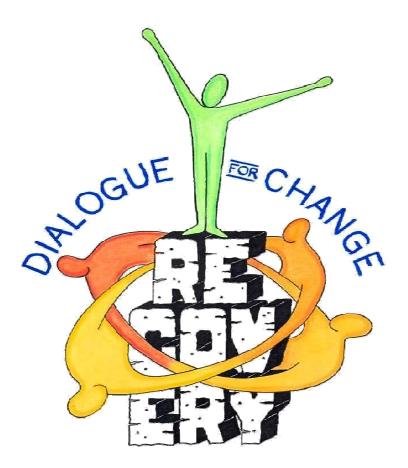# Intentional Peer Support

An Emerging Trend in Mental Health.

March 2014

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Acknowledgements

Abbreviations

CCU	Community Care Unit
IPS	Intentional Peer Support
POS	Peer Operated Service
WBMHAODS	Wide Bay Mental Health Alcohol and Other Drugs Services

Terminology

Consumer or Peer

There is much debate about how to most appropriately refer to people who use mental health services. Mental health peer workers frequently use the terms 'consumer' and 'peer' interchangeably. Hence that is the approach adopted in this paper.

Intentional Peer Support

A model of peer support founded and described by Shery Mead as a system of giving and receiving help built on key principles of respect, shared responsibility, and mutual agreement of what is helpful.[1]

Peer Operated Service

Services which have a minimum of 51% peer participation in management structures and/or staffed and managed by peer workers.[2]

Peer Support

This paper uses the term 'peer support' as a generic term that includes a variety of peer support models, self-help and mutual support.

Peer Workers

Workers recruited into paid and/or unpaid positions for which an acknowledged lived experience (of using mental health services) is an essential criterion for the appointed role. [3]

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[1] Mead, S. (2003). Defining Peer Support. p. 1. Retrieved 20/2/2014 from http://www.intentionalpeersupportforum.org/wp-content/uploads/2014/01/Defining-Peer-Support.pdf

[2] Queensland Government. (2009). *Overview of Future Directions: Consumer Operated Services Program*. Disability Services Queensland, p. 1

[3] Health Workforce Australia (HWA). (2013b). *Mental Health Peer Workforce Literature Scan. Draft.* Provided in private correspondence Health Workforce Australia dated 4/3/2014   p. 6

Executive Summary

This paper considers current literature about the expanding role peer support is playing in mental health care internationally. This has implications for service development and planning at the local level. Issues impacting the emerging peer workforce are introduced.

Formal peer support is increasingly recognized as an evidence based and distinct model of mental health care. The literature indicates people engaging in peer support tend to show reduced admission rates; longer community tenure; reduced use of emergency rooms and hospitals; and reduced substance use among persons with co-occurring substance use disorders. Other reported benefits include increasing staff awareness of personal values; decreasing 'us-and-them' thinking; and promoting a recovery-oriented culture within the mental health system. A 2008 South Australian study identified that within 3 months of beginning operation, a peer operated service saved 300 bed nights, or in excess of $90 000 AUD (after costs), concluding that peer support was highly effective as an adjunct to mainstream mental health services.

In 2008, (then) Department of Communities contracted internationally renowned peer academic and founder of the Intentional Peer Support (IPS) approach, Shery Mead, to deliver training to promote the development of a Queensland peer workforce. IPS articulates peer specific practice values that differentiate peer and non-peer support for people living with severe psychological distress. This socio-political approach provides a framework for peers to intentionally develop mutually beneficial relationships. From a basis of connection built on shared experience, peers respectfully share individual worldviews to explore 'how we've come to know what we know.' In this way they challenge assumptions; promote critical thinking; and create opportunities for new learning.

IPS is distinctly different from non-peer approaches. Therefore the integration of IPS programs into mainstream mental health services create tensions that must be negotiated. Such tensions include (but are not limited to) managing power dynamics between peer and non-peer staff; managing dual relationships that are common in peer support; negotiating differences in assessing and managing risk; and ensuring peer workers have access to peer specific training and support. Strong organizational leadership and commitment to peer work is seen as the most fundamental determinant for the successful integration of a peer workforce

In line with international trends, Australian government planning frameworks reflect a commitment to developing a mental health peer workforce. In February 2014 Health Workforce Australia circulated a draft report, which recommended establishing National Mental Health Peer Workforce Development Guidelines.

Integrating peer support into mental health service delivery is a growing trend internationally and is supported across Australian policy and planning frameworks. The subsequent emergence of a peer workforce and the corresponding interest in relevant literature creates both opportunities and challenges for mainstream mental health services.

INTRODUCTION

Background

There is an increasing international and national trend of integrating paid peer support in mainstream mental health services.[4][5][6][7] In America, the Centre for Medicare and Medicaid Services recognizes peer support as an evidence-based and distinct model of mental health care.[8]

The Australian commitment to incorporate peer support into mental health services and strategically support the development of a certified peer workforce is invigorated by government policy and planning frameworks at national [9][10][11] and state [12] levels including:-

- National Mental Health Strategy;
- Fourth National Mental Health Plan;
- COAG Roadmap for National Mental Health Reform 2012 – 2022;
- National Safety Quality Health System Standards;
- National Standards for Mental Health Services;
- National Practice Standards for the Mental Health Workforce;
- National Cultural Competency Tool (NCCT) for Mental Health Services;
- National Framework for Recovery-Oriented Mental Health Services;
- National Mental Health Workforce Strategy;
- Queensland Plan for Mental Health 2007 – 2017;
- Supporting Recovery: Mental Health Community Services Plan 2011-2017; and the
- Consumer Carer Family Participation Framework.

Priority 1 of the COAG Roadmap for National Mental Health Reform 2012 – 2022 promotes strategies for "increasing the use of trained mental health peer support workers, promoting careers and improving career pathways for those in the mental health field"[13]. In the Fourth National Mental Health Plan 2009 – 2014, Priority Area 1 describes best practice recovery

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[4] HWA, 2013b, pp 19-20

[5] Kemp, V. & Henderson, A. (2012). Challenges faced by mental health peer support workers: peer support from the peer supporter's point of view. *Psychiatric Rehabilitiation Journal* 35(4) pp 337-340. p. 338

[6] Mental Health Workforce Advisory Committee (MHWAC). (2011.) *National Mental Health Workforce Strategy.* Victorian Government Department of Health. Melbourne. Retrieved 2/3/2014 from http://www.health.gov.au/internet/mhsc/publishing.nsf/Content/7AB7430A612FAB6FCA257A5D001B9942/$File/strat.pdf, p. 23

[7] Health Workforce Australia (HWA). (2013). *Mental Health Workforce study: Mental Health Workforce Data Inventory.* Health Workforce Australia. Adelaide. Retrieved 22/2/2014 from http://www.hwa.gov.au/sites/uploads/HWA-Mental-Health-Workforce-Data-Inventory_LR.pdf p. 33.

[8] Health Workforce Australia (HWA). (2013a). *Mental Health Peer Workforce Study. Draft.* Provided in private correspondence Health Workforce Australia dated 4/3/2014   p. 8

[9] Council of Australian Governments (COAG). (2012). *The Roadmap for national mental health reform 2012 – 2022.* Retrieved 2/3/2014 from http://www.coag.gov.au/node/482   pp. 24-25

[10] MHWAC, 2011, p. 25.

[11] Commonwealth Department of Health and Aging (CDHA). (2013). *A national framework for recovery-oriented mental health services: Policy and theory*. Retrieved 4/3/2014 from http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-recovpol p. 26.

[12] Queensland Government. (2008). *Queensland Plan for Mental Health 2007-2017*. Queensland Health, Brisbane. Retrieved from http://www.health.qld.gov.au/mentalhealth/abt_us/qpfmh/default.asp p. 23

[13] COAG, 2012, pp. 24-25

oriented service provision as including a certified peer specialist workforce.[14] Subsequently, Outcome Area 2 of the National Mental Health Workforce Strategy advocates strategies to build and define work roles in peer support. This includes expanding workforce profiles and career pathways for peer workers which link to nationally recognized vocational qualifications in the Community Services Training Package.[15]

Shery Mead's model of Intentional Peer Support (IPS) is increasingly popular as the approach used in peer support services internationally.[16][17] The IPS approach is unique in clearly articulating a framework for intentionally developing mutually beneficial relationships that enable peers to learn new ways of seeing the world. In 2008 the (then) Queensland Department of Communities contracted Shery Mead Consulting to deliver Intentional Peer Support training to support the establishment of a peer workforce capable of staffing POS programs, which were subsequently established in 2010.[18]

ABOUT PEER SUPPORT

All forms of peer support share a common belief that relationships between people with a sense of shared experience are the foundation for supporting people to manage difficult life experiences. Peer support also typically seeks to reconnect people to a community base of support.

Informal peer support occurs naturally as people who share common experiences of adversity seek to support each other. Formal peer support builds on the common experience, but within formalized structures and frameworks. This paper is focused on peer support in a formal context, as provided by paid or unpaid peer workers recruited by government or community based services.

Although frequently attributed to the consumer/civil rights movements of the late 1960's and 70's,[19] formal peer support in mental health care (and the related activism agitating for social change) has been recorded as far back as the 18th century.[20][21] Despite peer support's long history, the formal recognition and provision of peer support by funded, mainstream services is a relatively recent trend.[22] Thus, the recognition and inclusion of peer support as a key

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[14] Commonwealth Department of Health and Aging (CDHA). (2009). *Fourth National Mental Health Plan— An agenda for collaborative government action in mental health 2009–2014* Attorney-Generals Department, Barton. Downloaded from http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-f-plan09, p.28

[15] MHWAC, 2011, p. 25

[16] Faulkner, A. & Basset, T. (2012). A long and honourable history. *The Journal of Mental Health Training, Education and Practice.* 7(2). Emerald Group Publishing. DOI 10.1108/17556221211236448, p. 58

[17] Australian Healthcare Associates (AHA). (2013). *Evaluation of the Community Mental Health Intentional Peer Support Training and Consumer Operated Services*. Report commissioned by Department of Communities, Queensland Government. Retrieved 15/2/14 from http://www.ahaconsulting.com.au/Documents/IPS-COS-Evaluation-Final-Report-and-Appendices-Jun.aspx, p. 6

[18] AHA, 2013, p. 33-34

[19] AHA, 2013, p. 13

[20] Davidson, L., Bellamy, C., Guy, K., & Miller, R. (2012). Peer support among persons with severe mental illnesses: a review of evidence and experience. *World Psychiatry*. 11(2) pp 123 – 128. Retrieved 17/2/2014 from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3363389/pdf/wpa020123.pdf p. 123

[21] Faulkner & Basset, 2012, p. 53

[22] Repper, J., & Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal Of Mental Health*, *20*(4), 392-411. doi:10.3109/09638237.2011.583947 p. 400

component in recovery-focused mental health care is commonly referred to as an 'emerging' trend in mainstream psychiatric care in Australia. [23] [24] [25] [26]

Efficacy and Benefits

> *The literature suggests that peer workers can provide an important and useful complement to the traditional teams delivering mental health services. Particular benefits of using this workforce can include improving the recovery orientation of services; better engagement with consumers; reduction in hospital admissions; and reduced load on other practitioners. For some people using services and their families and carers, peer workers offer an improved experience of treatment, care or support.*
>
> **Health Workforce Australia (2013b, p. 21)**

In response to the expanding nature of formal peer support internationally, there has been a corresponding increase in research (including randomized control trials) to evaluate its efficacy.[27] The literature commonly shows that employing peer workers produces either improved outcomes for consumers or (at worst) no change from services provided by non-peer professionals only.[28] [29] However, the majority of evidence report positive results, indicating that people engaging in peer support tend to show reduced admission rates; longer community tenure; reduced use of emergency rooms and hospitals; and reduced substance use among persons with co-occurring substance use disorders. [30] [31] Other reported benefits include promoting the ongoing recovery of peer workers through the impacts of employment and validation for peer work; increasing staff awareness of personal values; decreasing 'us-and-them' thinking; and promoting a recovery-oriented culture within the mental health system.[32]

Peer support that involves positive self-disclosure, role modeling, and conditional regard has been found to increase recipients' sense of hope, control, and ability to effect changes in their lives; increase their self-care, sense of community belonging, and satisfaction with life; and to decrease levels of depression and psychosis.[33] This was especially important for people staying in inpatient units, where consumers tend to feel most disempowered.[34]

Peer support workers have less professional distance than non-peer workers and have the credibility of having 'been there'. Consequently they often find it easier than non-peer workers

[23] HWA, 2013, p. 33

[24] Byrne, L. (2013). *A Grounded Theory Study of the Collaboration of Lived Experience Mental Health Practioners within the Wider Workforce.* Draft PHD, Central Queensland University, Rockhampton. Received in private correspondence. March 2014.   p. 23

[25] Kemp & Henderson, 2012, p. 337-338

[26] Faulkner & Basset, 2012, p. 53

[27] Byrne, 2013, p. 212-213

[28] Walker, G. & Bryant, W. (2013). Peer support in adult mental health services: A metasynthesis of qualitative findings. *Psychiatric Rehabilitation Journal.* 36(1) pp 28-34 DOI: 10.1037/h0094744 p. 28

[29] Repper, & Carter, 2011, p, 395

[30] Repper & Carter, 2011, p. 396

[31] Davidson, et al, 2012, p. 123

[32] Slade, M. (2013), One Hundred Ways to Support Recovery: A guide for mental health professionals. Second Edition, Rethink, London. http://www.rethink.org/media/704895/100_ways_to_support_recovery_v2.pdf p. 11

[33] Davidson, et al p. 123.

[34] Ockwell, C. (2012). Challenges and triumphs: Developing an inpatient peer support project. *The Journal of Mental Health Training, Education, and Practice, 7*(2), 94-100. doi:http://dx.doi.org/10.1108/17556221211236501 p. 95

to build rapport; promote hope and the possibility of recovery; encourage greater self-esteem; and foster a greater sense of social inclusion.[35] [36]

Social isolation is often one of the most significant challenges faced by individuals with mental health problems. As such it is unsurprising that there is evidence to support the value of a shared identity as a basis for a 'transformatory' experience. [37] Accessing support from peer operated services has shown to improve social functioning to a greater degree than accessing support only from traditional mental health services. This could be attributed to being exposed to differing perspectives and successful role models[38] and/or the experience of seeing once marginalized "mentally ill" voices being valued for their experiential knowledge.[39]

Being employed as a peer worker provides people with the benefits associated with meaningful work, whilst validating the learning they have gained from personal experiences of extreme psychological distress. This builds self-esteem, confidence and promotes ongoing personal recovery. Furthermore, employment as a peer worker increases chances of further employment and continued recovery.[40] Other benefits identified by peer workers include 'growth in knowledge' and 'putting a bad experience to good use'.[41]

Peer Operated Services (POS)

Peer operated services are those which have a minimum of 51% peer participation in management structures and/or which are staffed and managed by peer workers.[42] There is a growing international trend of establishing such services and a subsequent emerging evidence base attesting their effectiveness.[43] [44]

A 2008 evaluation found that, within the first 3 months of operation, a South Australian POS saved 300 bed days or $93,150 AUD (after project set up, delivery and administration costs). Feedback from all stakeholders (including people who use services, mental health staff, GP's and peer workers) was overwhelmingly positive. Hence the evaluation concluded that peer support was highly effective as an adjunct to mainstream mental health services. It has personal benefit to consumers and peers, substantial savings to systems, as well as much potential for encouraging mental health service culture and practice towards a greater recovery focus and improved collaboration with GPs.[45]

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[35] Walker & Bryant, 2013, p. 30
[36] Repper & Carter, 2011, p. 400
[37] Faulkner & Bassett, 2012, p. 54
[38] Repper & Carter, 2011, p. 396
[39] Adame, A.L & Leitner, L.M. (2008). *Breaking out of the mainstream: The evolution of peer support alternatives to the mental health system.* Ethical Human Psychology and Psychiatry, 10(3). DOI: 10.1891/1559-4343.10.3.146 p. 149
[40] Repper & Carter, 2011, p. 400
[41] Ockwell, 2012, p. 98
[42] Queensland Government, 2009, p. 1
[43] Doughty, C. & Tse, S. (2011). Can consumer-led mental health services be equally effective? An integrative review of CLMH services in high-income countries. *Community Mental Health Journal.* (47) pp 252-266. DOI 10.1007/s10597-010-9321-5
[44] Queensland Government, 2009, pp. 1-2
[45] Lawn, S.; Smith, A.; & Hunter, K. (2008). Mental health peer support for hospital avoidance and early discharge: An Australian example of consumer driven and operated service. *Journal of Mental Health*. 17(5): 498-508. DOI: 10.1080/09638230701530242 p. 503

Queensland POS initiatives were established in 2010 to support people experiencing psychological distress to continue their personal recovery journey and maintain a meaningful lifestyle in the community.[46] An independent evaluation in 2013 found POS providers now fill a central role and that, without exception, stakeholders (including clinical service providers) viewed the programs positively.[47] The evaluation reported people using the services identified improvements in ability to manage daily life; relationships; ability to manage emotions; social interaction; and reduced hospitalizations.[48]

Models of peer support

As mentioned above, there is some variance in research results evaluating the efficacy of peer support. Some studies conclude that people accessing peer support do better than those accessing clinical support alone; while other studies conclude there is little or no significant difference.[49] [50] It is plausible that the variance in outcomes could be attributed to differences in the particular approaches to peer support being practiced.

Most research evaluates peer support by contrasting peer support programs against clinical and/or non-peer support. Typically research either studies a specific approach or program (eg WRAP [51] or IPS [52]), or assumes a generic definition of peer support [53] [54] rather than contrasting the outcomes associated with different peer support practice models. This is unsurprising considering the recognition and formal inclusion of peer support is in its infancy and only beginning to develop unique, peer-specific practice theories and models.[55] [56] But different underlying assumptions and values impact on the manner in which peer support is practiced.

There are important distinctions (in terms of the foci on the personal, interpersonal, and/or socio-political elements of recovery) that contextualize the different ways in which peer support may be practiced.[57]

Remedial approaches

Remedial peer approaches focus support to motivate individual change to overcome some form of social maladaptation or dysfunctional behaviour.[58] Typically these groups don't seek any degree of change in the broader mental health or social systems. Alcoholics Anonymous could be considered an example of a peer support model implementing a remedial approach.

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[46] Queensland Government, 2009, p. 5

[47] AHA, 2013, p. 10

[48] AHA, 2013, p. 11

[49] Walker & Bryant, 2012, p. 28

[50] Repper & Carter, p. 395

[51] Higgins, A., Callaghan, P., deVries, J., Keogh, B., Morrissey, J., Nash, M., Ryan, D., Giijbels, H., & Carter, T. (2011). Evaluation of mental health recovery and Wellness Recovery Action Planning education in Ireland: a mixed methods pre-postevaluation. *Journal of Advanced Nursing.* Blackwell Publishing.

[52] AHA, 2013

[53] Walker & Bryant, 2013

[54] Repper & Carter, 2011, p. 400

[55] Repper & Carter, 2011, p. 400

[56] Byrne, 2013, p. 125

[57] Adame & Leitner, 2008 p. 148

[58] Cohen, M.B., & Mullender, A. (2005). The personal in the political: exploring the group work continuum from individual to social change goals. Retrieved from http://www.olc.edu/~jolson/socialwork/OnlineLibrary/Cohen%20&%20Mullender,%202005,%20The%20personal%20in%20the%20political_%20exploring%20the%20group%20work%20continuum.pdf pp 189

Partnership or Interactional approaches

Partnership or interactional peer support approaches also emphasize remedying 'defects' in the individual through psycho-social support such as assistance with daily living tasks, skills training, social connection activities and individual advocacy. Partnership approaches also commonly seek some reform in the mental health system. However, the predominant medical model approach and the associated power imbalance between professionals and people with lived experience remains largely unchallenged.[59] [60] The Queensland Health Consumer Companion Program could be described as adopting a partnership or interactional approach to peer support.

Socio-political approaches

Politically attuned or social goals approaches to peer support have grown out of people being drawn together by a shared dissatisfaction with mainstream mental health services; a desire for mutual support; and/or a motivation to collectively agitate for social change. As such, they seek to simultaneously support individuals to cope with day to day living, whilst raising awareness of the socio-political contexts of psychological suffering.[61] [62] This approach intends to enable people to acknowledge the psychological impact and injustice of experiences such as domestic violence, racism, homophobia, and human rights violations, rather than passively seeing their difficulties only through the lens of mental illness.[63] It allows people to talk about experiences (such as hearing voices) without such phenomena automatically being labelled as a symptom of illness. This approach facilitates processes for exploring the context of people's experiences and offering alternative approaches to support. It accepts that mainstream psychiatry plays a role in recovery, but also advocates social reform and the need for alternatives outside of the mainstream system so that people can have real choices when they seek support.[64] Hence, it is socio-political approaches to peer support that are at the forefront of creating alternative discourses around the experiences of severe psychological distress.[65] Examples of this approach include the Hearing Voices Network and Intentional Peer Support.

Intentional Peer Support (IPS)

Mead defines IPS as "a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful." [66] It articulates a process that encourages peers to learn to use relationships to support each other to see things from new angles, develop greater self-awareness and encourage each other to try new experiences.[67] [68] [69] In so doing, IPS offers a systematic approach that is purposeful in stepping outside the illness paradigm to explore a person's context and the ways they have learnt to make sense of their experiences.

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[59] Adame & Leitner, 2008, p. 151
[60] Cohen & Mullender, 2005 pp 189
[61] Adame & Leiter, 2008, p. 151
[62] Cohen & Mullender, 2005 pp 190
[63] Adame & Leiter, p. 156
[64] Adame & Leiter, 2008, p. 157
[65] Adame & Leiter, 2008, p. 146
[66] Mead, 2003, p. 1
[67] Jackson, C. (2008). Peer to peer. *Mental Health Today,* , 10-2. Retrieved 1/3/2014 from
    http://search.proquest.com.libraryproxy.griffith.edu.au/docview/212486979?accountid=14543   P. 10
[68] Mead, S. (2014). What is IPS? Webpage http://www.intentionalpeersupport.org/what-is-ips/ viewed 28/2/2014.
[69] AHA, 2013, p. 12

There are fundamental differences between the support offered by IPS and that provided in service type relationships including:-

- IPS relationships are viewed as partnerships that invite both parties to learn and grow, rather than as one person needing to 'help' another;
- IPS promotes a trauma-informed way of relating. Instead of asking "What's wrong?" IPS asks "What happened?";
- IPS pays attention to how we have learned to make sense of our experiences, then uses the relationship to create new ways of seeing, thinking, and doing;
- IPS encourages peers to move towards what we want instead of focusing on what we need to stop or avoid doing. [70] [71]

A Trauma informed Approach

IPS adopts a trauma informed approach to peer support by asking 'what happened to you' rather than 'what's wrong with you'. Trauma informed approaches encourage people experiencing extreme psychological distress to identify the correlation between past violence and current life difficulties, rather than simply thinking of their difficulties only as 'mental illness'. Rather than teaching problem-solving skills on the basis of illness narratives, trauma-informed peer support requires people to reflect on "how they have come to know what they know". IPS conversations and training provide an alternative perceptual framework for understanding the extent to which trauma and past abuse impact self-concept, relationships, and community connections.[72] [73] [74]

Tasks in Intentional Peer Support

Shery Mead's model explains the process and philosophy of IPS through describing four central tasks.

Task 1: Connection

Most peer support is founded on a common belief that people who share a common experience are able to create a 'comradery' or 'bond'.[75] IPS deliberately nurtures the connection provided by shared experience to further promote and develop intentional relationships. Commonly this involves

- Being open, interested and curious;
- Sharing relevant stories;
- Being aware when and why you disconnect;
- Being able to reconnect; and
- Valuing self reflection.[76]

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[70] Mead, 2014

[71] Repper & Carter, 2011, p. 400

[72] Mead, 2003, p. 2

[73] Mead, S., Hilton, D., & Curtis, L. (2001). Peer support: A theoretical perspective. *Psychiatric Rehabilitation Journal, 25*(2), 134-141. Retrieved 2/3/2014 from http://search.proquest.com.libraryproxy.griffith.edu.au/docview/204746827?accountid=14543 , p. 139

[74] McNeil, C. & Mead, S. (2005). A narrative approach to developing standards for trauma-informed peer support. *American Journal of Evaluation* 26:231 DOI: 10.1177/1098214005275633. Retrieved from http://aje.sagepub.com on 27/2/2014 p. 234-235

[75] Repper & Carter, 2011, p. 397

[76] Mead, S. (2008). *Intentional Peer Support: An alternative approach.* Plainfield, NH. p. 135

Task 2: Worldview

A basic assumption underlying IPS is that meaning and perception are created within the context of culture and relationships.[77] Hence, IPS is intent on listening from a position of 'not knowing' and generating good questions. It emphasizes creating safe spaces where people can safely examine assumptions and explore new possibilities.[78] [79] [80]

As much as the intent is to support the individual, IPS is equally focused on consciousness raising and systemic change.[81] [82] Most peer approaches encourage people to share their stories in a bid to encourage people to become proactive participants in their own recovery. However as a socio-political peer approach, IPS also uses the sharing of personal stories to inform critical thinking, political action and the formulation of alternative theories or discourses that have ultimately influenced mainstream psychiatric practices.[83] [84]

Task 3: Mutuality

The commitment to a mutual approach emphasizes the sharing of experiences, both giving and receiving support, to encourage new ways of making meaning.[85] [86] This is achieved through sharing worldviews and experiences; ensuring the needs of both people are being met; and offering and receiving reflective/critical feedback.[87]

The commitment to support that is given and received as equals is a fundamental feature that distinguishes IPS from other forms of support services.[88] [89] As such, this defining feature is critical when considering integrating paid peer support within mainstream mental health services.

Task 4: Moving towards

Most support conversations in mainstream, non-peer, mental health care are about problems and solutions. Rather than helping each other to find solutions to problems, IPS deliberately focuses on identifying and moving towards a vision of a desired life goal. This is achieved through

- Co-creating a vision of where you want to go
- Planning the steps to get there
- Learning and growing together.[90]

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[77] Mead, 2003, p.1
[78] Mead, 2008, p. 39
[79] Mead, Hilton & Curtis, 2001, p. 138
[80] Mead, Hilton & Curtis, 2001, p. 135-136
[81] Faulkner & Basset, 2012, pp. 53-54
[82] Mead, S. & McNeil, C. (2004). Peer Support: What makes it unique? Unpublished paper Retrieved 28/2/2014 from http://www.intentionalpeersupport.org/wp-content/uploads/2014/02/Peer-Support-What-Makes-It-Unique.pdf , p. 1
[83] Faulkner & Bassett, 2012, pp. 54-55
[84] Mead, 2003, p. 1
[85] Adame & Leitner, 2008, p. 149
[86] Mead, Hilton, & Curtis, 2001, p. 139
[87] Mead, 2008, p. 137
[88] Faulkner & Basset, 2012, p. 53
[89] Mead, 2008, p. 15
[90] Mead, 2008, p. 138

IMPLICATIONS FOR PRACTICE

Integrating Peer Support in Mainstream Services

Promoting Innovative Practice and Social Change

"It is … about creating dialogues that have influence on all of our understandings, conversations and relationships." Shery Mead, 2010, p.1

There is an inherent tension between IPS and mainstream psychiatric approaches to supporting people in extreme distress.[91] However, it is the very point of tension between different ideologies that promotes learning, innovation and progress. The trend towards integrating peer work across mainstream mental health services validates lived experience perspectives. In so doing it creates a platform for dialogue exploring diverse and/or opposing views. Promoting a learning culture is therefore essential to capitalizing on the potential for innovative practice that can be gained from respectfully exploring different perspectives.[92] [93] [94]

Consumer activists value the increasing recognition of peer work by mainstream mental health services. However, the credibility of peer work (as distinct from non-peer support work) depends on the extent to which peer workers remain committed to using uniquely peer approaches as opposed to mimicking mainstream service style support relationships. Retaining the independence to continue to develop alternative discourses is considered essential in ensuring peer work maintains its relevance both in practice and in stimulating social change.[95] [96] [97]   Consequently Byrne (2013, p. 125) identifies that a major issue for the emerging peer workforce is the need for consistent theories that underpin peer approaches.

IPS provides an essential underpinning theoretical perspective by articulating the practice values that identify points of difference between peer and non-peer support approaches. It empowers peers working in the service delivery system with a unique and fully distinguishable practice framework. In so doing it enables their ongoing efforts to challenge themselves, each other and psychiatric services to explore "how we've come to know what we know". In this way IPS promotes reflective practice that informs the emerging peer literature and empowers peer workers when engaging with non-peer professionals in discussions about etiological perspectives.[98]

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[91] Repper & Carter, 2011, p. 400
[92] Ockwell, 2012, p. 96
[93] Adame & Leiter, 2008, p. 159
[94] Walker & Bryant, 2013, p. 32
[95] Mead & McNeil, 2004, pp. 13-14
[96] Faulkner & Bassett, 2012, p. 57
[97] Byrne, 2013, p. 227-228
[98] Mead & McNeil, 2004, p. 2-4

In 2005, Queensland Health described the (now mainstream) commitment to recovery oriented mental health care as marking "a substantial shift in philosophy from more traditional models of service provision" that "represents a change in beliefs, services, practices, anticipated outcomes and power relationships".[99] Significantly, this paradigm shift is a direct outcome of the discourse between the different ideologies of the various sectors of psychiatric services and the (peer driven) consumer movement.[100]

Power

"Identifying and talking about power dynamics is a beginning step toward breaking them down" Mead, Hilton and Curtis (2001, p. 140)

Services seeking to implement peer programs need to consider how professionalism is defined in their work place and how the lived experience voice is embraced within that definition. Mainstream mental health care focuses on psychiatric examinations of symptoms, diagnoses and provision of treatment. This creates a power imbalance that is exacerbated by the extraordinary provisions of the Mental Health Act to over-ride the civil rights of people unwilling to accept psychiatric treatment. It is common for peer workers to find themselves working alongside professionals who they have previously accessed (and may continue to do so) for support and treatment. As a member of a marginalized group, peer workers have faced negative attitudes and/or being treated as a 'patient' rather than a colleague by non-peer staff. Consequently there is a risk that if services emphasise traditional definitions of professionalism and related power dynamics, peer support workers may feel reluctant to openly speak out about their lived experiences.[101] Hence, the degree to which peer worker roles are tokenistic or embraced as professional colleagues depends on the values of the clinical leadership and their openness to genuinely sharing power.[102] Consequently, strong organizational leadership and commitment to peer work is seen as the most fundamental determinant for the successful integration of a peer workforce.[103]

Professional Boundaries

Although the degree of reciprocity in peer support varies depending on the approach adopted, mutuality is recognized as the key feature that distinguishes peer support from non-peer power-over support and is integral in IPS. However, recruiting, training and paying peer workers in organizational settings inevitably creates power differences. The peer worker can be perceived as the 'giver' with more experience and 'further along' in their recovery. The person who accesses their services is seen as 'unwell' and needing support. This inequality drives the need for boundaries, training and supervision. It can also foster the potential for peers to mimic the power over non-peer approaches that they are familiar with (from having accessed support services themselves).[104] [105] [106]

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[99] Queensland Health. (2005). *Sharing responsibility for Recovery: Creating and sustaining recovery oriented systems for care for mental health*. Brisbane: Mental Health Directorate. p. 4

[100] Lakeman, R. (2010). Mental health recovery competencies for mental health workers: a Delphi study. *Journal Of Mental Health*, *19*(1), 62-74. doi:10.3109/09638230903469194, p. 63

[101] Walker & Bryant, 2013, p. 32

[102] Byrne, 2013, pp 208-210

[103] Franke, C.C.D, Paton, B.C. & Gassner, L.J. (2010). Implementing mental health peer support: A South Australian experience. *Australian Journal of Primary Health*, 16. pp179-186. CSIRO. Norwood. p. 183

[104] Repper & Carter, 2011, p.p 394-395

[105] Faulkner & Bassett, 2012, p. 56

[106] Mead, 2008, p. 55

Managing boundaries in dual relationships is a constant challenge for peer workers who must daily negotiate the tensions inherent in being a peer and a staff member. Peer workers are frequently both a consumer and an employee or volunteer of a mental health service. They may be a paid worker of the service that they are in opposition to when advocating with peers about issues that may cause difficulty with or concern for other staff. As such they can fear risking their paid employment and frequently feel conflicted. Peer workers' professional colleagues may also be the same professionals they have accessed (or continue to access) for support during times of psychological distress. People seeking assistance from peer workers may assume their role is that of a 'paid friend'. It is common for peer workers to be approached for formal support by people with whom they have pre-existing friendships or by people they have previously known as fellow inpatients. Formal peer relationships may also evolve to genuine friendships.[107] [108] [109] [110]

Clinical style boundaries have been the accepted model for what is appropriate in mainstream service delivery relationships. Rather than exploring each individual interaction and the relationship as it develops, professional service boundaries provide a rigid construct to be applied, especially in situations that are difficult to negotiate.[111] However, the essence of peer work is based in mutuality and sharing personal stories - concepts that directly contradict mainstream professional service delivery practices. Hence expecting peer workers to unconditionally apply professional approaches to boundary setting fails to respect the fundamental nature and complexity of peer work.

Peer workers need support to learn how to negotiate boundaries in ways that are professional but also flexible and consistent with the philosophy of peer approaches. Peer workers must be supported to learn how to reflect on and articulate relationship limits if they are to develop the skills necessary to effectively negotiate the difficulties associated with the dual relationships commonplace in their work. Without doing so, peer workers risks perpetuating the power structure of mainstream, non-peer, professional relationships.[112] [113] [114]

Services employing peer workers (in paid or unpaid capacities) must recognize and value the differences between boundary setting approaches in peer and non-peer work. Doing so requires resolving the complexity of supporting flexible, individually negotiated boundaries for peer workers employed in mainstream service settings. Failing to do so (by directing peer workers to unconditionally apply clinical style boundaries) abandons workers to manage the complexity of their roles without appropriate support; compromises peer values; and serves to diminish the integrity and independence of peer work.

Risk management

Tension also exists between statutory approaches to risk management and IPS values that honour self-determination and the dignity of risk.[115] [116] IPS promotes shared responsibility that moves away from risk assessments towards mutually responsible relationships wherein

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[107] HWA, 2013b, p. 16
[108] Franke et al, 2010, p. 180
[109] Adame & Leiter, 2008, p. 149
[110] Kemp & Henderson, 2012, p. 338
[111] Mead, Curtis & Hilton, 2001, p. 139
[112] Adame & Leiter, 2008, p. 149
[113] Mead, Curtis & Hilton, 2001, p. 139
[114] Mead, Curtis & Hilton, 2001, p. 139
[115] AHA, 2013, p. 10
[116] Repper & Carter, 2011, pp 399-400

control, as far as possible, remains with the person who appears to be at risk. IPS approaches ask someone in distress what can be done to help them to feel safe; what they would like, where they want to be. Peer workers might identify their own discomfort, fears and concerns and/or suggest alternatives that they themselves have found useful or that others have utilised. However, ultimately the decision lies with the individual about what will make them feel most comfortable.[117] Hence, there needs to be a collaborative process for exploring the implications of the differences in approach to risk management and negotiating acceptable practice frameworks to successfully implement IPS within mainstream services.

National Peer Workforce Development

Health Workforce Australia (2013, p.10) acknowledges peer workers as a *primary workforce* providing community, hospital and residential care. Primary workforces are those whose 'primary role involves early intervention, referral, treatment, care or support to people with a mental illness, in a mental health service or other health service environment, including non-government community mental health services.' [118] Despite the significant growth in the employment of peer workers in recent years, there has been little attention to a systematic development of the peer workforce. Consequently there is now a critical need for clear role delineation; articulated position descriptions; career pathways, access to peer specific training, appropriate support and supervision provided by people with experience as peer workers; and national standards for remuneration.[119] [120] [121]

A major challenge for peer workforce development is to maintain the integrity of peer support, whilst gaining recognition as health professionals who offer a distinctive practice framework not provided by non-peer professionals.[122] Peer workers are frequently employed in part time, low paid positions. Low hours means less opportunity to access professional development and network with colleagues, which negates capacity for integration as a valued team member and/or to develop a shared vision. Low pay is also associated with low job security and a devaluing of the role. [123] [124]

As an 'emerging workforce,' it is not uncommon for peers to find themselves breaking new ground as the first peer worker employed by a mainstream organization. They may also be the only peer worker employed by the service or in a particular town or region. Often they have had no peer specific training before accepting their first position as a peer worker and the organizations employing them are often unsure what to expect from the role. Non-peer professionals are often pessimistic about the usefulness of experiential knowledge. Hence, peer workers commonly experience discriminatory and negative attitudes from their non-peer colleagues who doubt the capacity of people with mental illness to contribute to service delivery.[125] Consequently, they often experience being undervalued[126] and 'allocated to the fringes of service delivery.'[127]

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[117] Repper & Carter, 2011, pp. 399-400
[118] HWA, 2013, p. 15
[119] Byrne, 2013, p. 24
[120] MHWAC, 2011, pp. 14-15
[121] Faulkner & Bassett, 2012, p. 56
[122] Kemp & Henderson, 2012, p. 340
[123] Walker & Bryant, 2013, p. 32
[124] Byrne, 2013, p. 242
[125] HWA, 2013b 15
[126] CDHA, 2003, p.51
[127] Byrne, 2013, p. 221

There is significant concern by consumer activists and peer workers that peer support is being incorporated into mainstream services in a compromised form that weakens its independence and increases the risk of peer workers being more likely to simply mimic non-peer support approaches, rather than promoting a distinctly 'peer' approach.[128] Hence, it is critical that peer workers are enabled to network and access co-supervision with other peer workers who relate to the unique complexities associated with the role. Access to peer specific training and other relevant professional development is key to addressing many of the challenges facing the peer workforce.[129] [130] [131]

The limited research into peer workforce development commonly describes unclear role definitions that ultimately compromise efforts for strategic workforce development.[132] [133] Clearly articulated position descriptions are essential if recruitment processes are to assess the degree to which applicants possess the required skills and values for the peer role being filled. Lived experience alone, in the absence of other qualifying criteria, is insufficient.[134] Furthermore, clearly articulated expectations about the purpose and scope of peer roles are essential if peer workers are to be successfully integrated into multi-disciplinary teams. Ill-defined peer roles also contribute to difficulties in determining and maintaining role related boundaries. Common consequences include confusion about the right of peers to control disclosure of their peer status; the extent to which consumer records should be shared with peers; and the extent to which peer staff should share consumer information to which they were privy with non-peer staff. Therefore, creating clearly articulated roles are essential for establishing supportive work cultures and a critical success factor in integrating a peer workforce into mainstream organizations.[135] [136] [137]

Health Workforce Australia (HWA) was established in 2010 as a national health workforce agency to drive strategic, approaches to health workforce development. In September 2013, HWA completed a Mental Health Peer Workforce study to provide "recommendations that will strengthen and develop the mental health peer workforce as an important component of quality, recovery-focused mental health services."[138] The study proposes establishing National Mental Health Peer Workforce Development Guidelines.[139]

[128] Faulkner & Basset, 2012, p. 58
[129] Kemp & Henderson, 2012, p. 338
[130] HWA, 2013b, p. 16
[131] Walker & Bryant, 2013, p. 32
[132] Byrne, 2013, p. 223
[133] HWA, 2013, p. 28
[134] Queensland Government, 2009, p. 3
[135] Byrne, 2013, p. 223
[136] Kemp & Henderson, 2012, p. 338
[137] HWA, 2013b, pp. 15-16
[138] HWA, 2013a, p. 4
[139] HWA, 2013a, p. 18

Success Factors

The Western Australian Mental Health Commission contends that the below tasks are required if peer support is to be successfully recognized and embedded within mental health services:

- Defining the role of a peer support worker;
- Educating clinicians and mental health professional about the benefits of peer support and recovery;
- Addressing issues of confidentiality and information boundaries;
- Ensuring appropriate support mechanisms and supervision are structured through out the program;
- Developing a consistent and effective training program for peer support workers; and
- Integrating the role of peer support workers into the multidisciplinary teams in inpatient and community settings[140]

Options for Integrating Peer Support across Wide Bay

The author advocates WBMHAODS research and develop a comprehensive organisational development strategy to

- Incorporate Intentional Peer Support into the model of service under consideration for the Wide Bay CCU as a key component of recovery oriented service delivery.
- Incorporate Intentional Peer Support into WBMHAODS model of service as a key component of recovery oriented service delivery.
- Formalise partnerships with local Peer Operated Services to facilitate the provision of IPS to WBMHAODS consumers.
- Formalise partnerships with Peer Operated Services to develop and implement peer workforce development strategies.

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[140] HWA, 2013a, pp. 31-32