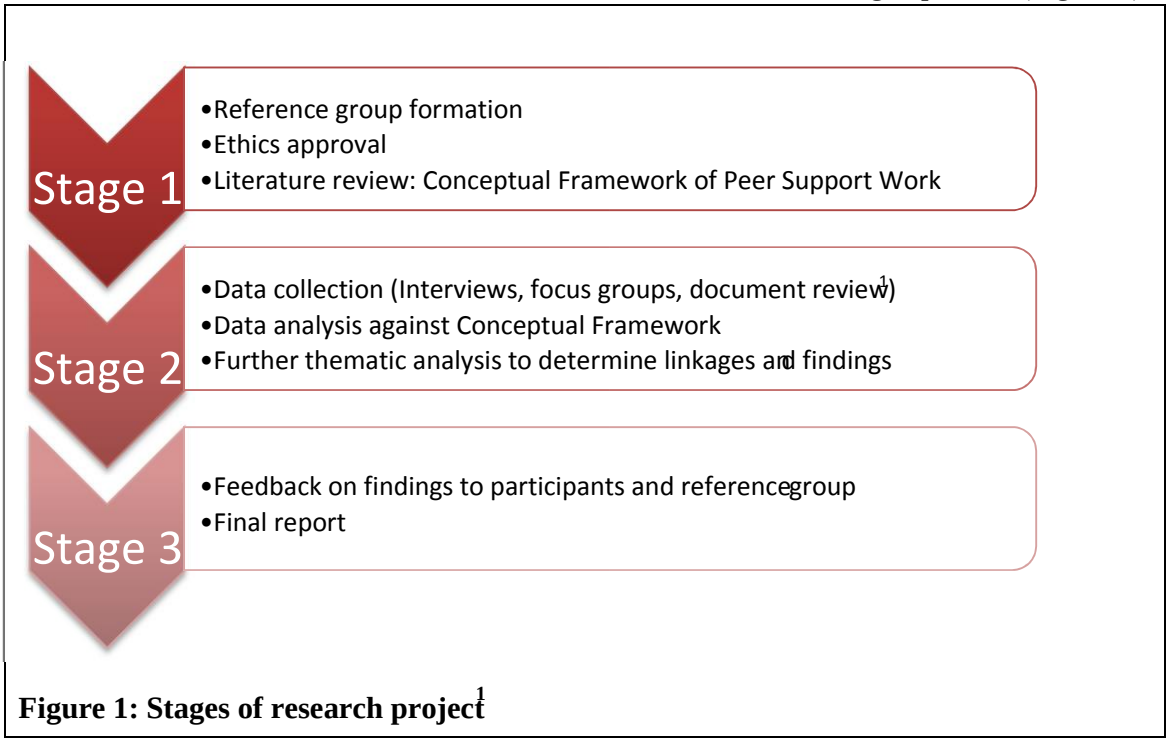


Figure 1: Stages of research project

[1] Initial study design included the collection of peer report documents to increase the triangulation validity of study findings. Peer reporting documents were unable to be obtained from participant organisations.

In **Stage 1** a Reference Group was established to contribute and provide input and feedback on research design and outcomes. The Reference Group was established through the identification of key stakeholders and individuals who were most informative in providing advice and recommendations to the research team and facilitating the research process with the two peer support services. Membership of the Reference Group included representation from Queensland Alliance for Mental Health, Griffith University, two peer support nongovernment organisations (NGO's), Queensland Mental Health Commission, Queensland Health and a consumer consultant expert. In addition, a systematic search of the peer reviewed literature was undertaken to develop a literature review and concept analysis of peer support in mental health. The concept analysis provided the framework to develop the research questions and code collected documentation and data in Stage 2.

In **Stage 2** semi-structured interviews and two focus groups were undertaken to determine how the peer support model was operationalised within the two services as well as gain a deeper understanding of the processes undertaken within the peer support relationship. Data was collected from peer support workers, managers of peer support services and stakeholders (such as referrers to peers support services, funders and experts in the field).

In **Stage 3** management and peer support workers from the organisations were invited to participate in a focus group where the conceptual framework and results of the data analysis were presented to ensure validity of results. Participants were given the opportunity to provide feedback to the project team. This information was also presented to the Reference Group for discussion and feedback.

2. METHOD

This was an exploratory, qualitative study. Data were collected through a series of focus group discussions and interviews with a broad range of stakeholders. Qualitative methods, such as interviews and focus groups, are used in research to address issues of process, implementation and improvement. These methods can answer questions such as: how or why an intervention works, for whom, and in what circumstances (Palinkas et al., 2011). For this study, a post-design was utilised due to the small number of participants and the identified gap in knowledge and skills regarding processes and outcomes of peer support work. The

short time period of this research project did not allow for the identification of any medium or long-term outcomes for peers, peer support workers or organisations. However, it was possible to identify current operationalisation of the peer support within two organisations through experiences of peer support from peer consumer, paid peer support worker, manager and stakeholder perspectives.

The research project undertook a review of the published literature to develop a conceptual framework, and tested these findings with stakeholders in order to complete the picture of paid peer support work (Appendix 1).

Research commenced in July 2014 and ethical approval for the project was obtained from the Griffith University Human Research Ethics Committee (HSV/25/14/HREC).

2.1 Study setting

The two consumer-operated organisations that participated in the research were very different in terms of geographical location and programs offered through their paid peer support programs and within the larger organisation. This research is not an evaluation of those services, but the context in which they operate in may be useful to understand. Table 1 provides a summary of the two organisations in terms of governance, location, types of programs and staffing arrangements.

Table 1: Organisation context

Organisation	Governance	Location	Types of Programs	Staff
A	Part of a large organisation that reports regionally and not directly to the Board.	Regional Centre	• Peer support phone line. • Run support and learning groups (e.g. men's group). • Visit inpatient ward every week. • 60-70 people access the service.	Four Peer Staff working on any given day, with approximately seven peers.
B	Direct Reporting to a Board.	Two sites in Brisbane	• Residential: short term active recovery up to 3 weeks for up to four people. Not crisis support (State Funded). • Federal Funding (Department of Health and Aging) for other projects (e.g. partnerships) that use a peer approach. Number of participants unclear. • Planned activities (nutrition workshop, arts group) and drop in type responses provided.	Staffed by one full time coordinator but not 24hr staff. Unsure of staff numbers for other activities

2.2 Study participants

The project was conducted in two regions to reflect diversity in geography, accessibility and models of service delivery. Participant access and recruitment for interviews and focus groups was facilitated by third party recruitment (i.e. the NGO's involved in the research, reference group participants or Queensland Alliance for Mental Health) in accordance with the agreed participant targets.

Peer consumers were approached from each organisation to participate in a focus group to be held at each organisation's premises. Participation was voluntary and informed consent was obtained from all participants (Appendix 2). An appreciation voucher of $50 was provided to all peer participants. Peer workers and managers from each organisation were invited to participate in a face-to-face interview and key stakeholders were identified through recommendations from the Reference Group, and approached to participate in a face-to-face or telephone interview. All interviews and focus groups were recorded and transcribed verbatim prior to analysis.

Table 2 presents a summary of participant and data collection sources.

Table 2: Data collection: source, organisation and type

DATA	PARTICIPANT	ORGANISATION		
		A	**B**	**OTHER**
Focus groups Interviews	Peers	n=12	n=9	
	Manager/ coordinator	n=2	n=2	
	Paid peer support worker	n=1	n=2	
	Board member	n=1		
	Referrer			n=1
	Expert in peer support work			n=1
	Funder			n=1
		n=16	n=13	n=3

A total of 32 stakeholders participated in the study through focus groups and interviews. Two focus groups were conducted across two organisations with 21 peer participants who were consumers of peer support services. Most participants (n=9) were aged between 40 and 50 (43%) and identified as their cultural background as Australian (76%). On average the participants had been mental health consumers for 16 years (range from 1 – 30 years) and had been accessing peer support on average for 7 years. Participant characteristics can be found in Appendix 2.

Interviews were conducted with a range of other stakeholders (n=11). Peer support worker participants included managers of the two organisations (n=4) and paid peer support workers (n=3). Experience as a peer support worker ranged from 18 months to 7 years (average of 3 years), five were female and two male. Other stakeholder interviews included a board member of one of the organisations (n=1), a representative of a referring organisation (n=1), an expert in the area of peer support (n=1) and a representative of a funding agency (n=1).

Appendix 3 provides a copy of the questions used to prompt discussion for the focus groups and interviews.

2.3: Data analysis

The audio-recorded focus group discussions and interviews were transcribed verbatim with identifying information removed. The initial conceptual framework provided a coding system for collected data. All data were coded against the conceptual framework developed from the literature review using NVivo© software.

Once the initial coding was completed, an additional analysis was undertaken involving the use of a grounded theory approach to identify the dominant themes or categories and form linkages and relationships through constant comparative techniques (Corbin & Strauss, 2008; Dey, 1999). This was an iterative process that included multiple readings of the data and coding of categories and subcategories, identifying characteristics and relationships, and comparing these with other categories until the central category emerges. Each category that emerged through the data analysis is presented in detail in this paper. As is common in grounded theory analysis, the relationship between categories is often presented in a model or a diagram (Bazeley, 2009; Buckley & Waring, 2013; Creswell, 2013).

Direct quotes from participants are presented in the text as examples to support the key findings. The following codes are used to identify the data source:

- FG-P1 and FG-P2: Focus group with peer participants (two groups were conducted);
- I-M: Interview with service manager (four were conducted);
- I-PSW: Interview with peer support worker (three were conducted) and; • I-Other: Interview with other stakeholder (four were conducted).

3. RESULTS

Eight categories emerged from this analysis:

- Peer relationships based on a lived experience of recovery;
- The overall goal of peer support to facilitate recovery and healing;
- The characteristics of the relationships between paid peer support workers and peers;
- Workforce characteristics of the paid peer support workers including knowledge, skills and personal characteristics;

- The importance of clear principles to underpin peer support work;
- The context of policy and governance within which peer support takes place;
- Issues of power within the peer support relationship;
- The potential 'dark side' of peer support work.

The relationship between the eight categories is shown in Figure 2 below. Each category contributes towards understanding the key elements of effective paid peer support.

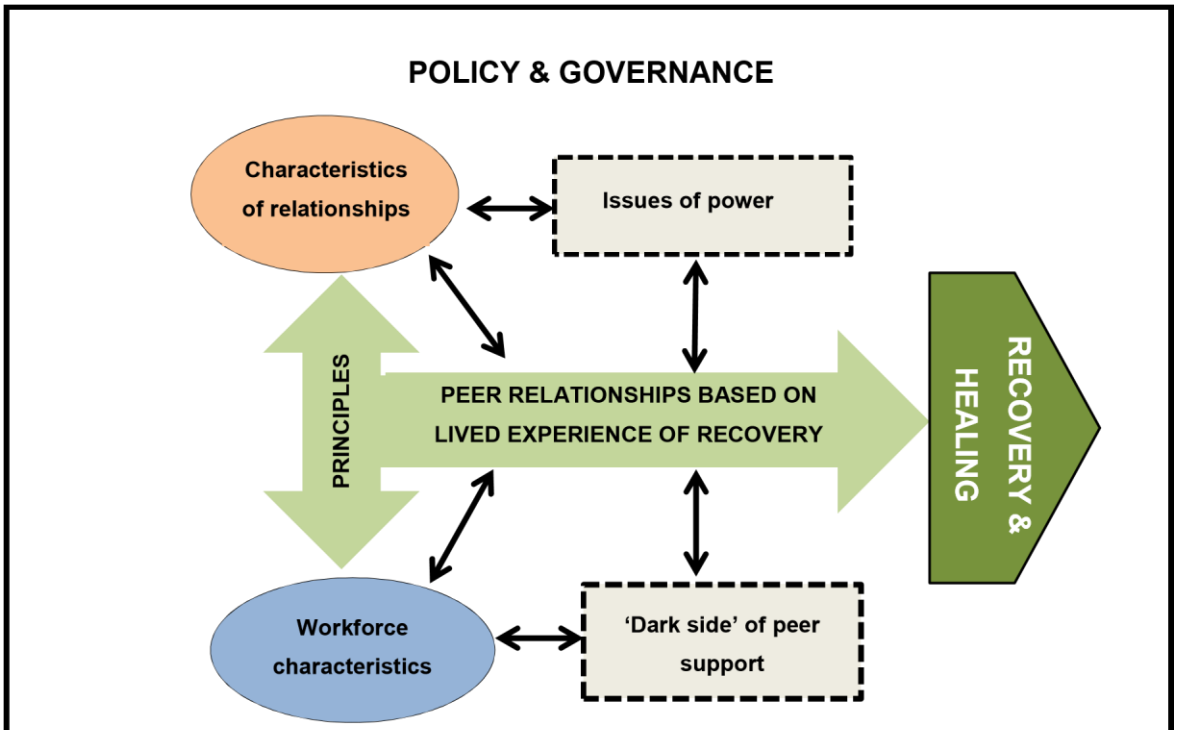


Figure 2: Relationship between key categories of peer support

The first six of these categories align well with the conceptual framework derived from the literature review (Appendix 1). However, the last two categories (issues of power and the 'dark side' of peer support) arose from the data analysis for the study. These categories are represented in the model with dotted lines. These themes have not previously been identified in the extant literature and, hence, add a new dimension to understanding peer support work.

3.1 Peer relationships based on a lived experience of recovery

The process of building peer relationships on the part of paid peer support workers, based on a lived experience of mental illness and recovery, emerged as the central category in this

analysis. It incorporates elements of most of the other categories, in particular the characteristics of the relationships and the workforce characteristics of the peer support workers.

One participant described peer support relationships as occurring in four ways:

1. Natural peer-to-peer relationships that occur "*outside of the service context, the person will have nothing to do with anyone else but the two people involved in negotiating that relationship*" (I-O2).
2. Informal peer support is where this relationship occurs within services, "*so then the construct or the space that's created is a service space*" (I-O2), however when they develop and occur outside the context they move back to natural relationships.
3. Formal peer support is not defined by paid or unpaid, "*it's more about I have a role that differentiates me out from other people in that group*" (I-O2) such as a group leader in support groups.
4. Professional peer is "*where I actually have a professional role, a paid role, it's an exchange of my skills*" (I-O2) but it is not about ongoing long term relationships.

There are two key aspects to this category that emerge from the data analysis. First, study participants discussed what they identified as the components of the peer relationship. Second, it was clear that having a lived experience of, not just mental illness, but also of recovery was, by definition, an essential aspect to peer support work.

Much discussion was generated about what makes peer work different from other support models. It was noted that generally peer work can be similar to support work "*but just a difference in the how. So I don't think there's roles that peers do that non-peers don't*" (IO2). However, the lived experience with recovery was a central characteristic that underpinned much of how peer work was enacted, "*using your lived experience of mental health recovery as a part of your tool kit to working with people*" (I-M1) and "*If they're not in an active space of self-management then they're not fit to work*" (I-O2).

It was clear that rather than having a lived experience of mental illness, it was important for peer workers to have a lived experience of recovery: *"The last thing that you really want is someone with an illness identity in that space. You're wanting someone who's overcome the impacts of an illness, not just someone who has an illness"* (I-O2).

Peer recipients identified the importance of their worker having a lived experience, "*There's a big difference - it helps a lot if they had suffered or suffer from a mental illness*" (FG-P1), with an acknowledgement that experience of caring for someone was also valued, " *I would have to say the lived experience, either personal or through family or friends. That's my understanding of what the difference is*" (FG-P2).

There was acknowledgement that just because you have had a lived experience does not mean you make a good peer worker: *"It's about at the end of the day being a good worker, because we've had employees who definitely identify as having a lived experience, but actually aren't really good at relationships and aren't great at communication"* (I-M2).

Ultimately, it was acknowledged that, "*The only person that can determine whether you are a peer is the person who's receiving, not the person who says, I'm a peer worker*" (I-O2).

It is important to understand how lived experience is actually used in the relationship. Some workers described using it as a way to set people at ease, particularly during initial contacts. Others described employing their stories when similar experiences are described by a peer "*I can have those conversations and say… I remember a time when I was feeling like that and this is what I did. Or this is what worked for me*" (I-PSW3), or when people were stuck.

Lived experience was certainly identified as a key tool to rapidly developing rapport "*be it right or wrong, there is an immediate sense of rapport that generally comes with people, as soon as they know that we have all got a lived experience"* (I-M1) and it "*kind of gives you credibility, in a funny way*" (I-PSW3). One participant articulated the benefits in developing a therapeutic alliance, "*Peer work does it fast, really efficiently and it's a more resilient bond because somebody can say to you from the perspective of saying, look I've been there…*" (I-M2).

The opportunity to build rapport was not necessarily about the disclosure of a particular diagnosis or experience but it was seen as a way of connecting, "*It's about being able to relate to somebody that's going through something in a similar area*" (I-M4). One participant described this as, "*you're not scared to come close and ask different questions…. I don't want you to get upset about this but I know you've been where I am*" (I-O2). Others identified that the opportunity for disclosure put people at ease "*It allows them to sort of relax and feel comfortable and trust in me when they're sharing their information with me*" (I-PSW3) and

facilitates deeper connections over time "*I think that's how it starts to create a deeper rapport, a deeper connection partly about someone else* [who] *has been there*" (I-PSW1).

3.2 The overall goal of peer support to facilitate recovery and healing

Facilitating recovery and healing was a central element of peer work, for example: *"There's also determination to want to get better and recover"* (FG-P1).

Concepts such as hope and the notion that everyone can learn, change and grow were explored in some detail by participants. Whist hope is an important element in the recovery paradigm (Australian Government, 2013), it was directly raised by more than 50% of the respondents making it an important concept to discuss within the conceptual framework of peer support. The concept of hope was also associated with the belief that all people can learn, change and grow. The following table provides examples of how concepts of hope in recovery were discussed by respondents.

Table 3: Concepts of hope in recovery

Participant Type	Quotes
Manager	"It made a major difference in my own personal recovery journey. I think a big part of that was the re-introduction of hope, because that didn't exist before that" (I-M1).
Peer	"For years, I'd try to do things and I have my reasons why I struggle so much. But I think the main reason was just that loss of hope was gone. It was like, what's the point? What am I going to do with my life? All my hopes and my dreams and plans I'm basically being told I'm never going to reach. So losing all of that" (FG-P2)
Peer support worker	"I guess there's very rock solid core ideas of people are capable, that mental illness is not a lifetime disability" (I-PSW1).
Other	"Being able to reframe that experience and recognise that I guess help people to move from the experience being the totality of their life to reclaiming some degree of citizenship and some degree of person" (I-O1)
Other	"Challenge is the hope…That they are. See, challenge sometimes is seen as adversarial. But I actually think it's the perfect example of practices of hope because if you don't challenge you're actually saying, I don't believe you can change" (I-O2).

Other	"I think hope is a huge one and I know that's probably a little bit tokenistic, but I just think when you're engaging with someone who also shares a lived experience and it kind of - just actually having that conversation with that person and you're actually in that moment and you're seeing someone and talking with someone who's got an experience of overcoming challenges and things like that. They may or may not be similar challenges to what you're facing, but it really kind of just hits home I think in a much more genuine way that this is possible; I can change my life from this moment" (I-O3)

The notion of working towards recovery was important, not just from the perspective of the peer consumers, but also for the peer support workers themselves. As pointed out above, it is an essential component of peer support work and is seen as an ongoing process:

> *"I think that anyone to become a peer facilitator will have to have their own story of recovery. I don't think recovery ever ends. So I'm hoping from that, there is no idea that a peer support or peer facilitator is any more recovered than anyone else"* (IPSW1).

3.3 Characteristics of the peer relationships

The conceptual framework of paid peer support work (Appendix 1) identified that the peer relationship was built on acceptance, equality, connection, respect, trust and presence. All of these concepts emerged in the participant data; however, there was also a significant expansion on the notion of presence in terms '*holding space*' and '*honestly challenging'*. Interestingly, these aspects of the peer relationship were identified as aspects of any good relationship of support "*I imagine if other workers who don't identify with lived experience weren't in a paid role but were in a relationship with people they would be similarly relating to them as peers*" (I-O).

Acceptance

Acceptance was described as "*non-judgemental*" (FG-P1, FG-P2, I-PSW2, I-O4) "*more tolerant*" and "*unbiased*" (FG-P1) particularly in comparison to participant relationships with other mental health professionals. Acceptance was also seen as an important element of the peer environment, (e.g. "*But this kind of environment, they haven't had that judgment of where you come from*" [FG-P2] and "*they feel a lot more comfortable here and I think when there is no judgments you're also more likely to talk about things more honestly*" [I-PSW2]), and in juxtaposition with the other people in their life. Peer consumers were able to achieve

a feeling of acceptance due to the paid peer support workers personal lived experienced: "*It's that total acceptance, that total understanding, it's that whole thing of I've been there, I can understand what this is like*" (I-O1).

Equality

Participants strongly linked the concept of equality to a rights based and social justice approach, "*everyone has got a right to their opinion...it doesn't matter if theirs differs from mine… everyone is equal. No one is any better than anyone else*" (I-PSW2). Equality was a key concept for workers "*Everyone is equal, equity is a cornerstone of how I operate*" (IPSW1) and an important principle in the peer relationship.

Equality and power were strong themes, "*like there's no separation saying that they've got a job and all that because we've been through the same thing"* (FG-P1) and participants identified the peer support worker's lived experience as contributing to equality, "*So we know they're not perfect...kind of makes us feel equal*" (FG-P2).

Peer consumer participants recognised that workers were receiving payment but still felt an equal relationship, *"I say I don't really see you as someone that's just looking after me and supporting me I actually see you as mates at the same time and they agree"* and *"Yeah, so I think we're all on an even footing. The only difference is they get paid I guess*" (FG-P1).

Interestingly, concepts of equality and the impact of payment for services was a source of tension for many of the peer support workers. Further discussion on aspects of this tension is included later in this report.

Genuine connections

Connecting with people in authentic and genuine ways was identified as important by participants, "*the culture of peer work is we're really good at connecting*" (I-M2). Peer support work was seen as flexible, with relationships and needs determining work tasks, "*there's been people on the other workers' lists that I've made a good connection with. I might just be standing there at the phone and think, I'll just give* [name removed] *a call, or something like that. Even though he's not my peer, I'm not told that he's not my responsibility*" (I-PSW3). Participants clearly identified a genuine desire to connect with people to make sure they were ok, "*They actually care*" (FG-P1).

The concept of connection however, also encompassed issues such as boundaries and friendships. It is important to recognise that some recipients of peer support did perceive friendship as the basis of peer relationships "*it's not like talking to a support worker it's like talking to one of your mates*" (FG-P1). Honesty and authenticity were seen as important in managing these issues.

Respect and trust

Respect was a concept that was implicit in much of the conversation regarding peer relationships, "*they respect the fact that we've got - that we are people with real lives*" (FGP1). Peer consumer participants perceived a strong sense of trust with their paid peer support workers, "*Trust them - I can trust them..."* (FG-P1) particularly in the maintenance of confidentiality. Trust may have come from the sharing of stories and disclosure.

Being present and 'holding space'

The concept of '*presence'* or *'being present'* was discussed at length by many of the participants. A practical example of *'presence'* is the importance of the peer being present during any conversation about themselves, "*we don't like community peers talking about others without them being present*" (I-O4). Additionally, participants discussed the importance of *'being present'* for someone during their journey of recovery: *"one thing I've noticed… was the amazing capacity for people just to be with somebody when they're going through some pretty awful stuff…"* (I-O1). '*Being pre*sent' was also expanded to the groups that people were involved with. There was discussion regarding a '*discomfort agreement*' that is undertaken in group processes, "*They explain what sitting through discomfort means first. But then we also set out the little guidelines to keep it comfortable, as comfortable as possible*" (FG-P2).

'Holding space' for participants was seen as being able to sit with the ambiguity of someone's situation and hold hope, "*It's about focusing on people's strength and holding hope for people, when they can't hold hope themselves*" (I-M1). Holding space required sitting with people in distress.

Challenging people honestly

Being present and holding space with a person was closely linked to challenging people honestly on their recovery journey. Challenging was widely identified as a key aspect of peer

support work that helped people to achieve their recovery goals: *"It's important, to challenge people about their particular issues and to challenge them in new ways of thinking or seeing those issues"* (I-PSW1).

As one participant noted the opportunity to challenge came from a strong peer relationship, *"once you have that really deeper connection, people tend to open up more to feedback and critique as long as it's still extremely honest"* (I-PSW1) and "*I don't have to make them take that challenge….but my obligation to them is to put the challenge*" (I-O2). Challenging peer support workers and peer consumers was seen as complex, but an honest and respectful approach was important, "*I think if I'm honest and respectful of the person I think it's easy*" (I-PSW2).

The concept of challenging was also important for peer to peer support worker interactions, highlighting the importance of mutuality, *"I think some of the peers* [support workers] *get challenged by us too or we can challenge them in their role"* (FG-P2). A number of participants described instances where they challenged their relationships with other mental health providers, identifying the importance of this concept and the opportunity for mutuality within all service provision.

3.4 Workforce characteristics of the paid peer support workers

This category was closely aligned to the central category of peer relationships based on a lived experience of recovery. This category incorporates the knowledge, skills and personal characteristics of the peer support worker. As pointed out above, it is not sufficient for a peer support worker to have a lived experience of mental illness and recovery – they must also have the requisite knowledge and skill set to perform the role, along with appropriate personal characteristics to underpin that.

3.4.1 Knowledge

Study participants identified three main types of knowledge required for effective peer support work:

- Sound theoretical knowledge of key concepts such as human rights, citizenship, recovery-based practice, recovery knowledge narrative, self-determination theory (IO2);

- Systems navigation knowledge – that is, a knowledge of the mental health system and an ability to help people navigate their way through it, combined with an idea of the frustrations that can be involved with this (I-O1) and;
- Peer knowledge – that is, a knowledge of how to use the lived experience of recovery in working with peer consumers (I-M1).

3.4.2 Skills

Study participants discussed the importance of peer support workers having the skills of a professional helper such as good communication skills, being a good listener, being nonjudgemental, being able to be straight and being accountable to each other (I-O4, I-M1, IM3). In addition, peer support workers need to be good facilitators: *"They can bring the best out of the people and everyone. I think that's a great skill they have"* (FG-P2). Peer support workers and managers also identified that professional tools such as motivational interviewing or appreciative inquiry can be a useful part of the skill set for this work.

However, for effective peer support work, three key skills identified were self-care/selfreflection, the use of disclosure and boundary setting.

Self-care/self-reflection was identified as an important skill in the context of a peer support workers lived experience:

> *"Self-care - you really have to be good at your self-care, know if you're not travelling well, because we all do have lived experience and there are times when a team member is not travelling well. So we expect that that person is going to take responsibility"* (I-PSW3).

Consciousness and reflection about the what, when and how of disclosure was seen as an important skill of peer support work:

> *"I can use my story in ways that support one another, support other people. I can also abuse that story. So there's a lot of personal reflection about when to use it or how to engage with other people ... I usually use my story as a way to connect, never as a way to say, this is the way to go"* (I-PSW1).

The skills involved in boundary setting emerged as a source of tension, ambiguity and difference of opinion in peer support work. By its very nature, peer support work can at times

involve 'blurred boundaries' in relationships. Some peer participants talked of the relationship as a 'friendship' that involved a two-way confiding in each other. For managers, they saw this as a potential source of stress for peer support workers: *"…having to be the person that has those hard conversations and says…that I'm here for you, I care for you, - but it's within these parameters because that's what we do. That takes its toll on you…"* (IM1). Some participants were clear that peer support workers were not allowed to contact service users outside of service provision, while others identified instances when this had occurred, "*I've had them come to my house - I have had them there for a cup of coffee…. I suppose I shouldn't have said that*" (FG-P1).

3.4.3 Personal characteristics

Study participants described a number of personal characteristics that were important for peer support workers to possess. This included having a sense of humour, courage, openness, having a sense of concern. However, the most important characteristic that emerged from the analysis was the trait of empathy and understanding.

Empathy and understanding

Empathy and understanding are key aspects of the paid peer support framework "*I think having that core empathy and that ability to relate your experiences is vital*" (I-PSW1). Lived experience was seen as an important element of empathy, "*I believe that like a bit of lived experience is good as well, really helps you understand things through someone else's eyes and build that connection as well*" (I-PSW2), with participants identifying that, "*They can also understand what you're going through*" (FG-P1) by having walked in "*those shoes*" (FG-P1). Empathy and understanding was experienced by the way they were spoken with "*They don't talk like a textbook to you. They talk in normal words that we all relate to and understand*" (FG-P2) and by their experience with mental illness and service systems, "*even if there's no exact understanding of the specific mental* [illness] *diagnosis or issue. There's still an understanding of issues that can arise from that*" (FG-P2).

For the peer support workers there was a deliberate sense of coming from a place of empathy, "*I've walked a similar road to you, and using that*" (I-M1) but also a caution around checking meaning and understanding by asking " *What does that mean for you?*" (I-M3). As one worker so articulately described:

"I would say everyone is different. A good peer worker, I think is someone that can detach from their own beliefs for a while and maybe step into someone else's shoes and see things through their eyes or try to" (I-PSW)2.

3.5 The importance of clear principles to underpin peer support work

Three key principles to underpin peer support work emerged from both the study data and the conceptual framework: mutuality and shared responsibility; belonging and community inclusion; and empowerment.

3.5.1 Mutuality and shared responsibility

Mutuality and shared responsibility can be described as involving collaboration, helping one another and reciprocity. These concepts are inter-related but were all mentioned by participants. Mutuality was described as the removal of the "expert" in the relationships: *"It's more about what can I learn from you and what can you learn from me"* (I-M4). Mutuality was also closely linked to the concept of equality, "*The balance is equal and it's mutual as well*" (FG-P2) and disclosure through lived experience "*I think it's good too that the peer workers aren't held back with sharing their life story and their journeys…*" (FG-P2).

Shared responsibility toward a person's recovery was seen as an important concept of paid peer work, "*they're there to help but you should help yourself*" (FG-P1). Shared responsibility is also described in terms of relationship "*you're both taking responsibility of your own part in that relationship*" (I-M4) and "*what have you got to offer me and what have I got to offer you?*" (I-O2). Whilst mutuality is an important aspect of peer support work, the impact of payment was evident.

Participants also identified the importance of collaboration and shared responsibility within the service context to ensure services meet participant requirements and participants are given opportunities for leadership, "*they can assign a community member to run that group and share the responsibility*" and "*I gathered 15 weeks' worth of activities and that was community engaged request and asking them what the community wanted*" (I-O4). Diversity of experiences was also valued, "*having all those varied experiences and everyone's from somewhere different just really adds to the richness of the service that we can provide*" (IM4).

Additionally, a number of participants identified mutuality as a key difference between peer support work and traditional services, "*This peer relationship is very different. We're both in it together*" (I-M3). The peer support role was seen as different to traditional support, "*if we see our role is to prop up and to support then, yes. But if we see our role is an exchange of learning..."* (I-O2).

3.5.2 Belonging and community inclusion

Whilst community was seen as an important element of peer support work, it is not clear whether this was due to the project's focus on consumer-operated services and the way these organisations provided peer services. For example, participants discussed the importance of support groups, group activities, drop in centres and short term respite in creating an overall sense of belonging and community, "*I wouldn't mind if they didn't have groups. It's just nice to come here and see a friendly face and have a cup of coffee and a chat*" (FG-P2).

Paid peer support workers also recognised the importance of the peer community, "*You've got a community rather than an individual*" (I-PSW3) and described striving to provide a supportive environment, fostering belonging and community, "*having a comfortable laidback environment. Like that's really what we try and have"* (I-M4). As one peer consumer participant observed, there are key differences in the peer environment than other settings: *"Here, I find that peers are basically paid to be here and spend all their time with us"* (PFG2).

It was acknowledged that the community provided social support, helped "*us develop skills and even just daily activities*", built confidence and "*created a sense of belonging*" (FG-P1, FG-P2). This was achieved through a process of connecting together as a community through lived experiences, "*people with mental illness they need to talk to other people with mental illnesses*" (FG-P2), and "*It's not just the peer workers talking with the peers. It's the peers having the connection and sharing stories between them*" (FG-P2). Community was described through belonging and connection "*You're coming here and being part of a community*" (I-PSW3), and was seen as an important element of maintaining health, "*I think that's important because I think if you don't have that you can feel isolated and get very unwell and go to hospital*" (I-PSW2). For others it was seen as an alternative space to sometimes difficult home environments, "*It's knowing that you can come in to a place where you feel safe and not judged*" (I-PSW3).

Attending activities and groups was important for reducing isolation for participants, "*Most of us don't probably work and we'll just be sitting at home.* [This] *is a place for us to go and spend the day*" (FG-P1), but the peer support worker relationship was identified as an important aspect of this "*It was import that the paid peer workers spent time with them*" (FGP2).

The sense of community and its stability, gave participants a sense of flexibility and control over when they accessed service support as their recovery progressed. This fluid notion of attendance was also helpful for relationship development between peer consumer and peer support worker "*It allows you to make that connection, because they can come in here for the whole day and they can come in five days week*" (I-PSW3).

3.5.3 Empowerment

Empowerment was a concept explored by participants as an important process within peer support work, "*They can connect with people here like they would with anybody in the community. That's really empowering for people. That really hits home that I'm not a mentally ill person I have so much more to offer than that*" (I-M4), and as an outcome "*They can help you build your confidence like if you want to try cooking something or you want to try something new they can give you*" (FG-P1). Empowerment as a concept was linked to an assumption of competence and "*introducing that hope and that idea of you can be an active participant in your own recovery, right off the bat*" (I-M1).

Empowerment was seen as a difficult concept because "*we can only disempower someone. We can't empower them*" (I-O2). There was identification that peers needed to have a core belief in an individual's own power, and empowerment is not given but rather "*you create a space that helps them recognise their own ME power*" (I-O2).

There were practical benefits identified for the person receiving peer support in terms of reduced hospitalisations e.g. "*people not so quick to say they've got to go to hospital and maybe sit there in their discomfort a bit and explore other things they could do*" (I-PSW2) and "*it has reduced hospital recidivism. There's people that have been coming here and haven't been back to hospital or, if they have, it hasn't been as frequent*" (I-PSW3). Other participants were able to identify benefits such as, "*my mother is not really sure about that*

but I think she's just noticed how much better I am in communicating and...confidence" (FGP1).

3.6 The context of policy and governance

There were three aspects to this category: service orientation, governance structures and human resource issues.

3.6.1 Service orientation

There was an understanding that peer support work did not operate in a vacuum and had in recent years become a funded model of practice within Australia "*It's become the hip thing to have peer support workers… It's pretty hip and hop with the government at the moment. Shove a peer worker on the front*" (I-M1). However, participants were very aware of the current funding impacts on mental health services from both Federal and State governments and the impact of funding responsibilities and obligations, "*The reality is, is that I'm beholden to* [service name removed]. *They fund me, they pay my mortgage*" (I-M2) and "*for reporting we have our funding guidelines we have to report against*" (I-M4).

Participants were able to describe concerns that peer support work may become similar to traditional service models, particularly those influenced by the medical model. Participants discussed at length their negative experiences with medical models with the focus on illness "*more focused on your illness and taking your medication*" (FG-P1) rather than the person, "*not a very holistic model… It's not looking at a person's whole life and their whole being*" (I-M1). In contrast, peer support models were seen as person-centred "*they see you as a person rather than as a mental illness whereas in traditional mental health services…they're trying to diagnose you and base your recovery on that*" (FG-P2), facilitating people to be experts of their own lives "*Some people feel that because they are an expert and they come with all these degrees… that they can't voice how they're really feeling in it. Well you're your own experts"* (I-M3).

> *"...peer support organisations like* [name removed] *it's not a treatment place. Treatment is different from recovery and it's just not medicated. It's focused on lifestyle, other activities to get your life back to independence and to reach your potential as well"* (FG-P1).

There was recognition that the medical model still can be important in people's recovery, "*with all due respect to the doctors and clinicians I know they need to do their job and I respect that ... medication has its place in your recovery...*" (FG-P1) and that both approaches are needed "*It's not rejecting the clinical, medical model but it's holding a space that's outside of that, a different option and different kind of views of recovery*" (I-M1). Some respondents also discussed how the nature of peer support work was not always valued in traditional mental health service settings although there was a recognition that this view was slowly changing.

3.6.2 Governance structures

Governance structures of the two peer support services were different with varied roles for peers in the operation of the organisation. One service was operated by a board with four positions identified for peers, "*while it isn't clearly mandated, it has been I think the tendency of the organisation to hire - to recruit it's Board from people who have lived experience as well*" (I-M2). Whilst the other service, operated from a much larger organisation where reference groups and peer advisory groups were included in the governance structures.

Governance was identified as more than just operational management, it was something about a commitment to the important concepts, "*strong organisational commitment to the ideas that people can recover, that the ideas that people are capable of taking their own initiative, that we should have fun*" (I-PSW1). For many of the participants this commitment should be recognised within the structure of the organisation, "*I struggle in this state when people are saying, yes, we're a peer-run organisation or peer-run program, but its board or its organisation structures are heavily non-peer"* (I-O2). There was also acknowledgement of when peer governance is tokenistic it loses something:

> *"when you have one or two token peers on a board the rest of everyone else goes, oh no, they must be right. We have to listen to them. We have to be seen to kind of honour whatever they say and it becomes this reverse bullying almost"* (I-O2).

Many of the peer participants had limited knowledge of the governance structure of the service but appreciated inclusion and consultation in decision making, "*Where instead of management deciding - members decide what they want because it's a members run organisation*" (FG-P1).

3.6.3 Human resource issues

The recruitment, training and supervision of paid peer support workers were identified as an important element in providing peer support work.

Recruitment

During the recruitment phase, there was a high degree of consciousness about not employing someone just because they have a lived experience with recovery. It was also recognised that workers should not be recruited for the purpose of their own recovery and that applicants needed to be work ready: *"So it can be really difficult when interviewing people to gauge whether that person is work ready or not"* (I-M4). In the context of meeting with potential applicants one participant was really clear to *"never ask anyone about their illness story. I only ask them about their overcoming story"* (I-O2).

Training

There was varying degrees of investment and emphasis on the importance of training for paid peer support workers. One peer consumer felt that training was highly relevant to enhance the skills of the paid peer: *"I think any training is relevant, not just lived experience. Any training they've done"* (FG-P2).

Peer participants also identified that peer support workers needed training in suicide risk assessment, intentional peer support and understanding mental health. Peer support worker participants identified they had had training or wanted training in human rights, mental health first aid, intentional peer support, cultural awareness, specific mental illnesses, motivational interviewing, narrative practice, and one identified that the "*best training that I had was some recovery practice training*" (I-M1). Other identified training needs included group facilitation, boundary setting, person-centred practice, dignity versus duty of care and organisational guidelines and policies.

Qualifications were not described as mandatory although one person described how "*peer support is the value that gets laid upon top of the qualification*" (I-M1). There was some acknowledgement among participants that there is a new national level Certificate IV in Peer Support Work, but commitment to this training was mixed with concerns over the TAFE system and the skills of the teachers/facilitators, "*I still have that question mark around it….it would be awful to see it just become something that's taught by people who have no lived experience*" (I-O1). One organisation identified that it is a path they may explore in the future

and may even be an opportunity to become involved in providing the training. In addition, it was identified that currently the general mental health workforce has limited understanding of peer support work and, "*training on how to educate non-peers around what the role of peer workers is, that would be really good*" (I-O3).

Supervision

Supervision and workplace support was seen as essential within peer support work, but there was recognition that workers were required to take personal responsibility to manage stress and access appropriate support, "*there's high expectations on us to be managing our own stuff and managing our own self-care*" (I-M1).

Participants identified that informal supervision, co-supervision, manager supervision, external supervision and team meetings were all currently offered in the workplace. For one organisation active supervision was viewed as more important than training "*we're not actually currently providing a lot of training, although we provide a lot of supervision around the peer model stuff and the values*" (I-M2). However this was occurring informally "*it's very much an informal supervision*" with access to "*external supervision from time to time*" (I-M1). Participants valued flexibility and team support when needing to discuss

issues, "*We do a lot of ad hoc reflective stuff where people kind of pop in and talk and ask questions*" (I-M).

Co-supervision with colleagues was seen as an important element of support and supervision: *"Also the amount of debriefing that goes on here and co-supervision when you're talking to other workers about, how would you deal with this situation?"* (I-PSW3).

3.7 Issues of power

A central theme identified is the tension where a model (peer support) which is built on breaking down power structures through the mutuality of experience and understanding is changed by paying one person in the relationship. As one participant noted the power imbalances need to be acknowledged, "*yes I'm paid and you're not…but I'm really here for you. It's not about the whole expert thing. We're peer to peer…"* (I-M4).

Ultimately peer support workers did recognise that being paid meant an obligation to fulfill certain responsibilities, *"I'm responsible for other people's - not responsible for their welfare,*

but I'm responsible for maintaining relationships with my peers" (I-PSW3). There was recognition that peer support workers were not there to have their own needs met, they were there to meet the needs of peers "*So if I'm here it's not for myself. It's to be here and to be here for others and to be here for support*" (I-PSW2). Concerns regarding the risk of overprofessionalising the work were apparent with fears that the quality of connection and meaningful presence would be lost, "*They lose the us, and they become - they start to demarcate the differences between I'm a paid peer and you're receiving off me….. It's that expertise model*" (I-O2). This tension in shifting paradigm (unpaid to paid peer support) presented some unique complexities:

> *"That's where things have gotten really blurry, because a lot of those original models based very strongly on mutual support and we didn't - I don't know that we rethought some of those things when we moved into a paid model…I don't think we did a really good job of understanding that when we start to pay people - and we fall under some pretty prescriptive legislation - actually the relationship changes… the power dynamic changes"* (I-M2).

One manager commented that the focus on mutuality failed to take into account the power imbalances that happen with a paid role.

It is clear that paid peer support work models and services will need to better understand and manage this tension as it moves into the future.

3.8 The 'dark side' of peer support work

Whilst all peer support worker participants were happy with their work in the peer services, a number of difficulties were also identified.

When someone is employed as a peer support worker it is explicit that they have a lived experience of mental illness. Whilst identifying as someone with a lived experience had positives "*all that stuff that I saw as negative, yeah, has all turned out to be a positive*" (IPSW2) there were also concerns about what this would mean for future employment opportunities "*Once you out yourself in this sector, you're outed. So that - it's not a stepping stone choice that should be taken lightly*" (I-M1). Concerns of discrimination were apparent, "*that title alone identifies them as a person with lived experience. So it's quite distinct from any other…professional grouping or any other helping type function within mental health*" (IO1).

Another concern was raised which involved the idea that by bringing peer work and peer workers into the mainstream service system, the voice of the vulnerable and drivers for service change would be lost:

> *"We've taken all those people who were the reformed voice for mental health, who used to stand outside the fence and shake and maybe have a sign - we've taken them, we've gone come on in, we'll pay you…. and actually to a very large extent we have lost the reform voice because we've brought it into the system"* (I-M2).

There was also a recognisable tension around the workforce and position as it currently stands and opportunity for career progression, "*I think people see it as a step into work but not a career or not a profession in its own right*" (I-O2). As one manager noted "*I felt like I had a pack of staff who were really unemployable in any other model*" (I-M2).

Risks regarding how peer workers access mental health services for their own health or returning to using peer services themselves once a paid position was discontinued were articulated "*I did peer support work for eight months. My contract ran out. That's why I don't have the job anymore*" (FG-P2). One participant identified the potential risk of peer workers experiencing trauma or re-traumatisation through peer work "*when people are there for the wrong reasons, they're re-traumatised*" (I-O2).

Conclusion

This project identified eight themes that articulated the key elements of effective paid peer support within a consumer-operated service environment. The first six align well with the conceptual framework derived from the literature review (relationship based on lived experience of recovery, goal to facilitate recovery and healing, relationship characteristics, workforce characteristics, clear principals, policy and governance). However, two new categories arose from the data analysis for the research (issues of power and the 'dark side' of peer support). These themes have not previously been identified in the extant literature and, hence, add a new dimension to an understanding of paid peer support work.

This research provides first-hand insight into the perspectives of a range of key stakeholders including peer support recipients, paid peer support workers in facilitation roles and management roles, and other people involved in the governance of consumer-operated services, funding these services, referring to these services and a local peer support expert. This study recruited participants from only two consumer-operated services and therefore the findings cannot be generalised to other services or settings. Because the research relied on an exploratory qualitative investigation of stakeholder perspectives at one point in time, the relationships among themes could not be established. In addition the study used self-reported data, which can be influenced by interviewer bias. However, the potential for interviewer bias (arising from three different interviewers) was minimised with the use of a standardised interview guide and the involvement throughout the entire project of a consumer researcher with lived experience of recovery ensuring that the findings were grounded in consumer experience.

Overall it was clear that having a lived experience of, not just mental illness, but also of recovery was, by definition, was the essential aspect to peer support work.

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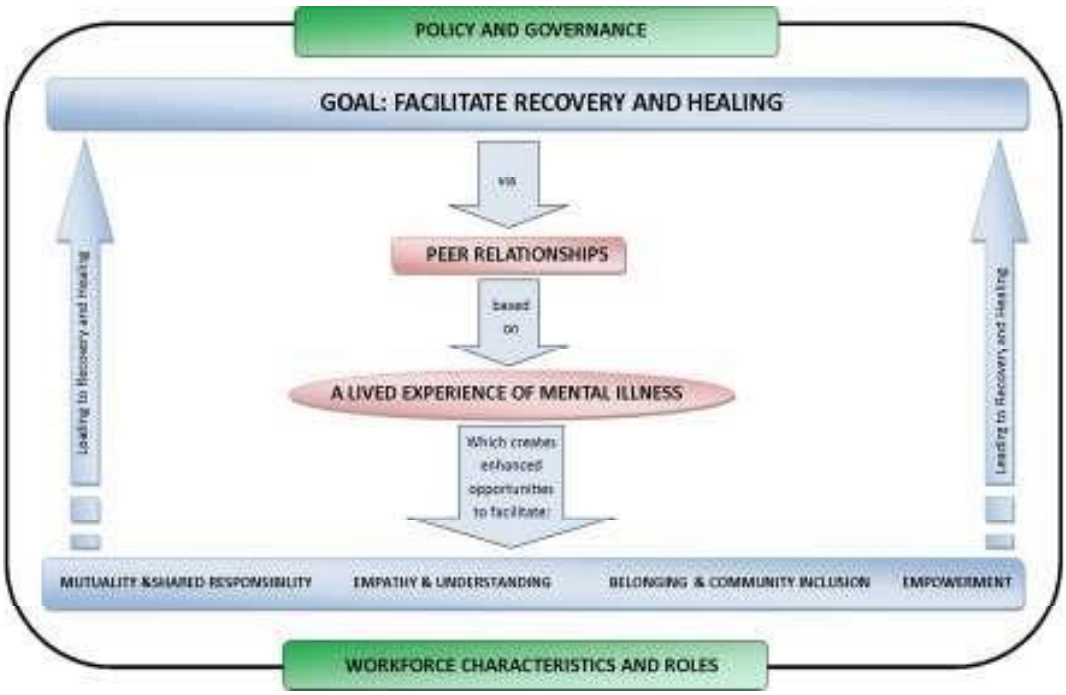
APPENDIX 1: Summary of literature review

Within Australian mental health policy and service delivery, a recovery focus is emphasised (Australian Health Ministers, 2009b) with the employment of peer support workers being seen as an important tool in the transformation of services to a recovery orientation (Sledge et al., 2011). Peer support includes support or services provided to people experiencing mental health concerns by other people who have a lived experience of mental health concerns (Davidson, Bellamy, Guy, & Miller, 2012) and assumes that people who have similar experiences can better relate and offer empathetic support (Mead, et al., 2001). Mental health peer support work is a relatively new approach to service delivery (Health Workforce Australia, 2014). The literature reveals that there is an array of terminology, definitions, roles and evidence related to peer support. Only one article was identified which explored the concept of peer support within a general health care context (Dennis, 2003).

A systematic search of the literature on peer support work in mental health led to the development of a paid peer support conceptual framework[1]. This dynamic conceptual framework (below) addresses the key elements of paid peer support namely policy and governance, principles and values; and workforce characteristics and roles.

[1] Concept analysis is a formal, rigorous process by which an abstract concept is explored, clarified, validated, defined and differentiated from similar concepts to inform theory development and enhance communication (Walker & Avant, 2005).



Policy and governance as well as workforce characteristics and roles form the context for peer support to occur, whilst the principles and values of paid peer work are represented as a dynamic process of interacting elements that explain the process of peer work.

Policy and governance operate as a key context to paid peer work. Policies, at both a legislative and localised responses inform the ways that paid peer support are described, funded and implemented. Wolf, Lawrence, Ryan, and Hoge (2010) highlight organisational changes which need to occur to ensure there is sustainable employment of people in recovery through peer work. These include reframing policies, leader engagement and commitment and peer involvement in decision making. It is important that governance structures are planned to facilitate the voice of the users.

When exploring the principles and values that underpin peer work it is apparent that these aspects are closely inter-related to facilitate recovery and healing. The peer relationship is a significant principle of paid peer work. It is built on a level of intimacy (Coniglio, Hancock, & Ellis, 2012), genuine connection (Ley, Roberts, & Willis, 2010), respect (Ahmed et al., 2012), equality, acceptance, trust and presence (Taylor, Jones, O'Reilly, Oldfield, & Blackburn, 2010). This relationship leads to healing and recovery when there is mutuality, understanding, community inclusion, empowerment and shared responsibility.

An important characteristic of a peer worker is the ability to utilise a lived experience to build rapport and validate understanding (Gillard, Gibson, Holley, & Lucock, 2014). The literature identified several skills that are required for undertaking peer work. Skills such as an ability

to navigate mental health systems (Adame & Leitner, 2008), role modelling (Jacobson, Trojanowski, & Dewa, 2012) and advocacy (Chinman, Shoai, & Cohen, 2010). Castellano (2012) identified four tasks in the context of reciprocal peer support including "connection and pure presence; information gathering and risk assessment; case management and goal setting; and resilience affirmation and praise" (p. 106).

This summary has presented the results of a rigorous literature search to develop a conceptual framework of paid peer support. This concept analysis is timely given the current international interest in peer support work and contributes to the common understanding of peer work, facilitating clarity in service provision and research.

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APPENDIX 2: Participant information

Participant Information Sheet

For a project entitled: Peer Support Evaluation

Griffith University Researchers: Chief Investigator Professor Amanda Wheeler; (a.wheeler@griffith.edu.au); Researchers Victoria Stewart (v.stewart@griffith.edu.au), Peter Walsh (p.walsh@griffith.edu.au) and Michelle Crozier (m.crozier@griffith.edu.au) **What is this research about?**

Griffith University has been funded by the Queensland Alliance to conduct research expanding on existing work at Griffith University that has focused on concepts of recovery and peer support when working alongside people with a mental illness. The research will provide insight into how peer support is explained and delivered currently in Queensland through the experiences of two nongovernment organisations. Peer support includes support or services provided to people experiencing mental health concerns by other people who have experienced overcoming mental health concerns themselves and assumes that people who have similar experiences can better relate and offer empathetic support. It is important to distinguish between self-help or informal mutual support and paid peer support. This research will focus on peer support in consumer-operated services. To date, there has only been one evaluation of consumer-operated services in Queensland. The formative evaluation has three central aims:

1. Determine how peer support is currently being operationalised in two organisations in Queensland.
2. Describe how peer support values and principals are enacted within service delivery to provide services to users
3. Develop a framework outlining effective components of peer support.

Who will see the results?

As a participant in the research unless you choose to share your results with others, no-one else will be able to identify your results. Any information that can identify you will remain confidential. It will not be disclosed unless you give permission to do so, and except as required by law. In any published information arising from the study, information will be provided in such a way that you cannot be identified. Only summarized data will be made publicly available so as to maintain your confidentiality. Your results will be stored securely in a lockable filing cabinet at Griffith University Logan campus. Any digital recordings taken during interviews and focus groups will be de-identified, transcribed and destroyed. Information you provide for this study will be retained for a minimum of 5 years. After this time, your results will be destroyed.

Who is eligible to participate?

People aged over 18 who are peer support workers, receive peer support or are managers in peer support organisations are invited to participate in this study. If you are unsure about your eligibility for the study, please contact the research team on Email: m.crozier@griffith.edu.au or Telephone: 07 3382 1310

What is involved?

This research project is being conducted over the next 6 months. This is formative research and will involve a multi-methods approach (i.e., a combination of interviews, focus groups and document analysis). A reference group will also be formed to assist in developing the research design. The first step in the peer support evaluation is a comprehensive literature review of existing peer support programs nationally and internationally. The next phase will investigate peer support through two

organisation via one-to-one recorded interviews, focus groups or document analysis with paid staff and participants involved in peer support. As this is a formative evaluation, a reference group will also be formed to assist in decisions on the research design. A confirmation of data validity will occur through a confirmatory focus group where management and peer support workers from both organisations will be invited to participate in a focus group where the results of the data analysis and findings will be presented. Participants will have an opportunity to provide feedback on the draft framework to ensure validity of results. Involvement in this research is voluntary and your consent to participate is important. Your involvement over this time may include:

- One, one-on-one interviews (face to face or on the phone) or attendance at a focus group with other people regarding your experiences with peer support OR
- Participation on a reference group aimed to inform key research decisions.

Chief Investigator Professor Amanda Wheeler; Researchers Victoria Stewart, Peter Walsh and Michelle Crozier will collaborate with Queensland Alliance, peer support non-government agencies and participants in peer support programs to provide information on peer support.

Do I have to participate?

No. Participation in any research project is voluntary. If you do not wish to take part you are not obliged to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. You are also able to participate in aspects of the research. If you are a consumer the decision not to take part will not affect your relationship with your service provider organisation or staff. Before you make your decision, a member of the research team will be available to answer any questions you have about the research project. You can ask for any information you want. Sign the Consent Form only after you have had a chance to ask your questions and have received satisfactory answers. The Consent Form seeks your approval to participate at all levels of inquiry, so select those that you are happy to participate in. Some questions may be of a personal nature but you will be free to skip questions that you feel uncomfortable answering.

Possible Benefits

Research is crucial so we can increase our knowledge of how we need to provide services in the future. As a participant you are eligible to receive the results from the study. Your participation will provide crucial information to develop insight and understanding on peer support in Queensland.

Possible Risks

There are no major risks to your participation in the project, although you will potentially learn more about, and be able to contribute to quality service provision of the future. All information will be de-identified and your responses will not be revealed to other parties. However, if you disclose anything that may indicate abuse or neglect in terms of your service, we will have an obligation to talk to you about reporting this through appropriate complaints mechanisms.

Ethical clearance

This project will be carried out according to the *National Statement on Ethical Conduct in Research Involving Humans* (2007) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies. Any concerns about the conduct of this research project should be directed to the Manager, Research Ethics, Office for Research on ph: 3735 5585 or research-ethics@griffith.edu.au. Griffith University conducts research in accordance with the National Statement on Ethical Conduct in Human Research.

Privacy Statement

The conduct of this research involves the collection, access and/or use of your de-identified personal information. The information collected is confidential and will not be disclosed to third parties without your consent, except to meet government, legal or other regulatory authority requirements. A de-identified copy of this data may be used for other research purposes. However,

your anonymity will at all times be safeguarded. For further information consult the Griffith University Privacy Plan at http://www.griffith.edu.au/privacy-plan or telephone (07) 3735 5585.

CONSENT FORM

TODAYS DATE _____/_____/_____

For a project entitled: Peer Support Evaluation

1. I have read and understand the Participant Information Sheet regarding my involvement in the project. I have had the opportunity to ask further questions and am satisfied that I understand the project.
2. I understand that if I agree to participate in this project, I will be asked to participate in an interview, reference group or focus group.
3. I have been informed that participation in the project is voluntary and I may withdraw at my own request at any time and that this decision will involve no penalty or loss of benefit as a result of my withdrawal.
4. I also understand that if I participate in the project, and choose to withdraw before its completion, no explanation is required.
5. I understand that information obtained will be stored in strict security and will not be disclosed to parties outside the project team. Confidentiality of the data collected or any personal records identifying myself will be maintained throughout the project and all data will be de-identified prior to sharing information with other researchers. Data collected will be stored securely in a lockable filing cabinet at Griffith University's Logan campus. My results will only be identified by an ID number and will not be stored with this consent form. Any digital recordings taken during interviews and focus groups will be de-identified, transcribed and destroyed.
6. I understand that if I have any complaints concerning the manner in which a research project is conducted, I may discuss this issue with the Manager, Research Ethics, Office for Research, Bray Centre, Nathan Campus, Griffith University (ph 3735 5585 or research-ethics@griffith.edu.au).

Your Name (print)_____
Signature_____
Date_____

Thank you for your assistance with this research project!

APPENDIX 3: Focus group characteristics

	N (n=21)	%
Participant Age		
18-40 years	8	43
40-70 years	17	57
Cultural background		
Australian	16	76
Chinese	3	14
Other	2	10
Current living situation		
Alone	8	38
With family	13	62
Length of time in mental health service system		
1-10 years	5	24
10-20 years	7	33
20-30 years	8	38
30+ years	1	5
Length of time in peer program		
1-10 years	15	71
10+ years	6	29
Contacts with peer program		
0 times/last month	3	14

1-10 times/last month	11	52
10+ times/last month	7	34
Where peer support provided*		
Centre	19	90
Home	3	14
Within community	5	24
Phone	10	48

** Participants could select more than one option*

APPENDIX 4: Interview, focus group questions

Research Questions

Board Member/Manager/Coordinator/Stakeholder/Peer Support Worker:

1. Please describe you understanding of what paid peer work is?
2. What are the principles and values that underpin paid peer work?
3. How is peer work different from other supports offered in mental health services?
4. What are the tasks and activities that paid peer workers do?
5. Who can be a paid peer worker?
6. What skills do paid peer workers need to do their work?
7. What training do you think paid peer workers require?
8. How are paid peer workers supervised and by whom?
9. Is there a pathway from paid peer work to other positions in your organisation?
10. What are governance structures in terms of peer work? (Additional Prompts: are managers peers? What is the board representation of peers? etc)
11. What are the risks and benefits of paid peer work?
12. Do peers want paid peer support and why?
13. How do funders accredit and check for quality in terms of peer support?
14. What else have to add about paid peer support services?

Peers:

1. Please describe your understanding of what paid peer work is?
2. What principles and values do you are important in paid peer work?

3. How is peer work different from other supports you have received in mental health services?
4. What are the tasks and activities that paid peer workers do to support you?
5. Who can be a paid peer worker?
6. What skills do paid peer workers need to do their work?
7. What training do you think paid peer workers require?
8. How are paid peer workers supervised and by whom?
9. What are the risks and benefits of paid peer work?
10. Do you want paid peer support and why?
11. What else have to add about paid peer support services?