School of Occupational Therapy, Social Work and Speech Pathology

Peer Provision in Mental Health Services: Peer relations and organisational contexts

by

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Author's Declaration

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgement has been made.

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

Human Ethics

The research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council National Statement on Ethical Conduct in Human Research (2007) – updated 2018. The proposed research study received human research ethics approval from the Curtin University Human Research Ethics Committee (EC00262). Approval Number # HR 179/2011 dated 13.01.2012. This study has also received human research ethics approval from the North Metro Health Service – Mental Health Research Governance Office (EC00273) dated 20.12.2012.

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Abstract

Introduction

Peer provision is a role in which a person who lives successfully with mental distress is formally employed to utilise a strengths-based recovery approach to provide increased opportunities of recovery for people whose lives are severely affected by mental distress. A series of research reports and policy developments culminated in funding for peer providers through three mental health programmes in the state of Western Australia which has seen an exponential growth in peer provision over the last decade. Whilst the challenges of introducing peer providers to mental health teams has been documented in the extant literature, there is a gap in the understanding of contextual factors that influence peer provider integration and practices. This study seeks to: explore the dynamics of the peer provision relationship; understand how this relationship helps a person overcome their mental health challenges; and examine the role of organisational contexts in the delivery of peer provision services.

Research approach and method

This study occurred in four phases. Following institutional ethics approval (HR179/2011), the first phase consisted of interviews with 16 stakeholders of peer provision services together with documentary analysis from organisations offering peer provision services. The second phase consisted of in-depth interviews with 12 peer providers and the third phase, in-depth interviews with 13 peers (consumers of peer provision services). With the permission of the participants, the interviews were recorded and transcribed. The data were analysed using an interpretive phenomenological approach. This approach seeks to uncover the lived experience of individuals through a process of in-depth reflective inquiry and is particularly useful for understanding under researched perspectives. The fourth phase consisted of a dialogic approach to member checking with stakeholders, peer providers and peers to ensure an accurate representation of themes. It also incorporated a survey that sought to validate a model of peer provision that arose from interviews in the earlier phases.

Results

The results validated the use of the Connectedness, Hope, Identity, Meaning and Empowerment framework (by Leamy, 2011), which highlighted how peers moved along in their recoveries from connectedness through to empowerment. Results also highlighted how, in this process, the role of peer providers evolved from being more directive to allowing themselves to be led by their peers. A stepped model of peer provision was then formulated, to include three stages: creating a safe place, which involves building trust and rapport with the peer; a working partnership, which peers and their peer providers work collaboratively toward their recovery goals; and a stepping out, where the peer-peer provider relationship is terminated. These stages demarcated the peer provider-peer relationship and accentuated the implicit and explicit use of the peer provider's lived experience in the process. Finally, this study demonstrated how the recognition of lived experience as a remunerated role sparked varied organisational responses ranging from adoption (where the recovery ethos shaped organisational practice) to co-option (where recovery work was undertaken but not shaped by the recovery ethos). This continuum highlighted the influence of the organisational culture and context in how peer provision evolved in services.

Discussion and conclusion

This study suggests the need for a dynamic co-existence between recovery and the medical model, which challenges policymakers to consider where peer provision services may be situated within mental health services. It also highlights that people with lived experience deliver peer providers' supervision and support. Hence, it is recommended that peer provision services may be contracted from NGOs to public mental health services as a way forward. Also, a process using Kotter's model of organisational change (Kotter, 2014) is proposed to facilitate an organisational shift towards an adoption response. Further research evaluating is needed to evaluate the work design of the peer provider's role and to validate the stepped model of peer provision in other practice contexts. Further research is also needed to develop and test explanatory models that account for broader systemic issues affecting peer provision.

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Dedication

To God, from whom all things flow. To You be all glory.

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List of Abbreviations

AHMAC	Australian Health Minister's Advisory Council
CHIME framework	Coined by Leamy et al. (2011), this framework describes five recovery processes that facilitate personal recovery: Connectedness (C), Hope and optimism about the future (H); Identity (I); Meaning in life (M); and Empowerment (E).
CINAHL	Cumulative Index of Nursing and Allied Health Literature (Bibliographic database)
COVID	Corona Virus Disease
DC	Donna Chung
DNA	Deoxyribonucleic Acid. In this context, it refers to the fundamental and distinctive characteristics of the organisation
GZ	Grace Zeng
HR	Human Resource
HSE	Health and Safety Executive
IPA	Interpretive Phenomenological Analysis
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NGOs	Non-government organisations
NHS	National Health System
PHaMS	Personal Helpers and Mentors Programme
PMHS	Public Mental Health SYstem
PIR	Partners in Recovery
PPs	Peer Providers

PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analysis
PSW	Peer Support Worker
SMS	Short Messaging SYstem
US(A)	The United States (of America)
UK	The United Kingdom
WA	Western Australia

Glossary

Emotional labour	Refers to the person's attempts to manage emotions related to their role in the context of paid employment. These attempts to manage emotions are constrained by professional and organisational rules (Mancini & Lawson, 2009).
Medical model/ Traditional psychiatry/ Biopsychiatry	These terms are used interchangeably with one another in this thesis. However it refers to the view of mental health challenges as a result of abonormal physiological and/or psychological events within the individual. These abnormalities are viewed independent of the person's context, relationships and values (Bracken et al., 2012). Treatment is targeted at ameliorating symptoms and solely priviledges knowledge, which is characterised by the employment of mental health professionals with a professional qualifications. These include: psychiatrists, nurses, and psychologists.
Non-peer practitioners	These refer to mental health practitioners who are not qualified by experience but by rather a professional qualification. These include: psychiatrists, psychologists, social workers, nurses and occupational therapists.
Psychosocial rehabilitation	Psychosocial rehabilitation refers to the "non-pharmaceutical interventions designed to help a person recovery from mental illness." (King et al., 2012, p.1). Current best practice of psychosocial rehabilitation occurs within the recovery framework which can occur at an individual level (to promote hope) or a community level (to support engagement). Although it is acknowledged here that the psychosocial rehabilitaton model is subsumed by the recovery model, NGOs embracing the psychosocial model in this study are largely driven by an epistemology that priviledges knowledge, which is characterised by the employment of mental health practitioners with professional qualifications (e.g.: psychologists, social workers and occupational therapists), who work alongside peer providers.

Servant leadership	A type of leadership that focuses on the followers, rather than organisational concerns. Servant leaders are characterised by virtue that shape their attitudes, characteristics and behaviours. These virtues refer to their good moral quality, a general quality of goodness of moral excellence (Dennis et al., 2010).
Trauma-informed approach	A process of organisational change that fosters recovery environments for staff, persons with lived experience and their supports. This approach involves the following elements, which permeates the relationships of stakeholders: • Seeing through a trauma lens • Appreciation of invisible trauma and intersectionality • Sensitive discussion about trauma • Trauma-specific support • Preventing trauma in the mental health system • Trustworthiness and transparency • Collaboration and mutuality • Empowerment, choice and control • Safety • Survivor partnerships (Sweeny et al., 2018)

Prologue

Personal experience

I would like to start with a personal account of my experiences to help the reader understand my perspective and what inspired work in this area. I grew up in Singapore and lived there until I was 24 before I came to Australia. My mother was diagnosed with psychotic depression when I was ten years old. When she was well, she was a social, compassionate person, one brimming with life. When she started to get ill, she was another person. She became withdrawn, angry, and strange. My father had a demanding career which required him to travel, and it was during those times that I was filled with dread, for I knew that when my mother was left with the three of us, she would be stressed, not sleep and slip down the slope into another episode.

Being the eldest, I shielded my younger siblings from the volatile environment as much as I could, especially when dad was not around. Undeniably, these experiences left an imprint on my heart that surfaced in the form of an eating disorder. I had a very negative view of myself and felt I could not control anything. I began reducing my food intake and started calorie counting, for if I could not control anything in life, this was one thing I could. This obsession had started to encroach on our family relationships until I met a peer who was five years older than me. Although I did not know what it meant at that time, she wanted to mentor me. She modelled whom I wanted to become and held my hope that things would get better. I believe that I had benefitted from finding a meaningful life before my situation got worse because she chose to come alongside me in my vulnerable times.

I worked with youth and people who were addicted to drugs after graduation as an occupational therapist. Even though there were no peer services available at that time, I could see a gap between the “patients” whom I served and me. I was not a peer per se. But I told them stories of my own experiences that I thought they might identify with. They seemed to appreciate the similarities in those experiences and I felt genuinely connected with my “patients” whom I came to appreciate as fellow human beings. Yet, I seemed to be one of the few that stood against a tide of hopelessness for the future.

Through my experiences, I became convicted of the value of peer provision in mental health. So when a colleague mentioned research in peer provision, I decided to pursue it. If it benefitted me in my vulnerabilities, what more could it do for people experiencing mental health challenges that were more than mine? I think that if more people - peer providers and mental health practitioners alike - can speak up about their mental health challenges and how they've recovered, that mental health will not be seen as taboo, but a human experience to be embraced and shared. Peer providers stand at the frontier of this revolution. They have the capacity and are positioned uniquely to start these conversations personally and professionally. Just as the right soil is crucial for a plant to grow and flourish, the right environment is needed for peer provision to grow and flourish, to keep those conversations going. Just as the right kind of environment is needed for peer providers, the right kind of environment is needed for peers in order for them to grow and flourish as human beings. It was my curiosity to understand the forces that shaped this unique workforce and how it turned lives around like mine for the better that inspired this work.

Chapter 1 Background and Rationale

The prologue highlighted my personal experiences which motivated me to initiate a research project which could potentially contribute to mental health reform. While I anticipated uncovering how peer provision works for persons experiencing mental ill-health in the original iteration of my project, my interviews and subsequent analysis have led me to understand that there are layers of extrinsic and intrinsic factors that shape peer provision services, and subsequently, the peer provision relationship. These layers have become the basis for this thesis. This chapter explores the context of the study by painting a historical backdrop to the study, and the vital role of peer providers in progressing mental health reform. This chapter then leads into two integrative reviews. The first review employs a values-based approach to peer provision, whilst the second review explores the organisational characteristics and culture that are vital to the sustainability of peer provision in mental health services.

1.1 Prevalence and burden of care of mental health difficulties

According to Section 5 Division 2 of the *West Australia Mental Health Act 2014*, a person is deemed to have a mental illness when a person has a condition that "is characterised by a disturbance of thought, mood, volition, perception, orientation or memory and significantly impairs the person's judgement and behaviour." It is interesting to note that the occurrence of trauma and trauma related disorders is significantly higher in persons diagnosed with mental or behavioural conditions (Mauritz et al, 2013). Concomitantly, childhood trauma is significantly associated with an increased occurrence of a mental health diagnosis in adulthood (Kessler et al, 2010).

The National Health Survey reports that 20.1% of Australians had a mental or behavioural condition – the most prevalent among chronic health conditions (Australia Bureau of Statistics 2018). Similarly, in the 'Young Minds Matter' survey, 16.5% of children and 15.9% of adolescents experienced mental health difficulties in the previous 12 months (Lawrence et al., 2015).This was estimated to be responsible for 12% of the total burden of disease in 2015 and the second largest contributor (24%) to the non-fatal burden of disease in Australia (Australian Institute of Health and Welfare, 2018). At a grassroots level, this burden of disease is attested by the higher rates of mental health difficulties experienced by carers of people with mental health challenges (Shah et al., 2010). In addition to these difficulties, there are significant costs associated with mental health conditions. The Australian Institute of Health and Welfare (2020) found that 9.9 billion Australian dollars were spent on the provision of mental health services in 2017-2018. Schofield et al. (2011) also found that persons experiencing mental distress are four times more likely to be unemployed compared to the general Australian population because they are generally reluctant or unable to join the labour force. This cost of the reduction in Australian employee productivity amounted to 11.8 billion Australian dollars (Lee et al., 2017). Unemployment is compounded by the impact of the COVID-19 pandemic on mental health distress, making the need for reform and evidence-based practice more urgent (Australian Institute of Health and Welfare, 2020).

1.2 Need for mental health reform

The corresponding impact of the prevalence of mental health distress on the Australian economy suggests the importance of an effective, trauma-informed approach (see glossary) to servicing the health needs of persons experiencing mental health difficulties (Bateman et al., 2014). Although such a need was acknowledged 26 years ago (Burdekin et al., 1993), contemporary authors suggest that the outcome of mental health policy and reform is yet to catch up with the service needs, particularly for persons living in rural areas and migrant populations. The lack of accountability and low level of genuine involvement or consultation with consumers (peers) and carers also reflects some resistance from the mental health workforce to such reforms (Grace et al., 2017).

1.3 Recent history of mental health reform in Australia

Following a series of consultations, professional group submissions and consumer fora (Whiteford, 1994), a referral was made by the Royal Australian and New Zealand College of Psychiatrists and the Australian National Mental Health Association to the Australian Health Ministers Advisory Council (AHMAC). This referral put mental health on the national political agenda. One of the first steps to mental health reform at a national level was the drafting and release of the Mental Health Statement of Rights and Responsibilities (Standing Council on Health, 2012). The prioritisation of mental health reform nationally sparked a series of inquiries into existing psychiatric services which was consolidated in the Burdekin Report (Burdekin et al., 1993). A national strategy for mental health reform was established that committed to:

- Ensuring consumers, carers and other stakeholders in mental health care are aware of the 'relevant rights and responsibilities and can be confident in exercising them' (Standing Council on Health, 2012, p. 3)
- Deinstitutionalisation through the mainstreaming of psychiatric services and the integration of hospital and community components of mental health services. (Gerrand et al., 2012)

This strategy sanctioned the mental health system to prioritise community care. It revolved around three key events in Western Australia (WA) from 1992-2005: (1) a shift to mental health 'wards' or 'beds' within public hospitals; (2) the down-sizing of stand-alone in-patient mental health institutions (North Metropolitan Health Service, n.d.); and (3) the expansion of community mental health services within non-governmental organisations (NGOs).

1.4 Recovery

The consumer-survivor movement that evolved following the shift of persons experiencing mental distress from hospitals into the community in the 1970s (also known as deinstitutionalization) gave consumers a voice and an opportunity to influence policymakers. From this time onwards, policies driving services began to focus more on fostering mental health and recovery rather than psychiatric disability and illness (Smith & Williams, 2008).

Academic and grey literature described numerous narratives of recovery (Deegan, 1988; Mead & Copeland, 2000). These narratives describe recovery as a journey in which a person learns to:

- makes sense of their own experience (Davidson & Strauss, 1997)
- manage their illness (Mueser et al., 2002);
- regain psychological and emotional wellbeing (Onken et al., 2007);

- take on socially valued roles typical of people similar in age, gender and culture (Brown, 2009);

In the descriptions of recovery, Ramon et al., (2007, p. 1131) emphasise that recovery is a journey and does not have a distinct endpoint representing the absence of mental ill-health. Instead, it is viewed as a journey of living alongside individuals. To sum up these narratives, an early author on the topic, Anthony (1993, p. 527), has described recovery as "… a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and a contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness."

Several authors have described the recovery process (Spaniol et al., 2002; Young & Ensing, 1999). However, Andreson (2003) consolidates the recovery process into five stages: (1) *moratorium*, characterised by denial, confusion, hopelessness, identity confusion and self-protective withdrawal; (2) *awareness*, characterised by an awareness that one can assume another identity apart from their sick role; (3) *preparation*, where the individual resolves to start working on recovery; (4) *rebuilding*, where the person works toward their personally valued goals; and finally (5) *growth*, where the person knows how to manage their illness and stay well, a term fittingly coined by Davidson (2003, p. 159) as "life outside of the illness".

Broadening the individualistic view of recovery, Topor et al. (2009) argue that recovery is social in nature, best seen in terms of social interaction. Consistent with Topor and colleagues' (2009) argument, Mead & Copeland (2000) suggest that peer provision is a critical component of recovery as it holds negligible assumptions about a person's capacities and limitations, and avoids hierarchical relationships between health care providers and patients. This equitable relationship affords opportunities for people experiencing mental distress to move away from their illness to attempt new, health-enriching behaviours with one another.

1.5 The Emergence of Peer Provision in Mental Health Policy

Recovery made its appearance in policy in the National Mental Health Plan 2003-2008, where it was encouraged that "A recovery orientation should drive service delivery" (Australian Health Ministers, 2003, p. 11). However, far from a recovery-orientation, consultation with consumers, families and carers indicated that the limited coverage of mental disorders and inadequate treatment intensity for inpatients and outpatients left negative encounters with the system amongst one-third of consumers and one-half of carers. Pressure for mental health reform intensified with the release of the Mental Health Carers Australia report and the impending release of the report by the Senate Mental Health inquiry (Gerrand et al., 2012). This report documented the need for carers to be heard and respected, the lack of appropriate services and supports for both them and the persons they were caring for. Coupled with a general lack of understanding of resources that were available to them, these carers experienced financial disadvantage, and comprised health and well-being (Mental Health Council of Australia, 2009).

In response, the Council of Australian Governments (2006) released the National Action Plan on Mental Health, replacing the National Mental Health Plan 2003-2008. This plan was sanctioned by a provision of $1.9b of new funding facilitated the commencement of the national Personal Helpers and Mentors (PHaMs) programme. The PHaMs programme provided "increased opportunities for recovery for people whose lives are severely affected by mental illness [using] a strengths-based, recovery approach" through one-to-one and ongoing support' (Department of Social Services, 2018, pp. 21-22). This led to a growth in the mental health workforce of Peer Providers (PPs) nationally (Department of Social Services, 2013; Grace et al., 2017).

There had been a growing consumer and NGO movement in mental health advocacy and new models of service delivery before Australia's first national mental health policy in 1993. These developments were part of the broader international anti-psychiatry and social psychiatry movements (Robson, 2008). For example, The Understanding and Involvement Project in 1989 at Royal Park, Victoria saw Australia's "first use of consumer consultants in a consumer-focused/ staff collaborative evaluation of a public psychiatric inpatient unit" (Pinches, 2014, p. 5). Subsequently, consumer consultants were employed in Victoria within Area Mental Health Services "opening possibilities in consumer participation over time" (Pinches, 2014, p.5).

In Western Australia, where the data for this thesis were collected, the release of the Duty to Care Report (Lawrence et al., 2001) lead to the development of the Health Right Model of peer support, which focused on meeting the physical needs of people with mental distress (Bates & Kemp, 2008; Bates et al., 2009). The funding provided through the PHaMs programme and the Department of Health accelerated what the Health Right Model started. It enabled non-governmental organisations and traditional mental health services in Western Australia to employ peers to help people with mental distress manage their daily activities; reconnect with their family, friends and community; and access appropriate clinical support (Australian Government, 2011).

Presently, the PHaMs programme has been discontinued and transitioned to the National Disability Insurance Scheme [NDIS]. This has transition has added a layer of complexity that has precluded people from accessing peer provision services, now funded under this new scheme. Such complexities include ineligibility for the NDIS, fear of the application process, competing priorities such as housing issues and the inability to obtain evidence required by the NDIA [National Disability Insurance Agency [NDIA], given the intermittent contact people with mental health difficulties have with services (Hancock et al., 2019).

In the thirty years of its existence in Australia, peer provision has evolved from being viewed as a consumer-led practice that disrupted existing mental health practices, to an accepted form of recovery-based psychosocial practice (Meagher & Naughtin, 2018). The Australian Government now recognises peer provision as a professional role that is critical in bridging the person experiencing mental distress to support persons and services they use. It is unique in its intent, skillset and epistemology. (Australian Government Department of Health, 2019).

1.6 Defining peer provision

The empowerment of people with mental health difficulties has been a widely accepted strategy to prevent illness, promote health and progress the equal rights agenda for the consumer movement (World Health Organisation, 2010). This focus has led to the growing significance of peer provision within the mental health sector in Australia, New Zealand, the UK, Canada, Africa, the USA and Asia (Meagher & Naughtin, 2018; Stratford et al., 2019). The benefits of peer provision have been widely acknowledged in the literature. These include better physical and mental health outcomes (Bates & Kemp, 2008; Chinman et al., 2014); enhanced quality of life (Salzer et al., 2016); and the reduction of service cost (Trachtenberg et al., 2013). A vast amount of literature has contributed to the role of peer provision in recovery which is summarised in the article in Chapter 2.

The language used to describe peer provision is intended to describe what it involved and the unique and necessarily different perspective of peer providers from that of traditional service roles (Mead & MacNeil, 2005). Similarly, language employed by peer providers must challenge the medical-model of understanding of consumer experience that many find stigmatising and damaging.

Historically, the language used and the blueprint of mental health systems promotes an "othering" of people with mental health difficulties (Deegan, 2007). This promotion of people with mental health difficulties as being vastly disparate from those who do not experience mental health difficulties reinforces an over-identification with diagnosis and illness. Besides, the medical language that pathologizes mental health difficulties reinforces stigma, often results in a loss of self; damage to personhood and negatively impacts recovery (Mead & MacNeil, 2005).

Peer workers are uniquely positioned to promote an alternative worldview that challenges people to view and speak of mental health difficulties as a reflection of a person's difficulty in coping with the psychosocial, economic, political and biological worlds that surround them (Szasz, 1960). Within the milieu of shared experience, trust and mutual respect, peer workers enable a person to test new behaviours and challenge self-concepts held earlier. It empowers their peers to reauthor their view of self and their being in the world (Mead & Copeland, 2000).

In the context of this study, the development of peer provision work in Australia occurred through the Personal Helpers and Mentors (PHaMs) Program, funded by the Australian Government. Within this program, the role of peer work is viewed as a professional one, in which the peer worker brings a unique purpose, skillset, knowledge and experience to the mental health sector. Such persons are employed by public mental health services and non-government organisations as "subject matter experts". The transaction between the peer and their peer provider usually results in the peers' connection to other supports and services they may use (Department of Health, 2016). However, what occurs within these transactions diversifies across different organisational types (i.e.: NGOs and traditional mental health services). Such a diversification reflects a growing trend to neglect the roots of reciprocity, embracing the view of peer workers as mentors (Murphy & Higgins, 2018).

Persons employed in such a role would have experienced a vast improvement in managing their mental health challenges (Davidson et al., 2006). They offer a paid service supporting other people who are deemed to be not as advanced in their recoveries (Davidson et al., 2006). Several terms such as “peer specialist”, “peer navigator”, “consumer provider” or “peer worker” have been used to describe the formalisation of this role in literature (Jones et al., 2019; Kelly et al., 2014; Hamilton et al., 2015; Chisholm & Petrakis, 2020). To avoid confusion with peer support work’s original intention, the term “peer provider” will be used from this point to capture the formalisation of this role.

Since Australia’s commitment to promoting and enabling recovery in mental health (Commonwealth of Australia, 2009), the term mental illness has become dated. The terms mental health difficulties or mental health challenges have been used as alternative terms in the literature to describe people who live with a mental health diagnosis (Mental Health Coordinating Council, 2018). In line with the language of recovery, I have chosen to use the terms mental health challenges, mental health difficulties and mental distress to highlight the distinctiveness of the person and the difficulties they encounter. Echoing the work of Mead and MacNeil (2006), these terms were chosen to feature a person’s mental health experience as a sole aspect that sits within a spectrum of the entire human experience.

Within this study, the terms peers will be used to describe persons accessing peer provision services, rather than persons employed as peer providers. The use of these terms represents an opportunity for the creative use of language within mental health research. Any debate that may be generated incidentally adds to an extant dialogue of tensions within the area and the need for more research.

1.7 Setting the stage for Peer Provision

In Western Australia where data for this thesis were collected, peer provision occurs in two main organisational types: NGOs and traditional mental health services situated within the public health sector (other wise known as Public Mental Health Services [PMHS]). This section describes the evolution of these organisational types and paints a picture of the setting in which peer providers practice.

NGOs have existed since the early 1900s under the auspices of community support services. These services evolved in the 1970s, often aligning with progressive models of support and rehabilitation such as: living skills programmes; step up step down facilities; and therapeutic communities (Gerrand et al., 2012). By 2014, there were 75 Mental Health Commission-funded NGOs in Western Australia with 960 full time equivalent staff delivering community treatment, community support or community bed-based services (Mental Health Commission, 2015). Based on psychosocial models of rehabilitation, the services of these organisations are based in the community and are centred on "providing well-being, support and assistance to people who live with a mental illness rather than the assessment, diagnostic and treatment tasks undertaken by clinically focused services" (Australian Institute of Health and Welfare, 2018, p. 1). NGOs employ a combination of health professionals and non-professionals under generic job titles (e.g.: community mental health worker) to support people living with mental distress living in the community. This contribution to mental health care has increased significantly over the past decade (Mental Health Commission, 2015).

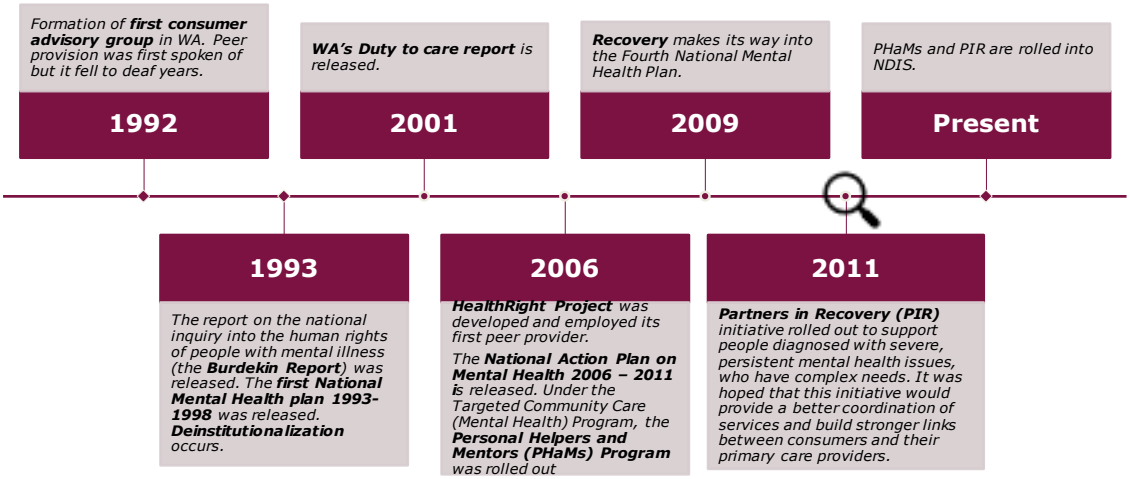
In contrast, the clinical services of PMHS cover a broad range of services within acute and community settings. The practice of PMHS are situated within the medical paradigm. Hence, its practice focuses on clinical issues such as assessment, diagnosis, treatment and rehabilitation, and are governed by both mental health and statutory policies (Government of Western Australia, 2014).

Peer providers employed by PMHS sit in the mental health programmes division and report to the community development officer (a non-peer mental health practitioner). Peer providers normally work on several wards supporting peers by engaging with practical or emotional issues that affect their health and well-being. They may also be funded to support home transition via phone coaching once a week for six weeks post-discharge. More often than not, peer providers in PMHS are supervised by a line manager who is a non-peer.

In NGOs, peer providers usually sit within a team that comprises practitioners from various backgrounds including social work, occupational therapy, psychology or nursing. In these teams, depending on their level of employment, they support a person to work towards their recovery goals (Meagher & Naughtin, 2018). Team leaders supervise peer Providers in these roles (S. Bailey, personal communication, March 23, 2012). Some organisations employ a Peer Support Work Coordinator (a peer) that arranges group peer supervision and personal development. Recent developments in peer provision include funding for peer providers to support people experiencing mental distress in an emergency department within Perth (K. Ferguson, personal communication, October 16, 2017). Also, a peer-led support network was established to provide opportunities for peer providers within the state to meet, share practice, network and support one another (Consumers of Mental Health Western Australia, 2016).

As demonstrated by the timeline in Figure 1.1, peer provision has existed in Australia in the past decade, making its way into Western Australia in 2006, where the data for this study is drawn from. This project began at the end of 2011(denoted by the magnifying glass in Figure 1.1): a point where peer provision had some time to evolve and funding for employing peer providers was at its peak.

Figure 1.1 Historical context of peer provision



Although there was strong support for peer provision by policy, organisations were in different places of understanding of recovery as espoused by policy, which attributed to their uneven development. Whilst NGOs started from the paradigm of psychosocial rehabilitation[1], their public sector counterparts began from the paradigm of the medical model[2] (Australian Institute of Health and Welfare, 2018) (see Table 8.3 for a comparison) . The development of recovery-oriented practice such as peer provision was further hampered by its statutory obligations in the public sector, leaving little place for recovery-oriented services to take root and evolve within the organisation.

[1] Psychosocial rehabilitation refers to the "non-pharmaceutical interventions designed to help a person recover from mental illness." (King et al., 2012, p.1). Current best practice of psychosocial rehabilitation occurs within the recovery framework which can be at an individual level (to promote hope) or a community level (to support engagement). Although it is acknowledged here that the psychosocial rehabilitaton model is subsumed by the recovery model, NGOs embracing the psychosocial model in this study are largely driven by an epistemology that priviledges knowledge, which is characterised by the employment of mental health practitioners with professional qualifications (e.g.: psychologists, social workers and occupational therapists), who work alongside peer providers.

[2] The term "medical model" is used interchangeably with "biomedical model", "traditional psychiatry" and "biopsychiatry" within this thesis. This model views mental health challenges as a result of abnormal psychological/ physiological events within the individual (i.e.: an illness), and largly independent of the person's context. Hence, treatment is targeted at specific symptoms. This model priviledges medically derived positivist knowledge and is characterised by employment of mental health practitioners with professional qualifications (e.g.: psychiatrists, nurses, psychologists).

1.8 Objectives

While many studies have focused on the benefits and challenges of implementing peer provision, no study has focused on building a framework that accounts for the broader sectoral influences on peer provision and its impact on the dynamics of the peer-peer provider relationship. As such, the objective of this thesis is to analyse the wider influences that affect peer provision and how this impacts the peer-peer provider relationship. The researcher posed three research questions to fulfil the objectives of this study:

1. How does the peer provision relationship help support the peer in their recovery?
2. What are the dynamics of the peer provision relationship?
3. In what ways does the organisational context influence the delivery of peer provision services?

To fulfil these objectives, 16 professional stakeholders in peer provision, 12 peer providers and 13 peers were interviewed. These participants were recruited from government statutory services, non-governmental organisations and a research organisation (see Chapter 5)

1.9 Overview of thesis

This thesis is presented as an exegesis and consists of a combination of sections with corresponding peer-reviewed publications. Earlier publications have utilised the terms “peer support” to refer to the service of peer provision. The change in terms reflects the researcher’s growing understanding of peer provision as a formal service, where the person rendering the service is expected to be further along in their recovery than the person receiving the service – a tenet that is different to the original tenet of peer support. Yet, the commonality of lived experience and the explicit use of that exists, which is why “peer” has been retained throughout the thesis.

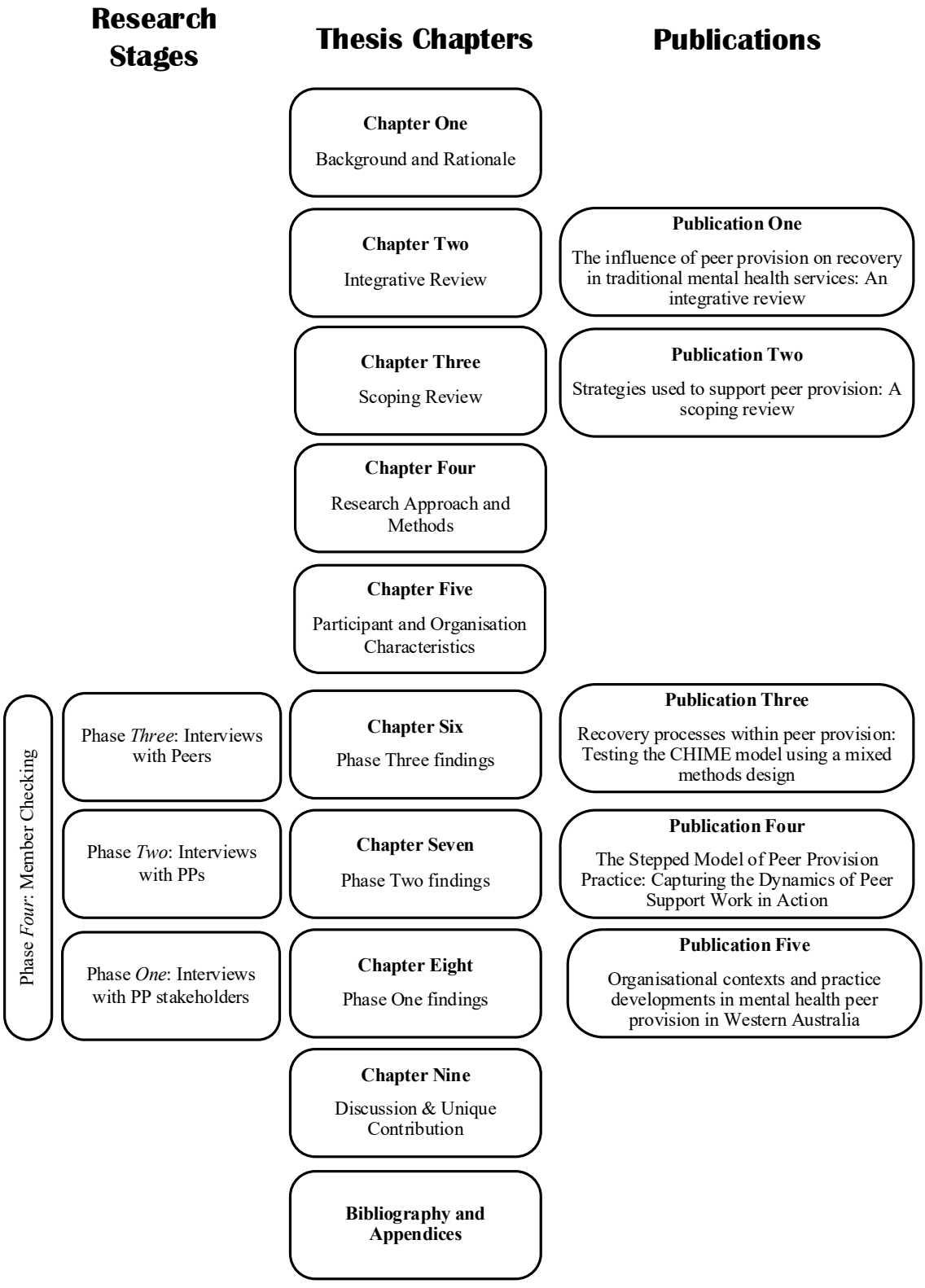
This chapter has introduced the researcher’s unique perspective, what inspired this thesis and the significance of the work to the broader context of mental health in Western Australia. It also situated this study within important events over the last two decades both internationally and nationally. It also highlighted the aims and objectives of the research. This chapter is followed by two reviews that utilised a values-based approach to describe the outcomes of peer provision (see Chapter 2) and the organisational strategies undertaken to support the implementation of peer provision (see Chapter 3).

Chapter 4 justifies the choice of epistemology, theoretical perspective and methodology, before detailing the application of the interpretive phenomenological analysis to this study. It also details the profile of organisations and participants that were involved in the study.

This is followed by the results chapters, which is presented by the phases detailed in Chapter 4 (see page 84). Chapter 5 details the profiles of participants in this study whilst Chapter 6 traces the journey of a peer and their relationship with their peer provider from connectedness to empowerment. This leads on to the dynamics of the peer-peer provider relationship that is described within a stepped approach to peer provision in Chapter 7, followed by the organisational and political influences shaping peer provision (see Chapter 8).

Chapter 9 consolidates the findings of the thesis and introduces relevant literature in a discussion of the findings. It discusses the flow-on effect from policy to the service user, which is mediated by several layers. It also proposes the use of Kotter's model of change (see 9.4) that may be used to guide the implementation of recovery-oriented practice into services for the future sustenance and development of peer provision.This thesis concludes by highlighting the unique contribution of this study to the wider body of knowledge in peer provision and implications for organisations, stakeholders of peer provision and peer providers.

Figure 1.2 Thesis Structure



Chapter 2 The influence of peer provision on recovery in traditional mental health services: An integrative review

Amongst the goals of peer provision to advocate, promote autonomy, and challenge current structures, power dynamics and ways of working (see Section 1.6), an important goal of peer provision is recovery (see Section 1.4), which has been conceptualised by Leamy et al. (2011) into five processes: connectedness, hope and optimism for the future, identity, meaning in life and empowerment (also known as the CHIME framework). Although Gillard's (2019) work on peer provision in mental health services calls attention to recovery-focused outcomes in the reporting of research, studies consolidating recovery-focused outcomes have been sparse. Hence, this literature review was formulated to review recovery-focused outcomes. It informs the first two objectives of this study, which addresses the dynamics of the peer provision relationship. The researcher chose to focus on traditional mental health services, given that literature has documented hindrances to its development extensively (Sinclair, 2018; Vanderwalle et al., 2016). Providing a comprehensive integrative literature review provides a baseline for recovery-focused outcomes in public mental health services and draws attention to the need for further research.

Presented in the form of a paper under review, this chapter utilises the CHIME framework coined by Leamy, et al. (2011) to map the outcomes of persons receiving formalised peer provision. This paper provides the background and impetus for the study reported in Chapter 6.

The manuscript was submitted for publication in the Journal of Mental Health in May 2021. An email confirming the submission of this publication can be found in Appendix F.1.

Inclusion in the thesis as an author submitted manuscript has been approved by the Publisher according to the copyright agreement. Details of this agreement can be found in Appendix F.2.

Reference:

Zeng, G., & McNamara. (In Review). Peer provision in traditional mental health services: Integrative review and implications for practice and policy. *Social Psychiatry and Psychiatric Epidemiology.*

Title

Peer provision in traditional mental health services: Integrative review and implications for practice and policy

Abstract

Introduction

In recent times peer provision has been incorporated into mental health services. Studies that have explored this trend tend to draw from administrative and empirical data. A values-based review has not been undertaken to understand peer provision from a recovery perspective.

Aim

This integrative review aims to map the outcomes of persons receiving formalised peer support against the CHIME (Connectedness, Hope, Identity, Meaning, Empowerment) framework (Leamy et al., 2011).

Method

Peer-reviewed articles were sourced from four databases and existing literature reviews. Following screening and evaluation, data were extracted from 20 quantitative studies; three mixed methods and three qualitative studies. Leamy's recovery framework informed a hybrid approach of deductive coding and analysis.

Results

Recovery outcomes were evident in the studies, though not routinely collected and reported. Contact with peer providers was most effective in the first 12 months.

Discussion and implications

Research that aims to identify and describe recovery is needed to fully understand the effectiveness of peer provision. Peer provision, particularly in early intervention, can support the promotion of mental health through valuing shared lived experience.

Keywords

Peer support; Recovery; Recovery-oriented practice; Integrative Literature Review

Introduction

Peer provision has existed internationally for over thirty years. It grew as part of a broader consumer movement, where disquiet was voiced about existing 'psychiatric' services and treatments (Penney & Bassman, 2004). Traditionally, self-help in mental health services involved those with lived experience supporting each other in an unpaid capacity (Christie, 2016). Now, as a consumer-led renumerated practice, peer provision has grown in legitimacy and gained a foothold in mental health services. While not all peer provision is recovery-oriented, it is often embraced as a valuable asset to good recovery practice in psychosocial services (Meagher & Naughtin, 2018).

With the aim of promoting psychological recovery (Andresen et al., 2011), peer providers may offer practical advice, emotional support and suggest strategies that professionals may not have considered, offered, nor had time to share (Meagher & Naughtin, 2018). However, their effectiveness is dependent on a number of factors, including where peer provision takes place. Peer providers work in a variety of peer and non-peer services and in government and non-government organisations. In these circumstances, formalised peer support occurs, where peers are employed to utilise their lived experience to instil hope and afford practical assistance within an empathic and therapeutic relationship (Zeng & Chung, 2019).

The interchangeable terms used to describe peer provision such as self-help, mutual support, peer support worker or lived experience worker contribute to the perception of diversification. The various terms have been justified through policy mandates which aim to bring peer provision to those accessing mental health support (Murphy & Higgins, 2018). Within traditional mental health services, a formalised peer support model is assumed: peer providers are recruited, trained and remunerated for their roles. Persons recruited within these roles often work alongside other mental health professionals without a lived experience (also known as non-peer providers). They bear a less reciprocal relationship compared to informal, non-remunerated peer roles in mental health (e.g.: self-help groups) as they are considered to be further along in the recovery process (Billsborough et al., 2017). For the sake of clarity and consistency in this review we have chosen to refer to persons providing peer support as peer providers (PPs).

With each role adaptation in peer provision there may also be a risk to peer provision's authenticity. This is particularly so for PPs operating in traditional mental health services where a diminished sense of power is experienced from operating within a philosophically incongruent host environment (Murphy & Higgins, 2018). While peer provision is most often driven by the recovery approach, traditional mental health services may be more closely aligned with a medical model which focuses on symptoms and treatment. These services are characterised by hierarchical helping relationships where PPs offer support as a member of a multidisciplinary team. Factors which undermine the capacity of peer provision to contribute have been explored within traditional mental health services (Ibrahim et al., 2020), but little is known about the recovery outcomes of peers in these services. It is important that recovery outcomes are reviewed carefully and that the host environment is clearly identified.

There has been a recent call to pay attention to the values underpinning peer support and to acknowledge this in the design and reporting of research (Gillard, 2019). Where they occur, recovery outcomes should be presented as evidence which validates the authenticity of peer work. This study reviews reported research to determine which components of recovery are evident in the studies. While some reviews have included studies reporting recovery outcomes (Davidson et al., 2012; Gillard et al., 2015; Pitt et al., 2013; Walker & Bryant, 2013), some of these are dated and none examined client reported recovery focused outcomes methodically through a recovery-based framework. This integrative review aims to describe outcomes in peers who have received formalised peer support. A well accepted framework that is used to conceptualise five interrelated recovery processes was selected to provide a means by which recovery can be operationalised for the purpose of identifying research outcomes. The CHIME (Connectedness, Hope, Identity, Meaning, Empowerment) framework (Leamy et al., 2011) provides a way to examine how peer provision influences recovery in peers.

Materials and Methods

Conceptual Framework

In contrast to other frameworks that view recovery in clinical terms (e.g.: psychiatric service use, treatment compliance, symptom amelioration), Leamy et al.'s (2011) conceptual framework, CHIME, highlights five key recovery processes that are characteristic of personal recovery. These processes (see Table 1) can be construed as definable elements of change that commonly occur during recovery against which outcomes in selected studies may be mapped.

Table 2.1 Elements of change occurring during recovery

Category	Description
Connectedness	Peer support and support groups
	Relationships
	Support from others
	Being part of the community
Hope and optimism about the future	Belief in possibility of recovery
	Motivation to change
	Hope-inspiring relationships
	Having dreams and aspirations
Identity	Dimensions of identity
	Rebuilding/redefining positive sense of self
Meaning in life	Meaning of mental illness experiences
	Spirituality
	Quality of life
	Meaningful social and life goals and roles
	Rebuilding of life
Empowerment	Personal responsibility
	Control over life (including service usage)
	Focusing upon strengths

Adapted from (Leamy et al., 2011)

Integrative review

An integrative review was chosen to accommodate a combination of diverse methodologies in selected studies (Whittemore & Knafl, 2005). To be included studies needed to be set where PPs operate within a traditional mental health service; be original empirical studies; describe recovery outcomes of peer provision; and be published in English. Table 2 expands on the inclusion and exclusion criteria used.

Table 2.2 Inclusion and Exclusion Criteria

	Inclusion Criteria	Exclusion Criteria
Population	Adults People with mental health challenges (and co-occuring substance use disorders) Receive peer provision services	People with substance use disorders and no diagnosed mental illness People who offer peer provision services Non-peer providers
Intervention	Formalised peer provision that can consist of: Peers *added onto* teams Peers in existing roles Peers as *consultants* to mental health professionals Peers *delivering* structured recovery curricula Characteristics of formalised peer provision: They are remunerated for their role. Peer provision services provided in person	Informal peer provision (eg: naturally occurring peer support; clubhouse models; self-help/ mutual peer support) Peers that are not remunerated for their role. Peer provision services that do not involve direct contact. Eg: warm lines/ online programmes Peer provision services that do not involve medical/ non-peer staff within intervention. Ie: Peer Provider has no contact with medical or non-peer staff.
Context	Non-peer organisations (eg: Assertive Community Treatment teams, case management; outpatient services; inpatient services; crisis management; emergency rooms; acute wards)	Peer organisations (eg: peer run peer support services within community services)
Outcome	Quantitative and Qualitative outcomes related to one or more of the following: 1. Connectedness 2. Hope 3. Identity 4. Meaning 5. Empowerment	Outcomes that are not coded are: • Outcomes not related to the framework
Other	English; Peer-reviewed journals	Languages other than English; Non-peer reviewed sources

Data base searching

A literature search was conducted from June 2020 to July 2020. Searches began from 1998 (when recovery was first coined) to July 2020. The Cumulative Index of Nursing and Allied Health Literature; PsychINFO, Web of Science and MEDLINE databases were used to search for articles that met the criteria. Search terms used were based on the concept grid (see Table 3) that was refined iteratively as the literature search progressed. Once studies were identified from this initial search, hand searching ensued by going through references of selected studies and existing systematic reviews.

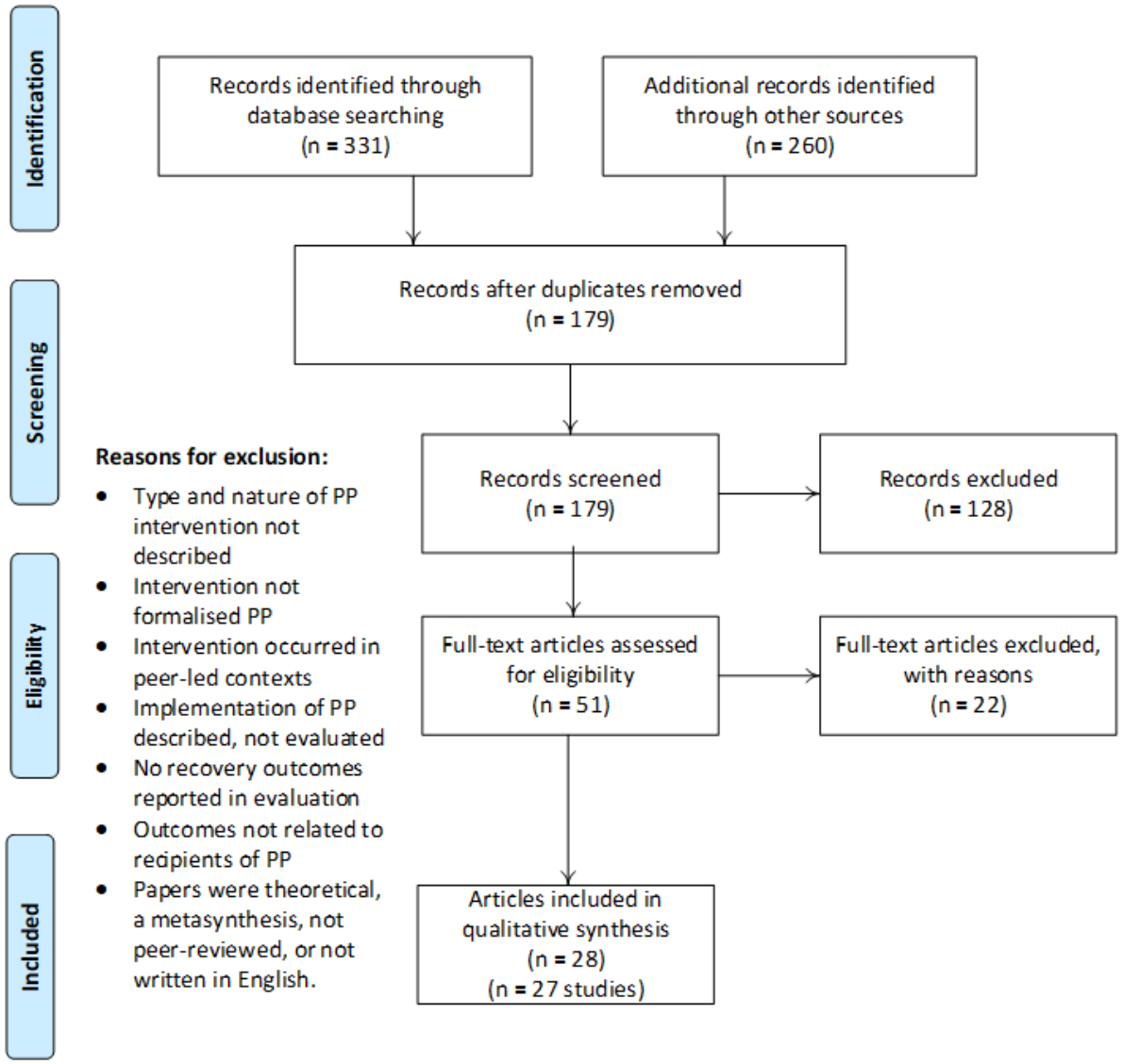
Table 2.3 Concept Grid

Peer Provision	Mental Health	Peer Provision Service Recipient	Outcomes
Peer counsellor Peer advocate Consumer-provider Peer health care assistant Peer case manager Consumer advocate Peer provider Peer service provider Peer navigator Peer Worker Peer specialist Peer support specialist Peer consultant	Mental illness Mental health Mental distress	Consumer Patient Client Peer Service Recipient Service User	Personal recovery Connectedness Hope Identity Meaning Empowerment

Selection Process

In total 591 references were found. Figure 1 highlights the flow of information through the different phases of the selection process. A total of 29 articles on formalised peer provision outcomes in non-peer services published in peer-reviewed journals comprised the final sample for this review (Figure 1).

Figure 2.1 PRISMA Diagram



From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). *Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement.* PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097

For more information, visit www.prisma-statement.org.

Analysis

The data were analysed using a hybrid approach of deductive coding driven by the personal recovery framework (Leamy et al., 2011) and inductive coding driven by the data set (Fereday & Muir-Cochrane, 2006). First, the articles were read through with the following research questions in mind: How have data been collected and analysed in these studies? How are the outcomes aligned with recovery? To enable us to answer these questions, we extracted data from each article and mapped reported outcomes using Leamy et al.'s (2011) framework (see Table 4). Measures and outcomes documented related to connectedness (indicated by C in the table 4); hope (H); identity (I); meaning in life (M); empowerment (E); and recovery measures (R). As recovery outcomes are the focus of this study, other outcomes were not included in the extraction table.

Table 2.4 Studies on Recovery and Peer Provision included in the review

Reference	Study Aim	Outcome Domains						Significant Findings
		C	H	I	M	E	R	
Randomised Controlled Trials (n = 12 studies)								
1. (O'Donnell et al., 1999)	Investigate the provision of client focused services on adverse outcomes; functioning, disability, and QOL and burden of care. (n = 119)				✓			Significant differences in quality of life favouring consumer advocacy group at 6 months. No significant differences at 12-month follow up.
2. (Clarke et al., 2000)	Examine adverse outcomes of persons receiving ACT vs usual care. (n = 163)				✓	✓		Clients served by the consumer ACT team had longer community tenures, decreased hospitalisation rates, shorter stays in hospital, and lower rates of ER visits.
3. (Craig et al., 2004)	Investigate the impact of employing mental health service users as health care assistants (HCAs) within an assertive outreach team.	✓			✓	✓		Clients served by HCAs attended more appointments, social care activities and had fewer unmet needs. The type of health care professional made differences in social networks or service satisfaction.
4. (Jewell et al., 2006; Sells et al., 2008)	Examine if peers have a more positive perception of their PPs than non-peer professionals. To investigate effect of peer provision on service attendance, motivation and use of community-based services. (n = 137)	✓				✓		Therapeutic relationship (viewed as more validating) favoured peer delivered case management. Peers also reported improved quality of life and obstacles to recovery. Therapeutic relationship had no effect on outcomes at 12 months.
5. (Rivera et al., 2007)	Evaluate whether consumers enhance health care satisfaction, quality of life and symptoms through social support, compared with non-consumer assisted case management and standard clinic based care (n = 203)	✓			✓			No significance between group differences found on health care satisfaction and quality of life at 12-month follow up. Small changes in network behaviour were noted across groups.

Reference	Study Aim	Outcome Domains						Significant Findings
		C	H	I	M	E	R	
6. (Barbic et al., 2009)	Examine the effectiveness of a recovery workbook intervention (n = 33)		✓	✓	✓	✓	✓	Significant improvement favouring PP delivered intervention in hope and success orientation, personal confidence, goal orientation, empowerment. No significant differences were found in quality of life.
7. (Sledge et al., 2011)	Examine the feasibility and effectiveness of using PS to reduce recurrent psychiatric hospitalisations (n = 74)					✓		Participants with peers had significantly fewer admissions and fewer hospital days
8. (Chinman et al., 2013)	Compare the recovery outcomes of clients involved with Peers Specialists (PS) with usual care (n = 282)				✓	✓	✓	Significant difference was found favouring the PS group on activation. No significant difference on quality of life and recovery.
9. (Chinman et al., 2018)	Assess association between level of Peer Specialist (PS) engagement and reliable positive change. (n = 140)		✓					High level of engagement with the PS was positively correlated with a reliable positive change in symptoms, but not hope.
10. (Corrigan et al., 2018)	Examine impact of Peer Navigator program (PNP) on service engagement, recovery, empowerment and quality of life (n = 110)				✓	✓	✓	Outcomes favoured PNP group compared to control group in recovery, quality of life, service engagement and empowerment.
11. (Johnson et al., 2018)	Investigate if self-management intervention facilitated by peer support workers (PSWs) reduces readmission rates for people discharged from crisis resolution teams (n = 441)					✓	✓	Readmission, time to readmission within one year, self-rated recovery and satisfaction with mental health care received favoured the PSW group.
12. (Kelly et al., 2014)	Examine effectiveness of peer health navigation (PHN) for improving health and healthcare utilization. (n = 24)					✓		PHN group were observed to seek care from primary care providers rather than acute mental health services.
Quasi-Experimental Studies (n = 6 studies)								

Reference	Study Aim	Outcome Domains						Significant Findings
		C	H	I	M	E	R	
1. (Felton et al., 1995)	Explore the effect of peer specialists (PS) in intensive case management programme on self-image, outlook, programme engagement, social support, quality of life and community tenure. (n = 104)	✓	✓	✓	✓	✓		Outcomes favoured the PS group in quality of life, self-image and outlook, programme engagement, social support and community tenure.
2. (Klein et al., 1998)	Examine effectiveness of peer social support (PSS) as a supplement with intensive case management. (n = 61)	✓			✓	✓		Outcomes favoured the PSS group in social functioning, quality of life and inpatient days.
3. (Kane & Blank, 2004)	Examine the impact on psychiatric and physical outcomes through enhancing a standard ACT with Advanced Practice Psychiatric Nurses (PACT) and Consumer providers (NPACT) (n = 58)	✓	✓		✓			Significant improvement favouring NPACT for consumer satisfaction, community adjustment. No significant differences were found in health promoting lifestyles.
4. (Min et al., 2007)	Examine the effect of attendance in the Friends Connection on re-hospitalization rates and length of community tenure, in persons with co-occurring mental health and SUDs. (n = 556)				✓	✓		Participants with peers had longer community tenure and less inpatient days.
5. (Schmidt et al., 2008)	Examine the effect of substitution of consumer provider CM on low intensity case management (LICM) teams on outcomes. (n = 142)				✓	✓		No significant between group differences found in retention rate, face to face contact, acute care use and adherence to medication , service use, substance use and housing stability.
6. (van Vugt et al., 2012)	Examine whether employing consumer-providers (C-Ps) in ACT teams influences working alliance, function and adverse outcomes (n = 530)	✓			✓	✓		C-P presence was positively associated with social functioning, met and un met needs in relation to personal recovery and number of homeless days. It was negatively associated with number of hospital days.

Reference	Study Aim	Outcome Domains						Significant Findings
		C	H	I	M	E	R	
Case Control Studies (n = 3 studies)								
7. (Chinman et al., 2000)	Compare outcomes of services provided by consumer CMs vs non-consumer CMs. (n = 1203)	✓			✓			No significant between group differences were found on outcomes over a 12-month period. The authors noted that given the clients on the consumer sites had more difficulties than clients on the non-consumer sites, 'the equivalence in outcomes… was even more impressive.' (para 25)
8. (Cook et al., 2010)	Evaluate the outcomes of the wellness recovery action planning taught by peers. (n = 381)		✓			✓		Participants reported significant increases in hope for recovery, awareness of early warning signs, use of wellness tools, symptom triggers, having a crisis plan, having a plan for dealing with symptoms, social support and taking personal responsibility for wellness.
9. (Landers & Zhou, 2011)	Investigate how peer support (PS)relates to psychiatric hospitalisation and crisis stabilisation utilisation. (n = 35668)					✓		Increased use of crisis services and fewer hospitalisation were observed.
Mixed Methods (n=3 studies)_								
10. (Lawn et al., 2008)	Evaluate first 3 months of operation of Peer support service providing hospital avoidance and early discharge support. (n = 49)	✓		✓		✓		AUD93 150 in bed days and AUD 19850 in administration costs were saved. Consumers appreciated their connection to their peer support worker as a role model and one who journeyed with them.
11. (Schmidt et al., 2008)	Examine the effect of substitution of consumer provider CM on low intensity case management (LICM) teams on outcomes. (n = 142)					✓		No significant between group differences were found in outcomes measured at 12-month follow up.

Reference	Study Aim	Outcome Domains						Significant Findings
		C	H	I	M	E	R	
12. (Salyers et al., 2009)	Evaluate the impact of integrating ACT and IMR (provided by peer recovery specialist - PRS) on knowledge of mental illness and increased perception of recovery. (n = 30)	✓	✓		✓	✓	✓	As a result of PRS, consumers reported improved relationships, a positive changed in their level of motivation and hope, greater involvement in meaningful activities, better illness management and PRS being the most helpful aspect of the programme.
Qualitative Studies (n = 3)								
13. (Rooney et al., 2016)	Explore patient's experiences of intentional mental health peer support. (n = 7)	✓	✓	✓		✓		Patients reported that the PSW's communication style was person centred. They built connections; modelled hope; gave practical and emotional support and facilitated recovery interventions with them.
14. (Gidugu et al., 2015)	Understand peer supports' mechanisms of action (n = 19)	✓				✓		Participants appreciated the non treatment based, normalising relationship that peer support offered. Peer support provided practical, emotional and social support to them.
15. (Weir et al., 2019)	Understand peer support's worker's (PSW) role in UK veteran engagement with health and well being services. (n=18)	✓		✓		✓		PSW made a positive first impression, were described to be an understanding professional friend, and connected/ reconnected the person with clinical / well being support when needed.
	Total number of studies:	**13**	**7**	**5**	**13**	**20**	**4**	

Legend: C: Connectedness; H: Hope and optimism about the future; I: Identity; M: Meaning in life; E: Empowerment; R: Recovery outcomes

Results

A total of 27 studies (28 articles) were included in this review. Most studies used quantitative rather than qualitative data. Twenty-four out of 27 were solely quantitative and included randomised controlled trials (n=12; 44%); quasi-experimental studies (n=6; 22%[3]); and case-control designs (n=3; 11%). Three studies (11%) used a mixed-methods approach and three studies (11%) were qualitative (see Table 4).

Evidence of recovery outcomes appeared scant for identity (n=5, 19%) and hope (n=7, 26%), amongst experimental studies. However, outcomes related to connectedness (n=13, 48%), meaning of life (n=13, 48%) and empowerment (n=20, 74%) were evident particularly within the first 12 months of receiving mental health services (see Table 4).

Outcome measures and description used to report on recovery

Quantitative studies reporting recovery outcomes focused on empowerment (e.g.: Corrigan et al. (2018) and Johnson et al.(2018)) and meaning (e.g.: Corrigan et al. (2018)). Mixed methods and qualitative studies explored connectedness and how it contributed to the peer's recovery (e.g.: Salyers et al. (2009) and Weir et al. (2019)

Recovery measures. Four studies (15%) employed recovery measures as an outcome of peer provision intervention. Recovery scores on these studies improved significantly over time (Barbic et al., 2009; Corrigan et al., 2018; Johnson et al., 2018; Salyers et al., 2009); or had no observable change (Chinman et al., 2013). Two out of the four studies with significant improvements to recovery tested a peer delivered recovery workbook curriculum (Barbic et al., 2009; Cook et al., 2010). This indicated that peer provision proved promising in facilitating recovery for peers, even within an intervention which involved structured curricula.

[3] Percentages indicate proportion of the total number of studies included in this review (n=27)

Connectedness

Peers appeared to value the connection they had with their PP in the 12 studies (46%) that evaluated connectedness. Connection related to the intentional efforts of the peer provider to foster connection and share their lived experience. To foster social connections, PPs were reported to organise activities, schedule regular home visits and reconnected their peers with their families (Rivera et al., 2007). These strategies improved discharge experiences and relationships with mental health practitioners (Lawn et al., 2008; Salyers et al., 2009). It also enabled peers to regain their confidence in interacting with people (Lawn et al., 2008) This was achieved by the normalisation of feelings and help seeking behaviours, through a mutual connection to the shared lived experience (Rooney et al., 2016; Weir et al., 2019). This effect, however, waned over time and by 12 months, there were no significant differences in measures of therapeutic alliance between PPs and non-Peer professionals (Dave Sells, Borg, et al., 2006).

Seven out of the 11 studies documented the degree of emotional and practical support received from peer providers. Where non-peer practitioners' attitudes were similar to the peer providers, there was no significant difference in strength of therapeutic alliance found for those receiving peer provision (Chinman et al., 2000). This suggests that the attitude and behaviours that make peers feel valued, supported, listened to and safe are more important than who delivers the mental health service (O'Donnell et al., 1999; Rivera et al., 2007).

Hope

All of the studies that measured hope (see Table 1 for characteristics) as an outcome (n=7; 26%) reported significant changes in hope and success orientation for one to one PP (Barbic et al., 2009) and peer-delivered curricula (Cook et al., 2010). Although it did not significantly predict the likelihood of positive change (Chinman et al., 2018), peers reported how hope was embodied in PPs, making curricula content more powerful (Cook et al., 2010). Study participants also reported that PPs provided an optimistic picture of the possibility of living a contributing life beyond their illness, fostering their own hope for recovery (Rooney et al., 2016; Salyers et al., 2009).

Identity

Of the five studies (19%) that reported outcomes in identity, one study reported a significant increase in personal confidence (Barbic et al., 2009) while the other study reported an increase in self-image (Felton et al., 1995). Qualitatively, peers reported finding new confidence in themselves (Lawn et al., 2008). By showing interest in their peers as a person and offering support without judgement, participants reported feeling valued, which in turn challenged existing negative self-image (Rooney et al., 2016; Weir et al., 2019).

Meaning in life

Thirteen studies (48%) reported outcomes of meaning in life. Whilst the outcomes of these studies have been equivocal, (Corrigan et al., 2018; Sells et al., 2008), the eight studies reporting significant improvements to quality of life indicates that peer provision may be instrumental in enhancing quality of life outcomes in the first year of contact (Corrigan et al., 2018). This included: frequency of social contacts, satisfaction with social relationships, leisure engagement and satisfaction with leisure engagement (Lehman, 1988). It also shows that recovery-focused intervention, such as assertive treatment programmes, proves to be as effective as peer provision for short term outcomes (Salyers et al., 2009). Anchored in the goal of acquiring daily living skills; coping skills to meet the demands of community life, whilst growing in autonomy, both peer provision and assertive community treatment programmes are characterised by an intensive, collaborative approach to service delivery within the community. Practitioners employed within these services typically take on both support and advocacy roles where needed (Salyers et al., 2009; Stein & Test, 1980).

Specific indicators alluding to meaning were also mixed. Whilst peer provision was significantly associated with improved community tenure - the length of time spent living in the community (Clarke et al., 2000; Min et al., 2007); and community adjustment – the extent of integration of the person into community life (Kane & Blank, 2004), it did not have promising effects on life situations such as homelessness and arrests (Chinman et al., 2000; Schmidt et al., 2008).

Empowerment

Twenty studies (74%) reported outcomes in the area of empowerment. Significant increases on Rogers et al.'s (1997) empowerment scale were reported in both studies that employed it as an outcome measure (Barbic et al., 2009; Corrigan et al., 2018). When PPs helped peers pursue their aspirations (Rooney et al., 2016), peers reported a significant increase in personal responsibility (Chinman et al., 2013; Cook et al., 2010), alongside an increase in knowledge about illness (Salyers et al., 2009), indicating an increased control over their lives (Leamy et al., 2011).

Of note, the most common measure used in this category is that of length and rate of service engagement with emergency departments, crisis services and acute hospitals (n=13). These studies found that peer provision was associated with higher service engagement (Corrigan et al., 2018; Craig et al., 2004; Doherty et al., 2004; Felton et al., 1995; Sells et al., 2006); significant reduction in hospital admissions (Clarke et al., 2000; Sledge et al., 2011); and decreased hospitalisation (Johnson et al., 2018; Klein et al., 1998; Min et al., 2007; Sledge et al., 2011).

Discussion

This review highlights that there is evidence of the five recovery processes in Leamy et al.'s framework (2011) reported in the studies included in the review. However, while the studies reported incidences of improved connectedness, meaning in life and empowerment, other recovery outcomes like hope and identity were barely investigated. This review did not cover the other clinical outcomes reported in the studies, like reduction in psychiatric symptoms and use of services, which in most cases overwhelmed the reporting of recovery outcomes. The review intentionally took a values-based approach to promote recovery, finding that little attention has been paid to identifying recovery outcomes associated with peer provision through research. The predominantly quantitative methods used in the reported studies appeared to privilege empiricism – an epistemology that lends itself to the medical model and an economic imperative. This points to the importance of pairing qualitative data with quantitative data to provide context in developing an accurate understanding of the role PPs play in recovery, as administrative data may be too blunt an instrument to gauge the outcomes of the practice. Qualitative studies could focus on lived experience and involve the peers in studies which investigate how their relationship with their peer providers influences their own personal recoveries.

Implications for practice and policy

This review provides evidence to suggest that recovery-oriented attitudes and behaviour are a stronger predictor of therapeutic alliance than the role of the person delivering the service (O'Donnell et al., 1999; Rivera et al., 2007). However, in the absence of recovery-oriented attitudes and behaviour, peers built a stronger relationship with their peer providers (Dave Sells, Davidson, et al., 2006). This suggests that recovery-oriented attitudes and behaviours (as opposed to service roles) may be more important in promoting the health and well-being of peers.

Research from the review supports recovery-oriented training amongst non-peer staff to promote a strengths-based approach to mental health promotion, prevention and early intervention. When such training is delivered in an environment that is well supported by management, changes in practitioner attitudes and behaviour are more likely sustained (Gee et al., 2017).

The lack of significant differences in quality of life and connectedness at 12 month follow up in studies included in the review demonstrates that the difference peer provision makes in outcomes wanes over time. This implies that peer provision may prove more effective in the early intervention space, particularly within the first year of experiencing mental distress. It would benefit policy makers and strategic leaders to consider the increase of PP-resourcing in early intervention teams; crisis management teams; emergency departments; hospital to home programmes and other services which receive referrals within the first year of encountering mental distress.

Gaps in Current Research and Implications for Future Research

In framing outcomes of formalised peer support against the recovery framework (Leamy et al., 2011), the findings of this review highlight gaps in research that may be a result of the influence of the medical model on research questions, methodology and outcomes. Of note, there are gaps in recovery outcomes that have not been captured by current research, particularly in the areas of hope and identity. Other aspects of recovery processes also need attention in research, for example: understanding the continuity of peer support; the trajectory of peers; citizenship; meaning making; and spirituality. Such data may be substantiated effectively by mixed methods studies that combine the empiricism of quantitative methods with the rationalism of qualitative methods (Hasson-Ohayon et al., 2016).

Strengths and Limitations

Overall, the number of articles reviewed was relatively low, indicating a lack of interest, or an inability to adequately investigate recovery outcomes in mental health services. Nevertheless, despite the small numbers of articles included in the review the subject matter is worthy of examination and the process chosen was rigorous. The data for this review were collected systematically using the CINAHL, Web of Science and MEDLINE databases to ensure the credibility of the review. In addition, the reference lists of the articles included were reviewed to ensure that all the relevant articles were found. A strict set of criteria was employed which enhances the trustworthiness of this review, but also limits the types of literature that were included. It is impossible to quantify a complex concept like recovery, so strict measurement may never be possible. While the CHIME framework focuses on processes rather than discrete outcomes, it can provide recovery related concepts which can be linked to behaviours and self-reports of lives that may be changed for the better.

Conclusion

Recovery outcomes in formalised peer provision are not often, nor adequately recorded, as this review has demonstrated particularly in the processes of hope and identity which require sense-making. Although, not without value, empirical studies do not reflect the value of peer provision in enacting reciprocity in mutual giving and receiving, understanding of distress and safety and mutual responsibility in its entirety. In future the authenticity and potential of peer provision may be best understood through the use of carefully designed mixed methods studies that focus on hope and identity.

2.1 Summary

This chapter highlighted the peer provider's role in the practical and sense-making aspects of recovery, demonstrating that they do contribute to peers'recoveries, particularly in the first 12 months of the peer relationship. It should be noted, however, that evidence of this was limited as most research focuses on clinical and administrative outcomes (e.g. service use, treatment compliance). Little attention has been paid to reporting recovery-focussed outcomes, despite the rhetoric used about the importance of recovery in both public and peer-led organisations. Methodologically the chapter demonstrates the importance of using mixed methods approaches to researching peer provision, given that its role in facilitating recovery cannot be encapsulated by one method alone. Quantitative data, particularly related to quality of life, may provide robust figures, where qualitative data can highlight context and detailed information about the peer relationship and how it works. The chapter adds to the knowledge base of the first two objectives, by utilising a recovery-based framework to chart a baseline of evidence which links peer provision to recovery outcomes. It sets the precedence for describing the mechanisms of peer provision's contribution to the recovery of peers in Chapter 6 and Chapter 7.

In order to better understand the work of peer providers, the following chapter looks at the organisational context in which peer providers practice and how the culture of the organisation influences peer provision work.

Chapter 3 Strategies used to support Peer Provision: A Scoping Review

As described in section 1.7, peer provision originated in Western Australia through the strong support for recovery-oriented practice in mental health policy. However, the development of recovery-oriented practice, such as peer provision, differed in organisations depending on the paradigms which informed their operations. This uneven development contributed to a number of challenges faced by peer providers, which has been documented extensively in a range of literature (Vanderwalle et al., 2016; Sinclair, 2018). This chapter reviews the strategies undertaken by organisations to implement peer provision and support peer providers. The chapter provides a background which helps to address the third objective of the thesis: to explore the organisational context influencing the delivery of peer provision services. The manuscript was submitted for publication in Administration and Policy in Mental Health and Mental Health Services Research in August 2020. An email confirming the submission of this publication can be found in Appendix F.3.

Inclusion in the thesis as a version on record has been approved by the Publisher according to the copyright agreement. Details of this agreement can be found in Appendix F.4.

Reference:

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ORIGINAL ARTICLE

Strategies Used to Support Peer Provision in Mental Health: A Scoping Review

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Abstract
The employment of peer providers (people who draw on their lived experience of mental health challenges) has grown in conjunction with the increased acceptance of recovery as a key principle in mental health policy and practice. Barriers to the integration of peer providers in mental health services have been well documented. This review addresses an under-explored area by consolidating strategies undertaken by mental health organizations for the successful implementation of peer provision. A scoping review was chosen to facilitate the rapid summary and dissemination of research findings that are relevant to policymakers and practitioners. Peer-reviewed articles and grey literature were sourced from three databases, key peer support websites and a hand search of the included studies. Following screening, data were extracted from 28 studies: 25 qualitative and three mixed methods studies. The data were analyzed using thematic analysis and organized into themes. Four themes emerged from the data. Championing of peer provision initiatives by organizational leadership is central to the success and sustainability of peer provision. Leadership undergirds three strategies that were discussed: organizational preparation, recruitment, training and induction, and support and development. When peer provision is championed by organizational leadership, measures can be undertaken to prepare the organization for peer provision; recruit, train and induce peer providers successfully into the organization; and support peer providers on the job.

Keywords Peer provision · Organization · Leadership · Recovery · Scoping review

Background

Peer provision is a well established practice in mental health services (Chinman et al. 2019). Peer providers are remunerated within formalized roles to utilize their lived experience "explicitly and intentionally to instil hope and afford practical assistance" to persons experiencing mental distress (Zeng and Chung 2019, p. 106). They take on a variety of roles that are tailored to the needs of their peers. These may include: recovery facilitation, social integration, education, community integration, vocational support, accommodation support, transitional support, and/or assisting people to access and manage social funds (Meagher and Naughtin 2018; Watson 2019). Peer providers work within governmental mental health services, non-governmental mental health services and not-for profit organizations within the hospital and community.

The recovery paradigm, which emphasises social inclusion, self-determination, and lived experience expertise, has been well established in international mental health policy and practice (Mental Health Commission of Canada 2009;; Commonwealth of Australia 2013; World Health Organisation 2013; Vandewalle et al. 2016). The value of peer provision in promoting recovery is well documented in the literature. Peer provision is instrumental in fostering confidence in interacting with others (Lawn et al. 2008), enabling peers to connect to their families (Rivera et al. 2007) and mental health providers (Salyers et al. 2009). Peers also report hope through interactions with peer providers, encouraging them to live a life beyond their illness (Rooney et al. 2016). In demonstrating genuine interest and offering support without judgement, peers reported feeling valued in their relationships with their peer providers (Weir et al. 2019). This relationship sets the scene for peer providers to enable their peers to pursue their aspirations,

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thereby increasing their sense of empowerment and personal responsibility (Chinman et al. 2015; Rooney et al. 2016).

These positive findings, mostly from qualitative studies (Fan et al. 2019; Mancini 2019; Weir et al. 2019), are challenged by quantitative studies and reviews which provide mixed evidence of the effectiveness of peer provision (Bellamy et al. 2017; Chien et al. 2019; Lloyd-Evans et al. 2014). However, encouragingly, quantitative evidence indicates that peer provision is helpful in reducing inpatient, crisis and emergency service use (Chinman et al. 2014; Pitt et al. 2013). Where quantitative studies provide mixed evidence, qualitative studies have focussed on context and descriptions of the challenges faced in implementing peer provision (Ibrahim et al. 2020; Vandewalle et al. 2016), as well as some of the factors which enable its integration in services (Chisholm and Petrakis 2020; Jones et al. 2020).

Peer providers experience many barriers to their integration in mental health services personally and contextually (Vandewalle et al. 2016). Barriers include the lack of credibility of peer provider roles (Gillard et al. 2013; Hamilton et al. 2015) and the subsequent lack of funding for these roles (Hardy et al. 2019), the negative attitudes of non-peer professionals (Kemp and Henderson 2012), struggles with identity construction (Moll et al. 2009; Jones et al. 2020), cultural impediments (Gillard et al. 2015) and poor organizational arrangements (Moran et al. 2013).These impediments indicate the need for peer provision to be embedded within the organizational culture and structure in order to protect its authenticity (Murphy and Higgins 2018; Scanlan et al. 2020).

Numerous studies have examined the effectiveness and challenges of peer provision (Vandewalle et al. 2016; Bellamy et al. 2017; Ibrahim et al. 2020). However, little is known about how mental health organizations encourage the implementation of peer provision through specific policies and procedures. Given that peer provision is an established service that continues to be fuelled by a philosophy of recovery and a strong consumer movement (Murphy and Higgins 2018), reviewing strategies to support its integration in mental health services is warranted. Hence, a research question was developed to remain broad, while considering gaps in the research already reported in literature reviews related to peer provision. With a focus on organizational culture, this study seeks to answer the question "what strategies do mental health organizations use to support peer provision?".

Methods

Scoping Review

Where other reviews provide evidence to support peer provision and the challenges faced, this review aims to summarize strategies to address the challenges documented in literature for explicit use by policy makers, practitioners and consumers. To facilitate the rapid summarization and dissemination of evidence related to these strategies, a scoping review was chosen. (Arksey and O'Malley 2005; Tricco et al. 2016).

Search Strategy and Study Selection

The search was conducted in July 2020. Three electronic databases were chosen for their broad coverage of peer-reviewed journals related to mental health: the Cumulative Index of Nursing and Allied Health Literature, PsychInfo and Web of Science. An initial search was conducted to identify keywords related to three concepts extracted from the research question: peer provision, mental health and organizational strategies. These keywords were collated into a concept grid (see Table 1) and used in subsequent searches. Utilizing keywords in the concept grid, a search was conducted in electronic databases and key peer provision websites from the U.S.A., Canada, Australia, New Zealand and the U.K for grey literature. This search was limited to those reporting on human subjects, and to the review period January 2001–July 2020, to encompass the time where the term peer provision was first coined and used thereafter (Mead et al. 2001).

The process of study selection was iterative (Levac et al. 2010). The first author composed a list of inclusion and exclusion criteria based on the study objectives and the research question (Table 2). This was agreed on by both authors before the articles were independently reviewed for inclusion. Discrepancies in article selection were discussed and recorded. Following abstract and full-text screening, articles that met inclusion criteria were identified. A hand search of included studies ensued to ensure that all possible articles related to the research question were retrieved. Searching continued until no new articles were found. Of the 28 studies included in this review, twenty-seven articles and one report were retrieved, including 25 qualitative studies and three mixed methods studies. The PRISMA diagram (Fig. 1) illustrates the inclusion of studies (Moher et al. 2009).

Following the concept identified in Table 1, detailed information about the strategies used was extracted. In addition, authors, country of origin, study method, study sample, and organizational type were extracted to map the countries and organizational types being studied. As a rich description of organizational culture and detailed information about strategies used within the context of the organization were sought, quantitative outcomes were excluded. The first author conducted the extraction and charting of data with input from the co-author.

Table 1 Concept grid

Concepts	Peer provision	Mental health	Outcomes
Terms	Peer counsellor Peer advocate Consumer-provider Peer health care assistant Peer case manager Consumer advocate Peer provider Peer service provider Peer navigator Peer Worker Peer specialist Peer support specialist Peer consultant	Mental illness Mental health Mental distress	Integration Organization Culture Strateg*
Search string used	("peer counsellor" OR "peer advocate" OR "consumer-provider" OR "peer health care assistant" OR "peer case manager" OR "consumer advocate" OR "peer provider" OR "Peer service provider" OR "peer navigator" OR "peer worker" OR "peer specialist" OR "peer support specialist" OR "peer consultant")	("mental illness" OR "mental health" OR "mental distress")	(integrat* OR organi* OR cultur* OR strateg*)

Table 2 Inclusion and exclusion criteria

	Inclusion criteria	Exclusion criteria
Population	Peer providers (see definition in introduction)	Mutual support (or informal peer support) People with mental health challenges who provide mental health services without using their lived experience (Bradstreet 2006)
Interest	Organizational culture/ strategies which promote the peer provision implementation	Barriers to peer provision implementation
Context	Existing mental health services (i.e.: non-peer organizations)	Non mental health services
Study Type	Qualitative Studies Qualitative results of mixed methods studies	Quantitative studies
Publication Type	Peer Reviewed Papers and Grey literature	Guidelines/ reports with no clear methodology, Systematic Reviews, Protocols, Editorials, Scale development/ validation
Language	English	Languages other than English
Time Frame	Jan 2001–July 2020	Nil

Data Analysis

A thematic analysis was chosen to summarize organizational strategies featured within included studies (Nowell et al. 2017). To ensure consistency and cohesion of the analysis, an interpretative phenomenological framework was chosen to account for the contextual sensitivity of the data and for its commitment to understanding the subjective experiences of research participants (Shaw et al. 2014). Included articles were converted into text form and imported into QSR International's NVivo 10 Qualitative Data Analysis software (QSR International Pty Ltd, 2012). The methods, results and discussion sections of included articles were broadly coded apriori with the research question in mind. This meant that data relating to the strategies were coded. Data relating to challenges were excluded from the coding process. Similarities in codes were grouped to form themes. These themes were then reviewed and verified by the second author before defining them and consolidating them within a broader framework (Neuman 2014; Blair 2015; Nowell et al. 2017).

Results

The 28 studies focused largely on the experiences of peer provision, from which we drew organizational strategies for integrating peer providers into organizations. Nine (32%) studies garnered perspectives from peers, 25 (89%)

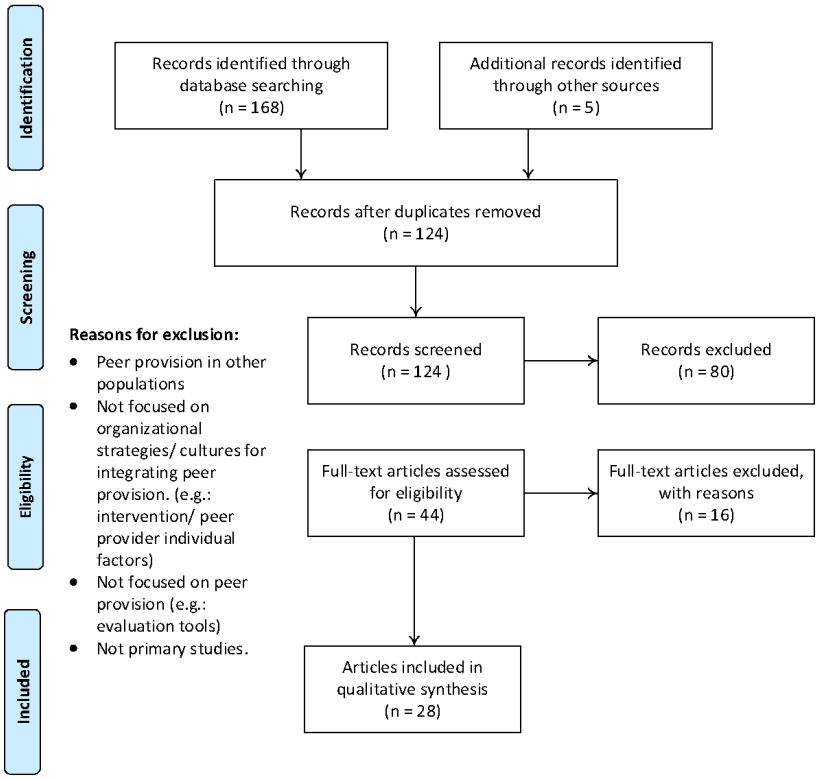

Fig. 1 PRISMA flow diagram

studies from peer providers, 13 (46%) studies from non-peer mental health staff that worked directly with peer providers (within a multi-disciplinary team or supervisors), 11 (39%) studies involved other staff not directly working with peer providers, and four studies involved case studies of organizations or services. Forty-three percent of the studies were set in the U.S. (12 studies), with a further seven (25%) set in the U.K., eight (28%) set in Australia and one (4%) set in Canada. Seventeen (61%) studies were set in statutory mental health services (e.g. led by medical professionals and focussing on a medical/psychiatric model). The remaining studies (39%) were either set in various types of non-government (voluntary) organizations within the community. These included: non-government organizations that comprised mainly of non-peer staff (25%), hybrid organizations in which peer and non-peer staff occupied various positions within the organizational structure (8%), and peer-run organizations (18%). There were six (21%) studies in which the structure of the organizations situated in the community were not clear. Although challenges were reported in all these articles, for the purposes of this review, only the data related to strategies supporting the integration of peer providers into organizations and supporting peer providers themselves were coded. Table 3 summarizes the findings under four themes and presents the sources and the number of studies that provide evidence.

The organizational strategies reported in the studies range from high level leadership support through to the daily practice of peer provision in organizations. Peer providers spoke mainly to the value of supervision, their support and organizational factors that could contribute to their integration within the organization. Non-peer staff spoke mainly to a combination of organizational factors and the

Table 3 Summary of themes and subthemes

Theme	Subthemes		Reference(s)
Leadership (n = 24)	Ensure consistent support for recovery-oriented practice and culture. Utilization of an organizational change framework to guide implementation of peer provision		1, 3, 4, 5, 8, 10, 11, 14, 15, 16, 20, 25
	Use of consistent recovery language		6
	Adopt attitudes that support recovery-oriented practice		6, 17, 18, 23, 26
	Identify and value peer provider contribution to mental health service		1, 7, 13, 23
	Champion peer provision by: tackling issues that arise at a systemic level ensuring continuous quality improvement		1, 2, 4, 7, 9, 12, 19, 23, 25, 26, 27, 28
Organizational Preparation (n = 18)	Obtain buy-in from organizational stakeholders		2, 3, 5
	Build confidence in existing staff through training, focus groups and frequently asked questions		4, 5, 7, 12
	Assess the readiness of the team to adopt a peer provider		4
	Formulate peer provision service goals, job descriptions and hiring decisions in consultation with non-peer staff, organizational leaders and people in recovery		3, 7
	Clear service design features and service roles, which may include:		2, 3, 5, 6, 7, 10, 11, 19, 21, 22, 23, 26, 27
	Service design features	*Service roles*	
	Emphasis on the use of self through: Role modelling personal recovery Use of shared experience and personal strengths Tailor preparation to service type	Facilitate personal recovery Supporting peers ADLs Facilitate connections with services Facilitate community engagement Facilitate return to work	
	Referral agencies should understand what peer providers can offer and taught how to formulate a strengths-based referral form		24
	Policies and procedures around confidentiality, access to medical records, fitness to practice and boundaries should be applied consistently to peer providers		3, 24
Recruitment, Induction and Training (n** = 14)	Recruitment		
	Recruit peer providers in pairs/ teams		7
	Look for and rate applicants based on intrapersonal attributes, interpersonal strengths and work readiness		2, 3, 5, 6, 8, 16, 22, 24
	Remove records/ notes from normal team processes		3, 24
	Training		
	Recruit to training, and train to develop		4, 8, 11, 17, 18, 23, 24, 25
	Induction		
	Offer a practice placement		24
	Shadow various staff members on the team		3

Table 3 Continued

Theme	Subthemes	Reference(s)
Support and Development (n = 13)	Procedural Strategies	
	Procedural strategies to support health and well being:	
	Allow peer providers as far as possible to choose their hours of work in keeping with their circumstances and challenges	19, 22, 24
	Implement *reasonable accommodations* (or adjustments) for illness (mental or physical) in conjunction with the peer provider and their team leaders	19, 24
	Formulate a keeping well at work plan which should be shared with their manager in conjunction with what should be done in the event of a crisis	17, 24
	Support for personal leave or annual leave. A pool of peer providers may be contracted to back fill posts when a peer provider is absent/ on leave	3, 14, 23
	Relational Strategies	
	Within organization:	
	Offer supervision and mentoring formally or informally. This is based on trust, with the intention of developing/ expanding the peer provider's skillset and tackling problems arising. It should not focus on the person's clinical status	3, 7, 8, 9, 23, 24, 28
	Implement protocols to keeping confidentiality	3,17,
	Facilitate communication within and between teams	10, 12, 17, 18, 24
	Outside the organization:	
	Facilitate opportunities for peer providers to connect with other peer providers within and outside the organization	20

References and respective numbers: **(1)** Bates and Kemp (2008); **(2)** Berry et al. (2011); **(3)** Chinman (2010); **(4)** Chinman et al. (2008); **(5)** Chinman et al. (2006); **(6)** Chisholm and Petrakis (2020); **(7)** Davidson et al. (2012); **(8)** Delman and Klodnick (2017); **(9)** Dragatsi and Alvarez (2012); **(10)** Franke et al. (2010); **(11)** Gates and Akabas (2007); **(12)** Gates et al. (2010); **(13)** Gillard et al. (2017); **(14)** Gillard, et al. (2015); **(15)** Gillard et al. (2013); **(16)** Gray et al. (2016); **(17)** Holley et al. (2015); **(18)** Kemp and Henderson (2012); **(19)** Kroschel and Casey (2011); **(20)** Mancini & Lawson (2009); **(21)** McCarthy et al. (2019) **(22)** Moll et al. (2009); **(23)** Ockwell (2012); **(2224)** Repper and Watson (2012); **(25)** Sheehan et al. (2018); **(26)** Siantz et al. (2017); **(27)** Smith-Merry et al. (2015); **(28)**Zeng et al. (2020)

**n represents the number of studies

value of supervision, other stakeholders spoke to wider systemic issues, including funding, that shaped organizational practice.

Leadership

Twenty-four out of 28 studies (86%) highlighted the role of leadership and/or provided examples of recommendations in policy and practice needed for a cultural shift towards recovery. This provided the foundation for a successful integration of peer provision in the mental health service. One key factor that facilitated the successful integration of peer provision services was the championing of peer provision initiatives by key leaders in the organization who could effect systemic change utilizing an organizational change framework (Chinman et al. 2006).

As highlighted in Table 3, several recommendations that were behavioural and attitudinal in nature were made to sustain the shift toward recovery-oriented practice. These included: the consistent use of recovery language (Chisholm and Petrakis 2020), the adoption of attitudes such as humanity, inclusivity, mutuality, collaboration, flexibility and autonomy (Ockwell 2012; Siantz et al. 2017; Chisholm and Petrakis 2020) and identifying the peer provider's contribution to the service (Davidson et al. 2012). These elements should underpin the design of job descriptions, training programmes, supervision and support, as well as service evaluation and service development (Bates and Kemp 2008; Mancini and Lawson 2009; Davidson et al. 2012; Ockwell 2012; Gillard et al. 2017). Supporting the building of safe and trusting relationships within the service in such a manner can contribute to the cultural capital of the organization, which serves to manage risk in a psychologically safe space (Holley et al. 2015). Support from leadership at the highest level enables the alignment of peer provision initiatives with the organization's agenda (Gillard et al. 2015). This prepares the organization for the introduction of peer provision, recruiting, inducting and training peer providers and affording support on the job.

Organizational Preparation

As shown in Table 3, 18 out of 28 (64%) of selected studies related to the organizational preparation for peer provision. The introduction of peer provider roles may be easier in smaller organizations that are less hierarchical and have less ingrained practice cultures (Ockwell 2012; Gillard and Holley 2014). Nevertheless, the introduction of peer provider roles is a pivotal step in moving toward recovery-oriented practice in all mental health organizations (Franke et al. 2010; Smith-Merry et al. 2015).

The themes highlighted in Table 3 indicate that organizational leadership should facilitate a buy-into peer provision initiatives, ensuring that existing staff are supportive, understand the role of peer providers and are confident in working alongside them (Chinman et al. 2006; Chinman 2010; Berry et al. 2011). To facilitate this, a list of answers to commonly asked questions may be disseminated, access to recovery-oriented training ensured and sessions providing opportunities for non-peer staff to talk to peer staff afforded (Chinman et al. 2008, 2006; Gates et al. 2010; Davidson et al. 2012). Thereafter, the readiness of the team to adopt a peer provider should be assessed (Chinman et al. 2008).

A co-production approach should be adopted in the design of the peer provision service (Chinman 2010; Davidson et al. 2012). Non-peer staff on existing teams, organizational leaders and people in recovery should be consulted in defining the goals for hiring peer providers; defining service design features (e.g.: one to one vs group, where the service should be delivered, structured curriculum vs unstructured tailored support); service roles (see Table 3); and formulating criteria for hiring (Berry et al. 2011; Chinman 2010; Chinman et al. 2006; Chisholm and Petrakis 2020; Davidson et al. 2012; Franke et al. 2010; Gates and Akabas 2007; Kroschel and Casey 2011; McCarthy et al. 2019; Ockwell 2012; Siantz et al. 2017; Smith-Merry et al. 2015). In addition, policies and procedures around confidentiality, access to medical records, fitness to practice and boundaries should be considered and applied consistently (Chinman 2010; Repper and Watson 2012).

Recruitment, Training and Induction

As highlighted in Table 3, 14 studies (50%) reported strategies pertaining to recruitment, induction and training. Studies suggest that the recruitment of peer providers should follow standard employment procedures. Job selection should be a competitive process, with the same recruitment and hiring procedures applied to both peer and non-peer staff (Gates et al. 2010; Repper and Watson 2012). Two studies reported that a group interview format is an effective means of assessing communication skills and team behaviour of applicants in real-time (Gates et al. 2010; Repper and Watson 2012). Applicants can be rated during these interviews on intrapersonal attributes (e.g.: non-judgemental, optimistic, strong evidence of personal recovery); interpersonal strengths (e.g.: confident communication skills, works well in a team, able to negotiate boundaries); and work readiness(Chinman et al. 2006; Moll et al. 2009; Chinman 2010; Berry et al. 2011; Repper and Watson 2012; Delman and Klodnick 2017; Gray et al. 2016; Chisholm and Petrakis 2020).

Repper and Watson (2012) recommend that first time peer providers may benefit from "recruit to training", i.e., training before commencing in paid employment. This not only provides a good opportunity to promote employment readiness, it also provides a platform to assess a person's readiness

for formal employment. Training in an appropriate physical setting and group size, should be aimed at giving them reassurance, and building their confidence in carrying out their roles (Holley et al. 2015). This can include developing a "listening heart", using their lived experience effectively (e.g., the purpose and process of self disclosure, keeping themselves safe); navigating their relationship with their peers (e.g.: creating positive relationships, empowerment, confidentiality); organizational administration (e.g.: documentation, managing administrative details on the job); and other topics indicated in Table 3 (Gates and Akabas 2007; Chinman et al. 2008; Kemp and Henderson 2012; Ockwell 2012; Repper and Watson 2012; Holley et al. 2015; Delman and Klodnick 2017; Sheehan et al. 2018).

Upon selection of the candidate, two studies recommended that organizations remove records from team processes if the person had used the service previously, to prevent access to the person's past records by non-peer colleagues (Chinman 2010; Repper and Watson 2012). As part of the induction process, organizations may offer a practice placement (Repper and Watson 2012) or shadow various staff on the team (Chinman 2010) to help peer providers develop organizational acumen. Where functions overlap with other members of the team, mandatory organizational training should be provided to all staff (peer and non-peer) (Gillard et al. 2013; Gillard and Holley 2014), such as risk training (Holley et al. 2015).

Support and Development

Table 3 highlights 13 studies (46%) relate to the support and development of peer providers. This was afforded to peer providers through procedures and relationships. While procedural strategies served largely to support the peer provider's health and well being (Moll et al. 2009; Chinman 2010; Kroschel and Casey 2011; Ockwell 2012; Repper and Watson 2012; Gillard et al. 2015; Holley et al. 2015), relational strategies afforded opportunities to develop the peer provider's skillset as well as affording emotional support (Chinman 2010; Davidson et al. 2012; Dragatsi and Alvarez 2012; Ockwell 2012; Repper and Watson 2012; Holley et al. 2015; Delman and Klodnick 2017).

A partnership between peer providers and their employers is crucial to managing their mental health. Studies show that managers found that having a "keeping well at work plan'' was useful in supporting their peer providers, especially in times of crisis (Kemp and Henderson 2012; Holley et al. 2015). As indicated in Table 3, when flexibility in work hours, staffing and reasonable accommodations were implemented for a person's illness, peer providers felt supported by the organization (Moll et al. 2009; Kroschel and Casey 2011; Repper and Watson 2012; Holley et al. 2015).

Within the organization (see Table 3), a sound relationship with supervisors plays a pivotal role in supporting peer providers' transition to the worker role (Gates and Akabas 2007; Dragatsi and Alvarez 2012; Gillard et al. 2013; Delman and Klodnick 2017; Sheehan et al. 2018). Rather than focusing on the peer providers' clinical status, Davidson (2012) highlighted that supervision should be based on trust, to tackle problems arising and developing the peer provider's skill set. This can include topics such as communication, tackling challenging situations, how to best support their peers, managing workplace issues, growing job skills and evaluating job performance (Chinman 2010; Davidson et al. 2012; Dragatsi and Alvarez 2012; Ockwell 2012; Repper and Watson 2012; Delman and Klodnick 2017; Zeng et al. 2020). Notably, (Mancini and Lawson 2009) noted the value of non-peer organizations contracting peer providers from peer-led agencies. In that way, supervision is conducted within a supportive network by peers who are knowledgeable and competent.

Discussion

This article reviewed studies which document the multi-level strategies undertaken to meet the challenges posed by the implementation of peer provision. As illustrated in Fig. 2, the role of organizational leadership is central in fostering recovery-oriented culture and practice. This paves the way for preparing the organization to integrate peer provision services, recruiting, training and inducing peer providers

Fig. 2 Strategic framework for peer provision implementation

into the service, and supporting them. As indicated by Fig. 2, all of the key issues (documented as themes in the results) are interconnected. The implications for strategic leadership, organizations and peer providers are discussed below.

Implications for Organizational Leadership

The majority of studies highlighting the role of organizational leaders in championing peer provision initiatives indicate the centrality of organizational leadership to implementing and sustaining peer provision. It is important for strategic leaders to recognize and value a person's experience of adversity and recovery from it, and to give permission to peer providers to relate to their peers reciprocally, sharing a "common sense of humanity" (Stratford et al. 2019, p. 4) as part of their role in the organization. By implementing an organizational change framework, peer provision initiatives are "eased" into the organization, giving space for co-production of the role to occur between organizational leaders, existing staff and people with lived experience (Chinman 2010).

Organizational leaders play a key role in legitimizing peer provision services by promoting the adoption of recovery language and attitudes in the organization, and sanctioning recovery-oriented practice by ensuring adequate resourcing to tackle challenges at a systemic level, and ensure continuous quality improvement. Where there is a clash of values, organizational leaders need to be prepared to mediate between peer providers and their non-peer counterparts to ensure shared recovery-values and mutuality of intent (Chisholm and Petrakis 2020). This ensures that the values that underpin peer provision are protected, and peer provision practice does not get diluted (Murphy and Higgins 2018). Of note, given the range of organizations included in the review, it seems unlikely and probably undesirable that there is a "one-size-fits all" approach to peer provision, except perhaps where these approaches integrate flexibility for local peer and community expertise to shape the peer support (Smith-Merry et al. 2015).

Implications for Organizations

With the championing of peer provision initiatives by organizational leaders as a form of recovery-oriented practice, a recovery-orientation will begin to emerge in the organization's culture (Franke et al. 2010). Such a culture is characterised by democratic procedures in daily operation and governance of services; shared accountability of both leadership and ground staff (peer and non-peer); safe relational spaces where mutuality thrives; and one that reflects respect, responsibility and reciprocity (Murphy and Higgins 2018).

The offer of supervision, rewards and flexible job conditions highlighted in this review are negatively associated with employment turnover and positively associated with employment satisfaction (Grant et al. 2012). Hence, it is imperative that organizations establish sound supervision processes, reasonable adjustments to work conditions and allowances for time away from work to deal with personal or health issues. In regard to the latter, Ockwell (2012) recommends contracting from a pool of peer providers to back fill posts to support a peer provider who is away.

Implications for Peer Providers

While the role of peer providers may appear like other primary roles such as occupational therapy and social work, the foundation on which these roles are built differ. Unlike traditional roles in mental health care, peer provision is founded on the use of autobiographical experiences rather than the professional knowledge and skills acquired in working with someone experiencing a mental illness (Gates et al. 2010; Berry et al. 2011; Gray et al. 2016). As peer providers negotiate their working relationships with other service users and their colleagues (both consumer and non-consumer), they inevitably perform routine emotional labour, which can lead to burnout and high turnover in the absence of support (Mancini and Lawson 2009). Self-care is needed to develop resilience and sustain the peer providers in the midst of their emotionally laborious jobs. This involves nurturing a personal life; investing in a broad array of restorative activities; constructing fortifying personal relationships and valuing an internal focus (Skovholt and Trotter-Mathison 2014).

Peer providers need to be aware of the tension between supporting people experiencing mental health problems and developing their personal identities that are not solely defined by illness, in using their lived experience that is integral to their job title of being a "peer" (Dyble et al. 2014). Richards et al.(2016) suggest that positive identity discourses integrating experiences as a service user and a professional can contribute to optimizing the social value of the service user, whilst bringing hopeful perspectives on mental distress to the foreground of therapeutic experiences. The authors suggest that strong championing for peer provision by organizational leadership can foster a recovery-oriented organizational culture which is characterised by: a positive work structure involving mentoring; the presence of enriching relationships; multiple life roles; and a recovery-oriented work environment that promotes health and well-being (Skovholt and Trotter-Mathison 2014). With the consistency of values that flow from the leaders, to the organizational culture and ways of working, it may be possible for peer providers to assimilate their identities as persons, professionals and ex-service users in the course of their work.

Study Limitations and Direction for Future Research

This review acknowledges the variability of peer support, but nevertheless attempts to distil strategies commonly used to support peer provision with the goal of providing practical advice to policy makers and practitioners alike. The authors found that excluding quantitative studies reduced the strength of numerical evidence. However, our intention was to provide context and specific strategies, something not afforded by the quantitative studies identified in our preliminary searches. A substantial number of qualitative studies were retrieved for the purpose of this review, but unfortunately there is a dearth of co-produced research with peer providers and very few mixed methods studies. As peer provision is a complex intervention, it requires the greater use of these methodologies to better understand its operation and impact.

Conclusion

The work of a peer provider is an emotionally laborious one and requires a delicate balance between being personal and being professional. This study suggests that when peer provision is championed by organizational leadership, measures can be undertaken to prepare the organization for peer provision, recruit, train and induce peer providers successfully into the organization, and support peer providers on the job. With the organizational culture clearly supporting a recovery ethos, peer provision is more likely sustained and advanced to promote mental health amongst people experiencing mental health challenges and the larger mainstream mental health system.

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Authors Contribution GZ conceptualised the review, retrieved, analysed and interpreted the data and was a major contributor in writing the manuscript. BM finalised the data for inclusion into the study and reviewed the themes in the data synthesis process. All authors read and approved the final manuscript.

Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

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3.1 Summary

The literature review section, commencing in chapter two, concludes here. The second paper in the literature review section, Chapter 3, has focussed on organisational strategies used to successfully implement peer provision in mental health services. This review centres on the importance of strategic leadership support in driving recovery-oriented ethos and practice to establish successful integration of peer provision in organisations. While it is important to retain the values of peer provision, this article makes a point that there is no one model of practice that will apply across organisations. With the third objective of the thesis in mind, this sheds some light on how organisational contexts influence the delivery of peer provision.

The literature chapters highlighted the role of organisational contexts, and the need for studies employing research methods that reflect the value of equity, respect, acceptance and understanding espoused by peer provision. This shaped the rationale and choice of research approach and methods which are presented in the following chapter.

Chapter 4 Research Approach and Methods

This chapter describes the research approach adopted and methods used in this project. The study focused on understanding peer provision practice and its development with those involved in undertaking peer provision. Hence, the principles of interpretative phenomenology were used for the study as it was considered an appropriate approach for an exploratory study. In this chapter, research with peer providers is described and the research design discussed. The methods employed for data collection and data analysis are detailed. Ethical considerations are given particular attention as the study focused on marginalised populations. This chapter concludes with a description of the research participants and key demographic data.

4.1 Theoretical approach

Quantitative paradigms have dominated the evidence about the effectiveness of peer provision (Bellamy et al., 2017; Chien et al., 2019; Lloyd-Evans et al., 2014). However, an emerging body of qualitative evidence reveals a complex interplay of systemic issues on peer provision practice (Vandewalle et al., 2016). Murphy and Higgins (2018) comment on the situatedness of peer provision practice within the mental health system, with some contexts privileging recovery while others privilege psychiatric models of practice. It is also a relatively new area of practice, and the predominant use of quantitative methods in this area has not always revealed the daily practices, activities and challenges of peer providers and those they work with. Such an emerging area of practice calls for the need to engage in qualitative methods of inquiry to uncover the complexity of peer provision practice and the worlds of those who experience it directly or indirectly. In the words of (Dahler-Larsen, 2018, p. page 867):

> "…qualitative methods can be understood as a rich set of ideas, concerns, and approaches characterized by sensibilities such as an attention to the larger context in which a phenomenon under study is embedded… an attempt to see whatever is evaluated in light of how it fits into the world as it is for those people whose world it is…"

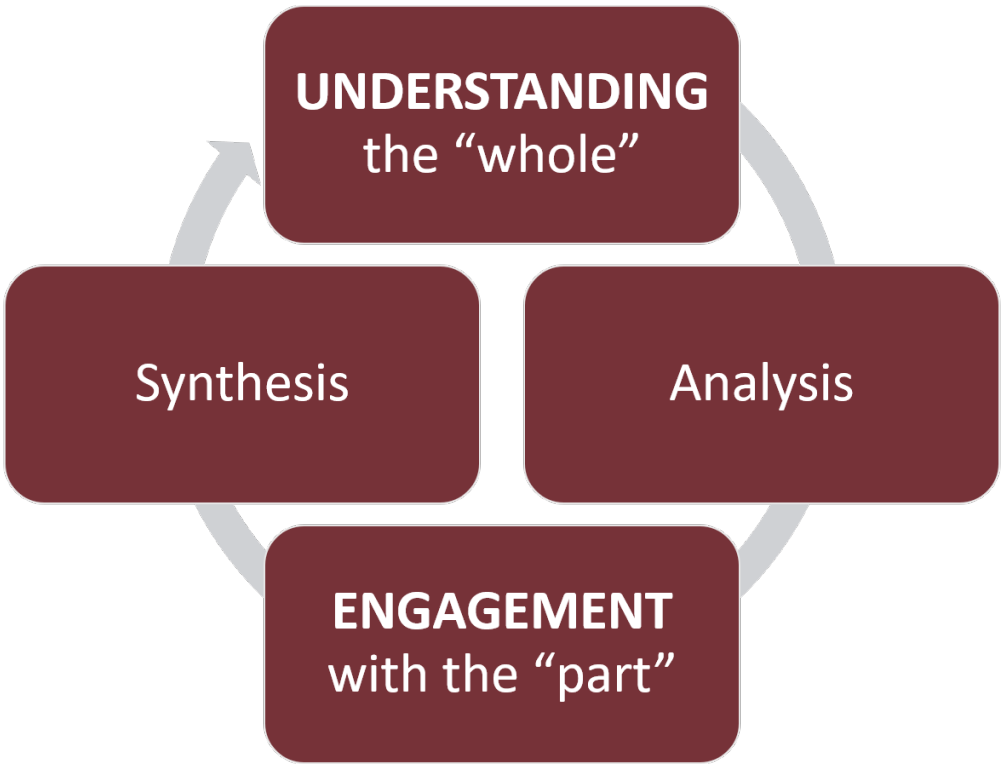
Within such an interpretive paradigm, qualitative methods were best suited to this study as the research questions were concerned with understanding peer providers' practices within the context of the mental health system, (in contrast with service outcomes or service usage which have been the focus of much research to date in peer provision and accessed mainly via quantitative methods). A methodology which privileged the voices and perspectives of participants, as well as being capable of generating a rich understanding of the interplay between lived experience and the broader context of being was needed to answer questions related to peer provision as experienced by different stakeholders.

Hence, an interpretive phenomenological analysis (IPA) was chosen because it employed a context-sensitive approach to making sense of the subjective experience of participants in the study (Shaw et al., 2014). Such an approach to analysis was particularly useful, given that this study examined the phenomenon of peer provision from multiple perspectives.

IPA embraces an idiographic focus, enabling the researcher to appreciate the unique, individual and concrete experiences of each participant. To do so, in-depth interviews that were narrative in nature, together with other tools of data collection such as documentary analysis and fieldwork observations were employed to enhance understanding between the researcher and participants (Larkin & Thompson, 2012). The interviews were aimed at understanding how participants made sense of their experiences. As such, the interviews proceeded as a dialogue between how participants understood their experiences and the interviewer's interpretation of it (Shaw et al., 2014).

To conduct the study's interviews, the researcher had to hone mental and personal capacities similar to that of their participants (based on the fundamental of humanness), while simultaneously accessing their experience through their account of it. This necessitated the researcher to 'go deep', immersing herself in the data to fully appreciate the meaning of the phenomenon to the participant. It also necessitated the researcher to 'see the big picture' which required her to step back from the data to appreciate the data as a whole, enabling her to situate the participant's experience of being in the world (Shaw et al., 2014). In this way, the researcher engaged in a hermeneutic loop (see Figure 4.1). The rationale was that as the researcher continued to do so over time, her understanding of the data deepened.

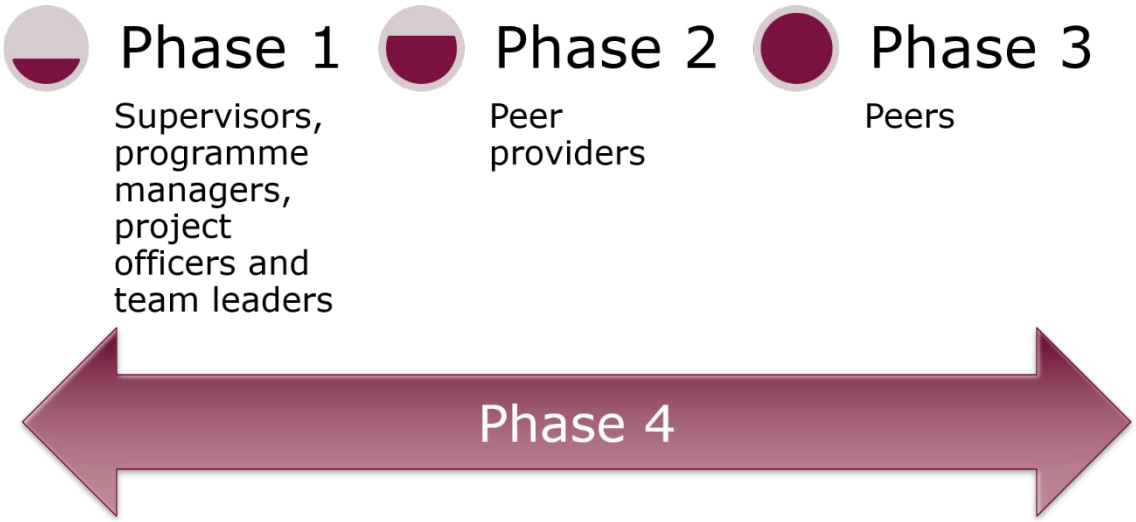
Figure 4.1 The hermeneutic loop



4.2 Research Design Overview

The study design has been conceptualised into four phases (see Figure 4.2). The first phase sought the views and experiences of peer provision from stakeholders, including programme managers; consumer advocates; and project officers involved in research and policy. The second phase sought the experiences and views of peer provision from the peer providers themselves while the third phase sought the experiences and views of persons receiving peer provision services (referred to in this study as "peers"). The fourth phase involved member checking, which discussed further in the data collection section (see page 89).

Figure 4.2 Research design overview



4.3 Study setting and peer provider role

The study was conducted in Western Australia across three public services and eight non-government mental health organisations that delivered peer provider services. Stakeholders from an independent organisation were also included in the first phase of the study. The public services involved in this study were funded by the Department of Health and had to fulfil statutory obligations, which included treating persons committed to mental health wards under the inpatient treatment order (Mental Health Act 2014). In the public mental health sector, peer providers were employed within the mental health programmes division and reported to the community development officer: a position usually occupied by a non-peer mental health practitioner. In some jurisdictions, a network of peer providers was formed with a peer support coordinator (a peer) supervising them. Peer providers typically worked on several wards supporting peers by engaging with practical or emotional issues that affected their health and well-being. Peer providers were also employed to support home transition via phone coaching once a week for the first six weeks of the peers' peer provision programme. They also operated from community mental health clinics and received referrals from other non-peer professionals.

Unlike public mental health services, non -government organisations did not have such statutory obligations to fulfil. Their funding came from successful applications from PHaMS and PIR. In non-governmental organisations (NGOs), peer provision services were offered to peers over two years more intensely initially and tapering off when nearing discharge from the service. Peer providers sit within a multidisciplinary team that comprised of practitioners who acted as case managers. These practitioners came from various backgrounds, including social work, psychology or nursing as examples. Peer Providers were supervised by their team leaders who were not necessarily persons with lived experience. Some organisations employed a Peer Support Work Coordinator (with lived experience) that arranged group peer supervision and personal development. Recent developments in peer provision have included funding for peer providers to support people experiencing mental distress in an emergency department within Perth (Wood et al., 2018). In addition, a peer-led support network was established to provide opportunities for peer providers within the state to meet, share practice, network and support one another (Consumers of Mental Health Western Australia, 2016). Research participant peers were recruited from both public and non-government mental health services.

4.4 Sampling and recruitment

To capture the entirety of peer provision development and practice, sampling and recruitment were conducted in three phases with three different stakeholder groups. The first phase focused on recruiting participants who supervised peer providers or had strategic involvement with peer provision (i.e. managers or team leaders in mental health services where peer providers were employed). The choice to recruit organisational stakeholders first, was to build trust between the researcher and the organisation, so as to gain access to increasingly vulnerable participants in the later phases of the study. The second phase focused on recruiting participants who administered peer provision services (i.e., peer providers), whilst the third phase focused on the recruitment of participants who received peer provision services (i.e., peers)[1]. Using a snowball sampling approach (Atkinson & Flint, 2001), 12 peer providers and 13 peers were recruited in the metropolitan areas of Perth Western Australia. While this strategy gave the researcher access to hard-to-reach populations, there was a risk of selection bias, limiting the generalisability of findings to peer providers in other settings (Atkinson & Flint, 2001), given that peer provision is varied (Salzer et al., 2010).

[1] While the recruitment began from organisational stakeholders to peer providers to peers, the presentation of results will begin from interviews with peers to establish the context, followed by peer providers and finally organisational stakeholders.

4.4.1 Phase 1: People supervising or having strategic involvement with peer provision

Following ethical approval from Curtin University Human Research and Ethics Committee (approval number HR179/2011 see Appendix A.1), organisations who were known to employ peer providers were approached to participate in the study through the researcher's networks. The researcher met up with programme managers and CEOs of these organisations to explain her study and invite clarification and questions. Ethical procedures for access to willing organisations were also clarified during the meeting. Through these meetings, programme managers were recruited, and through programme managers, supervisors and project officers involved directly or indirectly in peer provision were recruited for this phase of the study (see Table 5.2).

Through these organisations, the researcher also came to know of more organisations that employed peer providers and so approached them thereafter in the same manner described above. To be included in this study, stakeholders had to give their informed consent and had to be involved in peer provision services directly or indirectly. They also had to be able to communicate in English. Those were not involved in peer provision services were excluded from the study. With this cohort, the aim was to gain a contextual understanding of peer provision development and practice in the metropolitan region of Western Australia. Fifteen people from three public organisations; three NGOs and two independent organisations agreed to participate. Table 8.1 details the organisational context; the year peer provision was implemented and the role of each interviewee.

4.4.2 Phase 2: Peer providers

Thereafter, a snowball sampling approach was used to recruit participants for the study (Atkinson & Flint, 2001). After each interview in phase 1 was completed, supervisors/ stakeholders were asked if they could promote the study to peer providers in their organisation. So as not to pressure peer providers into participating, the researcher's details were included in the promotional flyers to peer providers (see Appendix B.3). Peer providers interested in the study then contacted the researcher, who gave them an opportunity to discuss and clarify concerns they had about the study over the phone, in person or via email. The peer providers then gave informed consent to participate in the study before interviews were arranged. The organisations from which participants in phase 1 were recruited, were also connected to a local consumer advocacy organisation supporting peer providers and peers, through which more peer providers and peers (see Section 4.4.3) were recruited in the same manner described above.

To be included in the study, peer providers had to give informed consent and had to be able to communicate in English. With this cohort, the aim was to gain an understanding of peer provision practice and the role of the peer provision in supporting a person in their recovery, from their perspective. Interested peer providers contacted the researcher who then sent them more detailed information about the study and a consent form. The researcher also invited further clarification should peer providers have further questions. The profile of peer providers who participated in this phase of the study is detailed in Table 5.3.

4.4.3 Phase 3: Peers

Following interviews in phase two, peer providers were asked if they could promote the study to the peers they worked with. As described above, a promotional flyer (see Appendix B.4) to peers was left with peer providers to give to any peer they worked with. So as not to pressure peers into participating, the researcher did not approach peers. Rather, her number was given to peers to contact her should they be interested to participate in the study. Upon contact with the researcher, the researcher invited further clarification and addressed concerns peers had about the study, before informed consent was sought. This occurred in person, over the phone or via email. Interest in participation was also garnered through a consumer advocacy organisation mentioned in Section 4.4.2.

Peers who gave informed consent and were able to communicate in English were included in this study. With this cohort, the goal was to gain an understanding of the dynamics of the peer provision relationship and how peer provision supported recovery, from their perspective. The profile of peers who participated in this phase of the study is detailed in Table 5.4.

4.5 Data collection

4.5.1 Considerations when interviewing vulnerable participants

Four issues were considered when interviewing vulnerable participants: power imbalance; informed consent; the emotional challenges that storytelling entailed; and researcher reflexivity (Sivell et al., 2019). Firstly, the researcher had to be aware of the imbalance of power that may exist with her participants. The participant with unmet needs may perceive the researcher as owning the expert knowledge, leading to a power imbalance in their relationship (Karnieli-Miller et al., 2009). This called the researcher to focus on the relationship and build trust with her participants to ameliorate this (DeJonckheere & Vaughn, 2019). This required an informal preamble that enabled the researcher to get to know the participants personally. This usually related to the participant's home and family environment (Silvell et al., 2019). The researcher ensured that the participant was interviewed in their place of choice, usually being their home (Gagnon et al., 2015). This ensured that her interviewees felt less restricted and more in control, which in turn invited deeper discussion and enabled the researcher to build a deeper connection with her interviewee (Kendall & Halliday, 2014).

Secondly, there was a need for balancing the burden of the consent process with upholding its importance (Sivell et al., 2019). The researcher was aware that processing the information related to the study could be an onerous task for her participants (Trivedi, 2006). Hence, information was reconstructed into a reader-friendly flyer (see Appendix B.3 and Appendix B.4), and consent forms were simplified and easy to read (see Appendix C.2 and Appendix C.3).

Thirdly, encouraging participants to relate their stories during the interview can enable the interview process to be a therapeutic one, allowing the researcher and interviewee to bond (Sivell et al., 2019). Inevitably, this story-telling process can be cathartic and invoke strong emotional responses from participants. Where it occurred in interviews, the researcher did not presume that the interviewee wished to continue. Instead, she allowed space for a cathartic response and asked if the participant would like to continue with the interview (Miller, 2017). The author also prepared a list of organisations which participants could contact should they need further support (see Appendix D). The researcher also contacted the participant the next day to ensure that they were well and satisfied with the interview process.

Lastly, as highlighted earlier (see Section 4.1), maintaining a neutral stance to data can be challenging and counter-productive in accessing rich information from the participant (Sivell et al., 2019). Hence, debriefing played an important role in the hermeneutic process. This included setting time aside after each interview to journal and summarise the interview and debriefing during supervision sessions. Attentive listening, with the lens of her own experiences, also enabled the researcher to 'hear' the data, enabling her to pick up nuances in the interview data (Liamputtong, 2007). There were other ethical implications in research with vulnerable participants discussed further in section 4.8.

4.5.2 Phase 1: People supervising or having strategic involvement with peer provision

Literature was reviewed on factors that enabled or challenged peer provision to inform the theme list used in the interview schedule. These factors included economic, political, organisational and social contexts in which peer provision operated; the relationships with service users and non-peer professionals; and the nature of the peer provision itself (Franke et al., 2010; Gates & Akabas, 2007; Gillard et al., 2013; Kemp & Henderson, 2012; Moran et al., 2013; Repper & Watson, 2012a; Vandewalle et al., 2016). The theme list was trialled with a colleague who had supervised peer providers and refined iteratively through the interview process with specific groups of interviewees. For example, interviews with policymakers and the consumer consultant focused on how policy and procedures were formulated and how they affected peer provision operations. Interviews with supervisors of peer providers focused on how these policies and procedures were enacted in their daily operations and interaction with peer providers.

Interviews with all participants covered two key questions: (1) What is happening in the operation of peer provision services? and; (2) What factors shape the way peer provision operates? The researcher conducted all the interviews and began with a general question: "Can you describe your involvement with peer support?". The interviews involved using probing questions such as "What are some of the needs you see in peer support providers as they perform their job? What is being done to meet their needs?" (see Table 4.1 below). The in-depth interviews lasted approximately an hour and were conducted at the interviewee's place of work. Participants were compensated with a modest gift voucher for their time. The interviews were digitally recorded and fully transcribed, and participants were allocated codes to protect their identities.

Table 4.1 List of topics and guiding interview question - Phase 1

Topics	Interview Questions
About the participant	• Can you describe your involvement in [peer provision]?
How peer provision operates	• What is the [peer provider's] role in the service? • What are the service's expectations of them? • What is involved in their work? • How are [peer providers] prepared for their role? • What are some of the needs you see in [peer providers] as they perform their job? • What is being done to meet their needs? • What are some policies and procedures that affect how [peer providers] do their work?
Factors that shape the way peer provision operates	• Can you describe how the service started? • What are some successes you've seen through this service? • What contributes to it? • What are some challenges that you face in implementing [peer provision]? • What contributed to the challenges?

*The term peer provision was substituted with the terms used to refer to peer provision in the service

4.5.3 Phase 2: Peer providers

The study design involved in-depth interviews with peer providers in order to engage them in conversation to elicit their understanding and interpretation of their practice with their peers (Serry & Liamputtong, 2010). A list of themes (see Table 4.2) with open-ended questions was designed to keep the interviewer focused on the information that was needed while maintaining openness to other related information so that it was not overlooked or missed out on (Liamputtong & Ezzy, 1999).This theme list was informed by the objectives of the study and extant literature highlighted in Chapter 2 and Chapter 3. This included the topics and questions listed in Table 4.2 below.

Table 4.2 List of topics and guiding interview questions - Phase 2

Topics	Interview Questions
What you do as a peer provider.	• If someone were to ask you about your role as a [peer provider], what would you say to them?
How do you support a peer through their recovery from the time you meet them to the time they are ready to stand on their own?	• How do you normally build rapport with your peer? • Things you normally say/do to establish a connection. • What do you do to support your peer through their recovery? • Can you describe some things that took place in the course of your work that contributed to their recovery? • How do you determine when the work with your peer should conclude? • How do you conclude?
The successes and challenges in supporting a peer.	• What are some successes that you have experienced as a [peer provider]? • What are some of the challenges you face as a [peer provider]? • Describe how you are supported in your work.

*The term peer provider was substituted with the term used to refer to peer provider within the service

The in-depth interviews, which took an hour to complete enabled a comprehensive exploration of the Peer provider-Peer relationship and how peer providers interpreted their everyday practice. Participants were asked about what they did as a peer provider and to describe their experience of working with their peers. Interviews were conducted by the researcher, at the agencies in which they operated, or a venue of their choice. The interviews were digitally recorded and fully transcribed, and participants were allocated codes to protect their identities.

4.5.4 Phase 3: Peers

Similarly, participants were interviewed between 45 minutes and one and a half hours, at a place of their choice (see Section 4.8.2for rationale). Although the offer of having their peer provider with them was stated in the information sheet (see Appendix B.4), only one peer had their peer provider accompany them during the interview. Following written consent, in-depth questions based around the CHIME framework (Leamy et al., 2011) and the stepped model of peer provision (Zeng & Chung, 2019) were asked. Participants were also asked to describe their encounter with their peer provider and how that had helped them in their personal recoveries. The list of topics was informed by the results of phase 2 of the study, the extant literature in Chapter 2, and the first and second objectives of the study (see Table 4.3).

Table 4.3 List of topics and guiding interview questions – Phase 3

Topics	Interview Questions
How you came to know about your [peer provider]	• How did you come to know about the [peer provider] Service? • How were you introduced? • How did you feel at that time?
How your [peer provider] connected with you	• How did you and your [peer provider] build that relationship? • What do you like about your [peer provider]?
What your [peer provider] did/ said that helped you in your recovery	• What do you and your [peer provider] do together normally? • How did that help you to move along in your recovery journey? • Has that changed over time? How?
What you hope to achieve with your [peer provider]	• What do you hope to achieve with your [peer provider]? ○ What were some of the challenges along the way? • What do you think your [peer provider] can do to help you in your journey now?

*The term peer provider was substituted with the term used to refer to peer provider within the service.

Having worked with people in mental health services, the interviewer (GZ) was well aware of their vulnerabilities. The topic list allowed the interviews to proceed in a conversational style to put the participants at ease (Liamputtong, 2007). Participants were encouraged to use specific examples in describing their encounter and probed by the interviewer where appropriate. With their consent, the interviews were recorded and transcribed. Participants were de-identified by the allocation of codes to protect their identities.

Survey. Once the interviews were transcribed and analysed (see below for analysis), an online questionnaire was constructed based on issues that arose in the interviews. It included closed- and open-ended questions and described in Phase 4: Member checking.

4.5.5 Phase 4: Member checking

In line with Morse's (2018) view of member checking as a continuance of analysis at a higher, more abstract level, and to validate concepts, member checking proceeded in a synthesized manner. Participants from phases one, two and three were contacted by email, presented with synthesized data and asked to comment. Synthesized data was also woven into interviews with newly recruited participants for verification as data saturation was approached. Such a form of member checking gave participants an opportunity to evaluate the application of others' experiences to themselves. It also added a layer of reflection to their own experiences (Harvey, 2015). In this way, a bigger picture was co-constructed with participants until no new themes could be added.

In addition to the process described above, a survey was conducted with peers from phase three. At this point of member checking, a number of participants had lost contact with the researcher. Hence, a survey method was added to garner the perspectives of more peers, as a number had left the sector, and to verify the results of the study in light of their own experiences. In this way, the researcher could ensure that the data remained current and relevant, and still accurately represented the voices of the participants who were interviewed earlier. Participants were presented with a summary of the three-staged process described in a publication presented in the findings of this thesis (see Chapter 7). These stages (creating a safe place, working partnership and stepping out) were designed to describe peer provision practice as a non-linear relationship between the peer provider and their peer. The questionnaire also contained questions which gathered demographic information about the peer and details of their contact with their peer provider (e.g., length of service and organisation). Questions were also asked about the value of peer provision (e.g., connection with their peer provider and the value of peer provision in reducing hospital admissions). Open-ended questions were asked to ensure that space was also given within the survey to comment on the questions in writing. This gave peers an opportunity to evaluate the application of others' experiences to themselves, adding a layer of reflection to their own experiences (Harvey, 2015). The questionnaire was sent via an email and SMS to peers who participated in the survey and through contacts in phase 1 and phase 2. Twenty-five people were contacted and invited to participate in the survey or to pass the information on through their peer networks.

4.6 Data analysis

In line with qualitative methodology, data analysis commenced together with data collection, once interviews had been transcribed (Green et al., 2007). Following the hermeneutic loop described in Section 4.1, a hybrid approach of inductive and deductive coding was used to develop themes from the interviews (Fereday & Muir-Cochrane, 2006). Analysis began *inductively* at the level of individual cases, with line-by-line coding of the participant's experiences, concerns and understanding (Larkin et al. 2006 from Larkin, 2012). NVivo qualitative data analysis software was used to help the researcher organize emerging codes and make comparisons across cases within codes, giving attention to the convergence of experiences and the nuances between experiences (Eatough & Smith, 2008 from Larkin 2012). To establish credibility, the researcher's supervisor randomly chose a small number of interviews to code. Differences between coding were identified, and a consensus between codes was made, with notes saved in memos made against the respective codes.

Analytic outcomes were used to create a dialogue with theories relevant to the phenomenon (Larkin & Thompson, 2012). This dialogue proceeded between the researcher's coded data, her current knowledge and what it might mean for the participants within their context. Peer debriefing to establish credibility ensued at this stage (Greenhalgh et al., 2020), with the coherence and plausibility of the dialogue and its emerging narrative tested in supervision sessions. This dialogue with theory was also further tested through consultation with peer providers and non-peer mental health practitioners in the field. This occurred through the presentation of initial mod els at conferences, community of practice meetings and with local researchers. This solidified the emerging narrative account of the participants' experiences and led to the development of frameworks which illustrated the relationships between themes (Shaw et al., 2014).

The process of deductive coding then ensued where each code was reorganized within the emerging framework. Themes that did not fit the emerging framework were noted. In this way, data could be traced throughout the analysis: from its initial codes to its thematic and final structure. The subsequent paragraphs describe this deductive process.

For phase one data, codes were generated iteratively under themes based on the three elements of Moore's Strategic Triangle (Moore, 1995): (1) Authorising Environment; (2) Operational Capacity; and (3) Public Value (Task Environment) (See Table 8.2). Each code was then categorised according to whether practices were shaped by the recovery ethos [adoption] (Australian Health Ministers Advisory Council, 2013; Bateman et al., 2014; Farkas et al., 2005; Grace et al., 2017) or not [co-option].

For phase two data, a framework which mapped the relationship between codes was generated (see Figure 7.1 The Stepped Model of Peer Provider Practice). This was validated in three subsequent interviews with peer providers (see page 78 for a description) and the survey with peers, which indicated a 75% agreement with the model (see Table 6.3).

For phase three, the emerging codes were categorised using the CHIME framework (see Table 2.1), which highlighted five recovery processes (Zeng & McNamara, in review). These were: (1) Connectedness; (2) Hope and optimism about the future; (3) Identity; (4) Meaning in life; and (5) Empowerment (Leamy et al., 2011). In this phase, another theme was created to capture challenges and hindrances in developing and maintaining the peer relationship.

For the survey in phase four, descriptive frequencies were used to analyse demographic and quantitative data. A qualitative stance described previously was used to analyse responses to open-ended questions in the survey.

A narrative of the analysis was then developed in the version of three journal articles which accounted for the interpretation in each phase thematically. Each narrative was supported by a visual guide (see Figure 6.2, Figure 7.1 and Figure 8.1).

4.7 Establishing Trustworthiness:

Given that the goal of this study was to understand the experiences of peer provision from the perspective of peer provider stakeholders, peer providers and peers, experiential data was elicited from the interviews whilst organisational data was garnered through organisational documentation to complement what was being elicited in interviews. Being largely interpretive in nature, the goal of establishing rigour in the study was to verify that the data used were appropriate and of adequate quality, that allowed for theme formation and theoretical models to emerge (Morse, 2018). Four strategies that contributed to this are discussed below: member checking, saturation, peer review and audit trails.

4.7.1 Member checking

Rather than the use of member checking to validate raw data, the process of synthesized member checking described earlier (see section 4.5.5) enabled the researcher to ensure the fidelity of data with emerging themes and models. Adding layers of reflection to participants' experiences enabled the researcher to co-construct models that illustrated participants' experiences more accurately (Harvey, 2015). This enlarged the researcher's capacity for analysis to continue at a higher, more abstract position, enriching emergent theoretical models rather than stunting them (Morse, 2018).

4.7.2 Saturation

Data saturation refers to the point where no new information or themes emerge that were of relevance to this study (Morse, 2015). Hence it is to be ascertained not by the number of participants recruited but rather, a robust, consistent, cohesive and mature formulation of the phenomenon of interest. In order to do so, attention needed to be given to the depth and breadth of the data as it relates to the phenomenon, and the essential characteristics of the phenomenon commonly described by the participants (Morse, 2015).

Saturation was facilitated in this study by sampling and honing in on the theoretical aspects of the inquiry. The researcher ensured that the sample of participants in this study was large enough for common characteristics of the phenomenon of peer provision development and practice to be noted and that the participants themselves had sufficient experiences to speak to the phenomenon. To that end, a range of stakeholders who had sufficient experience with peer provision to speak to the above phenomenon was identified and interviewed (see section 4.4). In addition, the researcher utilised the hermeneutic loop (see Figure 4.1) to identify gaps in the data so that these gaps could be addressed in subsequent interviews. To facilitate this, interview schedules were kept broad and iterative to accommodate for these gaps.

In this way, the researcher built her competence in understanding peer provision development and practice. She noted in her research journals that her description of the data broadened from particular cases to general themes described in interviews. She also noted as data collection progressed, numerous examples could be readily supplied to describe each theme. This resulted in a multi-layered conceptualisation of peer provision from a systemic perspective down to the details of daily practice.

4.7.3 Peer review

Findings were presented to colleagues at various conferences (Zeng, 2012, 2018; Zeng & Chung, 2018; Zeng & McNamara, 2012, 2014) and refined. Over the course of peer review, three journal publications (Zeng & Chung, 2019; Zeng & Chung, 2020; Zeng et al., 2020) were written up from each phase of the study and submitted for publication. Apart from presenting work to academics in a similar field, the models that emerged from the study were also presented to peer and non-peer practitioners in mental health through conference presentations and presentations at community of practice meetings. Informally, the researcher also consulted with local experts in the field (Mahboub, personal communication, 2019 and Kemp, personal communication, 2019) to verify emerging models. Such a consultation process with academics, lived experience educators and practitioners enabled the researcher to identify areas that needed development, refine theoretical areas and link her research to others' research.

4.7.4 Audit trails

An audit trail was kept in the version of a diary, which reminded the researcher of how she came to conceive the project, make decisions about sampling, coding and how themes/ models emerged. It also served to remind the researcher of "early thinking" as the study progressed, enabling her to appreciate how theory formulation got richer through the inquiry process and moments of epiphany (see also page 92). This enabled the researcher to further verify the concepts that were emerging from the data (Morse, 2018).

4.8 Ethical considerations in working with vulnerable populations

Although research has demonstrated that some aspects of stigma have decreased with public education, beliefs about dangerousness and unpredictability, particularly with psychotic disorders still exist in Australia (Reavley & Jorm, 2012). People who experience mental distress commonly experience stigma and discrimination. As a result, they are often disadvantaged in accessing opportunities that will afford them a better quality of life including employment, safe housing, satisfactory health care and social networks (Krishnan, 2015)

The researcher being aware of these vulnerabilities made her more aware that as a researcher, she had the "potential to invade, distort or destroy the private worlds" of her participants after she had entered them (Sque, 2000, p. 25). Hence, apart from a peer review and approval of ethical considerations by Curtin's Human Research Ethics Committee (Reference number HR179/2011: See Appendix A.1) and North Metro Mental Health Research Governance Office (Reference number 11/2012: See Appendix A.2), which were subsequently renewed till the study ended, the following measures were taken to ensure the safety and well-being of participants throughout the whole process of the research. These will be discussed as implemented in the research process, an approach coined by Cutcliffe et al. (2002) as "ethics as process" (Cutcliffe & Ramcharan, 2002, p. 1000).

4.8.1 Recruitment

To facilitate recruitment for the study, access to participants moved from those that were more accessible to those less accessible (see Figure 4.2). It was hoped that the introduction of the researcher to each participant group by the previous one would help develop trust between the researcher and participants in the research process, rather than a one-off event (Liamputtong, 2006). The study was explained to potential participants in the form of an information sheet and/ or a flyer for each phase (see Appendices B.2, B.3 and B.4). The researcher left her number with potential participants and encouraged them to contact her if they had any queries or concerns. She sent the consent forms over (see Appendices.C.1, C.2 and C.3.) to the participants only if they indicated an interest in participation so as not to overwhelm them from the outset of the study.

4.8.2 Data collection

The researcher gave time before the interview commenced to give participants space to address concerns regarding the study/ data collection before commencing with the interview. In such a way, informed consent was re-established during the research process (Cutcliffe & Ramcharan, 2002). The researcher also made sure that the participants understood that they had the right to withdraw at any time.

To uphold respect for and dignity of the participants, the researcher made a time for the interview at a venue and time that was convenient and safe for participants. She also prepared a list of numbers to call as a 'safety net' of support if needed (see Appendix D). Each interview started with opportunities for clarification and for the participant to get to know the researcher to establish trust before continuing. This was important as building trust and rapport with participants gave them space to self-disclose, enabling the researcher to understand the world from their perspective (Miller, 2017). This also led to thicker and richer data that is needed for trustworthiness in qualitative research (Liamputtong, 2006). The researcher was also careful to reiterate that she was there to learn from their experiences, rather than mining them for data. She was conscious of the power differential between researchers and participants (Raheim et al., 2016). As such, she utilised listening, reflection, paraphrasing, summarising, responding with humanness, kindness and empathy, especially when participants became emotional during the interview (Liamputtong, 2006). Permission was sought before the researcher recorded the interviews.

The researcher also wanted to give something back to her research participants to reduce the power imbalance with her participants. Compensation for their time was offered in the form of gift vouchers as a token of appreciation and respect for the experience and time of her participants (Umaña-Taylor & Bámaca, 2004). When participants came to the university to be interviewed, the researcher arranged free parking for them or ensured their parking was compensated for.

4.8.3 Data analysis

The representation of the participant's voices was the most important aspect of data analysis. As this phase occurred concurrently with data collection, the themes that emerged from the analysis were built into the subsequent interviews. In this way, opportunities were presented to participants to consider if any of the others' experiences applied to them or if any were dissimilar. This added a reflective layer to their own experiences, and a bigger picture was co-constructed with them till no new themes were added (Harvey, 2015). Using this dialogic approach to member checking ensured that the voices of participants were sufficiently represented in the results. Once this was ascertained, the recruitment of new participants for each phase of the study ceased.

Early on in the research, the researcher was made aware that the peer provision community was small, and participants might potentially know one another. This lent itself to the possibility of unintentionally disclosing the identity of participants while presenting themes to participants (Damianakis & Woodford, 2012). To maintain confidentiality, organisations and individuals were deidentified, and themes were presented in a generic manner so that participants accessing initial themes were not able to identify particular individuals or organisations.

4.8.4 Reporting results

A similar strategy was considered when reporting results. Participants and organisations were deidentified by allocating codes. These codes were used in reporting results so the reader could not identify particular participants or organisations.

Chapter 5 Participant and Organisation Characteristics

A total of 58 participants from 12 organisations took part in this study. Of the 12 organisations that were involved, three were publicly funded, eight were non-government organisations and one organisation was independently funded by research grants (see Table 5.1). Of the participants, 16 peer provider stakeholders (see Table 5.2), 12 peer providers (see Table 5.3) and 13 peers (see Table 5.4) were interviewed. The tables below outline the profile of the organisations and participants.

Table 5.1 Organisational Profile of Organisations Participating in the Study

Site Code	Organisational Type	Aim of Service	Year Peer Provision was Involved	Peer Provider involvement
PUB01	Government statutory service (Community)	Provides assessment, treatment and rehabilitation services to adults aged 18 to 65 years who have a mental illness.	2004	One-on-one within the community
PUB02	Government statutory service (Acute)	Provides assessment, treatment and rehabilitation services to adults aged 18 to 65 years who have a mental illness.	2007	Ward visits Phone calls once a week post discharge One-on-one within the community
PUB03	Government statutory service (Area Service)	Provides assessment, treatment and rehabilitation services to adults aged 18 to 65 years who have a mental illness in the area	2011	Coordination of peer providers in the area.
NGO1	Non-Government Organisation	Provision of wraparound support to help people deal with trauma of mental illness.	2006	One on one peer provision WRAP group facilitation
NGO2	Non-Government Organisation	Utilise a holistic approach to meet the physical, emotional, social and spiritual needs of participants.	2007	One on one peer provision through multidisciplinary community care team
NGO3	Non-Government Organisation	Provision of personalised mental health support aimed to make a difference to those experiencing severe and complex mental health issues in the community.	2006	One on one peer provision within community Facilitation of hearing voices group
NGO4	Non-Government Organisation	Full citizenship for all people living with a mental illness.	2007	One on one peer provision in residential care and the community
NGO5	Community Mental Health Peak Body	Promote growth of peer support and the peer workforce	2014	Coordination of peer providers and leaders of peer provision in state.
NGO06	Non-Government Organisation	Provide as much assistance to as many people across Perth and the Southern reaches of Western Australia	2004	One on one peer provision within community
NGO07	Non-Government Organisation (Hybrid)	Champion and support people who have experienced mental illness	2006	Recovery based groups Hospital to home programme One-to-one peer support
NGO08	Non-Government Organisation	Support to family and friends of people living with mental health challenges	2006	Programme Group support
IND1	Research organisation	Researching severe mental illness to improve lives.	2011	Research in peer provision

Table 5.2 Phase 1 Participant Profile: Professional/ Organisational Stakeholders

Participant Code	Gender	Organisational Affiliation	Role
CC01	Female	Nil	Consumer consultant
CC02	Female	Nil	Consumer Consultant
PO01	Female	NGO1	Project Officer – Policy
PO02	Female	IND1	Researcher
PO03	Male	IND1	Research programme leader
MNGR01	Female	NGO1	Team Manager
MNGR02	Female	NGO2	Team Manager
MNGR03	Female	NGO1	Programme manager
MNGR04	Female	PUB1	Programme manager
MNGR05	Female	NGO1	Peer Support Coordinator
MNGR06	Female	NGO2 and NGO5	Team Manager Consumer Advocate
MNGR07	Female	PUB3	Peer Support Coordinator
SUP01	Female	PUB1	Supervisor
SUP02	Female	PUB1	Supervisor
SUP03	Female	PUB2	Supervisor
SUP04	Female	NGO1	Team Manager

Table 5.3 Phase 2 Participant Profile: Peer Providers

Participant Code	Gender	Organisational Affiliation	Role/ Service Offered
PP01	Male	PUB1	Peer Recovery Worker: One-on-one support
PP02	Female	NGO1	Peer Support Worker: One-on-one support, Group facilitation
PP03	Male	NGO6	Mental Health Recovery Worker: One-on-one support
PP04	Female	PUB2	Peer Support Coordinator: One-on-one support
PP05	Female	PUB2	Peer Support Worker: One-on-one support
PP06	Female	NGO1	Peer Support Worker: One-on-one support
PP07	Female	NGO1	Peer Support Worker: One-on-one support
PP08	Female	NGO7	Peer Support Worker: Group facilitation
PP09	Female	NGO2	Peer Support Worker: One-on-one support
PP10	Female	NGO3	Peer Support Worker: One-on-one support
PP11	Male	NGO3	Peer Support Worker: One-on-one support, Group facilitation
PP12	Female	NGO3	Peer Support Worker: One-on-one support

Table 5.4 Phase 3 Participant Profile: Peers

Participant Code	Gender	Organisational Affiliation	Service Received
P01	Male	PUB1	One-on-one support
P02	Female	PUB2	One-on-one support Hospital to home support
P03	Male	PUB2	One-on-one support Hospital to home support
P04	Female	NGO7	Group participant
P05	Male	NGO07	Group participant
P06	Male	PUB1	One-on-one support
P07	Male	NGO3	One-on-one support
P08	Male	PUB2	One-on-one support
P09	Female	NGO8	Programme Group Support*
P10	Female	NGO1	One-on-one support
P11	Female	NGO1, NGO7	One-on-one support
P12	Male	NGO1	One-one-one support
P13	Female	NGO4	One-on-one support

*This participant was included because even though she received services from an organisation that supported carers, her experiences related in the interview pertained to how peer provision had helped her through her own mental health experiences

Chapter 6 The role of peer provision in helping a person overcome their mental health challenges

This chapter is the second of four results chapters that are presented in the thesis. Even though data were collected starting with organisational/professional stakeholders, followed by peer providers and then peers, the researcher has chosen to present the results chapters with data gathered from peers first (Chapter 6). Whilst the recovery orientation and peer provision form part of a whole of organisation shift, the presenting of peer provision experience first is intended to provide the reader with insight into the daily practice across different organisational sites. This perspective has been chosen to get a sense of the micro-dynamics of peer provision, followed by data gathered from peer providers to help the reader understand peer provision practice (Chapter 7). Finally, the broader organisational/ political context is achieved through the accounts of organisational and professional stakeholders (Chapter 8). Presented in the form of a published paper, this chapter adds to the extant literature documented in Chapter 2 by exploring recovery processes in peer provision in Western Australia. Drawing from the accounts from peers (Phase 3 and Phase 4 of the study), this paper will shed light on the first research question which asks "How does the peer provision relationship help support the peer in their recovery?".

The manuscript was accepted for publication with the Journal of Mental Health Training, Education and practice on the 4th of August 2020. An email confirming the submission of this publication can be found in Appendix F.9.

Inclusion in the thesis as an author submitted manuscript has been approved by the Publisher according to the copyright agreement. Details of this agreement can be found in Appendix F.10.

Reference:

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Title

Recovery processes within peer provision: Testing the CHIME model using a mixed methods design

Abstract:

Purpose

Previous studies have pointed to the need for more research which explores how peer provision brings about change associated with recovery. Hence, the main goal of this study was to test the CHIME model within the PP context.

Design

This mixed methods study was completed in two stages. 13 face to face interviews were conducted with peers and the transcripts were analysed thematically. A short online questionnaire was completed by 19 peers and analysed with both descriptive statistics and thematic analysis.

Findings

Participants spoke to the value of peer providers in building connectedness, fostering hope and optimism, growing identity, enhancing meaning and empowerment. However, their connectedness was hindered by external circumstances and the intrapersonal capacities of their peer provider.

Practical Implications

The CHIME framework was useful in highlighting stages in which peers moved through their recovery and its corresponding peer provider involvement. Peer providers were also found to promote motivation, which was a key driver in their peers' recoveries. Further research is needed to test frameworks that account for wider systemic issues and the role peer providers play in enhancing motivation.

Originality/ value

This study has identified the usefulness of the CHIME framework in describing peer provision. It contributes to our understanding of how peer provision can promote recovery in persons with mental health challenges. It lays the groundwork for future research into examining the role of peer provision in recovery and its distinctiveness from other forms of mental health support.

Keywords:

Peer support, recovery, practice

Introduction

Peer support began from a place of advocacy and self-help within the consumer-survivor movement (Murphy & Higgins, 2018). Its growth and formalisation internationally has been driven by the uptake of recovery principles in mental health policy and the growing recognition of the value of lived experience (Lee et al., 2019; Meagher et al., 2018; Vandewalle et al., 2018; Watson, 2019c). Aligning itself to the tenets of recovery, formal peer support is founded on a more equal power relationship that is holistic and strengths based. It assumes that a person with similar experience can offer a form of support which offers something different to the traditional helping professions (Gillard, 2019). Individuals are "formally employed to use their lived experience explicitly and intentionally to instil hope and afford practical assistance" (Zeng & Chung, 2019, p. 106) to persons experiencing mental health challenges. Various terminology has been used to describe formal peer support (e.g.: "consumer provider" or "peer specialist" or "lived experience worker"). However, for the purposes of this paper, the term 'peer providers' (PPs) will refer to individuals employed to offer formal peer support and the term 'peer' will be used to describe those receiving support from PPs.

Whilst extant literature indicates disparities in evidence for peer provision pertaining to outcomes that appear more important to funders (e.g.: mental health symptoms and service usage) (Lloyd-Evans et al., 2014; Pitt et al., 2013), evidence appears more promising in evaluating outcomes pertaining to hope, identity and quality of life (Bellamy et al., 2017). Likewise, its experiential benefits have been consistently supported by qualitative studies (Bocking et al., 2018; Rooney et al., 2016; Walker & Bryant, 2013).

Peers have valued the empathy, trust, emotional and practical support afforded by their PP. They saw their PPs as role models and were instrumental in instilling hope for and motivation towards recovery (Bouchard et al., 2010; Gidugu et al., 2015; Repper & Watson, 2012b; Weir et al., 2019). PPs were also instrumental in helping peers overcome stigma, developing a positive sense of self, enhancing skill development, accessing health care and community services and reducing inpatient admissions (Faulkner & Basset, 2010; Galloway & Pistrang, 2019; Kelly et al., 2014; Lawton-Smith, 2013; Repper & Carter, 2011). Such benefits may be encapsulated within five recovery processes using the framework proposed by (Leamy et al., 2011, pp. author-year) which consists of: connectedness; hope and optimism for the future; identity; meaning in life; and empowerment (see Table 6.1). This will be referred to as the CHIME framework thereafter in this paper.

Table 6.1 Experiential benefits of peer support framed within the CHIME framework

Recovery Process	Reference
Connectedness	
Emotional support	Repper & Watson (2012) Galloway & Pistrang (2019)
Practical support	Gidugu, et al. (2015) Rooney et al. (2016) Bocking et al. (2018)
Empathy, trust	Lawton-Smith (2013) Rooney et al. (2016) Weir et al. (2019)
Hope and optimism about the future	
Instil hope	Bouchard, Montreuil & Gros (2010) Repper & Carter (2011) Repper & Watson (2012)
Role models	Walker & Bryant (2013) Gidugu, et al. (2015) Rooney et al. (2016) Weir et al. (2019)
Increase motivation	Walker & Bryant (2013)
Identity	
Overcome stigma	Repper & Carter (2011) Bocking et al. (2018)
Shared identity	Faulkner & Basset (2010)
Developing a positive sense of self	Faulkner & Basset (2010) Repper & Carter (2011) Lawton-Smith (2013) Galloway & Pistrang (2019)
Meaning	
Increase social functioning	Repper & Carter (2011) Gidugu, et al. (2015)
Empowerment	
Decreased admission	Repper & Carter (2011)
Increased use of primary health care services	Repper & Carter (2011) Bocking et al. (2018)
Increased community integration	Repper & Carter (2011) Repper & Watson (2012) Kelly et al. (2014)
Skill development	Faulkner & Basset (2010)

This dissonance attests to the need for examining outcomes that accurately reflect recovery processes rather than clinical outcomes. Following from a previous qualitative study which led to the formulation of a stepped model of peer provision (Zeng & Chung, 2019), this study purports to determine the usefulness of the CHIME framework in describing the work of PPs. To do so, a mixed methods study was used to triangulate the experience of peers in their work with PPs and give depth to the results.

Methods

A two-staged exploratory sequential mixed methods design was used to triangulate data from a total of 29 peers. In Stage One qualitative data was collected using 13 face to face in-depth interviews (3 participants from public mental health system (PMHS), 9 participants from local non-governmental organisation (NGO) and 1 participant from an interstate NGO). In Stage Two quantitative data was gathered through a short on-line survey of 19 peers (5 participants from PMHS, 3 participants from NGO, 2 participants from both and 2 participants unsure). Ethics was approved by Curtin University's Human Research Ethics Committee (HR179/2011).

Study setting, participants and recruitment:

The study was conducted in Western Australia across two public and five non-government mental health organisations that delivered PP services. In Stage One, participants were peers who were working with a PP. In Stage Two, respondents to the survey were peers currently working with a PP or who had worked with a PP. Participants were selected because they had experiences of mental distress and engaged with PPs as part of their recovery process.

Peers were recruited from both public and non-government mental health services. Peer provision in these services varied according to organisational remits. In hospitals, peer provision services were offered when necessary by appointment throughout the peers' stay. A call from the peer provider once a week was also provided for the first six weeks following discharge to facilitate the peers' transition to the community. In non-governmental services, peer provision services were offered over two years more intensely initially and tapering off when nearing discharge from the service.

In Stage One, the participants were recruited through PPs who had participated in an earlier phase of the study which explored the views of PPs on how they facilitated their peers' recoveries (Zeng & Chung, 2019). The researcher left the contact information with the PPs who had been interviewed in the previous study. PPs were asked to tell their peers about the study and provide the researcher's contact if they were interested in participating. The researcher also left information about the study and contact details with consumer advocacy organisations. Peers then contacted the researcher if they were interested and were recruited into the study. Peers were recruited and interviewed for the study until saturation was reached. In Stage Two, 25 peers were contacted and invited to participate in the survey or to pass the information on through their peer networks. Peers who were interviewed in Stage One were contacted by mobile messaging or email and sent an invitation to take part in the survey. The researcher also contacted PPs and provided a template with which peers were invited to participate in the survey.

Data Collection:

In depth interviews.

In Stage One participants were interviewed in the place of their choice for between 45 minutes and one and a half hours. Following written informed consent, the first author (GZ) asked semi-structured questions based around the CHIME framework (Leamy et al., 2011) and the stepped model of peer provision (Zeng & Chung, 2019). Participants were asked to describe their encounter with their PP and how that had helped them in their personal recoveries (see Table 6.2)

Table 6.2 List of topics and guiding interview questions

Topics	Interview Questions
How you came to know about your PP	• How did you come to know about the PP Service? • How were you introduced? • How did you feel at that time?
How your PP connected with you	• How did you and your PP build that relationship? • What do you like about your PP?
What your PP did/ said that helped you in your recovery	• What do you and your PP do together normally? • How did that help you to move along in your recovery journey? • Has that changed over time? How?
What you hope to achieve with your PP	• What do you hope to achieve with your PP? ○ What were some of the challenges along the way? • What do you think your PP can do to help you in your journey now?

Having worked with people in mental health services, the interviewer (GZ) was well aware of their vulnerabilities. The topics list allowed the interviews to proceed in a conversational style to put the participants at ease (Liamputtong, 2007b). Participants were encouraged to use specific examples in describing their encounter and probed by the interviewer where appropriate. With their consent, the interviews were recorded and transcribed. Participants were de-identified by the allocation of codes to protect their identities.

Survey.

Once the interviews were transcribed and analysed (see below for analysis), an online questionnaire was constructed based on issues that arose in the interviews. It included closed- and open-ended questions. Participants were presented with a summary of the three staged process described in a previous paper (Zeng & Chung, 2019). These stages (creating a safe place, working partnership and stepping out) were designed to describe PP practice as a non-linear relationship between the PP and their peer. The questionnaire also contained questions which gathered demographic information about the respondent and details of their contact with their PP (e.g.: length of service and organisation). Questions were also asked about the value of peer provision (e.g.: extent of agreement to a deeper connection with PP versus non-peer and the value of peer provision in reducing hospital admissions). Open-ended questions were also asked to ensure that space was also given within the survey to comment on the questions in writing. This gave respondents an opportunity to evaluate the application of others' experiences to themselves, adding a layer of reflection to their own experiences (Harvey, 2015). The questionnaire was sent via an email and SMS.

Data Analysis

In Stage One, thematic analysis was used to categorise themes emerging from the interviews. This involved a process utilising open coding to identify broad categories and axial coding to identify further emerging concepts (Holstein & Gubrium, 1995). These emerging concepts were then categorised using the CHIME framework (Leamy et al., 2011), which highlighted five recovery processes. These were: (1) Connectedness; (2) Hope and optimism about the future; (3) Identity; (4) Meaning in life; and (5) Empowerment. Codes were generated iteratively under these broad categories and divided into core and sub-themes. The second author (DC) coded a random selection of interviews to establish trustworthiness. Differences in coding were then discussed and a conclusion was made as to which code was appropriate (Nowell et al., 2017). This was recorded in a memo in NVivo, a software application used to assist in the analysis (QSR International, 2018). A final code was created to capture challenges and hinderances in developing and maintaining the peer relationship.

In Stage Two, demographic and quantitative data were analysed using descriptive frequencies. A qualitative stance was adopted to analyse the free text information offered by the respondents. Similar to how data was coded in Stage One, concepts were also categorised using Leamy's framework. A final code was created to describe the challenges and hindrances to peer provision.

Findings:

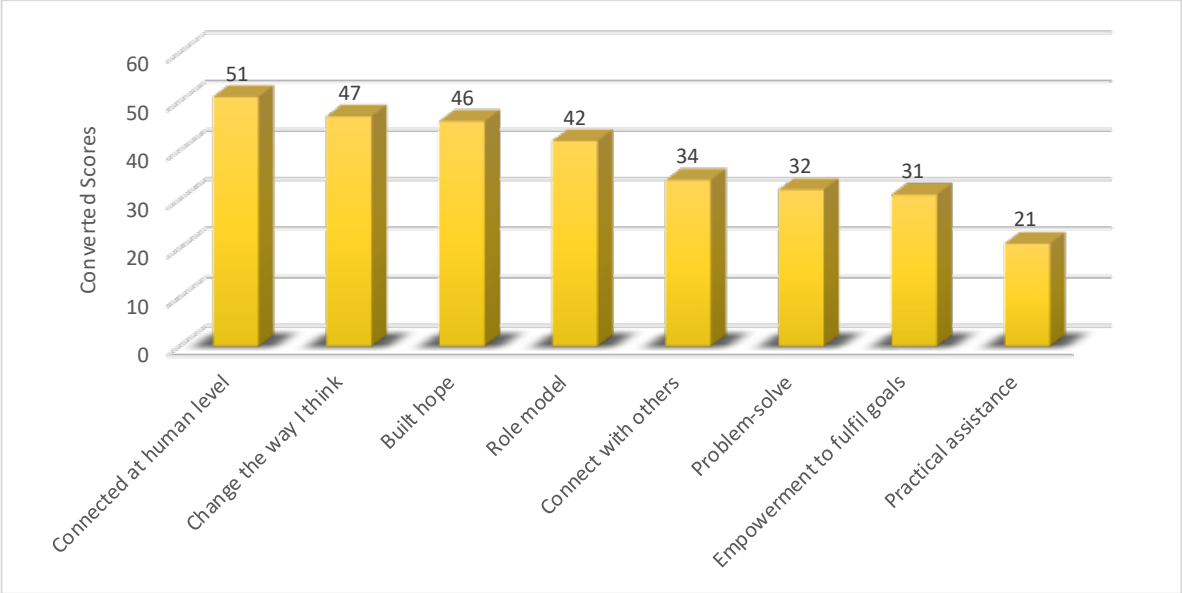
In Stage One, 13 peers were interviewed for the study. In Stage Two, 19 peers (76% response) completed the questionnaire, of which three were interviewed in the earlier phase of the study (Zeng & Chung, 2019). Five interview participants were uncontactable and five did not respond when contact was made.

The results indicated that participants mostly commenced contact with a PP within their first year of contact with mental health services. It also demonstrated a 92% agreement with the three staged process that emerged from the earlier phase of the study (Zeng & Chung, 2019). Table 6.3 and Figure 6.1 summarises the survey results.

Table 6.3 Survey responses: Engagement with PP

Description	Response
Are you still seeing your peer provider?	n = 19
Yes	7
No	12
How long have you been seeing your peer provider?	n = 7
Less than one year	6
One year or more	1
Where did you meet your peer provider?	n = 13
Hospital	0
Community mental health centre (Public)	5
Non government mental health centre	3
Both	2
Unsure	3
Agreement with the three stepped model of PP	n = 12
Not at all	1
A little	2
To some extent	4
Quite a lot	2
It matches my experience	3
Experience with a PP more positive than a health professional?	n = 12
Strongly agree	1
Agree	8
Neither agree nor disagree	2
Disagree	1
Strongly disagree	0
Experience with a PP helping peer to stay out of hospital?	n = 6
Strongly agree	0
Agree	4
Neither agree nor disagree	1
Disagree	1
Strongly disagree	0

Figure 6.1 Aspects of peer provision most important peers



The CHIME framework (Leamy et al., 2011) is used to guide the presentation of the themes, with hindrances to peer provision discussed as a separate theme. Table 6.4 highlights reference counts for each theme. Although this section draws from data in the interviews and survey, corresponding to reference counts in Table 6.4, greater weight has been given to the data from the interviews. In addition, greater attention has also been given to the first two processes as it was most valued most by peers in the survey.

Table 6.4 Recovery processes: Reference count

Recovery Processes	Reference Counts	
	Interviews	Survey Free Text
Connectedness	*n = 111*	*n = 12*
Referral	5	1
Empathy Connection	16	1
Peer's perspective of PP	22	5
Relationship with PP vs non-peer professional	36	5
Abrupt conclusions	1	
Celebrating recovery	5	
Hope and optimism about the future	*n = 56*	*n = 1*
Holding hope	30	1
Role modelling	12	
Story telling & metaphors	14	
Identity	*n = 58*	*n = 1*
Life before PP	3	1
Reciprocity	14	
Intrapersonal skills	24	
Life after PP	15	
Readiness to exit	1	1
Meaning in life	*n = 7*	*n = 1*
Healing	7	
Goal setting	0	1
Empowerment	*n = 130*	*n = 1*
Experiencing (doing & being)	17	
Advocacy	10	
Cognitive/ mindfulness strategies	22	
Facilitating access	14	
Developing resourcefulness	3	
Personal responsibility & accountability	38	1
Interpersonal skills	12	
Practical life skills	18	
Problem-solving	6	
Hindrances to Peer Provision	12	4

Connectedness

As illustrated in Figure 6.1, survey respondents indicated that connecting at a human level was the most valued aspect of the recovery process in their encounter with their PP. They appeared to value their relationship more with the PP than a mental health professional. Two main factors appeared to foster the connectedness which was valued: The PPs' lived experience and their interpersonal skills.

Lived experience appeared to play a role in fostering trust and balancing power between the PP and the peer. The importance of these aspects helps to explain why 75% of the respondents agreed that their experiences with their PP were more positive compared to health and medical professionals. As most participants all engaged with a PP in the first twelve months of mental health service engagement it may also be a highly valued experience because they began to realise early in their service use that other people had similar experiences to their own, offering a sense of commonality or community. The mutualising experience reduces the hierarchical differences in the helping relationship, enabling the PP to understand their peer's state of mind and work with them. The following quotes taken from excerpts of three interviews with peers illustrate this:

> "…knowing that [the person actually experienced it themselves understood what it was like] and not just … because they read about it or learned about it made me feel at ease straight away" (P10)

> "… she would like ask how I was doing and find out exactly where I'm at in my state of mind and then suggest ideas" (P03)

> "We sort of grew together" (P02)

Building upon the foundations of lived experience, peers spoke of the interpersonal skills that they valued of their PP. These interpersonal skills included: protecting their relational space, listening, speaking about the everyday and normalising experiences.

Peers valued the assertiveness of their PP in preventing others from encroaching into their relational space, yet attending to the needs of all involved. The following quote illustrates this:

> "…if I was talking to her and another patient came up and sort of butted in, she would quite assertively say 'excuse me, I'm actually talking with [the peer] at the moment, can I catch up with you later'" (P02)

Peers also valued that PPs listened to their experiences more than speaking of their own lived experience. In the words of a peer in relation to her smoking habit, she said:

> "…they didn't really… join in stories; their own stories about their smoking habits. They just said that's how long they hadn't had a cigarette. They were focussing on listening about what we had to say about our difficulties…They didn't spend a lot of time talking about their own mental health issues… most of the talking they did was passing on the information … and focussing on us" (P04)

Peers also appreciated the everyday experiences that PPs weaved into their conversations with them. These conversations helped to normalise and mutualise their experiences which helped them to feel human. In the words of two peers:

> "She spoke about life in general, what's she's been doing herself" (P05)

> "It made me feel like I wasn't unusual for once" (P09)

Limitations to connectedness:

Despite intrapersonal and interpersonal factors that facilitated connectedness, peers also described external and intrapersonal circumstances that hindered connectedness. Firstly, access to the PP was limited by the length of service which will be described later. Secondly, connectedness could also be limited by the PP's own challenges. Peers sensed a disconnect when they felt their PP's challenges was greater than their capacity to give to the relationship. As described by a peer:

> "I must admit the other lady with her; …was a bit different. You couldn't relate to her the same way … you could feel her illness if you will; … she was there because she had to be, not because she wanted to be" (P05)

Hope

Respondents ranked building hope as the third most important role of the PP. Peers in their interviews articulated a progression from hopelessness to having hope for recovery, to taking personal responsibility for their own recovery. A peer recounts how his encounters with his PP motivated his progress through hopelessness to personal responsibility:

> "I went into [hospital] … it's the first time I'd seen someone who had fully recovered from a mental illness … that's really planted that idea in me that I've got something to work towards … I was discharged too early and I didn't really reach hold of these services and so I was still struggling for quite a few weeks so I ended going back into [hospital] a second time … I sort of came to the realisation that nobody else is going to help me with my situation; it's me who has to help myself and I've; the only way I can do that is by reaching out and grabbing these services that are available… when I got out, straight away I started getting onto people and you know, that really helped me a lot…" (P03)

Peers also recounted how this process involved holding the hope, being a role model to them and changing the way they thought about their circumstances.

Holding the hope

Peers appreciated the messages of hope drip fed to them through story-telling: recounts of their PP's experiences. They felt that they were not pushed to believe that recovery is possible. Instead, they felt that there was someone who believed that they could overcome their mental health challenges, who waited for them to come to that same belief. The excerpts of interviews with three peers illustrate this:

> "[My PP]'s amazing like she'll share her stories with you straight away" (P11)

> "I think she believes in others a lot more and their ability to help themselves given the right help" (P03)

> "It's so overwhelming powerful when someone's actually said 'I'll just hold it for you until you're ready'. Not saying that I'm going to carry you through it but 'I'm just going

> to be here with you and I'm going to wait until; 'I know that you will be able to overcome it'"(P10)

Role modelling

Role modelling involves the PP being open and honest about their experiences and what helped them to overcome. It also involved witnessing personal recovery work coming to fruition in their lives through the assumption of their life roles and routines. This led the peer to grow in their belief that recovery was possible. In the words of two peers:

> "…she's on medication every day for depression and she's quite open about it; everyone knows but she's not embarrassed and she works five days a week helping other people so she is someone that I kind of find inspirational as well" (P11)

> "… [it] boosted my self-esteem and everything because it's like you know there is the possibility of fully recovering" (P03)

Hope builds positive identity

When built on connectedness, PPs challenged how peers thought about their circumstances, which promoted a greater belief in the possibility of recovery. This enabled them to pursue a course of healing that led to rebuilding a positive sense of self. As aptly articulated by two respondents:

> "In 12 step programs they refer to 'terminal uniqueness' - the idea that one's own unique circumstances are devastating and lead to despair because no one else could know what you're going through. In my experience with my peer [provider], this terminal uniqueness was challenged… My peer [provider] introduced me to new ideas and therefore challenged old, self-stigmatizing ones. …It opened a door previously closed to me and set me on a course to healing I mightn't otherwise have pursued without this relationship with my peer [provider]."

Hope builds meaning in life

This hope that was instilled in peers encouraged them to identify and pursue life roles that facilitated skill development and daily routines. This built a new rhythm for peers and helped them to cross over from their old lifestyle that compromised their health and well-being to a new lifestyle and roles that enhanced their health and well-being. In turn, peers indicated how this motivated their changing of habits and different ways of viewing their future selves. In the words of two peers:

> "I was involved in something real you know, it wasn't just sitting around having a chat, it was an actual project that we were working on with different things to consider." (P04)

> "… I started to [exercise] regularly and the weight came off, then I started noticing other changes that could go into my life that I could make that would help me like doing study and then doing work, it has been a really positive experience and feeling confidence and gaining in confidence and self-esteem and self-respect Drugs, drugs and all that… that's behind [me]." (P01)

Meaning in life and identity reinforces one another

Such routines coupled with positive reinforcement facilitated physical and emotional changes such as weight loss, increased confidence and self-respect. Such changes motivated them to build or rebuild their positive sense of self. As they grew in their positive sense of self, peers became more self-directed in their recovery. In the words of two peers:

> "I was in pretty much bad way and I knew I needed help… It has been a really positive experience meeting [my PP] and gaining confidence, self esteem and self respect" (P13)

> "… [After losing 70kg] it's got to the point where I'm feeling a lot better about myself. I see the changes and I wouldn't mind making a few other changes to get myself in the positive frame of mind and really having a crack at life and really getting stuck into it" (P01)

Empowerment

This congruous growth in their identity and meaning in life encouraged peers to assume personal responsibility in undertaking their life roles, and maintaining their own health and well-being. At this stage, peers valued the practical assistance and advocacy afforded by PPs. This enabled peers to pursue their recovery goals. In pursuing employment, P08 described how his PP gave him practical assistance and advocated on his behalf:

> "… meeting the employment service providers, [my PP] would show interest in coming with me, driving me to the appointment and any problems I could talk with him … he would speak on my behalf on how to you know 'make sure you give the best you can for [the peer] rather than say 'we can't do anything' so that's supporting practically rather than just talk" (P08)

PPs were also instrumental in empowering their peers to assume personal responsibility over their mental health. These included cognitive and mindfulness strategies and facilitating access to community resources and problem solving. The following quotes sheds light on how PPs equipped their peers with these keys to overcome obstacles to their recoveries.

> "… when you're in that psychotic state it feels like you're in that sort of state where you're able to live by your imagination and not by reality … so when she says; unpack your mind and pack it back in it actually really helps" (P03)

> "[My peer provider] set me up with a gardening crew [to] meet the people. [I've] been working there about three years…"(P01)

> "having a peer support worker has been really wonderful in that they are able to help with the steps along the way and if the wheels fall off the wagon they're able to help you put the wheels back on."(P12)

Other hindrances to the recovery process:

Apart from the hindrances related to the PP's capacity to support the peer, peers also described wider systemic issues that did not fit neatly into Leamy's (2011) framework. This hindered their relationship with their peers, and undermined their recoveries. This had to do with constraints placed around service provision and professional boundaries.

Constraints around service provision

Peers described their disappointment with a time-limited service that if extended, would have accelerated their recoveries and helped them to integrate into the community. This however did not appear to be an issue with peers who met their PP through an NGO. As articulated by a peer who saw his PP in the hospital (PMHS):

> "I was disappointed with was that it only went for six weeks after getting out. It was only one phone call a week; … I just wish it continued on and on and on until I got to a state where I'm on the same level as her you know. For me like, I would, I feel sort of like half way in between now "(P03)

Constraints around professional boundaries

Peers also described how professional boundaries prevented their PPs from sharing less than they would have liked to hear. This reticence undermined their rapport with their PP, which could have been easily established through sharing mutual lived experiences. In the words of a peer:

> I suppose it's just I had that yearning for them to share a little bit more… Instead of saying the rapport was 100% , it [probably dropped] back down to say 80, 85... if they'd shared a little bit more then the rapport would have been 100, 110% easily… the only thing I could identify to explain why they were maybe not as forthcoming on sharing their experiences is that they might have been safeguarding themselves… in that they were protecting their professional boundaries which is more than understandable. (P12)

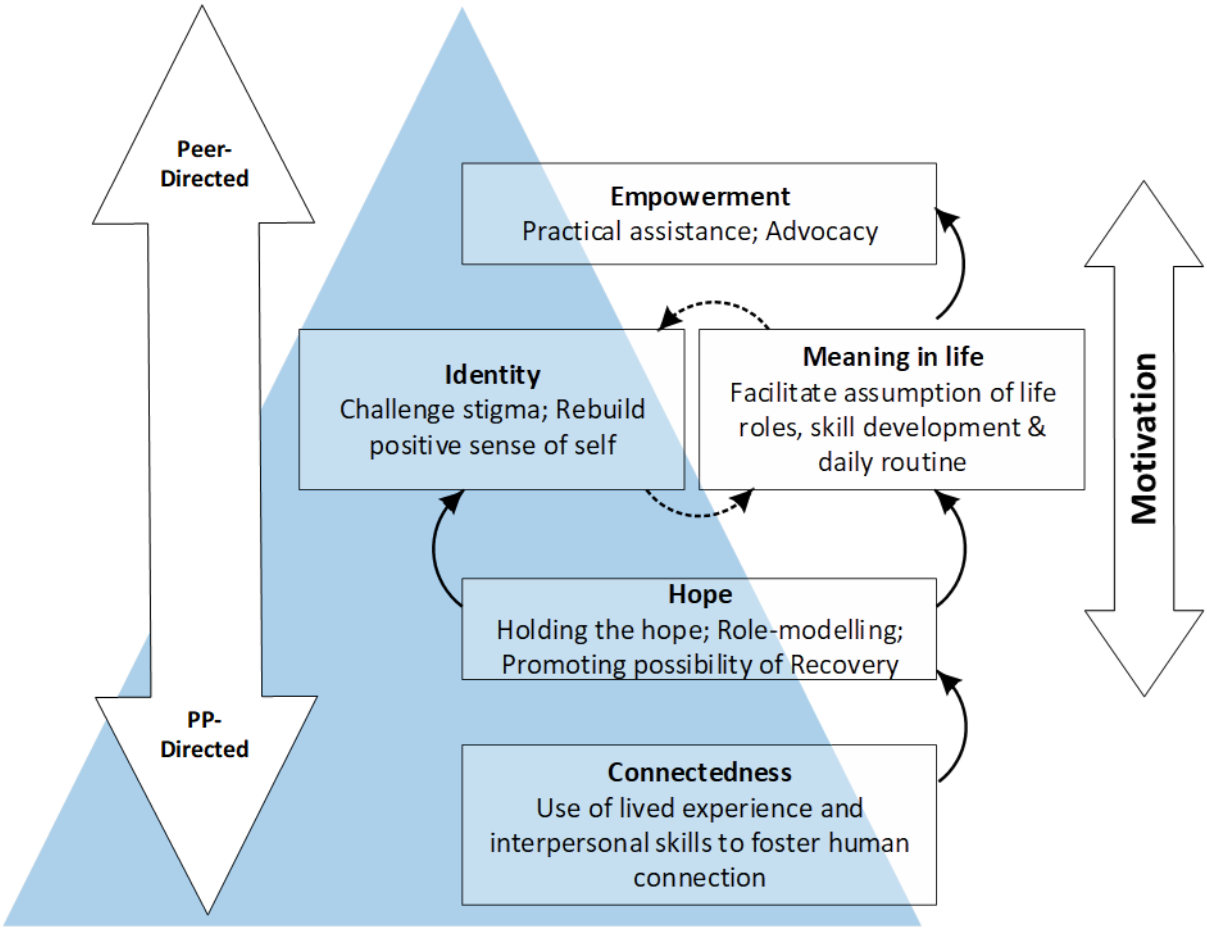
Discussion:

The findings of this study support the usefulness of the CHIME framework in describing the work of PPs. However, there were also other themes that did not align within the framework. In this section, we discuss the usefulness of this framework and propose a model which captures the changing roles of PPs in their work with peers. We then move onto highlighting themes that did not align with the framework, namely: the role of PPs in facilitating motivation; and systemic issues impacting the PP-peer relationship. We then conclude this section by highlighting limitations to the study and research implications.

The usefulness of the CHIME framework

Building on Saeri et al.'s (2018) report which suggests that interventions improving social connectedness are likely to enhance mental health regardless of mental health status, the five processes highlighted in this paper (connectedness, hope, meaning, identity and empowerment) may be presented as a pyramid. These processes represent a stage, beginning with connectedness and ending at empowerment. Each stage lays a foundation for the next to be built (see Figure 6.2). Within each process, the main role of PPs is identified and will be discussed in the following paragraphs.

Figure 6.2 Proposed CHIME framework in Peer Provision



Peers described their journey with their PPs as beginning from a place of connection (characterised by trust and mutual collaboration) and ending with a capacity for personal responsibility (birthed from empowerment). Such a collaboration was described as being directed more by PPs lower down the pyramid (e.g.: PPs connecting with the peers through lived experiences, speaking of everyday experiences apart from mental health challenges) but became more peer-directed as they moved toward empowerment, which was characterised by peers working towards their aspirations with support from their PPs (see continuum in Figure 6.2).

Peers identified specific interpersonal strategies used by their PPs to foster human connectedness. These included the deliberate sharing of their lived experiences as well as including conversation about everyday life into their conversations, the use of assertiveness and listening. Their connection with their PPs in turn promoted hope, which required PPs to hold, and promote hope to their peers. This was achieved through story-telling, role modelling and encouraging positive thinking. Facilitated by their PPs, hope and optimism served as a stepping stone for peers to rebuild a positive identity, assume new roles, routines and lifestyle changes. In encouraging their peers to embrace new roles and routines, PPs challenged stigmatising ways of thinking and a new, positive sense of self emerged. As PPs reinforced the new sense of self that emerged, new life roles, skills and routines were solidified. The results of these solidified roles and routines continued to reinforce the peer's identity (represented by the dotted arrows in Figure 6.2). This served as a platform to work towards new aspirations and a greater impetus to take personal responsibility in enhancing their own health and well-being. In this process, the practical assistance and advocacy afforded by PPs served a spring board in facilitating them to do so.

This model highlights the characteristics of the peer's recovery, allowing PPs to identify the recovery process that their peers are operating within and defines the end goal of peer provision: empowerment. In healthcare services, this takes the form of person-centred practice, which honours the person; prioritises their goals, is relational; demonstrates compassion; and draws on the person's strengths to facilitate engagement (Waters & Buchanan, 2017). It also identifies discrete roles/ tasks that PPs need to focus on as their peers progress through each process. It also draws attention to the level of directiveness afforded by PPs, allowing them to evaluate the prominence of their role in their work with peers. Whilst it is a person centred and supportive relationship it is still largely goal driven with particular ends in sight. To some degree this reflects the difference between a supportive friendship and the PPs occupation that is based on a helping relationship.

Themes that cannot be accounted for by the CHIME framework.

The role of PPs in enhancing motivation

While connectedness appears to be a precursor to hope, hope appears to be a precursor for motivation. The idea of motivation in this context differs from other notions of motivation in health promotion, which tend to focus on behavioural change (Prochaska et al., 2015). In contrast to the former, motivation work undertaken in this context is associated with intrapersonal changes and meaning making (Mead, 2013). This is based on a hope for recovery that is characterised by a peer's shift from pessimism to a more optimistic perception of themselves and the future.

Taking this further, witnessing the recoveries in PPs have challenged their negative self-concept. This provided an impetus for them to establish new roles, boundaries and lifestyles which reinforced a positive sense of self, boosted self-esteem and self-confidence. As this progressed, peers became more self-motivated, taking personal responsibility for working towards future aspirations and managing their health and well-being (see Figure 6.2). This motivational state has an important role in sustaining changes needed to maintain health and well being (Vancampfort et al., 2016).

Other themes not accounted for

This paper also highlighted the systemic and interpersonal factors that prevented peers from relating to their PPs. Peers identified the premature termination of peer provision services as slowing down their recoveries. The time limits placed on the peer provision relationship primarily reflects the funding constraints confronting most health and human services. It could also indicate the tension and unequal place of peer provision compared with traditional mental health roles that are the mainstay of the response. A systemic perspective incorporating the length and place of peer provision services within the service continuum is needed. Literature suggests that peer provision services are most effective in the first twelve months following initial contact with the mental health service system (Chinman et al., 2000; O'Donnell et al., 1999; Rivera et al., 2007; Sells et al., 2008). Hence, it is recommended resources should be focused on the availability of peer provision services over that period.

Research limitations and implications for future research

Although this mixed methods study has provided methodological triangulation which enhances the credibility of the results, it is not without limitations. Firstly, this study relied on a small purposive sample, which may limit broader issues associated with the peer provision relationship, particularly within acute mental health wards. Although the number of respondents to the survey were small, the results still hold some weight given the reticent nature of mental distress. Whilst recruiting participants through contacts in the former phase of the study and through peer networks enabled the researchers to gain access to peers for interviews and surveys, this may create a positive bias in results.

Whilst the heterogenous approaches to peer provision make it difficult to develop replicable studies that evaluate the role of peer provision in recovery (Bellamy et al., 2017), the findings of this study attest to the value of peer provision by documenting its role in the recovery process. A model that accounts for the wider systemic issues may be useful for policy makers and strategic leaders to understand and support the work of PPs. In addition, studies on the role of peer provision in facilitating the motivation of peers will build on the current evidence-base for peer provision.

Conclusion

In keeping with the need for studies which explore how peer provision brings about change associated with recovery (Gillard, 2019), the main goal of the current study was to test the usefulness of the CHIME framework in describing the work of PPs. This study proposes a framework that identifies the main role of PPs in each stage of the recovery process. These findings have significant implications for the understanding of how peer provision can enhance the motivation and mental health of persons with varying degrees of mental health challenges (Saeri et al., 2018). It lays the groundwork for future research into examining the role of peer provision in recovery and its distinctiveness from other forms of mental health support.

6.1 Summary

This paper confirms the importance of social connectedness in enhancing an individual's mental health (Saeri et al., 2018). It proposes a model that underscores how peer providers journey with their peers from a place of connection through to empowerment: a state where personal responsibility is taken to maintain their health and pursue their life's goals. Such a model of practice is akin to person-centred practice, in which service users are honoured, their goals prioritised and is characterised by compassion, relationality and strengths-based practices (Waters & Buchanan, 2017). The paper also identifies tasks peer providers need to focus on with their peers and their role at each stage of the process. It highlights how directed they should be, enabling them to evaluate their leadership style in light of where their peers are placed in their recoveries. It also documents discrete roles/ tasks that peer providers need to focus on as their peers progress through each process. While this paper highlights that peer provision is a person-centred and supportive relationship, it is still mainly goal-driven with personally-defined recovery in sight. To some degree, this reflects the difference between a supportive friendship and the peer provider's occupation that is based on a helping relationship. The next chapter elucidates the dynamics of that helping relationship further.

Chapter 7 Capturing the dynamics of the peer provision relationship: The stepped model of peer provision

This chapter, presented in the form of a published paper illuminates the dynamics of the peer provision relationship across time. Hinged upon a person-centred orientation, the stepped model of peer provision is articulated. This differs from the stepped care approach to mental health services, which is an evidence-based, staged system affording a hierarchy interventions to match the needs of the person sitting within a spectrum of mental illness (Australian Government Department of Health, 2019). Unliked the stepped care approach in mental health, this model serves to depict how a peer-provider relationship progresses. The stepped model of peer provision describes trust as the key foundation to developing a peer-peer provider relationship, on which sits three key stages: (1) Creating a safe place; (2) A working partnership; and (3) Stepping out. Whilst the previous chapter focuses on the process of how peers are supported by their peer provider; this chapter delves deeper into the dynamics that occur within that process (see Figure 6.2). Drawing from the accounts of peer providers, this chapter addresses the second objective of this thesis, which will shed light on the second research question: "What are the dynamics of the peer provision relationship?".

The manuscript was accepted for publication with the Journal of Mental Health Education, Training and Practice in 2019. An email confirming acceptance for this publication can be found in Appendix F.7.

Reference:

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Title

The Stepped Model of Peer Provision Practice: Capturing the Dynamics of Peer Support Work in Action

Abstract

Purpose - In recent years, the employment of peer providers (PP) has grown with the wider acceptance of lived experience expertise in recovery-oriented service provision. Although its effectiveness, theoretical foundations, and factors influencing outcomes have been studied, a framework accounting for the dynamics of the PP-peer relationship has yet to be formulated. The purpose of this paper is to employ a qualitative approach to explore the journeys undertaken by PPs with their peers and form it into a cohesive framework of understanding.

Design - In-depth interviews were conducted with peer providers who were employed specifically to use their lived experience in supporting someone through mental distress. These interviews were recorded, transcribed and coded using a framework approach. To enhance rigour, this framework was verified with the latter author and three other participants recruited after data analysis.

Findings - A stepped model of peer provision practice was crafted to capture the non-linearity of recovery, as well as the PP-peer relationship. This model is founded upon trust in the milieu of shared experience and involves: creating a safe place – a stage of building trust and rapport to a point where PPs are given permission to enter into their peer's headspace; a working partnership – stage of setting and working toward goals collaboratively; and stepping out – a stage marked by the termination of the PP-peer relationship.

Originality/ Value - This paper proposes a tangible framework underpinning the dynamics of peer provision practice, which furthers our understanding and complements current practice models in peer provision services.

Keywords

Model, Peer provision, Peer relationship, Mental Health

Introduction

Peer Provision as an Emerging Profession

With the prominence that recovery-oriented services has received in mental health policy, and a wider acceptance of lived experience expertise (Department of Health, 2015; Lawton-Smith, 2013; Stamou et al., 2010), organisations have created roles that employ individuals who live successfully with mental distress to support others in mental distress (Chinman et al., 2014). They are formally employed to use their lived experience explicitly and intentionally to instil hope and afford practical assistance within the context of an empathetic and therapeutic relationship (Bradstreet, 2006; Gillard & Holley, 2014; Scottish Recovery Network, 2005). Although various terms such as "peer specialist" or "consumer provider" have been used to describe this group, we have chosen to use the term Peer Providers (PPs).

Literature on PP practice

The role of PPs are well documented and is described in literature in terms of its function (Cabral et al., 2014; Nannen, 2015; Smith-Merry et al., 2015; Watson, 2014) and its values (International Association of Peer Supporters, 2012; Mental Health Commission of Canada, 2013; Repper et al., 2013). Cabral (2014) describes the function of PPs as (1) the key elements of their role; and (2) their function within the team.

PPs foster a unique relationship with their peers accessing mental health services that is based on mutuality, respect and hope. Through what the PP does to support the person (eg: catching public transport), PPs use their own narratives to enable them to connect with the person, relate to their struggle and instil hope in that process (Nannen, 2015; Smith-Merry et al., 2015; Watson, 2014). In addition to affording instrumental, informational and emotional support to the person, PPs also work in collaboration with the multi-disciplinary team, using their insights from their lived experience of mental distress, instilling recovery values in the process. By virtue of being a peer, PPs also act as models of recovery to the team (Cabral et al., 2014; Nannen, 2015; Smith-Merry et al., 2015).

Whilst the roles and function of PPs remain ambiguous in mental health services (Gillard et al., 2013; Kemp & Henderson, 2012; Moran et al., 2013), PPs have relied largely on the values that underpin their roles to guide their practice. This includes the intentional use of lived experience to communicate hope, empathy and facilitate connectedness; and the mutuality of the relationship (International Association of Peer Supporters, 2012; Mental Health Commission of Canada, 2013; Repper et al., 2013).

The helping process

Like other professional helping processes, the PP to Peer relationship is the process vehicle that meshes the Peer's problems with the expertise of their PP (Brammer & MacDonald, 1999a). Visualised as having three phases (the beginning, middle and termination phase), the relationship serves to meet the emotional and practical needs of the peer; as well as serve as a channel through which efforts to reason can be made (Levine, 2013). It enables the PP to interact with their peers as a human rather than a diagnosis (Deegan, 1996).

Akin to helping relationships, PP-Peer relationships are mutual transactions of verbal and non-verbal responses, requiring both parties to participate actively in the process (Brammer & MacDonald, 1999b). These relationships are also time limited, ceasing when peers have learnt how to access help or resources around them; and draw from their own capabilities (Levine, 2013). Unlike friendships, the PP-Peer relationships are geared to meet the needs of the Peer, where PPs possesses an authority of social sanction and knowledge from their own lived experiences (Brammer & MacDonald, 1999b; Levine, 2013). Despite the limitations of the relationship, service users have appreciated practitioners that communicated hope, shared power, and were willing to stretch their boundaries of the "professional" role (Borg & Kristiansen, 2004).

Like most complex interventions, the theoretical foundations underpinning peer provision have been discussed (Mead et al., 2001); its components which influence outcomes explored (Vandewalle et al., 2016; Watson, 2019b); and randomised trials conducted to ascertain its effectiveness (Castelein et al., 2008; Cook et al., 2012; Jonikas et al., 2013). Although a change model has been proposed for PP interventions (Gillard et al., 2015), a framework that accounts for the dynamics of the PP-Peer relationship in facilitating recovery has yet to be formulated. Hence, this study employs a qualitative approach to explore the journey that PPs undertake with their peers from rapport building through to termination, and forms it into a cohesive framework of understanding.

Methodology

The study design involved in-depth interviews with PPs in order to engage them in conversation to elicit their understanding and interpretation of their practice with their peers (Serry & Liamputtong, 2010). Using a snowball sampling approach (Atkinson & Flint, 2001), 12 PPs were recruited in the metropolitan areas of Perth Western Australia. Whilst this strategy gave the researchers access to hard-to-reach populations, there is a risk of selection bias, limiting the generalisability of findings to peer providers in other settings (Atkinson & Flint, 2001), given that peer provision is varied (Salzer et al., 2010).

A list of themes (see theme list and questions used in the interview) with open ended questions was designed to keep the interviewer focused on what information was needed while maintaining openness to related information that was possibly missed out on (Liamputtong & Ezzy, 1999). The in-depth interviews, which took an hour to complete enabled a comprehensive exploration of the PP-Peer relationship and how PPs interpreted their everyday practice. Participants were asked about what they did as a PP and to describe their experience of working with their peers. Interviews were conducted by the first author (GZ), at the agencies in which they operated from or a venue of their choice. The interviews were digitally recorded and fully transcribed, and participants were allocated codes to protect their identities.

Theme list:

1. What you do as a PP.

- If someone were to ask you about your role as a peer worker, what would you say to them?

2. How do you support a peer through their recovery from the time you meet them to the time they are ready to stand on their own?

- How do you normally build rapport with your peer?
- Things you normally say/do to establish a connection.
- What do you do to support your peer through their recovery?
- Can you describe some things that took place in the course of your work that contributed to their recovery?
- How do you determine when the work with your peer should conclude?
- How do you conclude that relationship with your peer?

3. The successes and challenges in supporting a peer.

- What are some successes that you have experienced as a per worker?
- What are some of the challenges you face as a peer worker?

Thematic analysis was used to categorise themes from interviews (Holstein & Gubrium, 1995) with open coding identifying broad categories, and axial and selective coding enabling identification of further emerging concepts, which were then reviewed, categorised, and clustered to form core themes, which were verified by the latter author (Neuman, 2014). A framework from the core themes (see Table 7.1) was mapped out and further interviews with three other participants ensued to validate the proposed model.

Table 7.1 Core Themes, Sub Themes and Reference Count

Core Themes and Sub Themes	Reference Count
Referral	1
Underlying Processes	
Empathy Connection Head Space	5
Experiencing (Doing and Being)	6
Holding Instilling Hope	24
Lived Experience Authenticity Humour	37
Creating a Safe Place	19
Connecting Working Phase	
Cognitive Mindfulness Strategies	14
Connecting Facilitating Access	4
Goal Setting and Planning	7
Interpersonal Skills	9
Intrapersonal Skills	6
Personal Responsibility and Accountability	14
Role Modelling	6
Story Telling and Metaphors	11
Concluding	
Celebrating and Validation	2

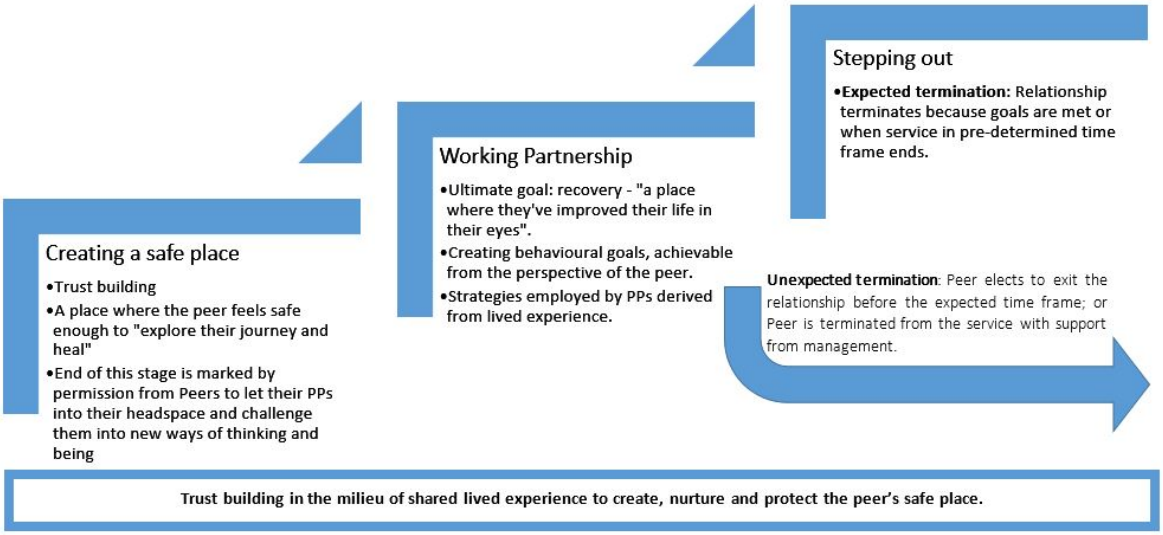
Results

An emerging PP approach: the Stepped Model of Peer Provider Practice

Some common practice processes emerged from the PPs' descriptions of how they provided support services in their workplaces. There was a strong focus on engaging and working with peers at a pace that suited them, and being adaptable about the direction and purpose of the PP's involvement. This approach to working with individuals is similar to person-centred orientations described in professional practice literature (Coyle, 2011; Smith & Williams, 2016; Waters & Buchanan, 2017). In describing the dynamics of working with their peers, participants reported trust-building as a key foundation to developing a valued relationship. We have translated these findings into the Stepped Model to capture the logic, foci and methods of PP Practice (see Figure 7.1). A stepped model was chosen to reflect the non-linearity of the PP-Peer relationship, as well as the Peer's recovery. PPs could go back and forth along the continuum with some uncertainty until their peers exited the relationship. In the words of PP04, she said: "Recovery is not straight, … going upwards but up and down because each time you will learn".

The three stages captured by the model are: (1) Creating a safe place, in which PPs work towards creating an emotionally safe place for their peer; (2) A working partnership, in which PPs establish and work toward jointly developed goals; and (3) Stepping out, in which PPs celebrate and/or conclude their relationship with their peer. This is important as the findings contribute to an emerging area of mental health practice in its own right.

Figure 7.1 The Stepped Model of Peer Provider Practice



Underlying Processes and Creating a Safe Place

There were a number of underlying processes in the PPs' interactions with the peers that were geared towards building trust. Different to mental health professionals, PPs build trust which starts with the mutual experience of living with a mental illness rather than an intellectual connection based on professional knowledge. These processes served to create, nurture and protect a safe place so that peers felt confident to engage and share with them. PP13 described the peer's perspective as "in a safe environment and with a strong therapeutic alliance… trauma is something that has…. many stories. It has a voice that needs to be heard… that is someone's unique experience that needs a safe place to journey and to explore and to heal."

In order to create a safe place, PPs had to meet peers on their terms, rather than their own. This was portrayed by PP13: "the first time [my peer] spoke to me was when I was on my hands and knees, cleaning his mum's bathroom floor.... he needed to see me inside his safe environment." PP06 described her experience of working with someone who had a negative experience with a previous PP. In creating that safe environment, she "had to start from a really gentle place… with pretty much nothing of pushing …"

PPs also highlighted two other strategies to nurture their safe place. This includes making a connection; and holding the hope in the milieu of shared lived experiences.

PPs highlighted that their identity as a person: having an intimate knowledge of who they were and liking themselves - was central in making a deep connection with their peers. In the words of PP09 "… I had to realise that if you want to be a friend and have friends you have to like yourself first before you can like someone else. You can superficially connect with someone but to connect at a deep level you have to find out the differences between you and the other person and the similarities between you and the other person." It was from that place of being secure in themselves that a deep connection which they described as "being in their headspace" was made. PP03 described this as "to meet the person at their view of the world… not bringing any judgement to that… to find out how the person feels about their own experience."

Rather than being involved with reinforcing the person's identity as being 'mentally ill', PPs built trust starting from the common experience of mental distress. In this milieu of mutual understanding, PPs drew on developing an emotional connection with peers. In the words of PP09: "When you say to people that you've got a mental illness as well, … immediately you feel a connection with them and that enables them to open up a little bit more and trust you and if people trust you they will trust your judgement …So it's all about connection as well."

Peers Providers also highlighted the role of using their lived experience in making a deep connection with their peers. Knowing what it was like to be seen as an illness, PPs emphasised the importance of enabling their peers to differentiate their identity from their illness, and the significance of treating their peers as a person rather than an illness. PP04 recounted: "I hated being seen as, as a person with an eating disorder, depression and anxiety… I was …able to find my identity again and go 'no, I'm [PP04]' …I'm more than the mental illness ... so I promote that you know… I said 'this is a part of you, it's not all of you'."

PPs highlighted the importance of holding the hope of recovery for their Peers in creating a safe place from which to work. PP04 portrayed this in an encounter with her peer: "I had one person who didn't even respond to me for months but I continued to say hello as I walked by, and then …one day he went 'hi [PP04]' …sometimes it requires waiting… for that person to … come to a point where: 'yeah, I'm ready to work towards recovery now'." This hope was held in a milieu of shared lived experience in which they expressed a mutual understanding of having experienced the loss of hope and to have it back again as they mastered their mental illness. In doing so, they expressed a personal belief in the person for recovery and modelled hope through their personal recovery journeys: "People when their down and ill they don't think there's a good future for them so yeah I think that the hope is the biggest thing and sometimes you have to share your stories to provide that hope." (PP12)

This safe place also had to be protected especially when peers were going beyond their levels of comfort. This was accomplished through building trust through proving their reliability. PP01 cites an example: "… you're going to get a text message from me on Monday morning and the group starts at 10:30. I'll text you around 9:15, ok? That text message had better get there otherwise those little things can do damage to developing the relationship." This then acted as a safe place in which they could practice new behaviours. This is also illustrated in how PP12 supported her peer in catching the public transport: "it's the same with the public transport, she'd get on the train but she knew when she got off I'd be there so she never felt that she was alone … So that's how we keep going with our system. We just keep providing safety nets for her".

The creation of a safe place marks the end of the first stage: one in which peers allowed their PP into their headspace, and a place where peers felt safe enough to be challenged by their PP to experiment new ways of thinking and being. This was described by PP06 as, "I just knew at the moment that it's ok for me to get a bit more bolshy with her because she trusts me too."

Working partnership

It is within this safe place that PPs begin to partner with their peer towards recovery, which PP12 described to be "a place where they've improved their life in their eyes.". Once the foundation of safety was established, PPs described goal-setting as crucial in helping them along in their recovery. These goals were described to be behavioural in nature and achievable from the perspective of the peer. Once a goal was identified, a plan was made to fulfil an achievable goal for which the peer could be held accountable to their PP. PP04 described the process with one of her peers as: "he can't imagine not living… "OK, what's one thing this very moment that can improve your everyday?" and that's getting enough sleep he'd say, …we set a sleeping routine and he's starting that… And it's keeping in touch with that."

In addition to the underlying processes that were occurring throughout the PP's interaction with their peer, PPs also articulated a number of strategies that empowered their peers to connect with the community. This involved role modelling; story telling; and cognitive strategies.

Role modelling.

PPs articulated how role modelling looked like in their work being two fold. They spoke of how by being who they were, that they saw themselves as models of recovery. As described by PP04: "I'm more of what, what recovery can look like, so a model of recovery not a role model." In being who they were it was a message of hope and holding the hope. In the words of PP03: "But knowing how devastated I have been in the past by this thing called the mental illness and coming out the other end of it… you've overcome something that a lot of other people said you'd never be able to do, so it enables me to know that other people can."

PPs also acted as role models on practical terms and how that served to empower their peers to connect with the community. An example of this was spoken of by PP06 in her work with a lady who wanted to use the gym but was too scared to: "I went with her to her first body balance class um and that was interesting because I was just myself… we walked in and … there was a class going on in there and she said "I don't know, maybe we should just leave" and I … just bravely walked in the class and said; excuse me is this a such and such class?" … she felt really brave afterwards … she kept going back and she's enjoying the gym."

Storytelling and metaphors.

Personal stories and metaphors were used intentionally by PPs to instil hope, offer a different perspective of a situation or served as a reminder for their peers. PPs often used personal stories to communicate mutual understanding of their peer's journey and to offer hope of recovery to their peers. In the words of PP09: "it's telling your story which can be a really sad, tragic story, but at the end of it … always has a good outcome so that they can see I've been through a similar journey." In addition to using personal experiences, PP also used metaphors to challenge unhelpful cognitive schemas and offer a hopeful perspective to their peers. PP06 described how she used a metaphor to respond to a peer who was grieving over the loss of her relationship for ten years. She told her peer: "you've got to think of your relationship like a vase. It's been smashed and while you can pick up the pieces, some of those pieces are missing so you're never going to be able to put it together the way it was, but you can pick up those pieces and create something new in your life." PPs also used metaphors to serve as a reminder of something that they needed to do for themselves in their personal recoveries. PP06 described how she bought her peer an orange lantern and asked her peer to hang it up when her husband came home "as a visual reminder that [she was] on amber and [to] proceed with caution. [She needs to] give [herself] a break around that and when he's gone take it down, [she'll] recover for a couple of days and then you'll get into [her routine]."

Cognitive strategies.

Whilst cognitive behavioural and mindfulness strategies were employed in their interactions with their peer, PPs emphasised that it was not their role to perform cognitive-behavioural therapy nor mindfulness per se, but rather to employ principles of mindfulness and cognitive behavioural therapy from a standpoint of having lived with mental distress. PP04 articulated this difference: "it's looking at that and going; 'well how about saying this or how about thinking this' … you can still actually say that but then also think about positive as well… I'm not a psychologist … I don't try and be, but I know what it's like, the ups and downs of the head space."

PPs employ cognitive strategies from two perspectives. Firstly, having lived with mental distress heightens PPs to sense and respond to distress more readily, enabling them to engage their peers in a 'just right' challenge in a situation whereby they feel safe. This is exemplified in PP01's recount of how he supported a peer who lived with agoraphobia: "If we're [outside] and we're walking half way up the stairs; the keys are in my hand. If you want to go, you give me the nod and we're gone; ... So they know there's an ejection button so to speak." He then goes on to recount how he employs his own experiences with mental distress to normalise what their peer is experiencing, "these feelings you might experience… that's perfectly normal to feel those things when you're challenging something your body's not used to..."

Secondly, they employ cognitive strategies that have worked for them in their own recoveries. PP06 recalls how she mentally blocked out external stimuli when going out to shopping centres: "what I realised … is I find myself in a bubble and I tune down everything that's not in my immediate area and I tune into a different frequency … she got the frequency thing… And you know this week she said 'I've been practising and it's definitely been helping that awareness'".

Stepping Out

There are two circumstances in which peers exit from the PP-peer relationships. The first occurs in an expected time frame, where PP-peer relationships was described by PPs to be governed either by a progress towards goals: "what they want to achieve" (PP09); or time spent in the service since "it's pretty much decided at the start roughly how long the service will go for" (PP07). PPs highlighted an intentional effort to prepare their peers for the conclusion of their relationship as soon as they start seeing them. PP01 likens the encounter to "sow[ing] the seed very early, walk with them for a period of time and slowly stepping back when they're confident." This was addressed openly and honestly with their peers, as PP07 recounts: "It's just all very up front … with this girl that's wrapping up I'm having a meeting with her and her primary worker next week to discuss like the final few weeks and how that will look and then conclude"

The other circumstance occurs in an unexpected time frame where the peer elects to exit the relationship before the expected time frame as they may not find it beneficial. PPs also may elect to exit the peer relationship when they don't sense that their peer wants to progress towards their goal. Reflecting on their experiences, PP03 and PP09 recount, "some people just want to be where they are for the moment and people are coming and trying to fix them up…. I was working harder than she was and she was … putting up roadblocks and barriers as to why she couldn't do it, so that was quite difficult and my supervisor exited her."

In most cases, when the goal is being reached, PPs describe a sense of fulfilment knowing personally how difficult it was to reach the goal and to acknowledge that. In the words of PP04 "to actually deeply know how hard that is to stop [self-harming],… It's, the, the overall fulfilment knowing … and knowing what that's like I can go "hey, I know that's so cool" and … for them to actually acknowledge it verbally". The closure can also be marked by doing something special such as "go[ing] out for cake." (PP07).

Discussion

The interview data revealed a process that enabled PPs to facilitate personal recovery through the implicit and explicit use of their lived experience, which was encapsulated in the stepped model (see figure 1). While the implicit use of lived experience informs how PPs understand their peers' views about themselves and their world; the explicit use of lived experience in the interaction and discussions with their peers forms part of their practical responses to their peers' issues in working towards their goals. This corroborates with findings from research demonstrating that the intentional and explicit sharing of one's own experience is beneficial to the goals of gaining confidence; self-esteem; social connection; understanding and managing symptoms (Repper & Watson, 2012b). The implications for Peer Provision practice and development of the mental health workforce are now discussed.

Implications for peer provision practice development

Central to the model of peer provision is person-centredness, which may be defined as a person-honouring; relational; socially inclusive; compassionate; strength- focused approach to facilitating participation and engagement (Waters & Buchanan, 2017). This is founded on the establishment and nurturing of health-giving relationships between all health providers, consumers and others significant to them (McCormack & McCance, 2017). Akin to the therapeutic use of self, when lived experience is used in a timely and appropriate manner, PPs can: enable peers to feel understood and valued; contribute to an atmosphere of general ease; establish a relationship that is more balanced in power; and encourage peers to share vulnerable information that they would not have otherwise shared (Audet & Everall, 2010).

This model highlights the unique place of lived experience that is fundamental to the delivery of peer provision (Mead & MacNeil, 2006). Conceived from basic helping processes (Brammer & MacDonald, 1999a), this model highlights the importance of building trust in the milieu of lived experience to create a place of psychological safety: an experience of showing and employing oneself without fear of negative consequence to self-image, status or career (Kahn, 1990). When relationships are viewed as supportive and trusting, peers have the flexibility of trying approaches without the fear of negative consequences. Hence, PPs should think of their roles in the organisation as being a model of peer support rather than a form of service provision (Mead & MacNeil, 2006).

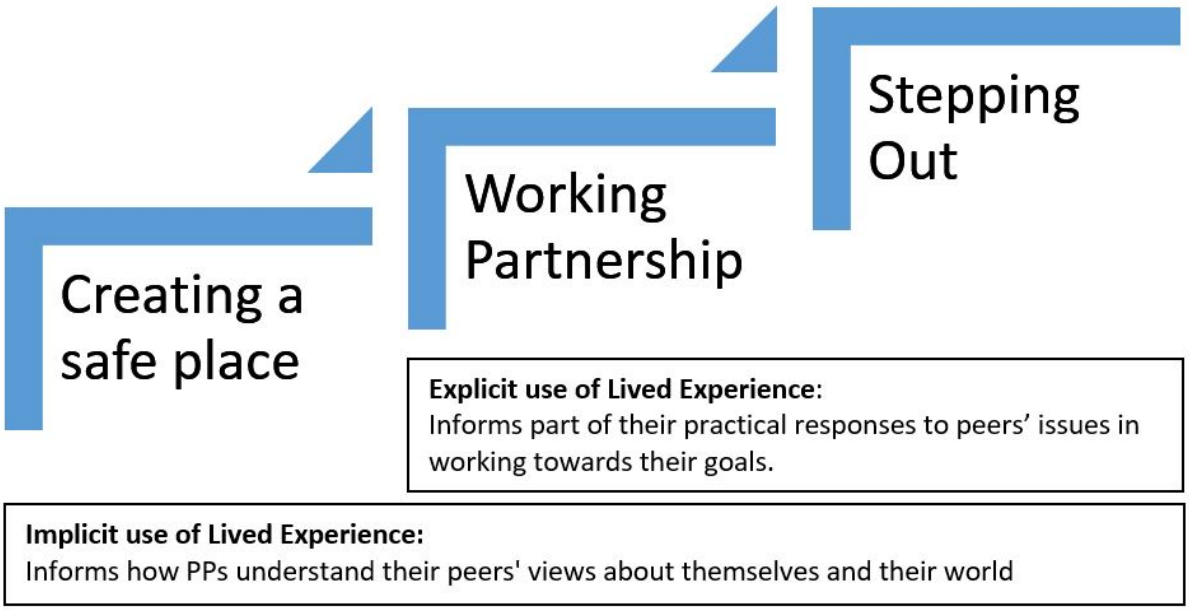
It is within this climate of mutuality that the peers' disclosure of emotionally salient experiences is divulged and reflected upon to bring about an integration of what happened with their emotional lives (Paivio & Angus, 2017). Meaning is generated as they begin organising their emotional experiences (Angus & Greenberg, 2011), to develop a new view of self and new outcome stories (White, 2004). It is necessary for PPs to embrace a phenomenological view of the helping process. This takes into account the peer's view about themselves and their worlds, and is geared towards the growth and integration of their life experiences (Brammer & MacDonald, 1999b). The findings also point towards PP as working in ways that are goal oriented with the peer. An important part of which is also recognising when peers are not wishing to be goal directed and how this may lead to the relationship ending.

Counselling and psychotherapy literatures suggest that the PPs' implicit use of experience to facilitate recovery is akin the role of wounded healers (Gilbert & Stickley, 2012). This paradigm focuses not on woundedness as a personal deficit but as an enhancement to the PP's capacity in offering an empathic response to facilitate recovery (Zerubavel & Wright, 2012). As fulfilling as it is for PPs to contribute through their roles, literature also signals that the emotional labour of peer provision can take on a toll on PPs resulting in stress, anxiety and burnout (Moran et al., 2013). However, there is a fine line between retreating to reflect on the influence of their own recovery on their peers; and advancing confidently in their practice knowing that they have healed sufficiently (Zerubavel & Wright, 2012). Hence, self-awareness and participating in reflective practice are vital to supporting the mental health of PP practitioners (Skovholt & Trotter-Mathison, 2014b). This suggests that affording opportunities and creating psychologically safe spaces will enable PPs to harness their experience of woundedness to work effectively with others in facilitating recovery (Zerubavel & Wright, 2012).

Implications for training and education of PPs

This model also highlights a number of topics that may be useful to help PPs understand how their lived experience may be used implicitly and explicitly (see Figure 7.2). Topics such as self-awareness; reflective practice; self-care; therapeutic use of self (which includes how to share their stories); building trust and understanding recovery is merited to enable PPs to establish and maintain trust with their peers as they progress within the model. Other topics such as behavioural goal setting; identifying and developing tools to recovery may be especially helpful in the working partnership phase.

Figure 7.2 Use of Lived Experience within the Stepped Model of Peer Provision



The trust that is built within a milieu of shared lived experience also speaks to the value of co-production in the training of Peer Providers. This involves the respect of lived and clinical experience between trainers; and mutual learning between trainers and trainees (as opposed the trainer getting the point across as an expert)(Watson, 2014).

Implications for mental health workforce development

The underpinning assumptions and approach of the model also raise important implications for professional education and workforce development in mental health. Rates of mental distress in university students being significantly higher than the general population (Stallman, 2010) presents an opportunity for educators to model a recovery practice that focuses on strength; self-determination; hope and empowerment (Deegan, 2002). This enhances the visibility and value of recovery practice to future generations of mental health practitioners (Prideaux et al., 2000).

Similarly in the mental health workforce there are individuals who also have lived experience of mental distress (Morse et al., 2012). As such, their insights gained from personal experience may bring a valuable influence on how they use language and interact with those traditionally called their 'clients' or 'consumers'. 'Professionalism' within psychiatry does not acknowledge this joint identity as a professional and person with lived experience. Nor would it necessarily be seen as an inevitable part of life that can enhance one's professional practice within the biopsychiatric paradigm (Bracken et al., 2012).

This model also advocates for organisational and supervisory environments that would broaden and deepen discussion for such professionals to reflect on how their lived experience has shaped their professional practice. Such environments call for an equal respect of both clinical and lived experience (Watson, 2014). Being individuals with clinical experience and lived experience, they operate in dual spaces, with greater power available to them as professionals (Cutcliffe & Happell, 2009). Operating in the shadow of biopsychiatry offers no space for this duality, but rather a binary of being either a professional (with clinical experience) or peer provider (with lived experience). When biopsychiatry is ready to move beyond the technical paradigm (Bracken et al., 2012), there is the possibility of a future where the place of lived experience and clinical experience merge, enabling professionals with lived experience to move between their experiences seamlessly within their professional roles.

Implications for workplaces

Given that their practice may not be orthodox or part of the organisational culture (particularly in traditional mental health services), it is imperative that additional courses be developed to support staff and organisations with the implementation of recovery (Watson et al., 2016). When mental health service staff develop the capacity to understand the person as a whole entity and appreciate the context in which that person sits, a culture that values the lived experience is cultivated (Harris & Fallot, 2001). In this way, it is hoped that PPs and their practice will be accepted and valued within the multi-disciplinary team.

Study limitations and implications for future research

This paper proposes a tangible framework underpinning daily Peer Provision Practice. This complements current practice models in peer provision. Peer Provision is grounded within a person-centred approach, which is inherently subjective. Hence, researchers cannot operate from the assumption that determining the effectiveness can be 'discovered' solely through quantitative measurement (Brammer & MacDonald, 1999a). Future research should include active co-production of research in the validation of this model. This can include descriptive accounts of practice that may comprise the employment of the narrative, psychoanalysis and cognitive frameworks and empirical testing.

Given the limited sample of 12 PPs recruited for this study, a sample bias may be present, limiting the generalisability of findings to peer providers in other settings, given that peer provision is varied (Salzer et al., 2010). Future research could also explore the dual role of mental health professional practitioner and an individual with lived experience of mental distress as a way of better understanding the importance of this duality and looking at emerging areas of 'new' practice within this area.

Conclusion

The research findings highlight that the practice of PPs follows a consistent pattern that is founded upon mutual lived experience, and operates synonymously with helping processes found in counselling literature (Brammer & MacDonald, 1999a; Levine, 2013). Given the conditions in which the peer enters into the PP relationship, Peer Provision is unique in that trust is built foremost on shared experiences, rather than professional knowledge of illness management. This challenges the current technological paradigm in which psychiatry is founded upon. Given that both most mental health practitioners have a lived experience or care for someone in mental distress personally, a corroborative approach in the education of health care practitioners is warranted. Such an approach affords equal respect for clinical and lived experience. This lends greater weight to co-production in the training and education of future mental health practitioners.

7.1 Summary

This chapter presents a model that demarcates the stages of the peer-provider relationship. Conceived from basic helping processes (Brammer and MacDonald, 1999a), this model highlights the importance of building trust in the milieu of lived experience to create a place of psychological safety: When relationships are viewed as supportive and trusting, peers have the flexibility of trying approaches without the fear of negative consequences. It also confirms peer provision as a social intervention: an intervention that enhances social connectedness and therefore, the mental health of a person (Saeri et al., 2018).

The chapter also validates the purpose of lived experience, highlighting its implicit and explicit use that is fundamental to the delivery of peer provision (Mead & MacNeil, 2006). Such use of lived experience makes peer provision an investment of emotional labour, requiring the peer provider to toggle between retreating to reflect on the influence of their own recovery in this process and advancing confidently in their practice. This points to the need for peer providers to have a psychologically safe space to enable them to do so.

7.2 Proposing a psychologically safe space through a multi-level approach

Such a psychologically safe space at its best needs a multi-level approach (summarised as beginning from a grassroots level to a government level (e.g.: through supervision) to an organisational level (e.g.: peer business meetings – where peer providers at different sites within the same organisation meet) to a sectoral level (e.g.: peer network meetings – where peer providers from different organisations meet to support one another), to a governmental level (i.e.: where peer provision is sanctioned by policy and funding) (Zeng, 2012). Table 7.2 summarises how psychologically safe spaces may be implemented at various levels.

Table 7.2 Multi-level lens to psychologically safe spaces

Level	Example
Grassroots	Supervision
Organisational	Peer business panel meetings: Where peers from different sites of the same organisation meet for support and professional development.
Sectoral	Peer network meetings: Where peers from different organisations meet for support and professional development
Governmental	Peer provision is sanctioned by policy and funding

Creating safe spaces at multiple levels enables a systemic approach to the integration of peer provision within organisations from within and externally. The next chapter provides an overview of the impact of policy on organisational culture and the delivery of peer provision services. It points the reader to the need for a cultural shift away from a medical model focusing on illness to a recovery model that is strength-based and honours the lived experience of peer providers.

Chapter 8 Organisational contexts and practice developments in mental health peer provision in Western Australia

While the previous two chapters focused on how peer provision contributes to recovery and the relationship between the peer provider and the peer, this chapter, presented in the form of an accepted paper, elucidates the impact of the organisational context on peer provision practice. Drawing from the accounts of peer providers, it compares the responses of interviewees in mental health services situated within the public mental health sector to those within non-governmental organisations. This paper highlights how organisational responses are constructed along a continuum ranging from co-option to adoption and answers the third research question which asks "In what ways does the organisational context influence the delivery of peer provision services?".

The manuscript was accepted for publication with the Journal of Health Organization and Management in 2020. An email confirming acceptance for this publication can be found in Appendix F.9.

Inclusion in the thesis as an author accepted manuscript has been approved by the Publisher according to the copyright agreement. Details of this agreement can be found in Appendix F.10.

Reference:

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Title

Organisational contexts and practice developments in mental health peer provision in Western Australia.

Abstract

Purpose – Over the past decade, the push for recovery-oriented services has birthed a growth in the recruitment of peer providers in mental health services: Persons who live with and manage their mental health challenges, and are employed to support persons currently using mental health services. The aim of this paper is to compare the responses of government and non-government organisations to the implementation of peer provision.

Design/ methodology/ approach – Employing a qualitative study design, 15 people who supervised peer providers, or who were strategically involved in peer provision were recruited using snowball sampling. Participants completed an in-depth interview that explored how peer provision services operated at their organisation and factors that shaped the way peer provision operates. The interviews were transcribed and analysed using Moore's Strategic Triangle. Synthesized member checking and researcher triangulation ensued to establish trustworthiness.

Findings – The way in which peer provision operated sat along a continuum ranging from adoption (where practices are shaped by the recovery ethos) to co-option (where recovery work may be undertaken, but not shaped by the recovery ethos). Political and legal mandates that affected the operational capacities of each organisation, shaped the way peer provision services operated.

Research Implications - The findings of the study highlight the need to reconsider where peer provision services fit in the mental health system. Research investigating the value of peer provision services may attract the support of funders, service users and policy makers alike.

Originality/ value – In employing Moore's strategic triangle to evaluate the alignment of policy (the authorising environment) with the operational capacity and practice of peer provision services (the task environment), this study found that the organisational response to peer provision is largely influenced by political and legal mandates externally. The successful implementation of peer provision is mediated by effective supervision of peer providers.

Keywords:

Moore's Strategic Triangle, Mental health care, Peer Provision, Australia

Introduction

Peer Provision: Setting the Stage

International pressure for mental health reform in the early years of the 21st century, saw the prominence of recovery-oriented services and the acceptance of lived experience expertise (Anthony, 1993; Bourgeault & Mulvale, 2006; Davidson et al., 2007; Gerrand et al., 2012). Recovery-oriented services typically fosters growth from mental distress through encouraging person orientation, person involvement and self-determination (Farkas et al., 2005). It acknowledges that recovery from mental illness is a personal, transformational and incremental process, where persons are viewed as active agents of growth rather than passive recipients of care (Davidson & Roe, 2007). It supports individuals to live "a satisfying, hopeful and contributing life despite limitations caused" by mental distress (Anthony, 1993, p. 527). It was within this shifting policy landscape that peer provision was birthed in North America, the United Kingdom, Western Europe, Australia, New Zealand and parts of Asia (Chinman et al., 2006; Lee et al., 2019; Meagher et al., 2018; Te Pou o te Whakaaro Nui, 2014; Vandewalle et al., 2018; Watson, 2014). Peer providers (also known as peer support specialists, peer support workers or lived experienced workers) are formally employed 'to provide increased opportunities of recovery for people whose lives are severely affected by mental illness [using] a strengths-based, recovery approach' through one-to-one and ongoing support (Bradstreet, 2006; Department of Social Services, 2013; 2018, pp. 21-22; Grace et al., 2017).

Like its international counterparts, peer provision services in Australia are situated within statutory (government) mental health services, non-government organisations and not for profit organisations. The range of organisations and organisational practice has led to challenges in guiding the introduction of peer providers in both policy and research. PPs work with consumers in hospitals, their homes and other services within the community, and take on a variety of roles such as: vocational support, social integration, education, recovery facilitation, community integration, accommodation support, transitional support and/or assisting people to access and manage social funds (Meagher & Naughtin, 2018; Watson, 2019a). Despite the acceptance of peer provision as an important aspect of recovery-oriented practice (Meagher & Naughtin, 2018), studies document consistently the organisational responses that have often undermined its inherent benefits. These include: not establishing the professional credibility of peer providers; the unclear description and operationalisation of peer provider roles; the stigmatising attitudes of health provider colleagues; lack of support for integrating and collaborating within multidisciplinary teams; and inadequate social and mental health policies (Rebeiro Gruhl et al., 2016; Sinclair, 2018; Vandewalle et al., 2016). Such response is not uncommon in Australia (Hurley et al., 2018; Kemp & Henderson, 2012).

Such challenges can be understood in light of the challenges to implementing recovery-oriented practice given the remit of psychiatric institutions to provide relief and stabilization of psychiatric symptoms(Hornik-Lurie et al., 2018; Shera & Ramon, 2013; Waldemar et al., 2016). These factors include: stigma coupled with a lack of a coherent ideology of what recovery looks like in daily practice, limitations in the operational capacity of wards to support recovery (e.g.: rapid patient turnover, crowded wards, increase acuity levels, physical structures that are limited in space in privacy), competing statutory obligations (e.g.: inability to offer treatment choice when person is admitted for compulsory treatment) and the prevalence of "the clinicians illusion" (the tendency to lower belief for recovery because of their engagement with the person at the most acute phase of their illness) (Shera & Ramon, 2013; Waldemar et al., 2016). Interestingly, the experiential impact of working alongside peer providers has been found to influence a humanistic and positive approach to patients (Hornik-Lurie et al., 2018).

To date evidence about the effectiveness of peer provision (PP) has focused on quantitative outcomes related to cost reductions to the health system and the personal health of those accessing peer support. The outcomes of note have included reductions in hospitalisation, overall symptoms, service satisfaction and quality of life measures (Lloyd-Evans et al., 2014; Pitt et al., 2013). However, findings from these studies are mixed and only provide a narrow view of the effectiveness of PP. Rather than investigating PP effectiveness in traditional ways, a different line of questioning may be appropriate. Approaches that investigate PP by drawing from local wisdom, the knowledge of context and the mechanisms of working may provide an alternative view of effectiveness (Berwick, 2008).

The organisational site as a focus of research interest about peer provision has received very little attention (Gillard et al., 2015). This study addresses this gap and aims to explore the organisational contexts where PP operates, covering both government health departments (PMHS) and other non-government organisations (NGOs). Organisations are key sites where policy is translated into practice; they play a crucial role in shaping practice in health and social services (Mitchell & Pattison, 2012). How these services are shaped is dependent on aspects of practice that are valued by the organisation (Mannion et al., 2005) and the goodness of fit between the organisation's values and its impetus to innovate (Klein & Sorra, 1996). Where there is a shared expectation of peer provider roles, the risk of dilution to the essence of PP is mitigated (Gillard et al., 2015).

Moore's strategic framework has been used (Moore, 1995) to examine how the policy environment influences organisational culture and practice across NGOs and PMHS. It assists in understanding how organisations change and promote public value. Moore (1995) argues that change within an organisation requires critical shifts in three key parts of the organisation: the authorising environment that affords legitimacy and support to services; the operational capacity that affords resources and support for services; and the task environment, which is the space in which services afford value to service users and the community. Moore's framework is built on an assumption that organisations are dynamic and changing; however, if there is not top down support legitmising an activity it is unlikely to be a valued and become a key part of an organisation. Moore's triangle was used as an analytical tool in this study because our early observations of the study sites indicated that PP was heavily mediated by the organsiational environment. Moore's approach offers a multi-level analysis of the organisation and can lead to a deeper understanding of how peer provision evolved in different organisations.

Methodology

Following ethical approval from Curtin University Human Research and Ethics Committee (approval number HR179/2011), we recruited people who supervised peer providers, or who were strategically involved in peer provision (eg. policy makers and leaders in organsiations). With this cohort we aimed to gain an understanding of the organisational contexts in which Peer Provision operated in the Perth region of Western Australia. Contact was made with programme managers in organisations that employed peer providers. Characteristic of the snowball sampling approach, the managers then recommended other people who fitted the criteria for our study and they were invited to participate (Atkinson & Flint, 2001).

Given that organisational settings vary in size, professional composition, authority structures, governance, organisational structures, culture, and purpose, it was anticipated that there would be some differences between peer providers' work experiences. Fifteen people from three public organisations; three NGOs and two independent organisations agreed to participate. Table 8.1 details the organisational context; the year peer provision was implemented and the role of each interviewee.

Table 8.1 Participant Profile

Organisational Type	***Public***			***Non-Governmental Organisations***			***Independent***
Organisation Code	*1*	*2*	*3*	*1*	*2*	*3*	
Year PP implemented	*2004*	*2007*	*2011*	*2006*	*2007*	*2006*	*2004*
Description (Participant Code)							
Supervisors (SUP)*	2						
Team Managers (TMNGR)*				2	1	1	
Peer Support Coordinator (PSC)*		1	1	1			
Program Managers (PMNGR)	1			1			1
Consumer Consultants (CC)							2
Project Officers (PO)				1			1

* Supervised Peer Providers

In addition to organisational type, other areas such as the length of time peer provision had been in place in an organisation also influenced peer practice. This afforded opportunities for services to evolve to the extent in which the organisation's leadership and staff (particularly supervisors and line managers) embraced recovery. This involved PPs as part of an integrated response to service users. It also involved appropriate levels of support for PPs. Such a response is indicative of organisational readiness in adopting the recovery orientation.

We reviewed literature on factors that enabled or challenged peer provision to inform the theme list used in the interview schedule. These factors included economic, political, organisational and social contexts in which peer provision operated; the relationships with service users and non-peer professionals; and the nature of the peer provision itself (Franke et al., 2010; Gates & Akabas, 2007; Gillard et al., 2013; Kemp & Henderson, 2012; Moran et al., 2013; Repper & Watson, 2012a; Vandewalle et al., 2016). The theme list was trialled with a colleague who has supervised peer providers and refined iteratively through the interview process with specific groups of interviewees. For example, interviews with policy makers and the consumer consultant focused on how policy and procedures were formulated and how they affected peer provision operations. Interviews with supervisors of peer providers focused on how these policies and procedures were enacted upon in their daily operations and interaction with peer providers.

Interviews with all participants covered two key questions: (1) what is happening in the operation of peer provision services? and; (2) what factors shape the way peer provision operates? The first author conducted all the interviews and began with a general question: “Can you describe your involvement with peer support?”. She then used probing questions such as “What are some of the needs you see in peer support workers as they perform their job? What is being done to meet their needs?” The in- depth interviews lasted approximately an hour and were conducted at the interviewee’s place of work. Participants were compensated with a modest cash gift voucher for their time. The interviews were digitally recorded and fully transcribed and participants were allocated codes to protect their identities.

A hybrid approach of inductive and deductive coding was used to develop themes from the interviews (Fereday & Muir-Cochrane, 2006). A set of codes based on the three elements of Moore's Strategic Triangle (Moore, 1995) formed the set of codes: (1) Authorising Environment; (2) Operational Capacity; and (3) Public Value (Task Environment). Codes were generated iteratively under these broad categories and divided into core and sub-themes. Each sub-theme was then determined according to whether the response indicated the adoption of a recovery ethos (where practices are shaped by the recovery ethos) or a co-option of a recovery ethos (where recovery work may be undertaken, but not shaped by the recovery ethos). Literature related to the recovery ethos informed this stage of the analysis (Australian Health Ministers Advisory Council, 2013; Bateman et al., 2014; Farkas et al., 2005; Grace et al., 2017). To establish trustworthiness in this process the second author coded a random selection of interviews. Differences in coding were then discussed and a conclusion was made as to which code was appropriate (Nowell et al., 2017). This was recorded in a memo in NVivo, a software application used to assist in the analysis (QSR International, 2018). In addition, synthesized member checking ensued, where participants were contacted by email, presented with synthesized data and asked to comment. This gave them an opportunity to evaluate the application of others' experiences to themselves. This process added a layer of reflection to their own experiences (Harvey, 2015).

Results

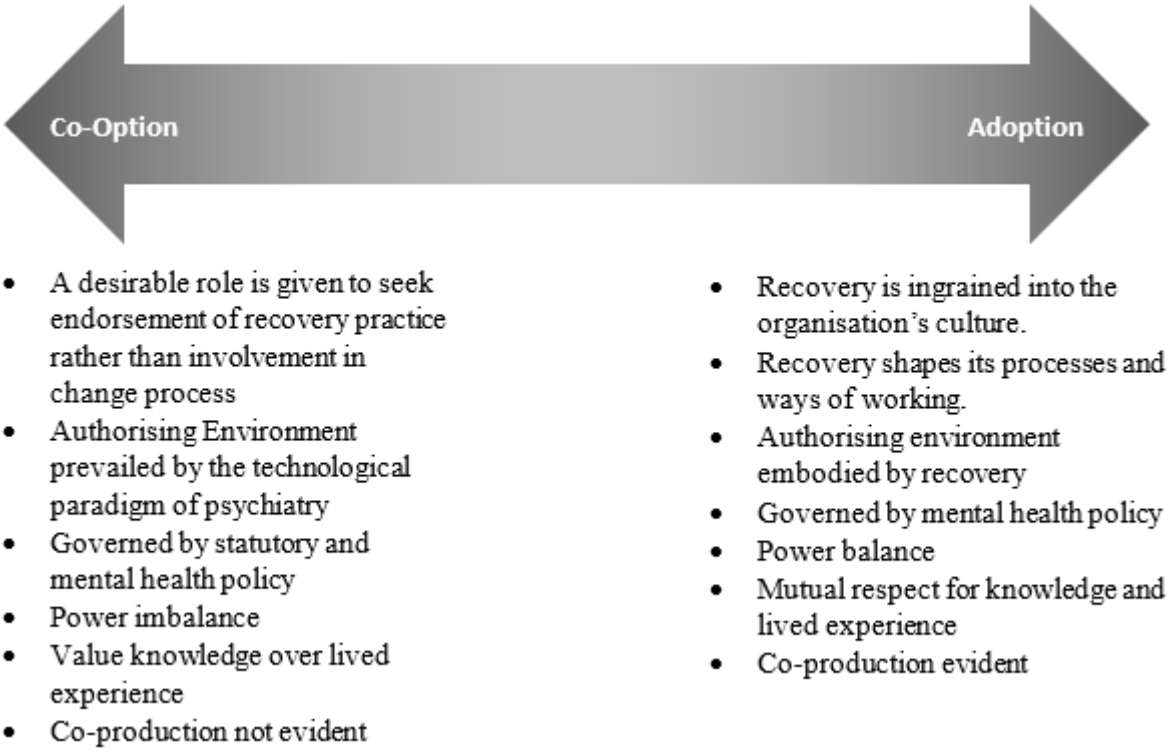
The analysis of the interview data revealed a wide range of how peer provision was operationalized in PMHS and NGOs. Consistent with Alberta (Alberta and Ploski, 2014) and Murphy's (Murphy and Higgins, 2018, p. year) work, it is proposed that peer provision fell along a continuum of co-option and adoption. On the co-option end, PP is largely a secondary 'add on' to the 'legitimate' work of mental health professionals: the PP role is viewed as an endorsement of recovery practice rather than a shift in dominant practice and organisational culture (Kotter and Schlesinger, 2008). In contrast, congruous with Murphy's description of peer directed organisations (Murphy and Higgins, 2018), recovery is subsumed into the organisation's culture and shapes its processes and ways of working, a term which we propose as adoption. To this end, peer provision is positioned as an integral part of the shift in organisational culture towards recovery.

Table 8.2 outlines the core and sub-themes determined through the analysis. The three core themes are based on Moore's Strategic Triangle (Moore, 1995): authorising environment, operational capacity and task environment (public value). The three themes are further divided into components that can be classified as either a form of adoption or co-option as described in Figure 8.1.

Table 8.2 Core Themes, Sub Themes and Reference Count

Core Themes and Sub-themes	Reference Count
Authorising Environment	
Adoption Response	
Champions	4
Policy	2
Recovery culture	4
Co-option Response	
Medical model/ Culture/ Stigma	8
Funding	2
Politics	2
Lack of champions	4
Operational Capacity	
Adoption Response	
Acceptance of Peer Providers	4
Advocacy by champions	1
Mental health management	4
Procedures supporting training and supervision	2
Co-option Response	
Lack of acceptance/ understanding of Peer Providers	6
Policies/ Procedures that may undermine PW values	2
Team structure	2
Cultural view of MH and MH management	2
Task Environment (Public Value)	
Adoption Response	
Strong leadership/ champions	1
Playing to PP's strength	2
Supporting peer's recovery	2
Upholding values of peer work	1
Recovery shaping perspectives/ values/ practice	2
Co-option Response	
Lack of acceptance in team/ micromanagement/ job scope/ by peers - Stigma	8
Lack of champion – PP and recovery work fizzles out	2
Mental health management	1
Mental health culture shaped by medical model & political forces (as opposed to recovery values)	3

Figure 8.1 Co-option Adoption Continuum



Authorising Environment of the Organisation: The role of legitimacy and support for peer provision

In this study, participants reported two key influences on the authorising environment that legitimised the embedding of PPs within organisations. Firstly, at the national level, the Personal Helpers and Mentors Programme (PHaMS) and Partners in Recovery (PIR) Programmes were funded through each state based Mental Health Commission (Researcher 01). Secondly, state government mental health commissions then allocated funds to both government and non-government organisations to deliver peer-based services. A consumer consultant (CC01) observed that these sources of funding "contributed greatly to the employment of peer providers, particularly within non-government organisations".

On the other hand, PMHS' required strong champions for peer provision in procuring federal funding for the service to be established. A consumer consultant (CC01) recounted an example of this: "[The Clinical Director]… employed new consumer and carer consultants - peer workers in that service. [When the director left], it fell by the wayside […] because there was a lack of higher leadership support for that." This response typified a co-option response. Although peer provision appears to be supported in state and national policy, the operationalisation of policies is largely dependent on the alignment of strategic leaders to it. This appears more pronounced in co-option organisations where the tension between recovery policies and legislation exists. Their makes their impetus to operationalize mental health policy even more critical.

Operational Capacity: Process and production of Peer Provision Services

Evidence of the operational capacity and task environment shifts were indicated by the employment and work practices of PPs. However, these varied across different organisations. Despite funding for both government and NGOs, the process and production of peer provision services differed. Co-option responses tended to operate in organisations whose structure and processes were founded upon the traditional medical model of psychiatry. Where operational capacities were mediated by regulatory, economic and institutional factors, models of care that disrupted medical power and practices were prevented from succeeding. PSC02 describes the circumstances in which this was the case: "I had to juggle the [organisation's] aims and all the policies and framework that we work with. Even within the [organisation] I couldn't just go off and do what I wanted…"**.**

On the other hand, co-production was evident in adoption organisations. Procedures included constituting the focus of a PP's work with their peer and documentation and discharge was formulated to guide the expectations of PPs in the service. Such procedures were formulated in "consultation with [PPs]" and "sought to enhance the role of PPs rather than place a constraint on them" or demand they fit in with existing ways of working (PO01).

Task Environment: Generating public value for peer provision

Collegial relationships

This introduction of PPs into the organisation highlighted a dissonance between the policy environment and the task environment. Despite prior preparation of existing staff for the introduction of PP roles, PPs were still met with resistance from non-peer colleagues and peers in some organisations. This was a response typical of co-option, where the organisation did not value the potential contribution of PPs (Burnett et al., 2010). Supervisors highlighted overt exclusionary tactics in the workplace such as the denial of PPs' access to case notes; physical resources (such as telephones and computers); and staff rooms (PSC02). Peers were also reluctant to receive services from PPs from co-option environments (TMNGR02). Whilst the policy environment had begun endorsing recovery and the role of PPs, this was not filtering into an understanding of peer provision within mental health services nor the wider community at that time. A manager's comment reflected the prevailing values of traditional paradigm:

> "..there is a whole culture in mental health for participants in the system and there is even a hierarchy of diagnosis … they have been … immersed in a culture that says, 'You're deficit, you're faulty, you're broken'. So then, [when] they are working with someone who has lived experience… they go 'oh you're giving me this person who is faulty and broken'." (TMNGR02)

However, resistance reduced as the team began to recognise the difference that PPs made to consumers: "… there was a little bit of resistance but … he made some amazing changes with people… he was very highly respected." (SUP02). It was evident that in adoption organisations recovery had made its way into the culture and redefined the way staff and consumers related to one another. As reflected by a manager: "Really it's hard to tell who is a [PP] and who is not … Because here we see mental distress or mental illness as a continuum from stress through to … what's defined as mentally unwell... They [community workers and PPs] are the same." (TMNGR02). This suggests the organisation described was operating at the adoption end of the continuum.

The differing cultures in turn influenced how organisations supported PPs in their roles. Two forms of support were identified: informational support and instrumental support.

Informational support.

Organisations have put into place informational support for PPs from induction through to training. Although both organisational types provided general staff inductions that constituted the organisation's mission, values, structure and practice, the nature and focus of these inductions differed. On one hand, a project officer in an adoption organisation (an NGO) highlighted staff inductions were designed with clear objectives that were specific to the anticipated development of PPs (PO01). This included: "acquainting [PPs] with local networks… visiting key agencies…; getting acquainted with key workers in those agencies" (PO02) and "shadowing various members of the team" (TMNGR02). In contrast, PP-specific induction in organisations that veered toward co-option consisted of more intense supervision apart from standard training with other staff (SUP02/ PSC02) such as clinical risk management.

Training in adoption organisations existed in two forms that were geared to enhancing the current skill set of PPs - supervision and in-house training. PSC01 described training in such organisations as "training …across different categories according to the needs [and] experience of the person… So when they first start out they will have [an] induction program and then something that builds onto that…" In contrast, training in co-option organisations occurred at an organisational level through "mandatory training" (PSC02) with non-peer employees. Organisational acumen and confidence in the PP role came from the supervisory relationship. This is discussed in greater detail in the following sections.

Instrumental Support: The Pivotal Role of the Supervisory Relationship.

As described earlier, supervision played a crucial role in the task environment, affording information, instrumental and emotional support. This enabled PPs to generate the value of their service that matched the worth of their lived experience. The instrumental support for PPs in both organisational types reflected a balance between the willingness to work with mental health challenges and meeting daily operational needs. For example, TMNGR01 described her support in the form of reasonable accommodation for a PP's sleep patterns: "… though she came to work then, she needed to go and have a bit of a lie down in the afternoon. So we had a like a roll up thing there so she did book off for … a few hours and go and have a bit of a sleep". Other forms of instrumental support (particularly in co-option organisations) were targeted at integrating PPs into the organisation. In the words of PSC02: "I personally would go to the wards and … introduce the [PPs]… I was the link between the [PPs] and the clinical teams." Supervisors also played a crucial role in affording emotional support to PPs, particularly in co-option organisations. The close proximity and availability of the PPs' immediate supervisor served as a platform for supporting PPs; discussing day to day issues (eg: boundaries) and affording opportunities for debriefing to occur. As described by TMNGR01:

> *"*I think one of the important things for me as a supervisor was to be … there frequently when the peer worker needed support or wanted to ask questions… we managed to get him to sit next to me in the clinic… just having that conversation just first thing in the morning …we were able to discuss that and find a way through, so that worked out very well."

In contrast, supervision in adoption organisations occurred at different levels. These included: individual supervision; team supervision (during which supervision could be contracted to external experts); and internal peer network meetings through which more mutual support amongst PPs occurred (PSC01 & MNGR15). Reflecting a constructive organisational culture, PPs were supported by the wider team rather than the supervisor alone.

Mental Health management.

Managers mentioned that their greatest concern was the mental health of their PPs, which brought challenges to managing clients. Described by TMNGR03:

> "… the current peer [provider] that we have …probably half that time she's been off for both physical and mental health reasons so it's very hard to… say to a client 'yeah it would be a really good idea to connect up' when you don't know [when they will return/ leave]."

Procedures to support a PP in a health crisis also differed between organisations. Although mental health management in co-option organisations was formalised through Ulysses agreements (written documents describing the treatment an individual wants/ does not want should they be judged to be incapacitated from mental illness), participants who supervised PPs veered towards cultivating an open and honest relationship. They sought to understand their PP's stressors, triggers and early warning signs rather than relying on formal documentation. As articulated by a supervisor:

> "…for myself and [the PP] … she's actually feels really open in coming to me to let me know what's kind of going on for herself … she [felt that she] didn't … need to formalize that … so that's … what we are… working with at the moment and I kind of trust that she will do that…" (SUP01)

In contrast, in line with the view that mental distress occurs along a continuum, well-being plans have been put in place for everyone in adoption organisations. TMNGR02 recounts: "some of the processes we put in place initially for peers we've actually adopted [for non-peer workers]… all of us have a wellbeing plan which is about maintaining and monitoring your own personal wellbeing at work...".

Discussion

In the context of this Australian study the funding for peer provision emerged as a means of implementing the national mental health policy (Council of Australian Governments, 2008). However, this research demonstrates that the organisational context of mental health services is critical to the implementation of peer provision, regardless of policy intent. For example, even though Australian peer provision was founded under the guise of the Partners in Recovery Programme (PIR), the Australian government mandates that "PIR is not intended to offer a new 'service' in the traditional sense... PIR will provide a 'support facilitation' service focusing on building pathways and networks between sectors, services and supports needed by the target group" (Department of Health and Ageing, 2012, pp. 4-5). Whilst such a mandate has resulted in peer provision services; they appear to operate differently in organisations. Our research demonstrates that the main contributor to such a difference is the type and remits of the organisation (PMHS or NGO). Although both PMHS and NGOs are directed by recovery-oriented mental health policies that focus on community support, PMHS are also influenced by the statutory requirements enshrined in the Mental Health Act that include the detainment of citizens (Western Australia Mental Health Act, 2014). PMHS are part of large government legal-rational bureaucracies and NGOs vary in size from large nationally federated organisations to smaller sized specialist organisations that have differing forms of governance to that of PMHS.

The findings of our study indicate that recovery-oriented and statutory policies guiding mental health practice have the power to shape the organisational culture, the associated workforce, and the operational capabilities of organisations that employ PPs. The authorising environments influencing these organisational types have affected the operational capabilities of mental health organisations and subsequently the task environment for peer provision. However, the extent to which the principles and knowledge underpinning the recovery paradigm influenced existing organisational practices varied. NGOs, characterised by a culture that was quick to adapt to external demands (Ogbonna & Harris, 2000) were more likely to make shifts in how the organisation operated. In contrast, the introduction of PPs into PMHS did not disrupt organisational practices that were influenced by the pre-existing dominant medical model. This is characteristic of a closed practice culture (Collier, 1998), Over time, there have been indicators of change and incremental shift towards embracing recovery-oriented practice. These adaptions were slow in PMHS compared with NGOs where the mission was more aligned to a recovery orientation.

Such a contrast highlights an epistemological chasm between the technology of psychiatry (based on positivist knowledge) and the expertise of lived experience (based on interpretivism). The former, however, is being challenged as it precludes other non-specific factors (eg: sociocultural) that account for 85 percent of the variance on therapeutic outcomes (Bracken et al., 2012). Our research suggests that although there is a growing acceptance of peer provision practice and understanding, its integrity or value may be diminished in contexts where positivist medical research is viewed as the preeminent form of legitimate knowledge (Murphy & Higgins, 2018). Whilst a continuum exists in practice, the epistemology on which practice is founded remains dichotomous with its strong and influential advocates.

Our study supports the argument of Grace (2017) that statutory policies have dominated the authorising environment of PMHS. As these statutory policies confer procedural power to mental health practitioners, recovery-oriented practice is either advanced by these practitioners or hindered. This explains why an 'implementation gap' occurs, whereby the intentions and expectations of mental health policy directions are not realised when implemented in practice (Proctor et al., 2009). This state is described as "mission stickiness" (Moore, 2000, p. 192), where organisations stay committed to the dominant medical model despite a change in their task environment to be more recovery-oriented. Such a phenomenon is evidenced in our study by the lack of autonomy in the implementation of PP services; the reluctance of the task environment (ie: organisational ways of working) to change; and the dependence on the supervisor in mediating between the PP in co-option environments.

In contrast, organisations where operations have not been dominated by statutory requirements (Dent, 1993; Suchman & Edelman, 1996), showed a greater adoption of recovery-oriented policy and approaches. Hence, these policies filtered down more readily into the task environment of peer provision. In addition, these organisations tended to operate from a psychosocial framework in which the tenets of recovery (eg: hope and the facilitation of social relationships) exist as necessary conditions for effective rehabilitation (Australian Health Ministers Advisory Council, 2013). This is evidenced in our study by the co-production of procedures; the layers of support that extended beyond the immediate supervisor; and reasonable accommodation in support of the PP's recovery.

As illustrated in Table 8.3 below, the paradigms from which the co-option and adoption responses operate are reflected in their purpose, outcomes, service models and human resourcing.

Table 8.3 Models of Practice in Mental Health

	Medical Model	Psychosocial Rehabilitation Model	Recovery Model
	← Co-Option		Adoption →
Purpose	Amelioration of symptoms	Resumption of roles	Developing a new meaning and purpose in life beyond mental illness
Desired outcome	Symptom improvement	Functional improvement	Living a satisfying, hopeful and contributing life even with limitations caused by illness
Service Model	Practitioner-driven	Client-centred	Person-centred
Human resourcing	Mental Health Practitioners	Mental Health Practitioners and Peer Providers in service delivery	Peer Providers at all levels of the organisation

(Anthony, 1993, 2000; King, Lloyd, Meehan, Deane, & Kavanagh, 2012; Sadock & Sadock, 2007)

Our study demonstrates that when leaders in the mental health sector authorise a recovery-focused orientation in their organisations, the whole "business" of peer provision is legitimised. For NGOs who provide psychosocial rehabilitation services as a core business (Australian Institute of Health and Welfare, 2018), outcomes are easily aligned to the recovery rhetoric (McKenzie, 1994). Therefore the "technologies" necessary (ie: people with lived experience) to produce recovery-oriented services such as peer provision are more readily accepted (Moore, 2007). In contrast, the technology of psychiatric medicine already exists in PMHS and is fuelled largely by the medical model, statutory policy and pharmaceutical interventions. In order for PPs to gain ground in these organisations, their practice requires support from both strategic leaders responsible for translating policy to practice; supervisors and colleagues.

The generic training of PPs in co-option environments also corroborates with Alberta and Ploski's findings (2014) that point to the acculturation of PPs into professional cultures in co-option organisations. This results in the undermining of peer support values and moves PPs toward professional models of service provision that align with statutory policies rather than the recovery rhetoric.

Implications for Policy and Service Structure

Writers have previously presented the notion of peer provision as being either co-opted or adopted (Alberta & Ploski, 2014; Murphy & Higgins, 2018) in mental health organisations. Our findings suggest that this dichotomy exists within an Australian context. However, organisations are not static. As peer provision becomes part of the organisation a continuum develops over time. For example, data from co-option organisations indicated that supervision and willingness to accommodate PPs evolved as the value of their contribution became evident.

The dual roles of PMHS to implement statutory requirements and recovery-oriented responses requires organisational balancing of what can appear to be competing expectations. The statutory requirements have a longer history than the work of peer provision, which means that this responsibility is better known and developed within the PMHS. In understanding this situation as one of dual expectations rather than contradictory activities the notion of dichotomous choice is disrupted. By contrast we can better appreciate there are a range of responses within organisations that have differing origins and approaches. We do not dispute that the traditional medical model holds a more privileged position within the organisation than a recovery-oriented approach, but we do argue for a valued co-existence. Based on the notion of co-existence, our study results suggest changes are required.

Whilst we acknowledge that the rapidly changing mental health landscape has impacted organisational leaders (Frawley et al., 2018), we propose that they consider decisions about supervision, support and line of reporting for PPs be based on their expertise in recovery and lived experience. Since “considerable work remains to be done to embed the values of peer support into systemic cultures… [where] a philosophically incongruent host environment [leads to peer providers] experiencing a diminished sense of power” (Murphy & Higgins, 2018, p. 444). This limits PP’s capacity to influence the quality and type of care provided even within their own portfolios (Voronka, 2017). Further to this, leaders in such organisations may benefit from an engaging leadership model, that focuses on empowering members in the team to demonstrate leadership qualities themselves (Mitchell & Pattison, 2012). Such teams are typified by connectedness, teamwork and collaboration. These types of shifts in orthodoxy of organisational practice take time to change, but with cultural change PP is likely to have greater traction in PMHS in the future.

Our study demonstrated that NGOs that deliver PP do not confront the same level of dominance of the traditional medical model and associated resistance to recovery orientations. We suggest that PPs, when commencing employment, may benefit from working in NGOs where peer supervision, support and reporting for PPs exist. Being based within a peer-run organisation creates a relational space in which individuals can "consider and construct alternative aspects of their identity and relationships… [empowering people within to] challenge each other, to rethink the lens through which they understand and give meaning to their experiences, including the language they use to describe it" (Murphy & Higgins, 2018, p. 442).

Taking this approach further, we propose that peer provision services may be contracted out to public mental health services (Eg: emergency departments; acute, open and forensic wards; Alcohol and Drug services; community mental health services) to provide appropriate recovery-oriented support to consumers who enter/ use the service. This calls for the development of a constructive-developmental cultures in organisations. i.e.: Team - empowering cultures whose processes are creative and adaptive, to promote greater intersectoral collaboration within the mental health system (Mitchell & Pattison, 2012).

When PP work is done within the NGO but connected to PMHS there are greater possibilities for safe spaces and more equal relationships. This model of service may provide opportunities to reconstruct narratives that connect PPs to their peers in meaningful ways. The value and cause of peer provision should be preserved and mental health consumers should receive the optimal benefit of recovery-oriented service provision envisioned by mental health policy.

PPs should function in an authorising environment in which peer work is legitimised and valued. Fully realised peer provision also has the added advantage of focusing on the co-production of policies and procedures that support the service of peer provision, to enable PPs to operate optimally within their environments and peer work values. In addition, co-production has been reported to help in PP's confidence; self-esteem and their personal recoveries (Repper & Carter, 2011; Stone et al., 2010). Strategic leaders may consider funding organisations that focus on PP separately from services that fulfil statutory obligations.

Implications for Research

This study contributes to the paucity of literature documenting and comparing the perspectives and experiences of diverse stakeholders involved in peer provision services. Although the 15 persons interviewed were not recruited from all services employing PPs (including NGO or PMHS), the persons interviewed would have covered the majority of peer provision services within the state and hence is representative of a typical peer provider service in Western Australia.

The need for situating peer provision outside PMHS concurs with Gillard's recommendations in support of peer provision as a complement to existing clinical intervention in the PMHS (Gillard, 2019). However, such an arrangement has yet to be evaluated for the design of peer provision roles and its impact on the health and well-being of peer providers and non-peer staff alike. This may be examined across six domains: demands, control, support, relationships, role and change (Health and Safety Executive [HSE], 2019).

This study also highlighted the tension between the philosophical tenets of peer provision and the organisational culture in which it sits. This points to the need for further research employing qualitative and quantitative methods to measure the fidelity of peer provision practices to peer provision values (Gillard, 2019).

Conclusion

This Australian study has provided an insight into the provision of peer services in mental health services. The findings of the study indicate that the differences in organisations' histories, structures and associated authorising environments have had tangible and differing impacts on how PP practice has developed in adoption and co-option environments. In this study NGOs have not had the legacy of the traditional medical model and have had more autonomy to develop PP services, creating an adaptive externally oriented culture. Peer providers in these organisations have described different experiences of commencing work as the environment was supportive and they felt valued in their roles. PP services in PMHS commenced within the remit of the traditional medical model. There was much variation across PMHS organisations in how PP was viewed and how peer workers were treated and viewed by both colleagues and peers using the service. This seems to reflect the constraints of the authorising environment that is antithetical to recovery or at best, in a minority position. The attitudes of non-peer health professionals toward the role of PPs have shifted in PMHS over time. However, attention must be given to prevent the co-option of PPs and preserve the authenticity and value of peer provision within organisations. This calls for a context-specific approach to the operation of peer provision services within a constructive-developmental organisational culture. Strategic leadership may benefit from the use of Moore's strategic triangle to proactively develop organisational policies and practices that support the development of peer provision, leading to better outcomes for service users in the future. The findings will hopefully be of relevance to other Western settings where both recovery and peer provision are emerging and developed.

8.1 Summary

What is clear from this chapter is that the growing acceptance of the formal use of lived experience in mental health care challenges the status quo of traditional mental health responses, particularly in public mental health services. One of the key factors that shape the challenge is organisational remit. Whilst non-government organisations are guided largely by mental health policy, public mental health services are obliged to adhere to statutory requirements. These requirements are antithetical to the tenets of recovery espoused by mental health policy.

The next chapter explains how policy is mediated at each layer of management to effect peers. It then discusses how organisations may be geared towards recovery using Kotter's eight-step model for leading organisational change. It also makes a case for the value of lived experience in mental health practice, and the need for peer providers to be seen as leaders of their peer and of themselves. It then highlights the alignment of peer provision to person-centred practice and concludes with some limitations to this study and implications for future research.

Chapter 9 Discussion and Conclusion

This study aimed to understand the factors influencing the development of peer provision as an emergent form of mental health practice that is underpinned by the principles of recovery. It was anticipated that because peer provision does not sit within the traditional medical model and hierarchy, that it would be under greater scrutiny. This contributes to the peer provider's sense of obligation to demonstrate their effectiveness in order to be viewed by mainstream health professionals as credible. Therefore, this study took a multifaceted approach to understand the practice of peer provision through the eyes of organisational leaders, consumer advocates, peer providers and peers.

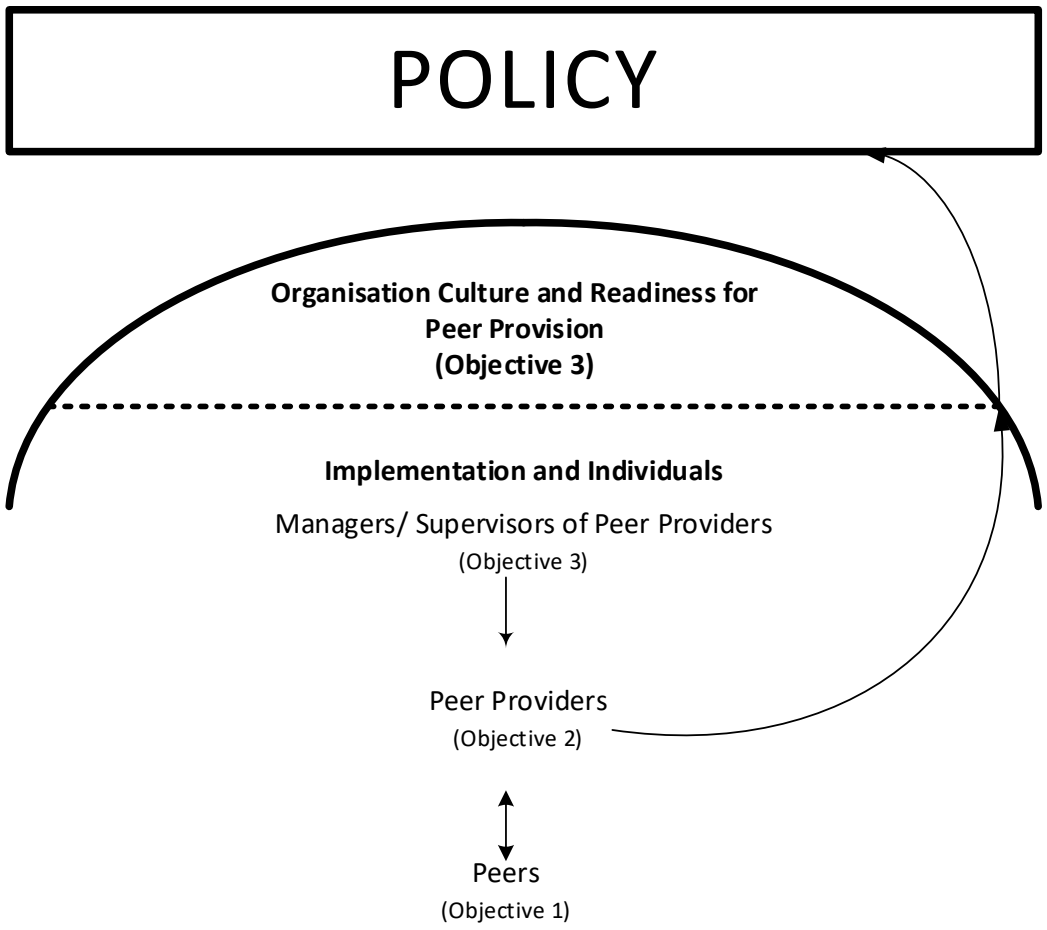
Drawing on interpretive phenomenological methods, this thesis explored how peer provision is practised and experienced across different organisational contexts which also required an examination of how it is constructed and implemented in policy and organisations. The objectives of this study were to:

1. Document how the peer provision relationship helps support peers in their recoveries.
2. Explore the dynamics of the peer provision relationship.
3. Examine the influence of organisational context on the delivery of peer provision.

This demanded a multimethod study design that ranged from understanding and documenting everyday practice and experience through to the macro aspects of policy and organisational decision making and implementation. This is represented in Figure 9.1. As shown in the figure, such a flow-on effect from policy to the service user for whom the policy is intended is mediated by several layers: the organisational culture and readiness for peer provision; the managerial layer; followed by the service provider (the peer provider) and finally the service user (the peer). To examine this flow-on effect, the discussion will begin by addressing the third objective and work its way to the first objective.

Using Figure 9.1 as a structure for this chapter, the discussion begins by drawing from the work of Mark Moore (2013) to elucidate the mechanisms of how policy is mediated at each layer of management to effect peers (the service user). The chapter then makes a case for the value of lived experience within mental health services and highlights the importance of peer providers being viewed as leaders of themselves and their peers. In addressing the second objective, the chapter then delves into discussing the value of lived experience and argues for its rightful place within mental health practice. Moving to the first objective, a case is made for the need for peer providers to be seen as leaders in their own right, thereby highlighting the importance of self-leadership in preserving personal wellness and reducing work stress (Furtner et al., 2018). It then highlights the alignment of peer provision to person-centred practice, which is foundational to delivering high-quality mental health care. This chapter concludes with some limitations to this study and implications for future research.

Figure 9.1 Effect of Organisational Context on Peer Provision



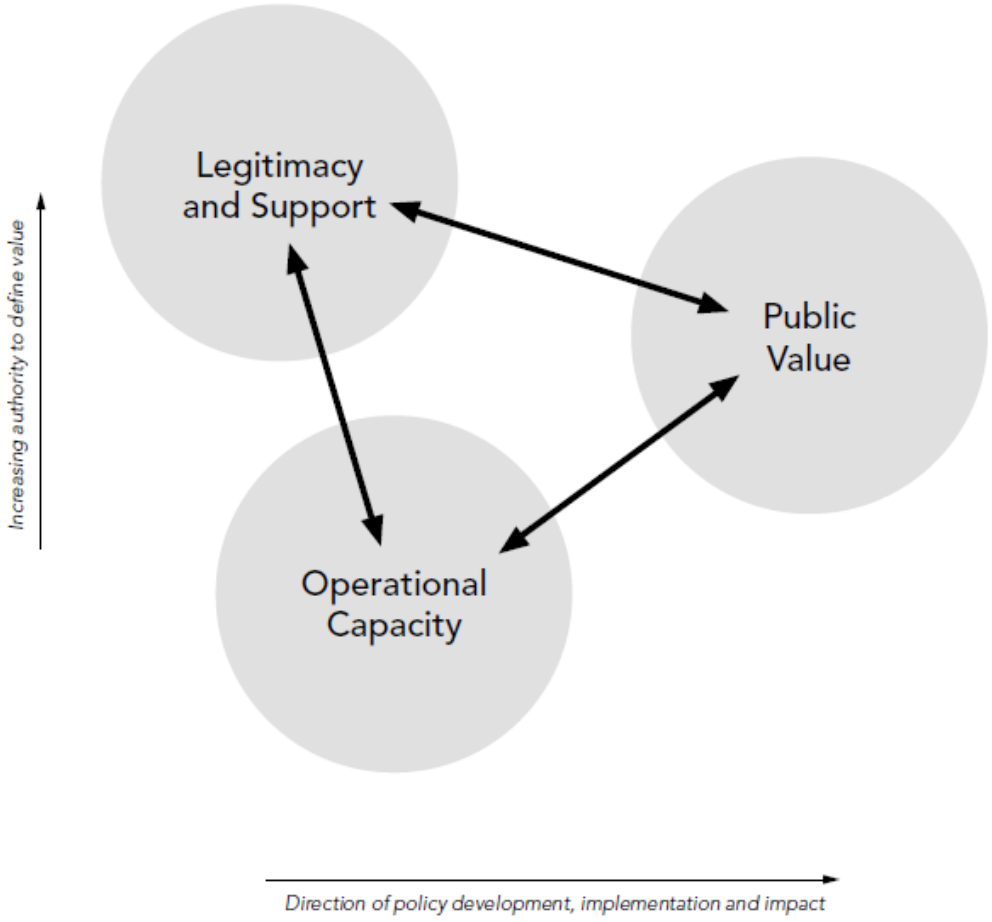
9.1 The implementation of contemporary mental health policy: The development and funding of the peer workforce.

This thesis demonstrated that although there was strong support for peer provision in mental health policy, organisations were differently placed in their understanding of recovery and the extent to which they integrated peer support into their mental health service delivery. This was evident in Chapter 7 where the variations in how peer support operated across different organisational sites was presented. Whilst NGOs started from the paradigm of psychosocial rehabilitation which creates an advanced state of organisational readiness (see Table 8.3), their public sector counterparts began from the paradigm of the medical model and also have to accommodate the statutory obligations of the West Australian Mental Health Act. The development of recovery-oriented practice, such as peer provision, was hampered in public sector organisations where statutory obligations were often prioritized over the goals of recovery.

By moving constantly in and out of the data, using the hermeneutic loop as discussed in Chapter 4, it became apparent to the researcher that what happened at a systemic level impacted peer provision at a practice level. Interestingly, whilst policy was pushing peer provision and organisations were taking up peer provision through the PHaMS and PIR funding (discussed in section 1.5), what the policy could not have accounted for was the readiness of the organisation to embrace the recovery-oriented practice embodied in peer provision. Moore' Strategic Triangle (Moore, 1995) was a useful conceptual tool to help examine such variation and explain how practices differed across organisational contexts.

Moore's Strategic Triangle (Moore, 1995), introduced in Chapter 6 offers a multi-level analysis of the organisation's impact on peer provision development. It highlighted how wider policies in mental health (i.e.: the authorising environment) legitimize and politicize peer provision (a producer of public value), which enables the service to become operationally and administratively feasible (operational capacity) (see page 143). By elucidating factors that contribute to peer provision that are external and internal to the organisation (Alford & O'Flynn, 2008), this model highlights the work needed to create conditions for management that is guided by recovery-oriented values (Moore, 2013).

Figure 9.2 Moore's Strategic Triangle



Adapted from "Mayor Anthony Williams and the D.C. Government: Strategic Uses of the Public Value Scorecard," by M.H. Moore, 2013, *Recognizing Public Value*, p.103. Copyright 2013 by Harvard University Press.

There is a large number of policy and organisational studies that report on the problems of the 'implementation gap' whereby the intentions and expectations of policy directions are not realised when implemented in practice (Proctor et al., 2009). In line with McConnell's view that such policy success and failure exist on a range of absolute achievement to absolute non-achievement (McConnell, 2015), this study found that peer provision services operated along a continuum of co-option and adoption, which reflected the integration of the recovery ethos into organisational practices (see Figure 8.1). This corroborates with Jones et al.'s (2020) findings of variations in organisational climate and support for peer providers.

The adoption of peer provision roles into an organisation was primarily shaped by how organisational practice was influenced by the recovery ethos (see Chapter 7). At the adoption end of the continuum, the recovery ethos is legitimised through the sanction of recovery practices by strategic leadership. Without the additional statutory requirements (Dent, 1993; Suchman & Edelman, 1996), recovery-oriented policy supports existing operational capacities of adoption organisations. Hence, these policies filter more readily into the task environment of peer provision. This is evident in the task environment through indications such as an equal balance of power between peer and non-peer staff, mutual respect for knowledge and lived experience, the co-production of procedures, the layers of support that extended beyond the immediate supervisor; and reasonable accommodation in support of the peer worker's recovery. As detailed in Chapter 6, this enables peer providers to support the recovery of their peers through connection, fostering hope, identity and meaning in life, and empowerment. In addition, these organisations tend to operate from a psychosocial framework in which the tenets of recovery (e.g.: hope and the facilitation of social relationships) exist as necessary conditions for effective rehabilitation (Commonwealth of Australia, 2013).

Conversely, when organisational practices were less influenced by the recovery ethos, *co-option* of peer provision roles tended to occur. At this end of the continuum, the influence of the authorising environment became apparent. Organisations which co-opted peer provision into their service structure were observed to be services that had a more complex authorising environment that included statutory obligations and accountabilities to implement all aspects (including the coercive aspects) of the WA Mental Health Act. 2014. Some aspects of the Act are premised on a bio-medical understanding of mental ill-health. As a result, psychiatry holds procedural power inherent to medicine in ways that can hinder advances in recovery-oriented practice. This may include: depriving a person of their liberties; lessening criminal conviction; and declaring one unfit for their vocation (Kraan, 2006). Therefore, the authorising environment (Mental Health Act compliance and Mental Health Policies with a recovery orientation) of public mental health services requires the organisation to meet multiple accountabilities that can be in tension, limiting the operational capacity in implementing recovery-oriented mental health policy. Consequently, the task environment within the co-option organisations has not changed significantly despite the presence of the recovery ethos in state and federal mental health policies (authorising environment). From an ontological perspective, the obligations of the Mental Health Act 2014 reproduce and support the medical hierarchy, given the accountabilities that are enshrined within it (e.g., the detainment of individuals). This maintains the status quo of the existing organisational structure, hierarchies and status that is characteristic of the traditional paradigm of psychiatry (Bracken et al., 2012). Such a task environment is characterised by power imbalances favouring professional staff, the valuing of knowledge over lived experience, a siloed way of working and a lack of co-production, which are characteristic of co-option organisations (see Chapter 8).

The policy shift from a solely biomedical model to one that includes the recovery ethos has shown that organisations sit along a continuum with the funding and development of a peer provision workforce. This points to the role of organisational dynamics in enabling or inhibiting change (Dalmas & Azzopardi, 2018). Whilst some organisations may have an entrenched culture such as those leaning towards co-option, cultural change is still possible. This requires traditional government mental health services to respond to the dual demands of their authorising environments that include both statutory requirements under the Mental Health Act and recovery-oriented practice.

9.2 Peer Provision: The use of lived experience in mental health

The earlier discussion on infusing change into organisations speaks to a need for the alignment of policy with organisational readiness. Unless organisations are well equipped to implement policy, policymakers can expect disparate ways in which peer provision is operationalized in practice, which has been the case in public mental health services and non-government organisations (Davies & Gray, 2015; Zeng & Chung 2020). This, in turn, results in outcomes that are different from expected policy outcomes, which has been the case for Western Australia.

A few factors can still mediate the successful operationalisation of peer provision in organisations that are less recovery-oriented. The first of these is the personal factors related to the peer provider. From interviews with professional/ organisational stakeholders (see Chapter 8), the researcher learnt that peer providers who were able to stand against the tide of resistance and proved their worth in the work that they did with their peers eventually won the respect of other colleagues and staff (Zeng et al., 2020). Patterson et al. (2009) highlighted that such persons are characterised by the possession of domain-specific knowledge (i.e. integrates recovery and lived experience), intrinsically motivated, open to experiences, take the initiative and are socially competent. Secondly, interviews with peer providers and professional/ organisational stakeholders highlighted the importance of supervisors in playing an intermediary role in bridging the peer provider to the multidisciplinary team (see Section 7.1 and Chapter 8). Regardless of the type of organisation (or organisational culture) that peer providers were working in, the essence of the peer provision relationship did not change (Zeng & Chung, 2020).

In turning to the second objective of this thesis, this section examines the dynamics of the peer provider-peer relationship. In so doing, this study formulated a stepped model of peer provision to capture the logic, foci and methods of peer provision practice (see Chapter 7). Based on trust as a key foundation to developing a valued relationship (Zeng & Chung, 2019), this model demarcates the stages and reflects the non-linearity of the peer-peer provider relationship (see Figure 7.1). In this model, peer providers begin from creating a safe place in which peers have engaged actively in the recovery process without the fear of negative consequences to themselves, their reputation or their journeys (Kahn, 1990). They do so by utilizing their lived experiences in a timely and appropriate way, so that peers feel at ease, heard and valued and empowered. It is within this empowering, supportive relationship that peers begin to work towards their goals till their time or work with their peer provider concludes. This scenario is characteristic of adoption organisations described in Chapter 8.

The dynamics of the peer provider-peer relationship are primarily shaped by the paradigm from which organisations operate (Zeng et al., 2020). Whilst adoption organisations operate mainly from the recovery ethos, co-option organisations tend to operate from the traditional psychiatric (medical) model. The implicit and explicit use of lived experience stood out as one of the fundamental features of the peer provision workforce (Zeng & Chung, 2019). Peer providers drew from their lived experiences implicitly to help them understand the peer's views about themselves and their world. They also drew from their lived experience explicitly in their practical responses to their peers' issues when working towards their goals (see Figure 7.2). Such use of experiential knowledge is respected and encouraged in adoption organisations. However, experiential knowledge is juxtaposed by expert scientific knowledge espoused by psychiatry, that is a more prominent characteristic of co-option organisations.

In contrast to the recovery-oriented mental health policy (Commonwealth of Australia, 2013), the Mental Health Act (Government of Western Australia, 2014) which contains the statutory role of mental health services and the associated roles of professionals dominates the authorising environment of co-option organisations (Grace et al., 2017). This study suggests that although lived experience is gaining credence in service delivery, there is an underlying implication that lived experience is marginal and does not constitute expert scientific knowledge, i.e., legitimate knowledge (Zeng & Chung, 2019).

Such expert scientific knowledge contrasts with peer providers developing knowledge in interaction with peers that is valuable to the organisation's responsiveness. Such 'local peer provision' knowledge is characterised by its orientation to the person; its phenomenological construction; its goal to make the tacit explicit. Such knowledge is often discounted by those who adhere to the psychiatric discourse that is characterised by 'expert' knowledge. This is likely to include those in positions of management and senior clinicians, both of which have power and influence. Yanow's (2004) work on the ways in which organisations resist and reject local knowledge by privileging only expert knowledge highlights the ways in which the two types of knowledge emerge and are differentially valued in the organisation. The first column in Table 9.1 below has been adapted from Yanow's work and is contrasted with the 'local' knowledge characteristic of peer provision developed from the findings described in Chapter 7.

Table 9.1 Comparison between the Characteristics of 'Expert' and 'Local' Peer Provision

'Expert'	'Local' Peer Provision
Theory-based	Person-based/centred
Abstracted, generalized	Person and context-specific
Scientifically constructed	Phenomenologically constructed
Academy-based	Lived experience-based
Technical-professional	Practical reasoning and self-awareness
Explicit	Tacit made explicit
Scholarly	Everyday

Note. Adapted from "Translating local knowledge at Organisational Peripheries," by D. Yanow, 2004, *British Journal of Management*, 15(S1), S12. Copyright 2004 British Academy of Management

The discourse above suggests a juxtaposition between public legislation and recovery-oriented mental health policy. The basis of public legislation stems from psychiatry. This is underpinned by an information processing model in cognitive psychology (Fernando et al., 2013), which leads its partisans to practice, assuming that mental health challenges are a sequenced manifestation of abnormal mechanisms occurring within the person. Following this same logic, these abnormal mechanisms may be divorced from the person's context and may be traced and classified. Hence medical intervention may be targeted to ameliorate specific symptoms.

Despite challenges to the reductionistic approach to medicine (Webb, 2018), the implementation of recovery-oriented practice such as peer provision has been challenging, given the lack of public support and political priority (Shera & Ramon, 2013). Although some consideration is given to the person's relationships, values and cultural practices particularly as the clinician becomes more experienced, such a deliberation is secondary to the reductionistic approach to medicine (Bracken et al., 2012). It is recommended that practitioners who are advocates of the systems approach, and clear in their understanding of how reductionism can interfere with effective collaboration, familiarise undergraduate medical practitioners with the psychosocial knowledge that is fundamental to medicine. In that way, mental health care practitioners of the future will be able to value 'local knowledge' and work collaboratively with lived experience colleagues.

This part of the discussion has focused on the epistemologies related to peer provision and its juxtaposition with the reductionist approach to psychiatry. The next part of the discussion will examine how that is translated into peer provision practice.

9.3 The role of peer provision in facilitating individual change.

So far, this chapter has charted how organisations mediate the implementation of policy to practice at a managerial level and service provider level (see Figure 9.1.). Akin to the therapeutic use of self, when lived experience is used in a timely and appropriate manner, peer providers can: enable peers to feel understood and valued; contribute to an atmosphere of general ease; establish a relationship that is more balanced in power; and encourage peers to share vulnerable information that they would have been more reluctant to share with other mental health professionals (Audet & Everall, 2010).

The first objective of this study focused on how the implementation of recovery-oriented mental health policy impacts on the daily experience of the service user (who will be referred to as a peer), by documenting the micro-practices of peer provision. The support of peer providers for their peers' recovery in this PhD study highlights the value of peer provision as an intervention that enhances the social connectedness of peers, and therefore their mental health (Saeri et al., 2018). Drawing from the CHIME framework by Leamy et al. (2011), the journey undertaken by peers with their peer provider begins from a place of connection and ends with a capacity for personal responsibility (see Figure 6.2). This is mirrored by a collaboration that begins with peer providers taking a more directive approach and moves towards peer providers taking a more supportive approach, in which the direction of the relationship is largely driven by peers (see Chapter 6).

The various roles undertaken by peer providers in their practice with their peers, highlight their role as leaders and the need to employ their own emotions to conduct quality interaction with others (Brown Sr., 2018). Such a variation in roles undertaken in their practice calls for the employment of different leadership styles for different stages of the journey ranging from leader centric to follower centric (Gandolfi & Stone, 2017). Peer providers may find themselves leaning towards an authoritative leadership style that is characterised by directedness towards recovery with space for flexibility and innovation (Greenfield, 2007). Over time, their directiveness wanes as their peers grow in confidence in their recoveries, and peer providers take a more supportive role that is akin to servant leadership (Zeng & Chung, 2020). This is characterised by servant leadership which leads through invitation, inspiration and affection (Ebener & O'Connell, 2010).

The role of peer provision is an emotionally laborious one, which can take a toll on peer providers. This can lead to stress, anxiety and finally burnout, as can also occur in all helping professions (Moran et al., 2013; Arledge & Wolfson, 2001). Such an invested role requires peers to maintain the fine line between retreating to reflect and forging ahead confidently in practice. In order to do so, self-leadership is required: a process of influencing oneself, that enhances personal effectiveness and performance. To that effect, behaviour focused strategies, natural strategies and constructive thought patterns need to be applied personally (Furtner et al., 2018). To foster these strategies, training is required, as well as temporal and relational space to enable peer providers to make sense of situations (see Section 7.1). Time is needed to reflect, and space is required to make sense of the situation, including through supervision (Zeng et al., 2020). Such a form of leadership has been shown to lead to effective coping styles, greater optimism, resilience, less ineffectiveness and interpersonal distrust. It is also characterised by greater perceived wellness and less work stress. (Dolbier et al., 2001).

In addition to self-leadership, an intimate knowledge of who they were and liking themselves is central for a peer provider to foster a deep connection with their peers. Aikawa and Yasui (2017) describe these qualities to emerge from a synthesis of the identity of a peer provider and a consumer at a higher level, through pursuing a sense of worth, and dealing with the distresses that arise from both roles. This enables peer providers to foster deep connections with their peers, enabling the creation of a unique relationship that is borne out of their unique identities. This calls for a need for supervision and training to provide relational spaces that would build their skills and knowledge, and insodoing promote the development of peer providers' identities. To this end, the Certificate IV in Mental Health Peer Work has been rolled out by the Australian government (Department of Education, Skills and Employment, 2015) to train peer providers in all states in Australia.

The pyramid highlighted in Chapter 6 (see Figure 6.2), and the foundation of the stepped model as discussed in Chapter 7 (see Figure 7.1) also point to the importance of human connection with peers. This underscores peer provision as a form of person-centred practice, which is foundational to the delivery of safe, high-quality health care (Australian Commission on Safety and Quality in Health Care, n.d.). Human connection honours the person, prioritises their goals, is drawn from the relationship with the person, and is strengths-based (Waters & Buchanan, 2017).

This section discussed the role of peer providers and the purpose of lived experience in facilitating recovery in persons with mental health challenges. What is clear from the discussion is that the flow-on effect from policy to the peers in the study was mediated largely by the organisational culture and the paradigm from which it operated. This paradigm shaped the organisation's capacity for integrating peer provision and hence, how peer provision is practised and experienced. The next section highlights limitations in this study and implications for future research.

9.4 Implications for the future development of peer provision in mental health services: Aligning organisations to recovery-oriented practice

The introduction of recovery into mental health policy sparked a policy and organisational shift which introduced peer providers into mental health care (Hudson et al., 2019). This involved introducing peer provision initiatives into mental health organisations and identifying and managing teething issues associated with privileging lived experience in the mental health workforce. Such teething issues earmarked opportunities for organisations to expand their capacity to integrate lived experience expertise (in the form of peer provision) into organisations. In Western Australia, this not only took place at a local level in some organisations but also at a sectoral level with the formation of the peer support network (Consumers of Mental Health Western Australia, 2016) and peer support community of practice (WA Peer Supporters Network, 2018). Whilst some organisations have committed themselves to the recovery ethos, others have been more reluctant and/or experienced barriers to change.

As discussed earlier, this study found that organisations reluctant to engage in such change were characterised by a tension between fulfilling statutory obligations outlined in the Mental Health Act 2014 and implementing recovery-oriented practice. As the enforcement of the Mental Health Act takes precedence in determining the accountabilities and daily operations of public mental health services, the biomedical paradigm tends to be privileged over recovery-oriented practice. Whilst this maintains the medical model hierarchy because the legislation specifies the roles of particular medical professionals, there is still a growing space for peer provision to co-exist in this more traditional system.

The inception of the National Disability Insurance Scheme [NDIS] (National Disability Insurance Agency, 2020) introduced another major policy change in which organisations had to adapt to changes in funding which privileged consumer choice in its policy intent. Organisations that previously built the capacity to integrate peer providers in their service models are now theoretically in a stronger position to attract funding with the NDIS. Coupled with a strategy of showcasing emerging evidence of positive outcomes for peer provision, this may serve as an incentive for organisational leaders and managers to shift their service orientation towards embracing recovery-oriented practices.

In moving forward, Kotter's model for change may provide useful guidance for implementing recovery-oriented practice. Underpinned by three main tenets (see Table 9.2), Kotter's model of change helps to identify and counteract organisational errors as change is introduced. This may include processes that are not created for sustaining and managing change, and individuals who are not prepared for the change. Though this model has been utilised and studied in business literature, its uptake in the health care environment has begun to surface in this decade. Kotter's model has been utilised in enhancing patient safety (Noble et al., 2011), and improving the quality of health services, specifically: the integration of electronic medical records into practice (Neumeier, 2013), closing care gaps (Carman et al., 2019) and enhancing clinical and provider communications (Small et al., 2016). Hence, this model may serve to aid organisations to sustain recovery-oriented practice, so as to sustain and grow peer provision in the future.

Table 9.2 Kotter's Tenets and Steps of Change

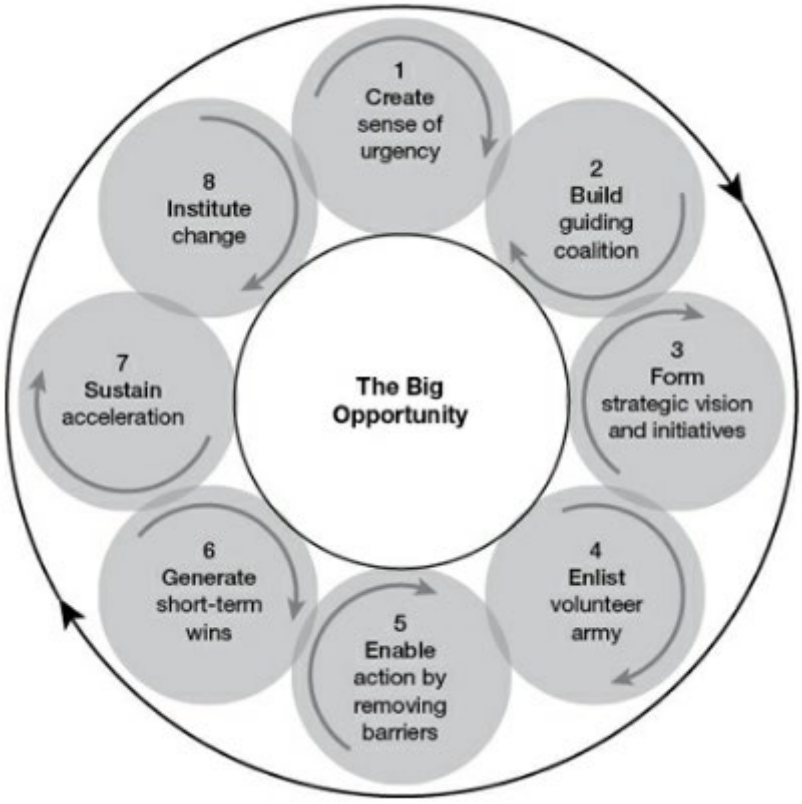
Tenet	**Step**
Tenet 1 Creating a climate for change.	Step 1 Create a sense of urgency. Step 2 Build guiding coalition. Step 3 Form strategic vision and initiatives.
Tenet 2 Engaging and enabling the whole organisation.	Step 4 Enlist volunteer army. Step 5 Enable action by removing barriers. Step 6 Generate short-term wins.
Tenet 3 Implementing and sustaining change.	Step 7 Sustain acceleration. Step 8 Institute change.

However, its implementation needs to be deliberate and planned strategically in such a way that it brings about change at an organisation and practice level, independent of existing funding. Literature suggests that change becomes more sustainable when sanctioned by strategic level management (Moullin et al., 2017). By assigning change initiatives that require swift action and creative solutions, a collaboration of different sets of expertise at different levels of the organisation, in the form of a network, is required (Kotter, 2014a). In line with Bates et al.'s (2009) recommendation, such a network-driven system should be championed, comprised partly of and maintained by top-level management. This is necessary to ensure alignment with existing hierarchy so that rather than operating in siloes alongside a management-driven hierarchical system, this network-driven system becomes an organic complement to it – with information and activity constantly flowing between systems (Kotter, 2014c).

The key to making this network function lies in the people that comprise it. Not only is a network-driven system comprised of top-level management, but it is also populated voluntarily with employees from all levels of the organisation who are committed to the cause and possess relevant skill sets and perspectives needed to drive change initiatives successfully (Kotter, 2014c). This approach is particularly useful for building a recovery orientation and strengthening peer provision because it is akin to the value of co-production, in which power is shared between top-level management and employees (with and without lived experience, who occupy peer or non-peer roles). This is a precursor to planning and delivering sustainable peer provision initiatives that acknowledge the vital role each party has to play (Slay & Stephens, 2013).

Practically, delivering a sustainable peer provision initiative can occur in eight processes (Kotter, 2014c) to foster a recovery-oriented culture in organisations. These processes are listed below and will be discussed in greater detail.

Figure 9.3 Kotter's eight accelerators for leading change



Adapted from "Seizing opportunities with a dual operating system," by J.P.Kotter, 2014, *Accelerate: Building strategic agility for a faster-moving world*, p.29. Copyright 2014 by Harvard Business Press.

9.4.1.1 Develop a sense of urgency

As peer provision increasingly demonstrates its value, leaders and managers need to develop and maintain a strong sense of urgency among as many people as possible around opportunities afforded by recovery-oriented practice (Reichenpfader et al., 2015). This is where building a dual system begins in the network-driven system, in which employees within begin to engage with the vision for recovery-oriented practice. Such a system sits alongside the hierarchy-driven system. Of course, some employees will already be engaged, and some will already be champions. In this study, it included project officers who co-produced procedures with peer providers, team managers who facilitated reasonable accommodation for the peer provider on their team (see Chapter 8). Several strategies may generate such urgency. This may include:

(1) Self-assessment: To assess the organisation's readiness for change and its relationship to recovery-related issues. Such a process may highlight the tension between the medical model practice and recovery-oriented practice, and its difficulties with making the shift. Self-assessment also serves to identify training opportunities and alert staff and service users that change is imminent. In such a way, staff and service users can be engaged in thinking creatively and early on in the process (Pascaris et al., 2008).

(2) Training, which may include: joint training (across roles and positions in the organisation), information sessions, workshops and conferences. Such training prioritizes the exchange of competencies and experiences and creates a safe space where doubts and fear regarding change may be addressed (Klinga et al., 2018). This occurred in one particular organisation in the study where peer providers shadowed non-peer members of the team as part of their induction (see Chapter 8).

(3) Role modelling a sense of urgency. Gaining people's attention by frequently disseminating information in a way that is succinct and relevant to them, compels them to be open-minded and pulls on their emotional heartstrings. Using data and logic on its own to create urgency will not be enough to build the momentum needed for change, rather a more holistic approach is needed. This could come in the form of celebrating what some staff have done to move toward opportunities toward recovery-oriented practice, and the results of that. Such a move creates positive energy that has ripple effects on the organisation (Kotter, 2014b). In this case, this could be showcasing recovery-oriented practice and the result of it. This was showcased in this study in a supervisor's account of their peer provider's role in making "amazing changes" with their peers, which led to a decrease in resistance to having a peer provider on the multidisciplinary team. (see Chapter 8).

9.4.1.2 Build a guiding coalition

Leveraging off the sense of urgency, a core network of individuals from across the organisation who feel deeply about the sense of urgency may begin to form (Kotter, 2014c). These individuals help top management take on strategic challenges, deal with hyper-competitiveness and drive recovery-oriented initiatives. They possess the drive, commitment, connections, skills and information to be effective players in this large network of change-makers. Apart from top-level management, this network could comprise of peers, peer providers, supervisors, managers, project officers and administrative staff. In this process, an effort may be expended by top-level management in ensuring people from a diverse range of roles, levels and expertise work around the opportunities that recovery-oriented practice presents with, rather than through the management hierarchy. This network of change-makers functions on information and activities that flow freely between systems. Such a group is characterized by two essential ingredients that when combined, makes such a group effective: the right people (i.e., people who possess position power, expertise, credibility and/or leadership), and trust (Lv and Zhang, 2017). This is essential in aligning the network-driven stream and management driven systems within the organisation (Kotter, 2014c). Such an alignment would require cross-hierarchical working: the support of organisational leaders, managers and employee motivation (Aarons et al., 2016).

9.4.1.3 Form a strategic vision and initiatives

When forming a strategic vision and identifying initiatives, this network of individuals (also known as the guiding coalition) should begin to clarify what recovery-orientation might look like in their service, and select strategic initiatives that enable the organisation to move with haste and finesse towards recovery-orientation. Whilst this process may start out having a divergence of ideas, strategies and design, this should converge to particular initiatives that its members are passionate about, which are well aligned to the organisation's modus operandi and culture (Braithwaite et al., 2018). Initiatives undertaken by the guiding coalition should be those that the management-driven system is not adequately equipped to handle effectively on its own (Kotter, 2014c). For example, one team leader in the study described how the organisation's view of recovery prompted the formulation of well-being plans for every member of staff, not just for peer providers exclusively (see Chapter 8). The initiatives undertaken by the guiding coalition should account for these key indicators, as summarized in Table 9.2 below.

Table 9.3 Key indicators of recovery orientation in mental health organisations (Adapted from Perkins (2012)

Key indicators of recovery-orientation in mental health organisations
Changing interactions between people with mental health challenges and service providers
Delivery of service user-led education and training programmes for staff
Establishment of a recovery college in which courses are co-produced and co-delivered to promote recovery and drive attitudinal change.
Value and behavioural change across the organization (e.g.: change in use of recovery-oriented language, collegiality between peer and non-peer staff)
Shift from risk averse to risk tolerance approaches
Co-production of services
Inclusion of lived experience expertise in workforce
Support for staff well being as indicated by institution of well-being plans for all staff

9.4.1.4 Enlist a volunteer army

With these initiatives identified, the guiding coalition should communicate the vision, the initiative, and action plans to members of the organisation at different levels, across different types of expertise. The help of those who buy into the flow of action should be enlisted, whether it is a particular initiative or the vision in general (Kotter, 2014c). The people enlisted should assist to action initiatives driven by the guiding coalition and comprise of multiple stakeholders. Apart from peer providers, this may include supervisors, members of the interdisciplinary team, team managers, programme managers, project officers and chief executive officers. They may be involved in garnering feedback from clients and feeding it back to the guiding coalition, so that adaptations may be made to the implementation process (Aarons et al., 2012). In this way, the organisation starts to shift as more people buy into the network-driven system driving the vision for change. Such a shift will be unique to organisations, calling for different strategies described in the following sections.

9.4.1.5 Enabling action by removing barriers

As the unique collaboration of people within the pro-recovery network continues to grow, recovery initiatives can shift into action, and new ones that are strategically relevant to the organisation's vision for recovery can be identified and acted on. This network-based team that champions recovery-initiatives should be characterised by innovativeness that is characteristic of entrepreneurial start-ups. They can identify and remove barriers that hamper activities which are strategically important to fulfil the vision. They also can focus their attention on what is being done within the hierarchical system; what has been done and their operational goals and strategic initiatives to avoid overlap and maintain alignment (Kotter, 2014c). Such a team may progress as a series of initiatives as outlined by Perkins (2012) in the figure below.

Figure 9.4 How recovery initiatives may progress (Perkins, 2012)

9.4.1.6 Generate short-term wins

As goals get fulfilled by initiatives highlighted in Figure 9.4, each win (that is, any results of a move toward recovery-orientation) should be showcased and celebrated. Celebrations might include items such as agendas at staff meetings, reports in newsletters and mental health awards, among other activities. From accounts of supervisors and peer providers in this study, these celebrations may include making remarkable changes with consumers who were not responsive to treatment, the equitable management of mental health for all staff, or reasonable accommodation for peer providers at the workplace, which attests to a recovery-oriented way of working in the organisation. Such show-casing can build greater credibility of recovery-orientation and draw respect, understanding and collaboration from every person within the hierarchical system. In such a way, the dual system driven by networks, and management can be built and sustained (Kotter, 2014c).

9.4.1.7 Sustain acceleration

There is a potential for complacency to set in as wins are being celebrated. To avoid complacency from setting in, the network team needs to focus on new opportunities and challenges presented by a recovery-oriented way of working. All organisations have their own histories, ways of working and cultures. So how the core values of recovery: connectedness, hope, identity, meaning and empowerment, are built and enshrined in organisations' ways of operating will vary (Ockwell, 2012; Leamy et al., 2011). As in the case of adoption organisations described in this study, peer provision initiatives are more likely sustained in the long term when organisational leaders afford sufficient finances, supervision, and monitor the fidelity of services to recovery principles and outcomes (Zeng & Chung, 2020; Bond et al., 2014)

9.4.1.8 Institute change

At this stage in the process, wins should get institutionalized within the management-driven system's processes, systems, procedures and behaviour. In this way, recovery can become infused into the organisation's DNA. This may look like the incorporation of a mental health wellness plan for all staff, not just peer providers, or other specific strategies that are wedded to the organisation's culture and mission (see Table 9.2). Peer providers can be invited to staff meetings, reference to peer providers may be made in policies and procedures; as they become part of the review processes for policies and procedures (Zeng & Chung, 2020).

In this manner, the culture of organisations can shift towards a recovery-orientated approach to service delivery, and in doing so, integrate peer provision more seamlessly into its ethos and operations. This implies a responsibility on the part of all staff should be undertaken to adopt recovery-oriented service delivery, not just peer providers themselves nor just top management (Gray et al., 2016).

9.5 Research limitations and implications for future research

Although this study has incorporated methodological triangulation at the third phase (see page 106), it is not without its limitations. Firstly, this study relied on participants that were sampled predominantly from non-government organisations. This may limit broader issues associated with the peer provision relationship, particularly within acute mental health wards. Given that peer provision is varied (Salzer et al., 2010), the results may not reflect the development of peer provision in settings not accounted for in this study. Secondly, whilst the use of a snowball sampling approach enabled the researcher to gain access to participants, such a sampling approach may inherently create a positive bias in results (Sedgwick, 2013). Notwithstanding, the range of participants recruited for this study would have covered the majority of peer provision services within the state and hence is representative of a typical peer provider service in Western Australia.

This study offers some insight into the tension between the philosophical tenets of peer provision and the organisational culture in which it sits (Zeng et al., 2020). Given this study was exploratory in nature, further research employing mixed methods could be useful in measuring the fidelity of peer provision practice to its values (Gillard, 2019). In addition, the evaluation of the design of peer provision roles and its impact on the well-being of peer and non-peer staff will further add to the current understanding of the development of peer provision services, depending on where they are situated (i.e., government vs non-government organisations). This may be examined across six domains: demands, control, support, relationships, role and change (Health and Safety Executive [HSE], 2019).

This study also formulated a framework which complements current practice models in peer provision. Grounded within a person-centred approach, the outcomes of peer provision are inherently subjective (Zeng & Chung, 2019) Hence, it will be erroneous for researchers to assume that its effectiveness can be elucidated solely through quantitative means (Brammer & MacDonald, 1999a). Apart from empirical testing, the co-production of research validating this model should also include descriptive accounts of practice comprising of the narrative, psychoanalysis and cognitive frameworks.

In addition, future research could also compare and contrast the integrated role as a lived experience practitioner and the dual role of mental health professionals with lived experience. This will add to the understanding of the importance of the duality of roles and look at emerging areas of 'new' practice in lived experience research.

The responsibilities of non-peer staff in recognising lived experience and working within recovery principles was also beyond the scope of this thesis and will be worth exploring in future research. This will add to the understanding of the role of non-peer staff in the integration of peer staff in current literature.

The introduction of recovery-oriented service in 2008 birthed a new policy cycle which introduced peer providers into mental health services (Commonwealth of Australia, Department of Health and Aging, 2009). Now that peer provision has become an understood and normal part of mental health (i.e., institutionalized), this policy cycle has ended (Hudson et al., 2019). The introduction of the National Disability Insurance Scheme in 2016 signalled the start of another policy cycle as peer provision progressed to a different policy space (National Disability Insurance Agency, 2019). The effect of this policy space on the development of peer provision will be worth investigating in future research.

9.6 Conclusion

This thesis makes a number of unique contributions to the existing body of knowledge around peer provision. It answers three questions in a progressive way:

1. How does the peer provision relationship help support the peer in their recovery?
2. What are the dynamics of the peer provision relationship?
3. In what ways does the organisational context influence the delivery of peer provision services?

The discussion section interpreted the thesis objectives by using Moore's strategic triangle and approach to consider how policy played a significant role in setting the agenda and filtered down to the organisation, the service providers and the service users.

To answer the first question, this thesis utilised the CHIME framework to consider the extant literature of peer provision. Beyond the practical aspects of recovery, peer providers were instrumental in facilitating sense-making, particularly in the first 12 months of the peer-peer provider relationship (see Chapter 2) However, data related to sense-making was better captured in qualitative studies than quantitative. This highlights the need for mixed methods approaches in furthering research in peer provision. Building on sense-making, Chapter 7 highlights the importance of the peer-peer provider relationship in creating a place of psychological safety, where peers have the flexibility of experimenting with ways of thinking and living that contribute to their recoveries, without fear of experiencing negative consequences of failure. It also draws the reader's attention to the implicit and explicit use of lived experience in the sense-making process. This highlights the need for the acceptance of experiential epistemologies in mental health services, to optimise the use of lived experience delivering effective recovery outcomes.

Secondly, this thesis documents the dynamics of the peer provision relationship. Building on the CHIME framework (Chapter 6); this thesis documents the journey of peers with their peer provider from a place of connection through to empowerment. It also highlights discrete roles and tasks that peer providers should hone on at each stage (Zeng & Chung, 2020). This is paralleled by the stepped model of peer provision (Zeng & Chung, 2019) which captures the peer provision relationship, particularly highlighting its non-linearity, similar to its recovery counterparts (see Chapter 7). This non-linearity of the peer provision relationship needs to be accommodated by peer providers in their leadership styles (see Section 9.3), as well as organisations in affording greater flexibility of entering, remaining and exiting the service when needed.

Systemic issues need to be addressed for organisations to afford such flexibility. This leads to this thesis' contribution in examining how organisational contexts influence the delivery of peer provision services. Drawing from the work of Mark Moore (1995), this thesis highlights the influence of public mental health policy on the organisation's capacity and readiness to co-opt or adopt peer provision (Zeng & Chung, 2020). It highlights that statutory policies serve to privilege the operationalisation of the medical bureaucracy in organisations, underscoring the need for statutory policy and mental health policy to be more aligned, in order for peer provision to have a complementary role, yet equal footing with other mental health services.

Finally, in order to progress the organsational shift towards the recovery paradigm and strengthen the capacities of the peer workforce in the future, the application of Kotter's (2014) approach to change is recommended because of its fit with the goals of recovery in mental health. The deliberate use of such an approach to building change is proposed so that change and development are not reliant on policies and funding cycles alone. Future research is also proposed to further the goal of embedding recovery-oriented philosophies and practices to support mental health and wellbeing services. Lastly, I would like to acknowledge again those involved in the research who have pointed to the positive contribution peer provision makes to people's lives which is the ultimate aim of this thesis.

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Copyright Statement

Appendix A Ethics Approvals

A.1 Ethics Approval: Curtin Human Research Ethics Committee

Curtin University

Memorandum

To	Professor Beverley McNamara, Occupational Therapy and Social Work
From	A/Professor Stephan Millett, Chair, Human Research Ethics Committee
Subject	Protocol Approval **HR 179/2011**
Date	13 January 2012
Copy	Grace Choo Ai Zeng Occupational Therapy and Social Work Professor Errol Cocks Occupational Therapy and Social Work

Office of Research and Development

Human Research Ethics Committee

TELEPHONE 9266 2784
FACSIMILE 9266 3793
EMAIL hrec@curtin.edu.au

Thank you for providing the additional information for the project titled "*How does Peer Support work for people recovering from a mental illness?*". The information you have provided has satisfactorily addressed the queries raised by the Committee. Your application is now **approved**.

- You have ethics clearance to undertake the research as stated in your proposal.
- The approval number for your project is **HR 179/2011.** *Please quote this number in any future correspondence*.
- Approval of this project is for a period of twelve months **13-01-2012** to **13-01-2013**. To renew this approval a completed Form B (attached) must be submitted before the expiry date **13-01-2013**.
- If you are a Higher Degree by Research student, data collection must not begin before your Application for Candidacy is approved by your Faculty Graduate Studies Committee.
- The following standard statement **must be** included in the information sheet to participants:

  This study has been approved by the Curtin University Human Research Ethics Committee (Approval Number HR 179/2011). The Committee is comprised of members of the public, academics, lawyers, doctors and pastoral carers. Its main role is to protect participants. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee, c/- Office of Research and Development, Curtin University, GPO Box U1987, Perth, 6845 or by telephoning 9266 2784 or by emailing hrec@curtin.edu.au.

Applicants should note the following:

It is the policy of the HREC to conduct random audits on a percentage of approved projects. These audits may be conducted at any time after the project starts. In cases where the HREC considers that there may be a risk of adverse events, or where participants may be especially vulnerable, the HREC may request the chief investigator to provide an outcomes report, including information on follow-up of participants.

The attached **FORM B** should be completed and returned to the Secretary, HREC, C/- Office of Research & Development:
When the project has finished, or

- If at any time during the twelve months changes/amendments occur, or
- If a serious or unexpected adverse event occurs, or
- 14 days prior to the expiry date if renewal is required.
- An application for renewal may be made with a Form B three years running, after which a new application form (Form A), providing comprehensive details, must be submitted.

Regards,

A/Professor Stephan Millett
Chair Human Research Ethics Committee

A.2 Ethics Approval: North Metropolitan Mental Health Human Research and Ethics Committee

Government of **Western Australia**
Department of **Health**
North Metropolitan Health Service Mental Health

11th December 2012

Mrs Grace Zeng
School of Occupational Therapy and Social Work
Building 104
Curtin University Bentley Campus
Kent Street
BENTLEY, WA 6102

Project 11/2012 **How does Peer Support work for people recovering from a mental illness?**

Dear Grace

The above research project was considered by the North Metro Health Service - Mental Health Research Ethics and Governance Office and found to be satisfactory and compliant with the NHMRC requirements and the WA Health Governance Policy.

On behalf of the NMHS-MH I hereby grant formal approval to proceed with the study.

Please note that this approval is in conjunction with the Terms of Approval statement, which is attached to this letter.

This approval is granted from 11/12/2012 to 31/12/2014 **(a period of two years)** as per your application. Initial approval is for a period of one year and thereafter for future periods of one year at a time subject to the receipt of satisfactory annual reports. If you would like to extend your project beyond this two-year period, please write to the Research Ethics and Governance Office requesting an extension of up-to 2 additional years.

Please note that your project is subject to institutional monitoring in accordance with section 5.5 of the National Statement on Ethical Conduct in Human Research and with the WA Health Research Governance Policy and Procedures.

In line with these specifications, the NMHS-MH REGO will conduct planned and ad-hoc audits of all research projects. To help you to comply with the auditing requirements, please find attached to this letter research logs which you are required to maintain during the course of your project.

The NMHS-MH REGO will also require an annual statement of progress of the project, as well as a final report upon completion. It is your responsibility to provide an annual report twelve months from this date.

For more information on how to comply with the NMHS-MH human research policy and procedures, please consult the Standard Operating Procedures for the Approval of Research which is available on the NMHS-MH REGO website http://www.nmahsmh.health.wa.gov.au/ethics/index.cfm.

The NMHS-MH REGO wishes you well for this project.

Please quote Project Number (11/2012) on all correspondence associated with this project and address it to:

NMHS-MH REGO
Executive Officer
Gascoyne House, Graylands Campus
Locked Bag No. 1
PO CLAREMONT WA 6910

Yours sincerely

Patrick Marwick
Acting Executive Director
North Metro Health Services Mental Health

Appendix B Recruitment Flyers and Participant Information Sheets

Please note that while the term “peer provider” was used in this thesis to reflect my current understanding of peer provision services in Western Australia, the term “peer support” was used as it was the more common term used at the time of recruitment.

B.1 Stage One Recruitment E-mail Template

Dear ...

My name is Grace Zeng and I am a PhD student and staff member at the School of Occupational Therapy and Social Work, Curtin University. I am seeking participants for my research into peer support, which involves an in depth interview with educators, supervisors and employers of Peer Support Workers. In the in depth interview, the establishment of peer support relationships, the role of the Peer Support Workers and the preparation and support of Peer Support Workers for their role within the service will be explored. Participants will also be asked if they are able to provide documentation around Peer Support (e.g.: selection criteria, job descriptions, policies and procedures around peer support, training material) for analysis. Participation is not onerous in terms of time and it should result in an interesting account of Peer Support in Western Australia.

Would you be interested to participate and/ or could you suggest others who would be interested to participate? If so, I can provide more information on the project and the task. Thank you.

I can be contacted on (08) 9266 2206 or Grace.Zeng@curtin.edu.au

Grace Zeng
Dip(OT), BSc(OT), MClSc(Mental Health)
Lecturer | School of Occupational Therapy and Social Work

Curtin University
Tel | +61 8 9266 2206
Fax | +61 8 9266 3636

Email | Grace.Zeng@curtin.edu.au
Web | http://curtin.edu.au

B.2 Stage One Recruitment Participant Information Sheet

Curtin University
Curtin Health Innovation Research Institute
Centre for Research into Disability and Society
CRICOS Provider Code 00301J (WA), 02637B (NSW)

PARTICIPANT INFORMATION SHEET

I am Grace Zeng, an academic staff member of the School of Occupational Therapy and Social Work and a PhD candidate. I am currently conducting a study entitled 'How does Peer Support work for people recovering from a mental illness?' The purpose of this study is to describe the key characteristics of peer support services in Western Australia and to explore how peer support contributes to the recovery of persons with a mental illness over time. I am seeking the experiences and opinions of supervisors and educators of peer support workers to explore: (1) the role of peer support workers; (2) how peer support relationships are established; and (3) how peer support workers are prepared for and supported in their role within the service.

Your Role:
I am interested in your experiences as an educator/ supervisor of peer support workers and would appreciate an opportunity to conduct an interview with you to explore the themes mentioned above. The interview will take approximately one to two hours at a time and venue which is most convenient and comfortable to you. Written records of the session will be made available for you to review and suggest changes, where necessary, to ensure the record provides an accurate account of the interview.

If possible, I am also hoping that you could make documentation regarding peer support in your organisation available for analyses. These may include policies and procedures concerning peer support; job descriptions; selection criteria; meeting notes and/ or training curricula.

Your input will help to inform my research question from an organisational/ supervisor's perspective. Therefore, your participation is highly valued to ensure that an accurate picture of how Peer Support works in Western Australia is represented.

Consent to Participate
Your involvement in the research is entirely voluntary. Should you choose to participate, please return a signed consent form to me prior to the interview. You have the right to withdraw at any stage without reason or negative consequence.

Confidentiality
Data obtained in the interviews will be digitally recorded and transcribed. Your identity will be disguised using pseudonyms in all transcripts, field notes and reports. When reporting findings, references identifying you will be avoided. Recordings of the interview will be stored in a password protected computer and records in a locked filing cabinet, only to be accessed by my supervisors and I. All original data will be kept for a period of five years before it is destroyed.

Further Information
This study has been approved by the Curtin University Human Research Ethics Committee (Approval Number HR179/2011). The Committee is comprised of members of the public, academics, lawyers, doctors and pastoral carers. Its main role is to protect participants. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Committee, c/- Office of Research and Development, Curtin University, GPO Box U1987, Perth, 6845 or by telephoning 9266 2784 or by emailing hrec@curtin.edu.au.

If you would like further information about the study, please feel free to contact me or my supervisor Professor Beverley McNamara by email: Bev.Mcnamara@curtin.edu.au.

Thank you for your kind consideration, your participation will be greatly appreciated.

Sincerely,
Grace Zeng
PhD Candidate
Grace.Zeng@curtin.edu.au

B.3 Stage Two Recruitment Flyer

For more information, please contact:

Grace Zeng
Grace.Zeng@curtin.edu.au
9266 7392
0433 473 701

Curtin University

School of Occupational Therapy & Social Work
Centre for Research into Disability and Society
Curtin Health Innovation Research Institute
Cricos Provider Code 00301J

This study has been approved by Curtin University Human Research Ethics Committee (Approval Number HR 179/2011). The Committee is comprised of members of the public, academics, lawyers, doctors and pastoral carers. Its main role is to protect participants. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee, c/- Office of Research and Development, Curtin University, GPO Box U1987, Perth, 6845 or by telephoning 9266 2784 or by emailing hrec@curtin.edu.au

How does Peer Support work for people recovering from a mental illness?

Grace Zeng
PhD Candidate & Staff Member
School of Occupational Therapy & Social Work
Curtin University

How you can help

I am looking for six to ten persons who work as a Peer Support Worker for at least six months to participate in this study. Your contribution to this study will involve:

- An interview with me around your work as a Peer Support Worker and how that has helped both you and your Peer in your recoveries.
- A joint interview with you and a Peer (who would feel comfortable enough to be interviewed) to explore the importance of the Peer Support relationship; reflect on the highlights and lowlights of the relationship; and paint a picture of a successful Peer Support relationship and how that might be facilitated. Your peer can choose to be interviewed separately if they wish.

There will be a compensation of $20 per hour for your time. You may choose to receive this in cash or in a gift voucher of your choice.

FAQs

"If you don't ask, you won't know."
-Mum-

About this project:

Research demonstrates that people living with a mental illness can contribute uniquely to mental health services through Peer Support. This study aims to:

Explore the dynamics of the Peer Support relationship

Document the contribution of Peer Support to the recovery of people from a mental illness

Investigate the development and sustenance of the Peer Support Worker role within an organization

Where will the interview be held?

Your safety and comfort at the interview is most important. As such, interviews will conducted in a venue that is private, quiet, comfortable and familiar to you.

How will the interviews be recorded?

The interviews will be digitally recorded and transcribed. The data will be stored securely in password protected computer files or locked in filing cabinets. Only my supervisors and I will have access to the records.

Will my identity be protected?

Yes. Details that identify you will be removed from the data. Your identity will be disguised by using pseudonyms (chosen by you) in all field notes, transcripts and reports. When reporting findings, references identifying the participant who made the comment will also be avoided.

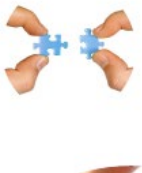
I'd like to participate, how do I do so?

If you have worked as a Peer Support Worker for more than six months, please contact me (see details overleaf) and I will send you an information sheet and consent form which I am obliged by ethics to ask you to sign. I will arrange a time for the interview with you and ask you to bring the signed form along.

Will I be able to pull out from the study?

Yes, you may withdraw from the study at any time. . All you need to do is to let me know.

B.4 Stage Three Recruitment Flyer



How you can help

I am looking for six to ten persons who have received services from a peer worker to participate in this study. Your contribution to this study will involve:

- An interview with you and your peer worker. (I'm also happy to interview you without your peer worker if you wish).
- Your participation in a focus group (I will inform you of when this will happen at a later date)

How you can benefit

There will be a compensation of $20 per hour for your time taken to contribute to this project. It is up to you how you would like to receive your compensation. (eg: cash, gift vouchers etc)

FAQs

"If you don't ask, you won't know."

-Mum-

About this project:

Research demonstrates that people living with a mental illness can contribute uniquely to mental health services through Peer Support. This study aims to:

Explore the dynamics of the Peer Support relationship

Document the contribution of Peer Support to the recovery of people from a mental illness

Investigate the development and sustenance of the Peer Support Worker role within an organisation

Where will the interview be held?

Your safety and comfort at the interview is most important. As such, interviews will conducted in a venue that is private, quiet, comfortable and familiar to you.

How will the interviews be recorded?

The interviews will be digitally recorded and transcribed. The data will be stored securely in password protected computer files or locked in filing cabinets. Only my supervisors and I will have access to the records.

How will my identity be protected?

Yes. Details that identify you will be removed from the data. Your identity will be disguised by using pseudonyms (chosen by you) in all field notes, transcripts and reports. When reporting findings, reference identifying participants who made the comment will also be avoided.

I'd like to participate, how do I do so?

If you have worked as a Peer Support Worker for more than six months, please contact me (see details overleaf) and I will send you a consent form which you will need to sign. I will arrange a time for the interview with you and ask you to bring the signed form along.

Will I be able to pull out from the study?

Yes, you may withdraw from the study at any time. . All you need to do is to let me know.

For more information, please contact:

Grace Zeng
Grace.Zeng@curtin.edu.au
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Curtin University

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Curtin University
Centre for Research into Disability and Society
Curtin Health Innovation Research Institute
Cricos Provider Code 00301J

This study has been approved by Curtin University Human Research Ethics Committee (Approval Number HR 179/2011). The Committee is comprised of members of the public, academics, lawyers, doctors and pastoral carers. Its main role is to protect participants. If needed, verification of approval can be obtained either by writing to the Curtin University Human Research Ethics Committee, c/- Office of Research and Development, Curtin University, GPO Box U1987, Perth, 6845 or by telephoning 9266 2784 or by emailing hrec@curtin.edu.au

How does Peer Support work for people recovering from a mental illness?

Grace Zeng
PhD Student & Staff Member
School of Occupational Therapy & Social Work
Curtin University

B.5 Stage Four Participant Check Email Templates

B.5.1 Email templates to Phase 1 and 2 participants

Hi ,

Hope the new year has been going well for you. Thank you again for organising to come down to tell our students about some of your experiences. It was a big thing to organise so I really appreciate your help! I said I would contact you again regarding my peer support project and I apologise for not having done so earlier as I have been caught up with my teaching responsibilities and parenting. My oldest girl who's now 4 (don't they grow up so quickly?!) has settled amazingly well in kindy and I'm just starting to get my head around it again and wanted to get in touch to follow up about your experience since the interview.

When we met a while ago to chat about peer support and your work as a project officer/ PW title/ program manager, some of the mains points you raised were to do with how you supported a peer through their recovery and the challenges you faced in your and how you built rapport with your peer. I have briefly summarised our interview into a few main points for your verification:

Key themes from interview here.

I am now keen to find out how things may have changed or developed since we spoke. Has what you shared about supporting a peer through recovery hold true till now? How has your skill set, role, understanding of peer work and personal recovery over this time? Can you describe any changes (good or bad!) that you have noticed in this service?

I understand if it may be rather onerous to respond over the email. So, if you'd rather talk about it in person or over the phone, rather than write it all down, please contact me on 0433 473 701 or e-mail me (Grace.Zeng@curtin.edu.au) to make a time.

Also, are you still in touch with [peer name] whom I interviewed together with you? I'd like to follow up on his journey since we last spoke but I haven't got his contact. If you are still in touch with him/her, please send him/her my contact details. Would love to catch up with where he's at. ☺

Many thanks for your time and looking forward to hearing from you,

Cheers,
Grace

Grace Zeng
Lecturer | School of Occupational Therapy, Social Work & Speech Pathology
Curtin University
Tel | +61 8 9266 1676
Fax | +61 8 9266 3636

Email | Grace.Zeng@curtin.edu.au
Web | www.curtin.edu.au

B.5.2 Email templates to Phase 3 participants

Dear

How are you? Hoping that this email finds you well. I interviewed a few peers a while ago about their experiences in peer support and I'm wanting to explore if the themes I have found is consistent with your experiences. I'm also interested in knowing how you're going in your journey.

Would you mind filling in this survey? The survey can be found by clicking on this link:

https://curtin.au1.qualtrics.com/jfe/form/SV_aVGm8A9GxuSW0bb

Password: peerwork

Should you want to do the survey on the phone, please scan the following QR code to your phone. It should take you to the link above.

Password: peerwork

If you're not comfortable with doing so, I'd love to arrange a time to catch up with you over the phone or in person. Could you please contact me on Grace.Zeng@curtin.edu.au or text/ call me at 0433 473 701. I must confess that I'm not very good with picking up calls straight away due to work and family commitments. If I don't pick up, please leave me a voice message and I'll get back to you.

If you know of anyone who has had experiences with a mental health peer worker I would love to get a sense of their experiences through the survey. Would you mind forwarding the link and password to them?

With gratitude,

Grace

Appendix C Consent forms

C.1 Phase One Consent Form

Curtin Health Innovation Research Institute
Centre for Research into Disability and Society

Consent form for persons participating in a research project

PROJECT TITLE: HOW DOES PEER SUPPORT WORK FOR PEOPLE RECOVERING FROM A MENTAL ILLNESS?

Name of participant: _____

Name of investigator: _____

1. I consent to participate in this project, the details of which have been explained to me, and I have been provided with a written plain language statement to keep.
2. I understand that after I sign and return this consent form it will be retained by the researcher.
3. I understand that my participation will involve an interview and analyses of relevant documentation and I agree that the researcher may use the results as described in the plain language statement.
4. I acknowledge that:

   (a) I have been informed that I am free to withdraw from the project at any time without explanation or prejudice and to withdraw any unprocessed data I have provided;

   (b) the project is for the purpose of research;

   (c) I have been informed that the confidentiality of the information I provide will be safeguarded subject to any legal requirements;

   (d) I have been informed that with my consent the interview will be digitally recorded and I understand that recording will be stored at Curtin University and will be destroyed after five years;

   (e) my name will be referred to by a pseudonym in any publications arising from the research;

I consent to this interview being audio-taped	☐ Yes	☐ No
I consent to giving the researcher access to documentation regarding peer support for analysis	☐ Yes	☐ No
	(please tick)	

Participant' Signature: _____ Researcher's Signature: _____

Date: _____ Date: _____

C.2 Phase Two Consent Form

Curtin Health Innovation Research Institute
Centre for Research into Disability and Society

Consent form for persons participating in a research project

PROJECT TITLE: HOW DOES PEER SUPPORT WORK FOR PEOPLE RECOVERING FROM A MENTAL ILLNESS?

Name of participant: _____

Name of investigator: Grace Zeng (Supervisor: Professor Beverley McNamara)

I confirm that I have read and understand the information sheet for the above study. I also had the opportunity to ask questions.	❒ Yes	❒ No
I understand that my participation will involve one/two individual interviews. I also understand that I might need to support my peer in their interview with the researcher, if necessary.	❒ Yes	❒ No
I also understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.	❒ Yes	❒ No
I agree to take part in the above study.	❒ Yes	❒ No
I agree to the interviews being audio recorded.	❒ Yes	❒ No
I agree to the use of quotes (with my identity concealed) in the presentation of findings from this phase of the research.	❒ Yes	❒ No

(please tick)

Participant' Signature: _____ Researcher's Signature: _____

Date: _____ Date: _____

C.3 Phase Three Consent Form

Curtin Health Innovation Research Institute
Centre for Research into Disability and Society

Consent form for persons participating in a research project

PROJECT TITLE: HOW DOES PEER SUPPORT WORK FOR PEOPLE RECOVERING FROM A MENTAL ILLNESS?

Name of participant: _____

Name of investigator: Grace Zeng

I confirm that I have read and understand the information sheet for the above study. I also had the opportunity to ask questions.	❒ Yes	❒ No
I understand that my contribution will involve an interview alone/ together with my Peer Support Worker[1] and participation in focus group.	❒ Yes	❒ No
I also understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.		
I agree to the researcher contacting me after the interview to: • Ask if there is anything more that add / amend to what was said in the interview • Ask if I would like to participate in the focus group • Provide details on where the focus group will be held.	❒ Yes	❒ No *(Please do not contact me after this interview.)*
I agree to take part in the above study.	❒ Yes	❒ No
I agree to the interviews and focus groups being audio recorded.	❒ Yes	❒ No
I agree to the use of quotes (with my identity concealed) in the presentation of findings from this phase of the research.	❒ Yes	❒ No
	(please tick)	

Participant' Signature: _____ Researcher's Signature: _____

Date: _____ Date: _____

[1] Delete where appropriate

Appendix D List of numbers to call

Source: https://www.healthdirect.gov.au/mental-health-services-infographic

Appendix E Phase 4 Survey

Peer Work Survey

Thank you for participating in this survey. This should take no longer than 10-15 minutes of your time. Your thoughts and experiences are very much welcomed. After finishing the survey if you have anything more to add I would be keen to hear from you about your experience with your peer worker, please call/text (0433 473 701) or email me at Grace.Zeng@curtin.edu.au.

Q 1

Are you still seeing your peer worker?

- ○ Yes (please go to question 2)
- ○ No (please go to question 3)

Q 2

How long have you been seeing him/ her?

- ○ 0-3 months
- ○ 4-6 months
- ○ 7-9 months
- ○ 10-12 months
- ○ More than 1 year

Please proceed to Q 5.

Q 3

How long has it been since you last saw your peer worker?

- ○ Less than 1 year
- ○ 1 - 2 years
- ○ 3 years or more

Q 4

How long was your contact with your peer worker?

- ○ 0 - 3 months
- ○ 4 - 6 months
- ○ 6 - 11 months
- ○ 1 - 2 years
- ○ More than 2 years

Q 5

Where did you see your peer worker?

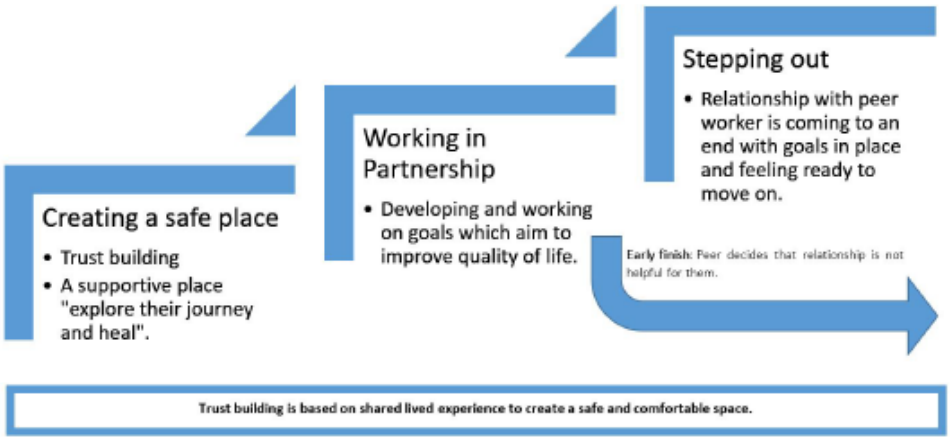
- ○ In the public hospital
- ○ In community mental health services
- ○ In a non-government mental health service
- ○ I've seen a peer worker in more than one of these settings
- ○ I'm not sure where

Q 6

Could you name the service you saw the peer worker in?
(Leave this blank if you can't remember/ don't want to reveal)

In talking with peer workers it seems that there are three stages to working together with you. What came out very strongly from the research was that trust was the key to the relationship between you and the peer worker. This trust was built on *shared experiences* with your peer worker. Trust involved you feeling comfortable and safe to speak with the peer worker and that they had a good understanding of your experience and how you were feeling. The image below represents what seems to be happening over the life of the relationship with the peer worker. It has 3 main stages:

- **Creating a safe place,** where trust was built and there was a sense of readiness for your peer worker to enter your headspace and work together with him/ her.
- **A working partnership,** where goals were set and worked on. Strategies that supported you in this stage were derived from your lived experiences (of yours and your peers)
- **Stepping out.** This was the point where you exited from your relationship with your peer worker. This could be because goals were met and there was a readiness to journey on your own; or the time with your peer worker had run out.



Q 7

To what extent these stages match or represent your own experiences with your peer worker?

- 1 Not at all
- 2 A little
- 3 To some extent
- 4 Quite a lot
- 5 It matches my experience

Q 8

Please tell me more. Which parts of your journey are described in the three stage model? Which parts of your journey does the model not cover?

Q 9

The previous stage of the research indicated that your experience with the peer worker is more positive than your experience with a non-peer mental health care professional. To what extent do you agree with this statement?

- ○ Strongly agree
- ○ Agree
- ○ Neither agree nor disagree
- ○ Disagree
- ○ Strongly disagree

Q 10

Could you tell me a bit more about the reasons for your answer to the above question?

Q 11

To what extent do you agree with this statement:
"My contact with the peer worker has helped (or helps) me stay out of hospital."

- ○ Strongly agree
- ○ Agree
- ○ Neither agree nor disagree
- ○ Disagree
- ○ Strongly disagree

Q 12

From your perspective:

What stands out as the most important aspects of peer work? Could you rank them in order of importance, where *1 is the most important* and *8 being the least important*.

- ☐ My peer worker was a role model to me.
- ☐ My peer worker helped build my hope.
- ☐ My peer worker helped me change the way I think about situations.
- ☐ My peer worker connected with me at a personal or human level.
- ☐ My peer worker empowered me to work on my goals.
- ☐ My peer worker helped me with practical things in life (eg: seeing the GP; budgeting; joining a fitness class)
- ☐ My peer worker helped me connect with others (eg: join a support group; reconnect with friends and family)
- ☐ When I ran into a difficult or unknown situation, my peer worker helped problem solve with me.

Q 13

Is there anything that stands out from your experience with your peer worker that you would like to tell us about (it can be positive or negative)?

Q 14

We would like to find out how things are going for you at the moment. Could you comment on any of the following aspects that you think are relevant:

- Personal and family relationships
- Health Social life
- Work/ Study

I would like to send you a voucher as a way of saying thank you for your time spent in filling in the survey. Would you be able to send me an e-mail (preferred) or a mailing address which I can send this card to?

Name:

E-mail (preferred):

Mailing Address:

Would you mind if I contacted you to discuss the results of this survey?

- ○ No, I don't mind. You may contact me
- ○ I do not wish to be contacted

If you do not mind being contacted to discuss the results of this survey, please leave your contact details here. Please tick your preferred mode of contact.

☐ Mobile Number: _____

☐ Home Number: _____

☐ E-mail: Provided above

If you have indicated a contact number, do you have a preferred time for being contacted?
(Please leave blank if you do not wish to be contacted.)

- ○ Anytime
- ○ Morning
- ○ Afternoon
- ○ Early evening

Thank you so much for responding to this survey. I would love to hear more from you if there's something more that you'd like to say in regards to your experiences. If so, please do not hesitate to contact me at ***Grace.Zeng@curtin.edu.au*** *or* ***0433 473 701.***

Appendix F Publications

The following section details confirmation of submission or acceptance of the five papers that were incorporated into this thesis. These are the references to the publications in running order:

Publication 1:

Zeng, G., & McNamara, B. (In review). The influence of peer provision on recovery in traditional mental health services: An integrative review. *Social Psychiatry and Psychiatric Epidemiology.*

Publication 2

Zeng, G., & McNamara, B. (2021). Strategies used to support peer provision in mental health: A scoping review. *Administration and Policy in Mental Health and Mental Health Services Research*. Advanced online publication. https://doi.org/10.1007/s10488-021-01118-6

Publication 3

Zeng, G., & Chung, D. (2020). Recovery processes within peer provision: Testing the CHIME model using a mixed methods design. *Journal of Mental Health Training Education and Practice*. Advance online publication. https://doi.org/10.1108/JMHTEP-01-2020-0007

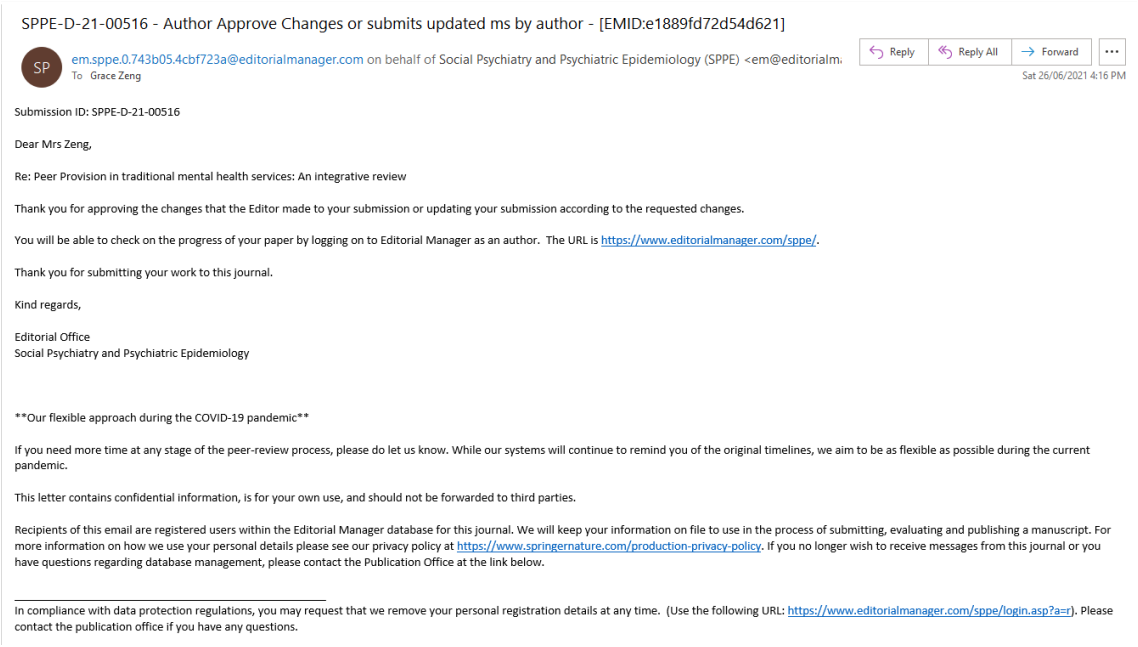
Publication 4

Zeng, G., & Chung, D. (2019). The stepped model of peer provision practice: capturing the dynamics of peer support work in action. *The Journal of Mental Health Training, Education and Practice, 14*(2), 106-118. https://doi.org/10.1108/JMHTEP-09-2018-0052

Publication 5:

Zeng, G., Chung, D., & McNamara, B. (2020). Organisational contexts and practice developments in mental health peer provision in Western Australia. *Journal of Health Organization and Management, 34*(5), 569-585. https://doi.org/10.1108/JHOM-09-2019-0281

F.1 Publication 1: Submission Confirmation



SPPE-D-21-00516 - Author Approve Changes or submits updated ms by author - [EMID:e1889fd72d54d621]

SP em.sppe.0.743b05.4cbf723a@editorialmanager.com on behalf of Social Psychiatry and Psychiatric Epidemiology (SPPE) <em@editorialm

To Grace Zeng

Reply | Reply All | Forward | ...

Sat 26/06/2021 4:16 PM

Submission ID: SPPE-D-21-00516

Dear Mrs Zeng,

Re: Peer Provision in traditional mental health services: An integrative review

Thank you for approving the changes that the Editor made to your submission or updating your submission according to the requested changes.

You will be able to check on the progress of your paper by logging on to Editorial Manager as an author. The URL is https://www.editorialmanager.com/sppe/.

Thank you for submitting your work to this journal.

Kind regards,

Editorial Office
Social Psychiatry and Psychiatric Epidemiology

Our flexible approach during the COVID-19 pandemic

If you need more time at any stage of the peer-review process, please do let us know. While our systems will continue to remind you of the original timelines, we aim to be as flexible as possible during the current pandemic.

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Decision on your manuscript #APMH-D-20-00224R1 - [EMID:be0057236d93f7e7]

AA em.apmh.0.70be49.958aa9ab@editorialmanager.com on behalf of Administration and Policy in Mental Health (APMH) <em@editorialmanag

To Grace Zeng

Reply | Reply All | Forward | ...

Tue 19/01/2021 12:15 AM

CC: cbbickman@gmail.com, daphnew@umich.edu, "Beverley McNamara" bev.mcnamara@curtin.edu.au

Dear Mrs Zeng:

I am pleased to inform you that your manuscript, "Strategies used to support peer provision in mental health: A scoping review" has been accepted for publication in Administration and Policy in Mental Health and Mental Health Services Research.

You will be contacted by Author Services in due course with a link to complete the grant of rights. Please note that you will receive your proofs after the publishing agreement has been received through our system.

Please remember to always include your manuscript number, #APMH-D-20-00224R1, whenever inquiring about your manuscript.
Thank you.

Congratulations and best regards,

Daphne Watkins, Ph.D
Associate Editor
Administration and Policy in Mental Health and Mental Health Services Research

Please note that this journal is a Transformative Journal (TJ). Authors may publish their research through the traditional subscription access route or make their paper open access through payment of an article-processing charge (APC). Find out more about Transformative Journals

Our flexible approach during the COVID-19 pandemic

If you need more time at any stage of the peer-review process, please do let us know. While our systems will continue to remind you of the original timelines, we aim to be as flexible as possible during the current pandemic.

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F.5 Publication 3: Acceptance Confirmation

Grace Zeng

From:	Journal of Mental Health Training, Education and Practice <onbehalfof@manuscriptcentral.com>
Sent	Tuesday, 4 August 2020 4:07 PM
To:	Grace Zeng; gracecazeng@gmail.com; Donna Chung
Subject	Journal of Mental Health Training, Education and Practice - Decision on Manuscript ID JMHTEP-01-2020-0007.R2

04-Aug-2020

Dear Grace and Donna

It is a pleasure to accept your manuscript JMHTEP-01-2020-0007.R2, entitled "Recovery processes within peer provision: Testing the CHIME model using a mixed methods design" in its current form for publication in Journal of Mental Health Training, Education and Practice. Please note, no further changes can be made to your manuscript.

Please go to your Author Centre at https://mc.manuscriptcentral.com/jmhtep (Manuscripts with Decisions for the submitting author or Manuscripts I have co-authored for all listed co-authors) to complete the Copyright Transfer Agreement form (CTA). We cannot publish your paper without this.

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If you have an ORCID please check your account details to ensure that your ORCID is validated.

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Thank you for your contribution. On behalf of the Editors of Journal of Mental Health Training, Education and Practice, we look forward to your continued contributions to the Journal.

Yours sincerely,
Dr. David Crepaz-Keay
Editor, Journal of Mental Health Training, Education and Practice dcrepaz-keay@mentalhealth.org.uk

F.6 Publication 3: Author Rights

From: Grace Zeng
To: Becky Taylor
Subject: RE: Permission to include articles in thesis
Date: Wednesday, 27 May 2020 6:00:00 AM
Attachments: image001.png

Hi Becky,

Thank you for your response. Sure, I'll use the AAM version of the manuscript for my thesis.

Kind regards,

Grace

Grace Zeng
BSc(OT), MCISc (Mental Health)
Lecturer, PhD Candidate | School of Occupational Therapy, Social Work & Speech Pathology
Faculty of Health Sciences

Curtin University
Tel | +61 8 9266 1676
Fax | +61 8 9266 3636

Email | Grace.Zeng@curtin.edu.au
Web | http://curtin.edu.au

From: Becky Taylor <btaylor@emerald.com>
Sent: Tuesday, 26 May 2020 6:22 PM
To: Grace Zeng <Grace.Zeng@curtin.edu.au>
Subject: FW: Permission to include articles in thesis

Dear Grace,
Please allow me to introduce myself, my name is Becky Taylor and I am a Rights Executive here at Emerald.

In regards to your query, you will need to use the AAM of the articles to submit your thesis electronically.

Many thanks for checking and best of luck with your thesis.
All best wishes,

Becky

Becky Taylor
Rights Executive I Emerald Publishing
I am currently working from home as Emerald's UK offices are closed in response to the Covid-19 pandemic. Our phone numbers are not being monitored.

btaylor@emerald.com | www.emeraldpublishing.com | www.emeraldinsight.com

From: Grace Zeng <Grace.Zeng@curtin.edu.au>
Sent: 23 May 2020 13:20
To: Permissions <Permissions@emeraldinsight.com>
Subject: Permission to include articles in thesis

To whom it may concern,

I am writing to clarify if the following articles in its final published form may be used for my thesis. They are:

1. Zeng, G., & Chung, D. (2019). The stepped model of peer provision practice: capturing the dynamics of peer support work in action. *The Journal of Mental Health Training, Education and Practice, 14*(2), 106-118. https://doi.org/10.1108/JMHTEP-09-2018-0052

2. Zeng, G., Chung, D., & McNamara, B. (Accepted). Organisational contexts and practice developments in mental health peer provision in Western Australia. *Journal of Health Organization and Management*. https://doi.org/10.1108/JHOM-09-2019-0281

As my thesis will be submitted electronically in a PDF format, I'd like to clarify if this is considered a "print version" of the thesis or should author accepted manuscript be used in my thesis (see screenshot below).

Inclusion of your article or book chapter in your dissertation or thesis	Yes	Yes	Yes, this version may be included in the print version of your thesis/dissertation. If an electronic deposit is required, this must be the SMUR or AAM version.

Your guidance on this would be greatly appreciated,

Kind regards,

Grace

Grace Zeng
BSc(OT), MCISc (Mental Health)
Lecturer, PhD Candidate | School of Occupational Therapy, Social Work & Speech Pathology
Faculty of Health Sciences

Curtin University
Tel | +61 8 9266 1676
Fax | +61 8 9266 3636

Email | Grace.Zeng@curtin.edu.au
Web | http://curtin.edu.au

F.7 Publication 4: Acceptance Confirmation

Grace Zeng

From: Journal of Mental Health Training, Education and Practice <onbehalfof@manuscriptcentral.com>
Sent: Monday, 19 November 2018 6:24 PM
To: Grace Zeng; gracecazeng@gmail.com; Donna Chung
Subject: Journal of Mental Health Training, Education and Practice - Decision on Manuscript ID JMHTEP-09-2018-0052.R1

19-Nov-2018

Dear Mrs. Zeng,

It is a pleasure to accept your manuscript entitled "The Stepped Model of Peer Provision Practice: Capturing the Dynamics of Peer Support Work in Action" in its current form for publication in Journal of Mental Health Training, Education and Practice. The comments of the reviewer(s) who reviewed your manuscript are included at the foot of this letter.

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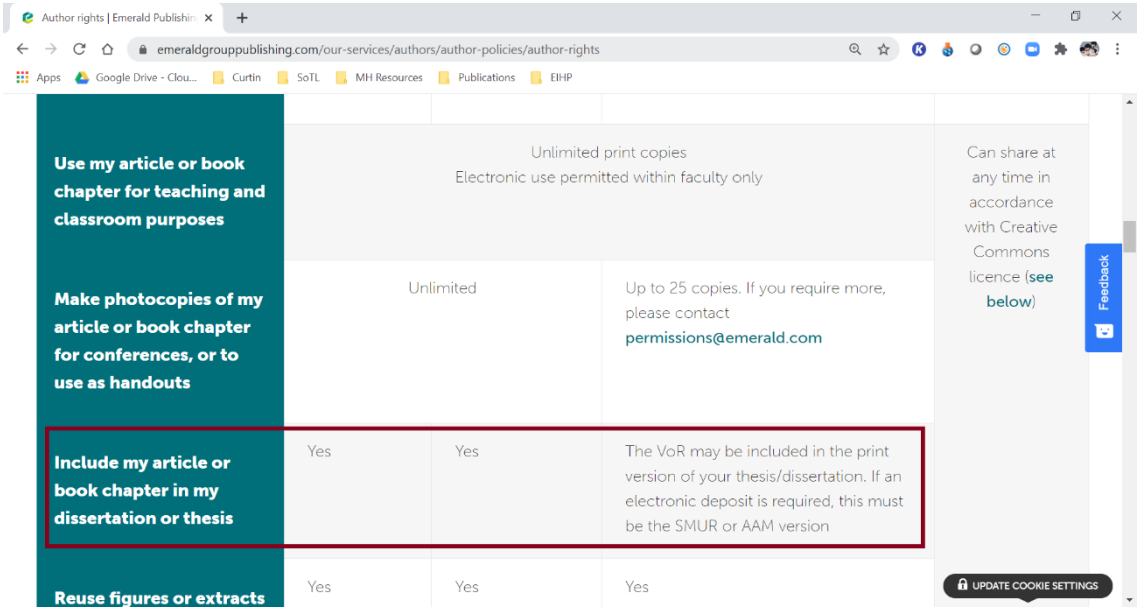
Yours sincerely,
Prof. Di Bailey
Editor, Journal of Mental Health Training, Education and Practice di.bailey@ntu.ac.uk

F.8 Publication 4: Author Rights



F.9 Publication 5: Acceptance

Grace Zeng

From: Journal of Health Organization and Management <onbehalfof@manuscriptcentral.com>
Sent: Sunday, 3 May 2020 11:59 AM
To: Grace Zeng; gracecazeng@gmail.com; Donna Chung; Bev McNamara
Subject: Journal of Health Organization and Management - Decision on Manuscript ID JHOM-09-2019-0281.R1

Follow Up Flag: Follow up
Flag Status: Flagged

03-May-2020

Dear Zeng, Grace; Chung, Donna; McNamara, Beverley

It is a pleasure to accept your manuscript JHOM-09-2019-0281.R1, entitled "Organisational contexts and practice developments in mental health peer provision in Western Australia." in its current form for publication in Journal of Health Organization and Management. Please note, no further changes can be made to your manuscript.

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Thank you for your contribution. On behalf of the Editors of Journal of Health Organization and Management, we look forward to your continued contributions to the Journal.

Yours sincerely,
Prof. Suzanne Robinson
Associate Editor, Journal of Health Organization and Management suzanne.robinson@curtin.edu.au

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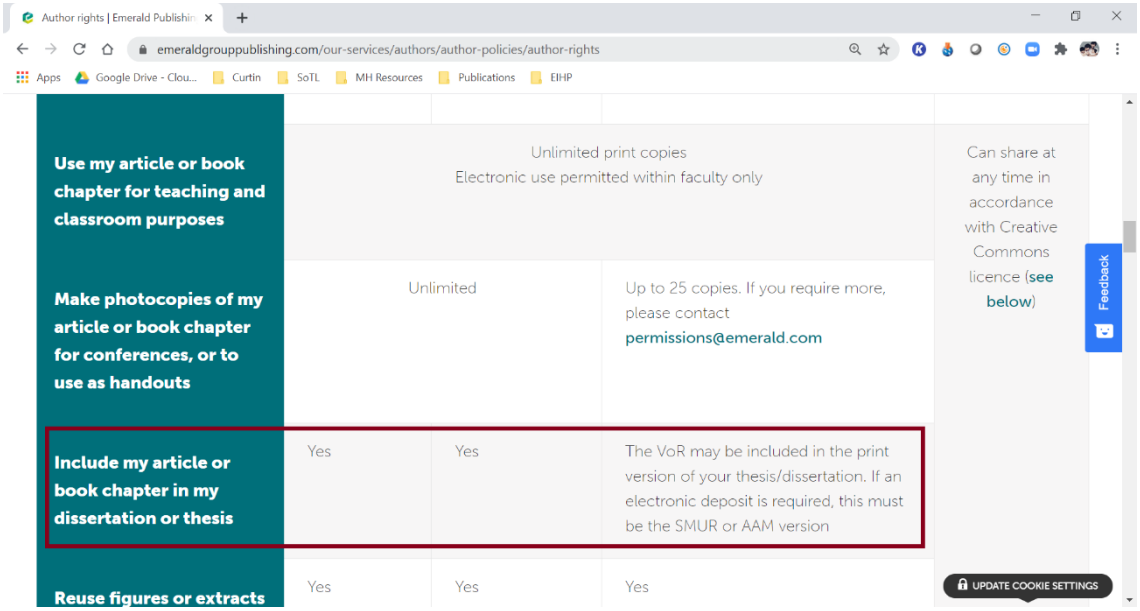

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