Peer support for women living with mental health issues

The views of ACT Women

Laura Pound, Kate Judd and Jenni Gough

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Acknowledgements

Sincere thanks to all of the women who participated in this research. WCHM's mission for a health system that meets the needs of all women is only possible due to your willingness to share your valuable insights and experiences. Particular thanks go to the Women Supporting Women and the Women And Prisons groups for participating in the pilot study and welcoming WCHM so warmly into your groups. Thank you also to the mental health and peer support community organisations who supported our research and encouraged women to participate.

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About the Women's Centre for Health Matters Inc.

The Women's Centre for Health Matters Inc. (WCHM) is a community based organisation which works in the ACT and surrounding region to improve women's health and wellbeing. WCHM believes that the environment and life circumstances which each woman experiences affects her health outcomes. WCHM focuses on areas of possible disadvantage and uses research, community development and health promotion to provide information and skills that empower women to enhance their own health and wellbeing. WCHM undertakes research and advocacy to influence systems' change with the aim to improve women's health and wellbeing outcomes. WCHM is funded by ACT Health. The findings and recommendations of this report are those of WCHM and not necessarily those of ACT Health.

About the ACT Women and Mental Health Working Group

The ACT Women and Mental Health Working Group (WMHWG) have been meeting since August 2007, and was formed to provide a regular forum for women living with mental health issues and service providers to work together on matters impacting on women in order to provide improved outcomes for them, and to develop and maintain a full range of women friendly services.

About the authors

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Contents

Executive summary

The prevalence of mental illness in the ACT community is rising, and women make up a large proportion of those affected. In the Australian Capital Territory (ACT), it is estimated that 3000 women access mental health services annually and approximately a third of these women have ongoing connections with the sector.[1] People living with mental health issues often find it difficult to develop and maintain social relationships[2], and social isolation is both more common amongst people living with mental illness and women. Women also experience mental issues differently to men. It is therefore vital to develop strategies to support women to manage good mental health and wellbeing and maintain social connectivity in ways that are gender sensitive.

In 2007 the Women's Centre for Health Matters (WCHM) consulted women in the ACT living with mental health issues. They highlighted that they are seeking: to support each other at vulnerable times, access to social support at times when services are not available to them, and gender specific or women centred services. Given that peer support does not use a medical framework but a focus on relationships, it was hypothesised that peer support may be an appropriate model to address the needs of women and to address gaps in their support systems and recovery processes. There was little specific research available and none specific to the ACT.

It is for these reasons that research was commissioned by WCHM with funding from the ACT Health Promotion Grants Program to carry out this research in 2009-11, with the involvement of a consortium of partners across the ACT. The aim of the research was to identify and document best practice peer support models internationally, nationally and locally; to identify and document the needs and experiences of women participating in peer support in the ACT; and to evaluate two peer support programs for women in the ACT based on the research findings concerning best practice.

Since peer support is about people with lived experience supporting each other, women's views and personal stories were sought through a methodology which included a literature review, interviews and focus groups with women participating in peer support, and the development and evaluation of two sustainable peer support programs for women based upon the findings about best practice in peer support. The two programs were the Women Supporting Women (WSW) and Women And Prisons (WAP) groups.

The literature review defines the context of peer support and explores what is known about it. It found that best practice in peer support includes a recovery focus, key principles of peer support,

[1] Australian Institute of Health and Welfare, *Australia's health 2002,* Canberra, 2002.
[2] L Davidson, G Shahar, DA Stayner, MJ Chinman, J Rackfeldt & JK Tebes, 'Supported socialisation for people with psychiatric disabilities: Lessons from a randomized controlled trial', *Journal of Community Psychology,* vol. 32, no. 4, 2004, pp. 453-77.

gender sensitive practice, and the need for facilitation, supervision and training. The findings of the focus groups and pilot studies showed that women participants experienced increases in their mental health and wellbeing, self esteem and confidence, and levels of social connectedness. This was possible through the non-medicalised atmosphere and the development of relationships in which women benefited from sharing information about mental health and recovery, learning new skills and the use of mutual support. It was also found that women-only peer support was preferred for a variety of reasons.

Given the positive outcomes from the peer support for women in the research, it is considered important that opportunities for peer support for women living with mental health issues in the ACT continue to grow. The study also found that there are barriers within the ACT for women wanting to participate in peer support and there can challenges in the peer support environment, so additional support is also required for peer support in the ACT, to ensure that it continues to follow best practice and to provide support to women living with mental health issues appropriately.

This report makes a number of recommendations that were developed through consultation with the women and organisations that participated in the research, the WCHM Board of Directors and WCHM staff.

Recommendations

The overall recommendations from WCHM's research were:

- WCHM to advocate within the ACT for the use of gender specific peer supports, including Women Supporting Women and Women And Prisons, because of the evidence of positive outcomes for both participants and the broader community.

- From identified best practice, WCHM to develop and distribute a user-friendly *Resource Kit for Mental Health Peer Support* to ensure that lessons learnt from the research are shared with stakeholders. The Resource Kit will outline best practice in peer support, gender sensitive peer support practice, options for evaluation frameworks and processes, resources for peer support programs and information about peer support in the ACT.

- WCHM to develop ways to improve ACT women's access to information about peer support including:
  - Working with the ACT Government and community sector to advertise peer support programs and improve women's access to this information
  - Providing information about peer support programs for women in the ACT in the WCHM's *Women's Health and Wellbeing Hub*
  - Educating health/mental health workers and community sector organisations about peer support availability in the ACT, and the benefits of peer support through the distribution of the *Resource Kit for Mental Health Peer Support*

- WCHM to advocate to ACT Government to improve women's participation in peer support by addressing barriers to participation, with a focus on transport, childcare and caring responsibilities, and monetary support.

- WCHM to explore opportunities for the ACT mental health sector to invest in training and supervision options for peer support facilitators, so that peer support practice continues to be supported, safe and sustainable.

- WCHM to work with the ACT Health Directorate and Community Services Directorate in relation to their role in providing support to peer support programs seeking funding.

- WCHM to continue working with and supporting the ACT Women And Prisons group to seek support and funding, as the peer support model addresses a need in the community and achieves positive outcomes for the health and wellbeing of women with lived prison experience.

Introduction

People living with mental health issues often find it difficult to develop and maintain social relationships.[3] While the deinstitutionalisation of mental health facilities has been positive, the move to more community-based mental health service delivery has resulted in increasing social disconnectedness amongst mental health consumers.[4] This has occurred in conjunction with an increase in the incidence of mental illness. In the Australian Capital Territory (ACT), it is estimated that 3000 women access ACT mental health services annually and approximately a third of these women have ongoing connections with the sector.[5]

Moreover, both social isolation and mental illness are gendered phenomena. Women experience marginalisation due to social, political and economic factors impacting on their social role, resources and lifestyle. And women experience mental illness diagnosis, illness and recovery differently to men. While the ACT has a growing body of support services for people living with mental health issues, mental health and community services and supports services are not always gender sensitive. It is therefore vital to develop strategies to facilitate and support women to maintain social connectivity and manage good mental health and wellbeing outside of traditional mental health services and facilities.

A key area of focus for the Women's Centre for Health Matters (WCHM) in the four year period 2008-2012 is to better understand the impact of isolation and marginalisation on women living with mental health issues, and to better understand the issues impacting on their social connectedness and wellbeing. In 2007 the Women's Centre for Health Matters (WCHM) consulted women experiencing mental health issues, who highlighted that they were seeking:

- To support each other at vulnerable times, for example post admission to acute care
- Social support when support services are not available to them, for example after hours and on weekends and public holidays
- Gender specific or women centred services

Peer support was seen as a potential and appropriate model to address the needs of these women and to address gaps in their support systems and recovery processes, given that peer support does not utilise a medical framework but instead focuses on building relationships that support learning and growth across people's lives. Peer support is "a system of giving and receiving help founded on

[3] L Davidson, G Shahar, DA Stayner, MJ Chinman, J Rackfeldt & JK Tebes, 'Supported socialisation for people with psychiatric disabilities: Lessons from a randomized controlled trial', *Journal of Community Psychology,* vol. 32, no. 4, 2004, pp. 453-77.
[4] A Riessman & F Gartner, '*The Self-Help Revolution',* Human Services Press, New York, 1984; SH Godley, MC Sabin, C McClure, M Smerken & L Manion, 'Paid friends for frequent recidivists: An evaluation of a multifaceted community aide program', *Psychosocial Rehabilitation Journal,* vol. 11, 1988, pp. 29-39; BW Skirboll & PK Pavelsky, 'The Compeer program: Volunteers as friends of the mentally ill', *Hospital and Community Psychiatry,* vol 35, 1984, pp. 291-305.
[5] Australian Institute of Health and Welfare, *Australia's health 2002,* Canberra, 2002.

key principles of respect, shared responsibility and mutual agreement of what is helpful".[6] It is "…rooted in the belief that significant interpersonal relationships and a shared sense of community lay the foundation for the process of healing".[7] Peer support has the capacity to provide women with a safe environment in which they can enhance their social skills, gain confidence and self-esteem, recognise personal strengths and gain opportunities to assume new roles and responsibilities.[8]

There were few methodologically sound research studies available regarding the efficacy of peer support, so two years funding under the ACT Health Promotion Grants in 2009 enabled WCHM to carry out research specific to the ACT, working with a consortium of partners including the University of Canberra (UC), the Women Supporting Women (WSW) group in the Peer Helpers and Mentors (PHaMs) program at Woden Community Services (WCS), and the ACT Women And Prisons (WAP) group. These partners helped to inform the project with their expertise and connections to the community.

This research aimed to:

1. Identify and document best practice peer support models in Australia and internationally, focusing on how they relate to women with mental health issues; important elements of peer support; methods of measuring success; and types of programs that have been undertaken locally, nationally and internationally.
2. Identify and document the needs and experiences of ACT women living with a mental health issue about peer support, as a means of connecting/reconnecting them with their community and building support/social networks.
3. Develop and evaluate two sustainable peer support programs in the ACT based on the research findings concerning best practice in peer support.

The research was undertaken by completing a literature review on peer support best practice; conducting interviews and focus groups with ACT women participating in various kinds of peer support, focusing on their needs and experiences of peer support in the ACT; and developing and evaluating two existing sustainable peer support programs for women in the ACT based on the research findings regarding best practice. While this research mainly focuses on peer support in a group setting rather than one-on-one peer support, some participants of the focus groups were not participating in group support.

This report begins with a literature review that places peer support within the context of current research and outlines best practice in peer support. The findings of the research are then presented

[6] S Mead & ME Copeland, 'What recovery means to us: Consumers' perspectives', *Community Mental Health Journal,* vol. 36, no. 3, 2000, pp. 315-28.
[7] A Adame & L Leitner, 'Breaking out of the mainstream: The evolution of peer support alternatives to the mental health system', *Ethical Human Psychology and Psychiatry,* vol. 10, no. 3, 2008, pp. 146.
[8] MS Salzer, 'Consumer-delivered services as a best practice in mental health care delivery and the development of practice guidelines', *Psychiatric Rehabilitation Skills,* vol. 6, 2002, pp. 355-382.

in three sections: the results of the focus groups and interviews, the results of the peer support pilot program with Women Supporting Women, and the results of the pilot study with Women And Prisons. These results are further investigated in the discussion section of the report. In the conclusion to the report, a number of recommendations are made regarding how WCHM, and Government and community mental health supports in the ACT should proceed with peer support for women into the future.

Methodology

The research design of this project involved three phases: a literature review, focus groups and interviews with peer support participants across the ACT, and the evaluation of two sustainable peer support groups. The design was implemented with the aim of capturing the complex dynamics of how peer support influences women participants. A more thorough description of the research methodology and evaluation framework is recorded in WCHM's *Peer Support Project Evaluation Framework.*[9]

2.1 Literature review

The literature review utilised a variety of sources in order to provide insight into the topic of peer support for women living with mental health issues. To ensure information was reliable and current, the majority of articles were sourced from peer reviewed journals. Older literature still frequently cited and relevant to current best practice, and reports on peer support pilot studies undertaken by governments and other organisations were also incorporated.

Initially, a comprehensive search for relevant peer reviewed articles in the academic databases SAGE, Proquest, ScienceDirect, HeinOnline, CINAL and OVID was undertaken. The search terms used were 'peer support', 'women', 'recovery' and 'mental health'. On review of the articles generated, it was found there was diversity in the terminology used to discuss peer support. Therefore, an additional search was undertaken using the terms 'social support', 'mutual support', 'socialisation' and 'consumer/survivor'. A number of frequently cited sources in the collected articles which had not previously appeared in searches were also utilised.

2.2 Focus groups and interviews

Focus groups and interviews were held with female participants and facilitators from various peer support groups in the ACT (see Appendix A for the list of participating organisations). Information was collected through semi-structured questions about how peer support might facilitate mental health and wellbeing for women and what barriers existed for women in relation to accessing peer support (see Appendix B for the question guide).

Participants were recruited via individuals, community organisations, peak community sector networks and services involved in the mental health sector. Focus groups were organised where a group of people were interested in participating, and interviews were organised where fewer women were interested or participants identified they were more comfortable in this setting.

[9] Women's Centre for Health Matters, *Peer support project: Evaluation framework,* 2009.

The focus groups and interviews were held in 2010 at locations that were convenient to the participants. Each discussion lasted between one and two hours and was recorded with the consent of the participants. The recordings were then transcribed.

2.3 Peer support program evaluations

The evaluation framework used to research two peer support groups in the ACT was designed to measure the effectiveness of peer support as a means of reducing mental health symptoms, and to measure levels of overall wellbeing and social connectedness in the lives of participants.

The existing groups Women Supporting Women (WSW) and Women And Prisons (WAP) were chosen as samples for the pilot because they provide two unique examples (see Appendix C for a comparison of the WSW and WAP peer support models).

The WSW group began in 2009 and is run fortnightly for two hours through the Peer Helpers and Mentors (PHaMs) program at Woden Community Service (WCS). WSW is for women living with mental health issues, and aims to improve social connectivity and mental health by creating a safe and non-judgemental environment in which women meet and provide support to one another. In consultation with the facilitator, WSW participants decide on group activities including craft and cooking, and participants bring stories and activities to share with the group.

The WAP group was founded in 2005, and through lived experience the Group provides emotional peer support to women inside and outside prison in order to advocate for better outcomes for women incarcerated in or involved in the ACT criminal justice system. WAP has three main functions: peer support for incarcerated women; peer support for women transitioning to the community from prison; and advocacy about the issues facing women in the prison system and transitioning from it. This study focused on the peer support aspects of WAP; however it was difficult to differentiate the impact from the advocacy component also.

WCHM evaluated the WSW and WAP groups using a longitudinal and multi-method approach. Methods included questionnaires producing both qualitative and quantitative data; interviews with peers and peer support workers or their support networks; participatory evaluation; group activities; and journal writing. These are discussed in further detail below.

2.3.1 Questionnaires

A questionnaire was administered to members of the peer support pilot groups three times over the period of six months, in order to monitor changes in participant wellbeing. The questionnaire was completed individually or with the evaluator depending on the needs of the participant. It sought to obtain information regarding demographics, mental health and wellbeing, self-esteem, social

connectedness and levels of peer support via both standardised scales and short answer questions (see Appendix D for questionnaires).

The standardised scales used include the Kessler Psychological Distress Scale (K10) which measures the level of a person's anxiety and depression symptoms; the Rosenberg Self-esteem Scale (RSES) which measures self-esteem; and the Social Provision Scale (SPS) which measures how people experience their social connectedness. These scales are described in detail in WCHM's evaluation framework for peer support.[10] The short answer questions gathered information about what participant's value in peer support, what impacts on their experience of the group, what they have gained from the group, and how peer support has impacted on their mental health, wellbeing and social connectedness.

A total of 24 valid questionnaires were collected between both WSW and WAP (see Appendix E for more information about how many questionnaires were collected over the pilot program). Quantitative data collected through the questionnaire were statistically analysed by a registered psychologist.

2.3.2 Interviews

Throughout the pilot program, interviews and focus groups were conducted with both WSW and WAP participants and facilitators (see Appendix F for more information about how many interviews were conducted). Interviews followed the same procedures as consultations with women participating in other peer support groups in the ACT.

2.3.3 Debriefing forms, participant observation and participant evaluation

The WSW facilitator completed a structured debriefing form after each meeting. This gathered information about how many participants attended, what activities were undertaken, how participants interacted, the successes and challenges of the group and changes in the participant's lives (see Appendix G for the debriefing form).

WCHM undertook participant observation of WSW and WAP to gain better understanding of the dynamics, content and purpose of peer support in the lives participants. Dialogue, interactions and activities were recorded by the evaluator during this process.

Participatory evaluation was undertaken in the WSW group to involve the women in constructing their own methods of evaluation and allow for a creative outlet for feelings towards the group.[11]

[10] Women's Centre for Health Matters, Carnovale, A & E Carr, *Peer support project: Evaluation framework,* Canberra, 2009.
[11] N Box, *Evaluation of the First Year of the Brindabella Women's Group*, 2005, pp. ii & iii.

WSW decided to undertake three evaluations as a group, two newsletters and one collage. Some participants also offered their personal writings in journal or letter form to the evaluation process.

2.4 Ethical considerations

Ethical principles outlined in the *WCHM Code of Conduct and Research Guidelines* (2008) were taken into account throughout the research process, acknowledging the potential vulnerabilities of women living with mental health issues who participated.[12] The ethical measures taken during the research included:

- Participants provided their informed consent and were notified that they were able to withdraw at any time
- The anonymity of, and confidential information from, participants was maintained
- Participants chose whether to have their interviews recorded
- Participants were provided with the opportunity to review their interview transcript

Researchers also considered the impact of the research on participant's wellbeing and safety, and the maintenance of trust and respect amongst peers, participants and researchers at all times. Participants were reimbursed with a gift card and provided with taxi vouchers if necessary, in recognition of the costs associated with participating in the research including transport and time. In the findings section of the report, the author's voice is used to summarise the views of participants at times, in order to convey a clearer narrative.

[12] Women's Centre for Health Matters, *WCHM Code of Conduct,* 2008; Women's Centre for Health Matters, *Research Guidelines,* 2010.

Literature review: Peer support in context and best practice in peer support

Objectives

- To place the emergence of peer support within the historical and social context of mental health in Australia
- To define peer support and different models of peer support
- To investigate research on the effects of peer support for women living with mental health issues
- To examine theories which explain the way in which peer support works and outline challenges to successful peer support for women
- To place WCHM's research findings within the context of local, Australian and international evidence based literature
- To investigate emerging issues in regards to the provision of successful peer support
- To define best practice peer support for women

Summary of findings

- People living with mental health issues experience lower levels of social connectedness
- Women living with mental illness report needing more social support in their lives, particularly friends[13]
- Women who have experienced institutionalisation in prison have lower rates of mental health and wellbeing compared with men in prison and women in the broader community
- Peer support for people with mental illness has developed from and sits within the recovery framework
- Definitions and models of peer support are diverse
- There are five key theories underpinning why peer support works: social support theory, experiential knowledge theory, the helper-therapy principle, social learning theory and social comparison theory
- Due to methodological difficulties, there is little evidence outlining the effects of peer support. However, existing literature shows that its impacts are positive for individuals, mental health services, families and society more broadly
- Peer support is also a mechanism of health promotion and social inclusion is a determinant of mental health and wellbeing that is linked to the Ottawa Charter for Health Promotion

13 Chernomas, W. (2006). Fostering social support for women living with serious mental illness. Mental Health and Addictions in Women. 5(1).

- The peer support environment has challenges which need to be managed for the most effective delivery and positive outcomes
- Best practice in peer support utilises the recovery framework, reflects the key principles of peer support practice, provides gender sensitive support, is appropriately facilitated, and provides opportunities for supervision and training in order to support facilitation

3.1 Contextualising peer support

3.1.1 Impacts of deinstitutionalisation on mental health and social connectedness

There is much criticism of the experiences of and care provided for people with mental illness in psychiatric facilities of the past. However, some argue that psychiatric facilities fulfilled a clinical and human need,[14] due to the 'forced togetherness' of hospital life which may have provided a ready-made social network and sense of belonging for inpatients.[15] Post deinstitutionalisation, which occurred in Australia in the 1970s, services moved to a more therapeutic community-based model of delivery.[16] This resulted in increased human rights for people living with a mental health issue, but also the unwanted consequence of increased social isolation.[17]

For example, people living with mental health issues find it more difficult than others to develop and maintain social relationships.[18] People with mental illness have comparatively smaller social networks than people without mental health issues,[19] and it is not uncommon for people with mental illness' interactions to be limited largely to medical practitioners, family members and peers living with mental health issues.[20] Barriers to socialising include the social stigma surrounding mental illness, loss of social roles associated with impairments in functioning, lack of social structures to bring people together in the community, and the social disability associated with the disorder itself.[21] Consequently, many people with mental health issues report spending much time alone[22] and experiencing feelings of loneliness,[23] a lack of community connectedness[24] and dissatisfaction with the social support they do receive.[25]

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[14] P Carling, *Return to community: Building support systems for people with psychiatric disabilities*, Guildford Press, New York, 1995.
[15] L Davidson, MA Hoge, ME Merrill, J Rakfeldt & EEH Griffith, 'The experience of long-stay inpatients returning to the community', *Psychiatry,* vol. 58, no. 2, 1995, pp. 122-132.
[16] LI Stein & MA Test, *Alternatives to mental hospital treatment,* Plenum Press, NY, 1978.
[17] Riessman et. al; Godley et. al.; Skirboll et. al.
[18] Davidson et. al, *Supported Socialization*.
[19] F Baker, D Jodrey, J Intagliata & H Strauss, 'Community support services and functioning of the seriously mentally ill', *Community Mental Health Journal,* vol. 29, no. 4, 1993, pp. 321-331; T Harris, GW Brown & R Robinson, 'Befriending as an intervention for chronic depression amongst women in an inner-city 2: Role of fresh-start experiences and baseline psychosocial factors in remission from depression', *The British Journal of Psychiatry,* vol. 174, no. 3, 1999, pp. 225-32; CC Tolsdorf, 'Social networks, support and coping: An exploratory study', *Family Process,* vol. 15, no. 4, 1976, pp. 407-17; J Walsh, & PR Connelly, 'Supportive behaviours in natural support networks of people with serious mental illness', *Health and Social Work,* vol. 27, no. 4, 1996, pp. 296-303.
[20] B Angell, 'Contexts of social relationship development among assertive community treatment clients', *Mental Health Services Research,* vol. 5, no. 1, 2003, pp. 13-25; Borge, L, EW Martinsen, T Rudd, O Watne & S Friss, 'Quality of life, loneliness and social contact among long-term psychiatric patients', *Psychiatric Services,* vol. 50, no. 1, 1999, pp. 81-84; WF Dailey, MJ Chinman, L Davidson, L Garner, E Vavrousek-Jakuba, S Essock, K Marcus & JK Tebes, 'How are we doing? A statewide survey of community adjustment among people with serious mental illness receiving intensive outpatient services', *Community Mental Health Journal*, vol. 36, no. 4, 2000, pp. 363-82; S Meeks & SA Murrell, 'Service providers in the social networks of clients with severe mental illness', *Schizophrenia Bulletin,* no. 2, 1994, pp. 399-406.
[21] Davidson et. al, *Supported Socialization.*
[22] L Davidson & DA Stayner, 'Loss, lonliness, and the desire for love: Perspectives on the social lives of people with schizophrenia', *Psychiatric Rehabilitation Journal,* vol. 20, no. 3, 1997, pp. 3-12; L Davidson, DA Stayner & KE Haglund, 'Phenomenological perspectives on the social functioning of people with schizophrenia' in KT Mueser & N Tarrier (eds), *Handbook of social functioning in schizophrenia',* Allyn & Bacon Publishers, Massachusetts, 1998, pp. 97-120.
[23] Davidson et. al., *Loss, loneliness;* Green, G, C Hayes, D Dickinson, A Whittaker & B Gilheany, 'The role and impact of social relationships upon well-being reporting by mental health service users: A qualitative study', *Journal of Mental Health UK,* vol. 11, no. 5, 2002, pp. 656-579.
[24] P Crotty & R Kulys, 'Social support networks: The views of schizophrenic clients and their significant others', *Social Work,* vol. 30, no. 4, 1985, pp. 301-09; Davidson et. al, *Supported socialisation;* RW Goldberg, AL Rollins & AF Lehman, 'Social network correlates among people with psychiatric disabilities', *Psychiatric Rehabilitation Journal,* vol. 26, no. 4, 2003, pp. 393-402; RL Leavy, 'Social support and psychological disorder: A review', *Journal of Community Psychology,* vol. 11, no. 1, 1983, pp. 3-21; E Rogers, SW Anthony & A Lyass,

A growing amount of literature identifies lack of community support rather than a person's symptomatology to be the dominant factor in re-admission to psychiatric inpatient care.[26] Up to half of all discharged psychiatric inpatients are re-hospitalised within twelve months[27] and in the ACT, a lack of transitional support and poor psychiatric discharge practices have been identified as major contributors to recidivism.[28]

There is a strong relationship between social status and mental health[29] which greatly affects women because their status remains lower than men's. This is reflected in the high incidence of violence against women; women's lower socio-economic status; an under-representation of women in positions of power; and an over-representation of women in part-time and casual work, amongst other things. As a consequence, women experience mental health issues at a higher rate than men.[30,31] They also experience it differently through the biological, psychological and social factors which cause the illness; the course and expression of the illness; the age of onset as well as the symptoms experienced and comorbidity with other illnesses.[32]

According to WCHM research, there are approximately 23,000 women living with diagnosed mental or behavioural conditions in the ACT, with 23.5 per cent of these women reporting only poor to fair health status. 14,000 women in the ACT are experiencing economic disadvantage. Women with diagnosed mental or behavioural conditions are over-represented in the lowest income quintile (approximately 7,300 women).

3.1.2 Women in prison and mental health

In addition to low levels of social support, the experience for women of being institutionalised in prison is also linked to poor mental health outcomes.[33] Compared with women in the broader

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'The nature and dimensions of social support among individuals with severe mental illnesses', *Community Mental Health Journal,* vol. 40, no. 5, 2004, pp. 437-50.

[25] A Bengtson-Tops & L Hansson, 'Quantitative and qualitative aspects of the social network in schizophrenic patients living in the community. Relationship to sociodemographic characteristics and clinical factors and subjective quality of life', *International Journal of Social Psychiatry,* vol. 47, no. 3, 2001, pp. 67-77; J Carron, R Tempier, C Mercier & P Leouffre, 'Components of social support and quality of life in severely mentally ill, low income individuals and a general population group', *Community Mental Health Journal,* vol. 34, no. 5, 1998, pp. 459-475; TA Furukawa, H Harai, T Hirai, T Kitamura & K Takahashi, 'Social support questionnaire among psychiatric patients with various diagnosis and normal controls', *Social Psychiatry and Psychiatric Epidemiology,* vol. 34, no. 4, 1999, pp. 216-22.

[26] L Davidson, M Chinman, B Kloos, R Weingarten, D Stayner & JK Tebes, 'Peer support among individuals with severe mental illness: A review of the evidence', *Clinical Psychology: Science and Practice,* vol. 6, no. 2, 1999, pp. 165-87.

[27] WD Klinkenberg & RJ Calsyn, 'Predictors of receipt of aftercare and recidivism among persons with severe mental illness: A review', *Psychiatric Services*, vol. 47, no. 5, 1996, pp. 487-96.

[28] Morgan Disney and Associates, *Needs assessment/analysis framework: Report for Women's Centre for Health Matters*, Canberra, 2007.

[29] D.E. Stewart, "Social Determinants of Women's Mental Health", *Journal of Psychosomatic Research*, Sep 2007.

[30] The Women's Health Council, *A Guide to Creating Gender-Sensitive Health Services*, 2007

[31] F. Judd, S. Armstrong, J. Kulkarni, "Gender-sensitive mental health care", *Australasian Psychiatry*, Vol 17, no 2, 2009.

[32] Ibid.

[33] L Berkman, 'The relationship of social networks and social support to morbidity and mortality', in S Syme & SL Syme (eds), *Social Support and Health*, Academic Press, Orlando, 1985, pp. 3-22; JR Bloom, 'The relationship of social support and health', *Social Science and Medicine,* vol. 30, no. 5, 1990, pp. 635-37; S Cohen, 'Psychosocial models of the role of social support in the etiology of physical disease', *Health Psychology,* vol. 7, no.3, 1988, pp. 269-97; JS House,, KR Landis & D Emberson, 'Social relationships and health', *Science,* vol. 241, 1988, pp. 540-545.

community, women with lived prison experience are more likely to have mental health issues, use alcohol and drugs, and to have experienced physical, emotional and sexual violence.

WCHM's report *ACT Women And Prisons, Invisible Bars: The Stories behind the Stats* (2009) found that many women have experienced trauma, abuse, alcohol and drug use or domestic violence, often intergenerational; and feelings of powerlessness, despair, low self worth, guilt, shame and fear; and social isolation. Mental health was a key theme in the report, with women discussing issues such as depression, anxiety, self harm and suicidal thoughts.[34]

Women in custody are twice as likely as male inmates to be diagnosed with psychiatric problems and nearly three times as likely to be on psychiatric medication at the time of their reception into custody.[35] Also, 57 percent of women in Queensland prisons have been diagnosed with a specific mental illness[36] compared to 5.8 percent of women nationally,[37] while 69 percent of women demonstrate symptoms of depression, higher than the national average of 6.8 percent.[38]

3.1.3 Peer support and the recovery framework

Peer support originates from the mental health consumer and recovery movements that emerged after deinstitutionalisation. As opposed to other support groups, peer support for mental health issues is unique because it "grew out of a civil/human rights movement in which people affiliated around the experience of negative mental health treatment".[39] Post institutionalisation, people living with mental health issues began to organise themselves, meet together, support one another and advocate, ensuring their voices were heard within both the medical sector and the wider community.

This was significant because traditionally, mental illness had been understood within a medical framework, whereby mental health consumers are subject to a medical interpretation of their experiences and views. From the medical perspective, mental illness is considered biologically based,[40] and experiences of mental health are essentialised, de-personalised and de-

[34] Wybron, D & D Kiri, *ACT Women and Prisons, Invisible bars: The stories behind the stats,* Women's Centre for Health Matters, 2009.
[35] T Butler, *Preliminary findings of the NSW inmate health survey*, NSW Corrections Health Service, Sydney, 1997.
[36] BA Hocking, M Young, T Falconer & PK O'Rourke, *Queensland Women Prisoners Health Survey*, Department of Correction Services and University of Queensland, 2002.
[37] Australian Institute of Health and Welfare.
[38] D Wybron et. al., p. 24.
[39] S Mead, & C MacNeil, 'Peer support: What makes it unique?', *International Journal of Psychosocial Rehabilitation,* vol 10, no. 2, 2006, pp. 29-37.
[40] S Mead, D Hilton & L Curtis, 'Peer support: A theoretical perspective', *Psychiatric Rehabilitation Journal,* vol. 25, no. 2, 2001, pp. 134-141; Zinman, S & HT Harp, *Reaching across: Mental health clients helping each other.* California Network of Mental Health Clients, California, 1987.

contextualised rather than understanding individual's varied personal histories,[41] and the social conditions and interpersonal support systems which people with mental health issues experience.[42]

A consequence of a medicalised approach to mental illness is the under-emphasis of the impacts of the social determinants of health.[43] A further consequence is that it renders an individual powerless to contribute to their own recovery process, because the diagnosis and treatment of mental illness is strictly within the domain of the medical practitioner's expertise and control.[44] Mental health consumers are therefore at risk of becoming passive and dependent service recipients, resulting in a disempowered 'mental patient' identity.[45]

An alternative way in which to understand and treat mental illness is within the recovery framework, and peer support has grown from this. The aim of the recovery perspective is to transcend the limitations of the medical framework by re-orienting the individual as an active participant in life, empowered to participate in their treatment, and empowered to redefine and recognise themselves as unique individuals, not (just) their mental illness.[46] The recovery model is therefore characterised by promoting hope, personal responsibility, and human rights; a non-judgmental attitude from those involved in the person's care; and management of illness and symptoms.[47] The term recovery does not necessarily refer to an absence of symptoms or injury, but rather "the opportunity to live a satisfying and fulfilling life (as defined by the person in recovery) in the presence or absence of ongoing symptoms".[48]

Moreover, the recovery model promotes peer support because it encourages mental health service providers to consider the impact of social determinants on mental health and wellbeing. Within the recovery framework practitioners recognise that a person's age, gender, income, housing status, transport requirements, caring responsibilities, and relationships and support networks influence their support needs. It is recognised that treatment of one's mental illness symptoms will not necessarily lead to good mental health outcomes. Instead, broader support mechanisms which address the social determinants of health, such as peer support, are required to assist individuals to be 'more than their mental illness'.

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[41] J Chamberlin, *On our own: Patient-controlled alternatives to the mental health system*, Hawthorn Books, New York, 1978; Cohen, O, 'How do we recover? An analysis of psychiatric survivor oral histories', *Journal of Humanistic Psychology,* vol. 25, no. 3, 2005, pp. 333-54; DB Fisher, 'People are more important than pills in recovery from mental disorder', *Journal of Humanistic Psychology,* vol. 43, no. 2, 2003, pp. 65-68; Mead et. al., *What recovery means to us;* R Unzicker, 'On my own: A personal journey through madness and re-emergence', *Psychosocial Rehabilitation Journal*, vol. 13, 1989, pp. 506-517.
[42] Adame et. al.
[43] Adame et. al.
[44] Adame et. al.
[45] Mead et. al., *Peer support: A theoretical perspective.*
[46] S Mead S & HP Palmer, *Recovery: Beyond disability, transcending difference,* Trinity College of Vermont, Centre for Community Change through Housing Support, Vermont, 1997.
[47] Mead et. al., *Recovery.*
[48] Mead et. al., *Recovery.*

Peer support has therefore grown from the context of both decreased social connectedness as a result of de-institutionalisation in mental health care, and the recovery framework which takes into account the social determinants of health and is a reaction to the medical model.

3.2 Defining peer support

There are various definitions and models of peer support. In the context of mental health, peer support can be described as "social and emotional support, frequently coupled with instrumental support that is mutually offered or provided by persons having a mental health condition to others sharing a similar mental health condition to bring about a desired social or personal change".[49]

The term generally refers to mutual support provided by people with similar life experiences as they move through difficult situations. At its most basic, the peer support 'approach' assumes that people who have similar experiences can better relate and can consequently offer more authentic empathy and validation.[50]

> *Peer support is not like clinical support, nor is it just about being friends. Unlike clinical help, peer support helps people to understand each other because they've 'been there' shared similar experiences and can model for each other a willingness to learn and grow. In peer support people come together with the intention of changing unhelpful patterns, getting out of "stuck" places and building relationships that are respectful, mutually responsible, and potentially mutually transforming.*[51]

There are six distinctive features which broadly define peer support:

1. Peer support has a focal concern that brings members to the group, where they attempt to deal with common issues[52] such as community survival, advocacy or restructuring larger systems.[53]
2. Peer support is based on the belief that people who have overcome adversity can provide support, encouragement and hope to others in similar situations.[54] It therefore places emphasis on experiential knowledge, not professional expertise.[55]
3. The notion of reciprocity is enacted in peer support, whereby members are both providers and recipients of help, and there are equal relationships among all members of the group.
4. Peer support provides a safe environment for people to take on new roles and responsibilities,[56] 'be themselves' and receive support to reach goals.[57]

[49] Soloman et al.
[50] Mead and MacNeil, *Peer Support, What Makes it Unique?*
[51] Mead and MacNeil, *Peer Support, What Makes it Unique?*
[52] T Borkman T, 'Experiential knowledge: A new concept for the analysis of self-help groups', *The Social Science Review,* vol. 50, no. 3, 1976, pp. 445-456.
[53] Mead et. al., *Peer support: A theoretical perspective.*
[54] Davidson et. al., *Peer support among individuals.*
[55] Borkman.
[56] K Humphreys, 'Individual and social benefits of mutual-aid self-help groups', *Social Policy,* vol, 27, 1997, pp. 27-46.
[57] Mead et. al, *Peer support: A theoretical perspective.*

5. Peer support is founded on the principle that interpersonal relationships - a shared sense of community and common experiences of overcoming problems and times of distress - is a foundation for the recovery process.[58]
6. Peer support normalises what has been named as 'abnormal' because of social stigma.[59]

The principles underlying peer support are therefore:

- Empathy, understanding, non-judgement and respect
- Shared responsibility and mutual agreement on what is helpful
- Story-telling using practical experience and a narrative framework
- Trust, connection and friendship with others
- Promotion of recovery, spirituality, hope and healing journeys
- Empowerment for individuals to change
- The transformative power of crisis
- Nurturing personal strengths
- Choice and person centeredness[60]
- Peer-driven, non-hierarchical and reciprocal support
- Non-medical and voluntary framework

3.2.1 Peer support models

There are multiple ways in which peer support is modelled. There are three main types:

1. Informal, unintentional and naturally occurring groups
2. Consumer or peer run groups and programs
3. Paid peers who run formal and intentional groups.[61]

Peer support can also fall within the categories of being based around social support, individual peer support, mutual help, self help, drop-in centres, education, skill development, recreation, advocacy and community education, and particular issues or interests.[62] In support groups, consumers attend regular meetings facilitated by consumers or service providers. In drop in centres, consumers attend a facility where a range of structured activities are provided and consumers play a significant role. In individual peer support, consumer workers provide one-one-one support so the worker is seen as more of an expert.

A key way to differentiate between peer support models is that they are either integrated within traditional mental health services (whether government or non-government), or independent of

[58] Adame et al.
[59] Mead et. al., *Peer support: A theoretical perspective.*
[60] Mead et. al., Peer Support: A theoretical perspective, p. 8; Mead et. al., *What recovery means to us.*
[61] Davidson et. al., *Peer support.*
[62] J Peters, *Walk the walk and talk the talk: A summary of some peer support activities in IIMHL countries,* The National Centre of Mental Health Research, Information and Workforce Development, New Zealand, November 2010.

these mainstream services and operated through service user-run organisations.[63] Peer support integrated into the traditional mental health system use a 'mental health consumer as mental health provider' model whereby consumers are recruited to supplement traditional interventions with peer support, case management or counselling. These peer support workers usually undergo training and supervision. On the other hand, in consumer-run services such as drop-in centres and residential, outreach and vocational programs, mental health consumers are employed to provide peer support, programs and activities as an alternative to traditional mental health services, in what is seen as a more consistent and supportive environment.[64]

Three further models of peer support highlight differences in approaches to recovery:[65]

1. *Remedial peer support* focuses on the personal process of recovery
2. *Interactional peer support* emphasises interpersonal relationships as well as personal experience in recovery and is usually provided by traditional mental health services
3. *Social peer support* integrates the personal, interpersonal and political aspects of a person's life in order to generate social change and empowerment

3.3 Theoretical frameworks for peer support

A growing body of literature broadly agrees upon five theoretical frameworks that underpin why peer support can be effective for its participants.[66]

1. *Social support theory*

   According to social support theory, interpersonal relationships and social connectedness are associated with good mental health outcomes. Social support includes emotional support; companionship; assistance in accessing information, services and transportation; assistance with problem solving; and validation of one's experiences. Programs designed to change the levels of social support in one's environment and relationships have been successful in facilitating psychological wellbeing and in aiding recovery from traumatic experiences.

2. *Experiential knowledge theory*

   Experiential knowledge theory outlines how through participating in peer support groups, individuals develop wisdom and 'know-how' - or experiential knowledge - from the experiences of others who share the same problems.[67] Individuals who come together to work through similar experiences often gain similar insights. By pooling these experiences,

[63] D Orwin, *Thematic review of peer supports: Literature review and leadership interviews,* Mental Health Commission, NZ, 2008.
[64] J Chamberlin, 'The ex-patients movement: Where we've been and where we're going', *Journal of Mind and Behaviour,* vol. 11, no. 3, 1990, pp. 323-336; Davidson et. al., *Peer support.*
[65] MB Cohen & A Mullender, 'The personal in the political: Exploring the group work continuum from individual to social change goals', *Social Work with Groups,* vol. 28, no. 3, 2006, pp. 187-204.
[66] Salzer.
[67] Borkman.

common elements of a problem and attempts to cope with it emerge. The individual is then able to utilise this knowledge to mitigate their own issues.

3. *Helper-therapy principle*

   The helper-therapy principle outlines that individuals providing assistance to one another in peer support groups feel increasingly competent, independent and socially valued.[68] Providing mutual support also creates an environment that is conducive to recognising personal strengths and needs, and provides opportunities to assume new roles and responsibilities. Therefore, supporting others in a similar predicament to oneself helps individuals to perceive themselves as having strengths, knowledge and skills to offer their peers, and helping others is associated with greater psychological wellbeing.[69]

4. *Social learning theory*

   According to social learning theory individuals learn new behaviour either through overt reinforcement or punishment, or via observational learning of social factors in one's environment.[70] When individuals observe positive, desired outcomes from others behaviour they are more likely to model, imitate and adopt it. In other words, positive role-modelling encourages positive behaviour in others. However, disapproving comments or invalidation from peer-based services has also been linked with favourable short-term outcomes.[71] Peer relationships are therefore safe mechanisms for social learning, because they support the giving of both positive and negative feedback in a culture of trust and mutual respect.

5. *Social comparison theory*

   Social comparison theory outlines that people look to others to evaluate their own ideas and abilities.[72] When there are discrepancies people strive to improve themselves and diminish the discrepancy. Upward comparisons tend to increase efforts for self improvement, while downward comparisons enhance self-image and increase positivity by providing examples of more negative experiences than their own.

According to these theoretical frameworks, peer support can have positive outcomes in the context of mental health because it assists participants to transcend the limitations of mental illness and become more accomplished, active and socially connected to the broader community. Participating

[68] F Riessman, 'The helper-therapy principle', *Social Work,* vol. 10, 1965, pp. 27-32; TM Skovholt, 'The client as helper: A means to promote psychological growth', *Counselling Psychologist,* vol, 43, 1974, pp. 58-64.
[69] LJ Robert, D Salem, J Rappaport, PA Toro, DA Luke & E Seidman, 'Giving and receiving help: Interpersonal transactions in mutual-help meetings and psychosocial adjustment of members', *American Journal of Community Psychology,* vol. 27, no. 6, 1999, pp. 841-68.
[70] JB Rotter, *Social learning and clinical psychology,* Prentice-Hall, New York, 1945.
[71] Sells, D, R Black, L Davidson & M Rowe, 'Beyond generic support: Incidence and impact of invalidation in peer services for clients with severe mental illness', *Psychiatric Services,* vol. 59, no. 11, 2008, pp. 13-22.
[72] L Festinger, 'A theory of social comparison processes', *Human Relations,* vol. 7, no. 2, 1950, pp. 271-281.

in peer support provides new information, perspectives and skills; exposure to successful role models; and enhancement of problem-solving skills.[73]

3.4 Strengths of peer support

Research on the efficacy of peer support is limited due to the methodological difficulties of measuring its impact; however, the research that exists outlines many positive outcomes both for participants generally and in the context of mental health.

3.4.1 Outcomes for participants

Mental health peer support groups are associated with a variety of positive outcomes. A study of peer support groups for mental health and addiction in western countries found that it decreased hospitalisation and mental health service usage, reduced mental illness symptoms, and resulted in less reliance on income support.[74] It was also associated with increases in quality of life, increased use of recreational and community organisations, improvements in social support including housing, an increased rate of working and volunteering, and improvements in physical health where this was a targeted outcome.[75]

Additionally, peer support participants with bipolar disorder are more likely to indicate increased subjective wellbeing and reduced self-reported psychiatric symptoms[76]. Studies of drop-in centres show that they are associated with increased life skills, "quality of life, enhanced social support and problem solving".[77] Peer support has been shown to result in reduced mental health symptomatology and substance use.[78] And peer support participants are more likely to demonstrate greater progress in terms of quality of life and overall reduction in the number of major life problems experienced.[79]

Evidence also suggests that peer support reduces isolation, enhances social networks, increases social connectedness and self-esteem, and assists mental health consumers to cope through reflection and accessing support.[80] For example, length of attendance in a peer support program was associated with improved employment status, physical functioning, social relationships and

[73] A Garner & F Riessman, *The self-help revolution,* Human Services Press, New York, 1984; LF Kurtz & TJ Powell, 'Three approaches to understanding self-help groups', *Social Work with Groups,* vol. 10, no. 3, 1987, pp. 69-80; Leavy.
[74] Peters, p. 6.
[75] Garner et al.
[76] B McCorkle, E. Rogers, E Dunn, A Lyass & Y Wan, 'Increasing social support for individuals with serious mental illness: Evaluating the Compeer model of intentional friendship', *Community Mental Health Journal,* vol. 44, no. 5, 2008, pp. 355-66.
[77] CT Tan & C Mowbray, 'Consumer-operated drop-in centres run by and for psychiatric consumers: Evaluation of operations and impact', *Journal of Mental Health Administration*, vol. 20, 1993, pp. 8-19.
[78] S Parkin & N McKeganey, 'The rise and rise of peer education approaches', *Drugs: Education, Prevention and Policy,* vol. 7, no. 3, 2000, pp. 293-310.
[79] Peer work project, www.peerwork.org.au.
[80] J Kroschel, *A peer evaluation of peer support: Evaluating hospital to home and phone connections services of consumer activity network (Mental Health Inc),* Consumer Activity Network, NSW, 2011.

personal care. A project which paired consumers with non-consumers also found improvements in functioning and self-esteem and decreases in symptoms.[81]

A recent study found that peer support participants experience a range of holistic benefits including:

- Increased confidence, self-development and coping abilities
- Better relationships
- Greater assertiveness
- A more supported recovery journey
- A meaningful path back to employment
- Increased openness about one's mental illness
- Education about how to reframe their experience
- Assistance to remain well[82]

In addition, peer leaders have reported increased confidence and self-esteem; social support and networking; aspirations; knowledge about mental health; employment or volunteering opportunities; and improved financial situations, all factors which enhance wellbeing.[83]

3.4.2 Outcomes for mental health services

Peer support has positive outcomes for mental health services. Participants of one-on-one peer support programs access traditional mental health services less often, with decreased rates of hospitalisation and high rates of remission.[84] This is positive for the consumer as it indicates less distress; however, reduced demand for services also impacts positively on the mental health system through potential savings from decreased hospitalisations and shortened length of stay. Peer support workers are also cost effective, because services are "provided at a low cost yet [it is a] valuable support mechanism for consumers at vulnerable times in their recovery journey".[85]

There are further positive impacts of peer support within traditional mental health settings, because peer workers are able to influence the attitudes of clinicians and build meaningful relationships between those living with mental illness and clinicians. Clinical staff who are more attuned to the consumer's voice can encourage reduced stigma, meet community needs and enhance recovery focused services.

Gender differences have an impact on mental health and the experience and course of women's mental illness. As a result, women's mental health can only truly be understood by considering not

[81] Davidson et. al., *Peer support.*
[82] A Scott &C Doughty, *Peer support practice in Aotearoa New Zealand*, March 2011, New Zealand. http://ir.canterbury.ac.nz/handle/10092/5258.
[83] Davidson et. al, Peer Support, p. 79.
[84] Harris et. al.
[85] Harris et. al.

only the biological and physiological, but also the social, cultural, economic and personal contexts of a woman's life.[86] Evidence suggests that practitioners who implement this knowledge into their services—that is those who are gender-sensitive—achieve better health outcomes for women. Gender sensitive mental health service delivery also acknowledges the role that health practitioners may play in empowering or disempowering those in their care. Gender sensitive mental health service delivery understands that women are their own experts and that women are best placed to make decisions about the issues that affect their health and wellbeing.

3.4.3 Outcomes for families and communities

Peer support has positive impacts on families, carers and community members because "the more effective, less coercive approach means that families may be more relaxed as the right support is provided to the individual and family".[87] Peer support also has positive impacts on society more broadly because it reduces stigma surrounding mental health through increased social connections; and participants and consumers provide a positive contribution to the health of others through peer support.[88] Furthermore, larger systems of care in society can change when mental health organisations become more positive in their attitudes towards recovery and mental health via peer support.[89]

3.4.4 Health promotion

Peer support is a tool of health promotion. The *Ottawa Charter of Health Promotion* defines health promotion as a "process of enabling people to increase control over, and to improve their health".[90] This can occur through developing personal knowledge and skills to understand your own health and the health care system.[91]

Peer support is a good mechanism for increasing health knowledge because evidence suggests that:

> *Peers are more likely to believe and trust information and ideas that come from someone with credibility as a 'consumer' within their network or group [and] …'experienced' peers may also be able to translate complicated messages and medical jargon into manageable pieces of information, and to relate health messages to the context of people's lives[92].*

Peers are therefore seen as credible sources of information because they have:

1. Person–based credibility due to their demographic characteristics

[86] D.E. Stewart, "Social Determinants of Women's Mental Health", *Journal of Psychosomatic Research*, Sep 2007
[87] Kroschel.
[88] Kroschel.
[89] M White M, & D Epston, *Narrative means to therapeutic ends,* W. W. Norton & Company, New York, 1990.
[90] World Health Organisation, *The Ottawa charter for health promotion,* 1986, http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf.
[91] World Health Organisation, *The Ottawa charter.*
[92] Parkin et. al; M Shiner M & T Newburn, *Young people, drugs and peer education: An evaluation of the youth awareness programme (YAP)*, Home Office and Drugs Prevention Initiative, London, 1966.

2. Experience-based credibility situated in life rather than theory
3. Message-based credibility by communicating information in a non-judgemental manner[93]

3.5 Challenges of peer support

While peer support has positive impacts, it also faces some unique risks and challenges. For example, bringing together people with mental illness risks perpetuating an 'illness assigned' culture, the medicalisation of mental illness, and the misguided belief that mental health issues are abnormal.[94] Some participants reinforce mental illness stereotypes and stigma by stating views such as: "the people that come [to peer support] are mentally disturbed. They're manic depressives… I don't like being around people that are just normal."[95]

A further challenge is that peer support facilitated by employed mental health consumers is not associated with reciprocity. Facilitators may take on a more professional or senior role in the relationship, so its intended informal nature may be constrained by traditional therapeutic boundaries. The autonomy and integrity of peer support aligned with traditional mental health services may also be questioned in regards to its commitment to recovery.[96] As Orwin argues, "peer support is most effective when it is operationally independent, led by service users, not tokenistic or viewed as just another contract supported by mental health managers…"[97] However, properly designed peer support addresses the role of power relations.

3.6 Facilitation, supervision and training

Facilitation can conflict with the idea of peer support being informal, non-hierarchical and outside the sphere of clinical services.[98] However, evidence suggests that effective facilitation and supervision is vital for successful and self-sustaining peer support,[99] because peer support can be a challenging environment requiring skilled management.[100] Facilitators should have experience in being both a participant and leader, there should be ongoing communication and support between group members and facilitators to minimise the risk of burnout, and group members should be encouraged to consider structural issues like leadership succession plans.[101]

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[93] Parkin et al.
[94] Mead et. al., *Recovery: Beyond disability.*
[95] Rogers.
[96] Orwin.
[97] Orwin.
[98] D Orwin, *Thematic review of peer supports: Literature review and leadership interviews,* Mental Health Commission, NZ, 2008.
[99] J McLean J, H Biggs, I Whitehead, R Pratt & M Maxwell, *Evaluation of the delivering for mental health peer support worker pilot scheme*, Scottish Government Social Research, Edinburgh, 2009.
[100] J McLean J, H Biggs, I Whitehead, R Pratt & M Maxwell, *Evaluation of the delivering for mental health peer support worker pilot scheme*, Scottish Government Social Research, Edinburgh, 2009.
[101] S Tse, C Doughty & F Bristol, 'Peer support groups for people with bipolar disorders in New Zealand: A pilot study on critical success factors', *International Journal of Psychosocial Rehabilitation*, vol. 9, no. 1, 2004, pp. 47-58.

Facilitation of peer support is an area where capacity building is required. Supervision can support peer leaders through the challenges of peer support and assist in the development of skills. Appropriate supervision for facilitators can include accessing monthly supervision through a formal line manager, team leader or external supervisor; group supervision fortnightly (either structured or less structured); and/or providing support to access professional counselling and other services. Best practice supervision must also incorporate an understanding of and belief in the peer support role, service model and philosophy, and supervision should be external to the organisation.[102]

Training is important for peer support facilitators, although currently accreditation in peer support is only available internationally. In Australia, *peerwork.org.au* run a 27 hour, free 'introduction to peer work' course which offers a foundation for specialist training, and training is available through local consumer operated services. The *Community Services and Health Industry Skills Council* are also developing a *Certificate IV in Mental Health Peer Work* and holding consultations about the qualification. Internationally, accredited courses aim to equip participants to perform the peer support role in a variety of settings. Useful topics for training include recovery; mental health; how mental health staff, services and systems operate; privacy and confidentiality; ethics; leadership; effective communication skills; giving and receiving feedback; and dealing with conflict.

Training is not only useful for peer support facilitators. It is useful for educating staff in traditional mental health settings about the role of peer support. Evidence shows that staff embrace peer support workers when they understand their effectiveness. It is also best practice for facilitators to undertake the same peer support training as members. [103]

3.7 Gender sensitive approaches

Women and men are diverse as a result of biological and social differences, and differences in the ways that they experience daily life. In addition to other social determinants, gender plays an important role in understanding individual's health needs and experiences of ill health, including the experience and course of mental health and wellbeing. Therefore women living with mental health issues may have different peer support needs.

3.7.1 Gendered experiences of mental health

The majority of psychiatric disorders, particularly mood, anxiety and eating disorders, are found in women.[104] There are also gender differences in regards to age of mental illness onset, symptoms, co-morbidity with other illnesses and the ways in which mental illness is expressed.[105] For example,

[102] Tse, pp. 47-58.
[103] Tse, pp. 47-58.
[104] F Judd, S Armstrong & Kulkarni, 'Gender-sensitive mental health care', *Australasian Psychiatry: Publication of the Royal Australian and New Zealand College of Psychiatrists,* vol. 17, no. 2, 2009, pp. 105-11.
[105] Judd.

depression in women compared with men is more often characterised by appetite changes, sleep disturbance and fatigue,[106] and is more likely to be accompanied by anxiety.[107]

Gender-stereotyping and bias in relation to identifying and treating mental illness can also impact on good mental health outcomes for women. Women are more likely than men to be diagnosed with depression, "even if they have similar scores on standardized measures of depression or present with identical symptoms".[108] This may be caused by stereotypical conceptualisations of women as emotional or hormonal.[109] It may also be a result of women being more likely to seek help for or disclose mental health issues than men, and women being more likely to disclosure drug and alcohol use.[110]

In addition to women experiencing and being diagnosed with mental health differently to men, women's lower social status increases their vulnerability to poor physical and mental health outcomes.[111] Women's lower social status is reflected in the high incidence of violence against women; women's lower socio-economic status; an under-representation of women in positions of power; and an over-representation of women in part-time and casual work. Therefore, if psychosocial factors are given appropriate consideration a woman's biological functioning has minimal impact on her mental health and wellbeing.[112]

[106] MA Young, WA Scheftner, J Fawcett & GL Klerman, 'Gender differences in the clinical features of unipolar major depressive disorder', *Journal of Nervous and Mental Disease,* vol. 178, 1990, pp. 200-203.
[107] SG Kornstein, GM Sloane & ME Thase, 'Gender-specific differences in depression and treatment responses', *Psychopharmacology Bulletin,* vol. 36, 2002, pp. 99-112.
[108] EJ Callahan, KD Bertakis, R Azari, LJ Helms, J Robbins & J Miller, 'Depression in primary care: Patient factors that influence recognition', *Family Medicine,* vol. 29, no. 3, 1997, pp. 172-76; G Stoppe, H Sandholzer & C Huppertz, 'Gender differences in the recognition of depression in old age', *Maturitas*, vol. 32, 1999.
[109] IK Broverman, SR Vogel, DM Broverman, FE Clarkson & PS Rosenkrantz, 'Sex-role stereotypes: a current appraisal', *Journal of social issues,* vol. 28, no. 2, 1972, pp. 59-78.
[110] World Health Organisation, *Gender and Women's Mental Health,* 2011, www.who.int/mental_health/prevention/genderwomen/en/.
[111] BP Dohrenwend,, 'Socioeconomic status (SES) and psychiatric disorders', *Social Psychiatry and Psychiatric Epidemiology,* vol. 25, no. 1, 1990, pp. 41-47.
[112] L Dennerstein,, E Dudley & H Burger, 'Well-being and the menopausal transition', *Journal of Psychosomatic Obstetrics & Gynaecology,* vol. 18, no. 2, 1997, pp. 95-101.

3.7.2 Gender sensitive practice

Understanding women's unique experiences of mental health and life circumstances more broadly changes peer support practice for women. Principles of gender sensitive practice should be considered. As outlined in WCHM's *Position Paper on Gender Sensitive Mental Health Service Delivery* (2009),[113] gender sensitive considerations include:

- Viewing women's lives in the context of their circumstances
- Acknowledging the power difference between facilitators and participants to avoid disempowering women
- Remaining aware of gender stereotypes and the objectification of women
- Making services available, accessible, affordable and appropriate

In sum, when inclusive of women peer support programs may require, for example, increased sensitivity, support and information provided for women who have experienced violence or trauma, as some situations may trigger feelings of powerlessness and cause re-traumatisation.[114]

3.8 Best practice in peer support

The above review of peer support literature found that there are a variety of peer support models which can meet the needs of different individuals. These models vary according to their formality, purpose, approach to recovery, integration into traditional mental health services, and facilitation style. Despite the variety of ways in which peer support can function, there are key characteristics which define best practice which have emerged from this literature. Important components of best practice include:

1. *Recovery framework*
   Best practice peer support is firmly located within the recovery framework, as opposed to the medical framework. The recovery framework emphasises the social determinants of health; empowers individuals to participate in their treatment; defines people as more than their mental illness; and promotes living in the presence and absence of ongoing symptoms, hope, personal responsibility, and a non-judgmental attitude.[115]

2. *Principles of peer support practice*
   Underlying principles which differentiate best practice peer support from other therapeutic environments include an emphasis on experiential knowledge, reciprocity, providing opportunities to learn and take on new roles, normalising and addressing social stigma,

[113] Women's Centre for Health Matters, *Position paper on gender sensitive mental health service delivery,* November 2009.
[114] Judd et al.; Peters.
[115] S Mead S & HP Palmer, *Recovery: Beyond disability, transcending difference,* Trinity College of Vermont, Centre for Community Change through Housing Support, Vermont, 1997.

shared responsibility, building friendship or interpersonal relationships, and being non-hierarchical and voluntary.[116]

3. *Gender sensitive peer support*

   There are differences in the way in which women and men experience mental health in regards to age of mental illness onset, symptoms, co-morbidity with other illnesses and the ways in which mental illness is expressed.[117] Gender-stereotyping and bias in relation to identifying and treating mental illness also impacts on good mental health outcomes for women. In addition, women's lower social status increases their vulnerability to poor physical and mental health outcomes.[118] Therefore, best practice is for peer support to be gender sensitive in order to consider individuals within the context of their gender as a social determinant of health.

4. *Facilitation*

   Facilitation is vital for successful and self-sustaining peer support because peer support can be a challenging environment requiring skilled management.[119] Best practice facilitation includes leaders as peers, and good communication and succession plans.

5. *Supervision*

   Supervision can support peer leaders through the challenges of peer support and assist in the development of skills. Best practice supervision for peer support leaders can be accessed through a variety of mechanisms and must incorporate an understanding of and belief in the peer support role, service model and philosophy; and must be external to the organisation.[120]

6. *Training*

   Training is useful for peer support facilitators, for educating staff in traditional mental health settings about the role of peer support, and best practice is for facilitators to undertake the same peer support training as members. [121]

Conclusion

Research discussed in this literature review highlights that peer support is a viable option to support women living with mental health issues who experience low levels of social connectedness. It

[116] S Mead, D Hilton & L Curtis, 'Peer support: A theoretical perspective', *Psychiatric Rehabilitation Journal,* vol. 25, no. 2, 2001, pp. 134-141.
[117] Judd et. al., pp. 105-11.
[118] BP Dohrenwend,, 'Socioeconomic status (SES) and psychiatric disorders', *Social Psychiatry and Psychiatric Epidemiology,* vol. 25, no. 1, 1990, pp. 41-47.
[119] J McLean J, H Biggs, I Whitehead, R Pratt & M Maxwell, *Evaluation of the delivering for mental health peer support worker pilot scheme*, Scottish Government Social Research, Edinburgh, 2009.
[120] Tse, pp. 47-58.
[121] Tse, pp. 47-58.

promotes recovery, and there are both theories and evidence underpinning why peer support produces positive outcomes for women's wellbeing. While there are challenges of peer support, there are a variety of models, so that peer support can be appropriate and accessible for a wide range of women living with mental illness. There are also a number of best practice principles which should be implemented in peer support in order to achieve good outcomes, including gender sensitivity and access to support.

Findings: Focus group and interviews

Women who are members of peer support programs across the ACT shared their needs and experiences of peer support in focus groups and interviews.

4.1 Peer support models

4.1.1 Defining peer support

The women who were consulted participated in a variety of peer support models for people with mental health issues. They most commonly defined peer support as a group of people who are on "an equal basis" experiencing a similar issue who share their personal support, encouragement and information, through "honest communication" and friendship. The women consulted in focus groups also discussed peer support within the context of a mental health recovery journey. For example, one woman stated:

> *A peer knows where the consumer peer is coming from, and they can offer experience and wisdom. They've been through the same or maybe similar issues. They have similar problems with recovery. And they can offer tips, go though their life experience, and offer hope.*

In terms of preferences for different peer support models, some women preferred groups with boundaries, structure and a clear purpose and goals; while others preferred groups that allow for flexibility. A woman who participated in consultations who prefers clear expectations stated she felt she was "going on a blind date". Another woman outlined that it is positive that there are various definitions and models of peer support, because people can then choose a model they are comfortable with:

> *I think [peer support is] as varied as individuals are, and what works for one person is definitely not going to work for someone else… if peer support works well, the best part is finding people who have a common understanding or who work in similar ways to you… it's about matching… I don't think its just one size fits all with peer support. I think it should be individualised.*

4.1.2 Mental health in peer support

Peer support groups can either be mental health specific, or their focus can be on other activities where participants may or may not experience mental illness. The majority of women who were consulted preferred the latter type of peer support. Many women reported that they felt joining peer support groups with a mental health focus could encourage stigma, for example by "reinforcing that we are 'mental' and that's who we are". In support of this view, other women who were consulted stated:

[In my peer support you] don't have to identify as depressed. It gets away from the 'victim mentality'. You can find out later down the track that the others had the same mental illness as you did.

I don't identify myself as depressed where that is the focus and everything else is around that. I'm [me], and [my depression] is something of me that I have to deal with, but there are so many other things. That's what I really like about the group, that it feeds everything, it's not just about my depression.

I guess for some people going to a group [for mental illness], would deter them straight away. So sometimes having the focus on a different area will still attract people… art groups or drama groups or people with other common interests, and then if [experience of mental illness] does come out it does come out.

Another woman who was consulted also believed that being in a peer support group where everyone is living with mental illness can encourage a 'sick role':

If you are improving and other people aren't, being pulled back into discussions can be difficult when you are moving on with your life and wanting to focus more on other things. And if a lot of your social network has now become people who are unwell, then it can be quite difficult to start getting well.

Other women who were consulted outlined that they prefer peer support that does not focus on mental health because it provides a more relaxing environment. Paradoxically, this can be more beneficial to their mental wellbeing:

[The peer support worked because] it was somewhere where I didn't have to worry about mental health, or think about mental health, or talk about mental health.

One of the things that I really liked about [the peer support] was that it wasn't... anything more than an art group. There was no therapy to it. There was no psycho-education to it. It wasn't like going to an art group… within a mental health organisation where there might be more demands than I could meet… it made me feel quite relaxed.

Additionally, women who were consulted outlined that they preferred peer support with a diverse range of participants rather than, for example, all participants having the same background or experiencing the same mental health issue. For instance, the following women felt they got more out of their relationships with people who they did not expect to connect with:

I value the inclusiveness and the diversity [of the peer support]. It really built my character and my self-esteem meeting a lot of the other consumers and people from all different educational backgrounds. It's good to see people come from all different walks of life. Often I actually found that I bonded with them more than I do my own friends and it made me feel more worthwhile, and we had a deeper connection.

> *I have gotten an enormous amount out of… people whom I may not have gotten to know if it wasn't for having a mental illness. And that has incredibly enriched my life. It has radically altered how I think about, see and communicate with a whole lot of people whom I didn't have much contact with previously. And it's been really important for how I see myself.*

However, a minority of women who were consulted reported that they prefer joining peer support where they know other members are experiencing mental health issues. They believe mental illness should be celebrated, not denied, and that group members with mental illness can provide positive role models for recovery:

> *I don't like being around normal, everyday, boring people. It's not so much the illness side of it, it's more, who wants to be average? Everyone in our group is… special. And I think that the variety in us is celebrated.*

> *Your illness doesn't define you but it made you what you are. It gave you the strength to be what you are, and [you should not] deny your roots. [Because we] live in a world where [if you're experiencing mental illness], you've got some nasty secret to hide, and you're not going to tell your mates.*

> *For me, being around other successful more mature people who have experienced mental illness, and they've come out the other end… is very inspiring. Even though they've got a mental illness, look at everything they've achieved.*

One woman also identified that while she would prefer to experience peer support with others with mental illness, there may be a point in her recovery where she stops wanting to be in this environment because the sigma may "rub off" onto her.

Therefore, as the following woman sums up, people have different preferences for peer support:

> *It's good to have a wide range of peer support options available… some which are mental health focused, some which aren't, so that you can decide what suits you best.*

Where those women who were consulted preferred accessing peer support with other mental health consumers, their response to the question of whether groups should be diagnosis specific was mixed. Some believe people with different mental illnesses should be relate together, to learn that they have more in common rather than differences:

> *[Irrespective of diagnosis], you're going to come across the same kind of problems. I think there is more scope to relate and share your experiences, and relate it to their experiences.*

Others felt they preferred an environment where people experienced the same mental illness and shared the same symptoms, due to fear that peer support dealing with different mental health issues could create lack of understanding and confusion.

> *I wouldn't understand a lot of their background, so I probably would be a bit scared to go because I really only know from my experience. I don't know whether they would understand my experience and vice versa.*

> *[Being in peer support with different mental illnesses would] just confuse me, really. I'm still on the road to recovery and trying to manage it… [and they might] have different ways of managing it to what I would be [open to].*

4.1.3 Recovery in peer support

Whether or not individuals preferred to participate in peer support that is mental health specific, the majority of women felt that people must be on their recovery journey, rather than experiencing an acute episode. They reported that interacting with recovering individuals provides hope, increases their mood, and enables them to connect and understand their story more easily. Additionally, people in recovery may have increased insight so can recognise issues and have greater capacity to help others:

> *I think generally the more confident you are in yourself and your illness, the more you understand it. And the more self awareness you have, the better you can help other people.*

Another participant of the focus groups felt that there could be instability if people who are experiencing different stages of mental illness are in the same group:

> *I guess it depends on where the person's at really… you could have a clash where some people are still struggling with their diagnosis or their illness and haven't come to terms with it, and some people have, and if you mix those people together then you're going to have less continuity.*

An example which reinforces the argument about people in similar stages of recovery is found in one woman's experience of compulsory peer support in hospital:

> *Within hospital, the enforced participation in groups, regardless of whether you are even remotely in a place where you can participate, is just really ineffective. It means you have a whole bunch of people who are peers, insofar as they have a mental illness, but who are having such different experiences at that time. [They may] be… actively psychotic… at different points in recovery, or just having different issues.*

4.2 Group facilitation

Amongst women who participate in peer support there are a variety of views about whether an appointed group facilitator is necessary, and if so, whether the facilitator should be trained. Some women argued they prefer peer support not to have facilitators because being self-mediated is a valuable group endeavour, and facilitation can affect the power balance:

> *The people running [big peer support groups], there's a 'them and us' agenda, where you have a facilitator. I hate power, where somebody is sitting there, a bureaucrat.*
>
> *If you put a professional in the mix it changes the dynamic... they're not one of us.*

Further, the majority of women who were consulted felt that trained facilitation was not necessary, because personal experience of an issue is more important. Some reported that with lived experience, facilitators "know what to say and what not to say" more than professionals because they have personal insight into the issue. For example:

> *I think lived experience qualifies people to help another consumer. With book learning, in parenting, people say 'you should do this, you should do that' with your kids, but when you've actually got the kids, it's a different matter all together.*
>
> *They may not be psychologists, but sometimes it's the people who have had the experience who are more the experts than the ones who haven't.*
>
> *It's like travel, someone can tell you about the Himalaya's easily from books and what they've heard, but I think it is more real when you actually talk to someone who has that experience.*

Other women described how someone with lived experience can offer a more meaningful and genuine therapeutic relationship. For example, peers offer hope and a role model; open up without fear of being judged or can choose to not open up at all; offer reassurance of normality and of not being alone; and provide a strong sense of connection described as being like family. The following woman also highlights that she feels more easily understood by peers:

> *When I've talked to my friends or my family or counsellors or psychologists, I feel like I have to explain more, go into more detail, and that can be more draining. When I've talked to people who have had a similar experience… you don't have to say as much, there's just more common understanding, so it's more open easily, you know there's less you have to work towards. It just comes naturally.*

On the other hand, some women believe that professionally trained facilitators are necessary for peer support to be effective, because they can manage the difficulties arising as a result of group dynamics:

> *[In peer support there are] too many [people] all vying for attention, and their idiosyncrasies. That actually is very demanding and not very helpful. And then you get little subgroups, where you relate to one person and not another group. But I think a skilled facilitator, a leader, somebody who has had that experience, the vision, and the knowledge and awareness, can steer [the group] in a healthy direction.*

Some women who were consulted also argued that skilled peer facilitators should operate and be paid in clinical settings:

> *It gives the person [with mental illness] a chance to share their knowledge, to be usefully employed, I think it is a good idea. I mean, often you talk to a bureaucrat and they wouldn't know diddly zit about a problem.*

> *There was an issue between service users and a staff member, and it worked very well in the way that nobody felt threatened by it [because of the paid peer support worker].*

Another point of view expressed in the consultations is that ideally, group facilitators should be skilled and have clinical knowledge, and also have lived experience or experiential knowledge:

> *The [trained] staff are supportive and I guess they also understand what you're going through, like you've had depression, and they know what you're going through because they've been through it. And I loved [one of the facilitators], she was really fantastic and actually I found my story more similar to hers than I did with the other girls in the group... I could talk to her about it because she went through the same thing.*

In addition to having lived experience and possible training, women who were consulted identified that good peer support facilitators are open, genuine and empathetic; understand confidentiality; have good communication, group management, assertiveness and leadership skills; and have some counselling skills.

Where peer support is facilitated, women recognised the importance of supervision and debriefing because group content and certain situations can be challenging and emotionally difficult. Participants of the focus groups suggested possible arrangements for facilitator support could include mentoring or debriefing with an independent person rather than a program supervisor.

Facilitators who were interviewed confirmed that they need support to manage their own mental health, receive encouragement to seek further assistance if necessary, and to learn skills about how to "leave it at work". In addition, women reported that debriefing is particularly important for people who are living with mental health issues:

I think [not de-briefing is risky], because everybody needs to debrief, to get something that's really affected you off your skin, because you've had a similar experience and it really gets to you.

Debriefing is very important for someone who has trauma or tragedy in their life. And it takes a skilled [supervisor] to be aware of that, to pick up the fine nuances when someone is not coping.

Women who were consulted also agreed that in addition to supervision or debriefing, opportunities for training should be available for peers, including opportunities for forming links with and learning from other peer support programs. One focus group participant reported her concern about her lack of training but also her uncertainties about whether she should be trained and paid when she is also a service user:

[Not having anyone with mental health qualifications] does worry me a bit… I'm the contact person for the group and I had a lady on the phone the other day who was in a bit of a bad way, and I've had no training to deal with that… It does worry me a bit that perhaps we're not doing the best we can. But then again, I don't get paid for the job and I'm like everybody else, a user of the group not a service provider. So there's that sort of conundrum really.

4.3 Access and participation

The first step to accessing peer support is finding information about the options available in the ACT. The women who were consulted reported they learnt about peer support programs through their case manager, the Women's Information and Referral Centre, mental health services, or organisations representing their issues. One woman discussed that when people are informed about the peer support options available, they can "try before they buy" until they find what they are comfortable with.

Some women outlined in focus groups that health professionals such as social workers or psychologists encouraged them to access peer support, or alternatively that they decided to access peer support because of negative experiences with health professionals. One participant who was consulted explains:

I was involved with a counsellor and a mental health crisis team but I'm not seeing either of them anymore… one of them I didn't feel very comfortable talking to, I found it very hard to open up and tell her what I was really feeling… I find the counsellors very formal and also intimidating.

Women also highlighted that a key reason they joined peer support is because it offers freedom in separation from other areas of their life, and anonymity. The following focus group participant describes how knowing someone in her peer support program disrupted her experience of peer support:

I walked in [to the group], and [a woman I know from work] was there and she was like, 'oh hi!', and I was like, 'oh no'! I came here to get away from that. She doesn't talk to me much, thank god… in a way it was kind of nice because it was a familiar face, but then I was like, I didn't want it to be you as the familiar face. I really wanted [the group] to be separate from everything.

Other women also admitted they would not invite their friends to join peer support due to the importance of anonymity, and a sense of ownership they felt over the group as their "special" experience:

I wouldn't want to refer any of my friends to [this group] because I want it to be mine. I don't want to share them. I thought I might invite this friend but then it won't be my thing, it will be ours. I want it to be my thing.

In addition when choosing peer support, trust was the most common aspect that was vital to the women who were consulted in focus groups, especially for those experiencing particular mental health issues such as Post Traumatic Stress Disorder (PTSD). To feel that there is trust in peer support women outlined they would need to know who their peers are, and build trust and rapport with them carefully in a safe environment. A further characteristic of peer support that is valued - because it facilitates trust and support - is stability in membership.

<u>Barriers to access and participation</u>

Some women who were consulted highlighted that it can be difficult finding information about peer support options in the ACT. One woman reported that when she was searching for mental health peer support, she felt too tired to do research or make decisions due to experiencing depression. Another participant of the focus groups reported that it can be very difficult finding information on the Internet:

You have to be really selective about where you go [online] and I find that it takes a lot of energy to surf endlessly to try and find what you need. When you're time poor and maybe not healthy, it is a bit impossible and can just be overwhelming… You can't just go '[this is my] problem', click, and voila, a neat little package of information [appears]. You've really got to slog through so much… It's not even of good quality and you just have to find the right bit.

Stigma surrounding mental health issues can also be a barrier to joining peer support for some women. Women reported that they previously held stigma towards groups of people living with mental illness, and that they feared joining peer support would stigmatise them further. For example:

I don't think I would have ever gone to a peer support group. Counsellors would often suggest it to me… and I was like 'no way', but I kind of accidently fell into [peer

support] and I realised what it actually was and how beneficial it was. Now I probably would consider it, but originally I never would have gone for it.

Some peer support programs in the ACT also have entry requirements which can act as barriers for when trying to access support. Entry requirements may include having a diagnosis of mental illness or not engaging in problematic alcohol or drug use. One woman consulted discussed that if she was not accepted into her peer support, she would have felt rejected and her mental health may have worsened. She states:

If [I hadn't gotten in] I probably wouldn't have listened to [advice on where to access other services] because I would have felt like I was being pushed aside and often… with mental illness you can feel like you're pushed to this door and pushed to that door and just everyone's pushing you away, so that probably would have been a very negative experience…

Once women are participating in peer support, there can be several barriers to continuing their participation, both practical and emotional. The practical issues that emerged in consultations are cost and transport. For example, some peer support participants may be reliant on income support after a period of being unwell:

Providing people with a bit of a subsidy to attend groups where there might be a cost [would be helpful]. When you're stepping away from that acute level, and trying to access other things in the community to broaden your life, it's very hard if you don't have much money.

There can also be transport issues when participants of peer support are reliant on public transport to attend programs because of the time involved and stigma experienced:

[It is difficult] if you are reliant on buses, as Canberra buses are incredibly appalling. If you are so unwell that you really just can't conceive of getting onto a bus, or you are sick of bus drivers telling you off because you seem to be talking to non-existent voices, it's hard to access a service. Also, it's difficult to get up and go somewhere if that involves going there an hour or two hours early, because that's the only bus that you can get.

For me, it's hard because of transport. I have huge issues with driving. Also, people who have to come a long way, they might not even want to get dressed anymore. They don't think its worth it… it's all too hard.

In consultations women also discussed that child care can be a barrier to participating in peer support. While some women who were consulted preferred mothers not to bring their children resulting in child care difficulties for parents, available child care was the most appealing aspect of their group and encouraged attendance for others.

In addition to practical challenges to participating in peer support, women reported emotional challenges such as feeling uncertain or nervous about socialising with new people, feeling overwhelmed or out of place, and experiencing self doubt. A focus group participant describes her experience of first attending peer support as follows:

> *I got halfway through and almost just walked out. I was just so anxious. I had my glass of water somewhere and then someone else sat in that seat. I didn't know where else to sit, and I didn't know anybody so I couldn't tell anybody how I was feeling. The first time I went… it was hard.*

4.4 Positive impacts of peer support

All of the women who were consulted reported positive feedback about their peer support experiences and described the ways in which it has impacted on their mental health and wellbeing, confidence levels and social connectedness. Overall, women reported feeling disappointed when programs with set timeframes finished with no alternatives and reported that there should be a continuity of peer support programs available for people living with mental health issues in the ACT.

4.4.1 Mental health and wellbeing

Several women who were consulted recognised the positive impact peer support has had on their mental health and wellbeing, even when this was not the main aim of the group. Women stated it "keeps me sane", "it has been one of my key supports to get me through", and:

> *I found myself being a lot happier. I wasn't sitting at home dwelling on everything that happened, and looked forward to going out and talking to other people. I could see a tiny light at the end of the rainbow. It was all black before, I didn't see myself going on.*

> *[Our activities] are really constructive. It's really low pressure. You can watch or participate to any degree that you feel capable of. There have been plenty of days when I just turn up because I can just sit there in a really warm, supportive environment, have a cup of tea, and take a load off. It's like a circuit breaker. So in a lot of ways it promotes good mental health.*

Moreover, it emerged that peer support for women results in improvements in mental health because it provides an alternative to the medical model. Women who were consulted outlined how being treated as "normal" and "as a person, not the symptoms" by peers is empowering:

> *[Peer support] is a holistic kind of support. It's you as a person… your health issue is not what first hits people about you. It's you and the rest of your life. It's making connections as you, not necessarily you and your problems.*

> *I liked [the group] because it really pulled you out of the patient role. It wasn't yet another group where you go to be psycho-educated, or 'therapied'… and that's an empowering model of peer support work. It was very challenging.*

Another positive impact of peer support for mental health and wellbeing is an outcome of learning and information sharing with peers. Women reported that they learnt to recognise mental health symptoms in others; shared stories about their successes and failures with treatment; discussed ideas about accessing the mental health system and resources; and learnt techniques for increasing positive mood. Women also reported that peers have helped them to identify when they are unwell. This is important if they lack awareness and insight due to the illness, are experiencing denial, or do not yet monitor their own symptoms.

Peer support also has positive outcomes for mental health by increasing participant's awareness about stigma and reducing self-stigmatisation. For example, focus group participants discussed that their family members may have a stigmatised view of mental illness, and explained that peer support is a forum to explore the stigma they have experienced in the wider community including workplaces. The following focus group participants reported feeling more empowered to discuss mental illness and question the meaning of 'normal':

> *That shared understanding, for me that's what broke down my stigma. I tell people now, and I never would've openly told people that I had mental health issues before [the peer support group]… I feel that now there are people who understand and don't judge me.*

> *I think nearly everyone's got a little mental problem. Everyone's got a crack in their cup. Everyone has got some idiosyncratic thing that's peculiar to them and makes them an individual. So, I mean, normal is a very boring word.*

Other focus group participants reported that their participation in peer support has promoted mental and physical wellbeing in general, for example through encouraging interests in enjoyable activities, and building new skills. Facilitating peer support can also have positive mental health outcomes for facilitators, who feel positive that they are able to offer their empathy, experiences and hope to others.

4.4.2 Self-esteem and confidence

Women who were consulted felt that their confidence and ability to cope had increased as a result of participating in peer support. Overall, women felt they had increased confidence to "escape from competitiveness and the pressure to be perfect" and felt more self-confident about developing relationships and disclosing mental illness:

> *It doesn't matter if people I meet now judge me, because I have a sense of security. I never had that before. So now I'm more open to tell people [about my mental illness], but I think if you don't have that security it's very difficult. Then you've got nothing if you disclose and you're rejected. See at the moment I have something.*

Women also reported gaining confidence to try new experiences which they would not have previously attempted. For example, applying for work:

> *[Peer support] has given me the confidence to write a job application. Writing a CV after staying at home with kids for six years… is daunting. I hadn't had experience [working] for that long… the stuff that I do [with the group] fits the job well. It's really helped me transition from just being a mum back to working.*

4.4.3 Social connectedness

Focus groups found that peer support helps women to address feelings of isolation through providing social connection. Many women reported experiencing loneliness due to lack of social contact or support in daily life, and also reported isolating themselves due to mental health symptoms such as not feeling safe outside of the home:

> *I'm home, I lock myself up, I take the phone off the hook. I don't go out, I just stay home.*

Other women who were consulted discussed feeling isolated because society is increasingly individualistic, or because friends have moved on over time due to having less in common and different priorities. Women also described how mental illness can change friendships:

> *[Mental health consumers often] lose their friendships. Even the people that know you're diagnosed can still 'break up' the relationship when you show symptoms or you're too anxious, or you're ringing them up all the time… because you want to talk to someone. They get sick of it and cut you off.*

Alternatively, some women described feeling isolated because they had difficult family relationships or do not want to burden family with their mental health issues. Women living with mental health issues may also lack confidence in their ability to form friendships and perform in social settings, as demonstrated by the following focus group participant:

> *I [feel socially awkward] every time I get into a group of people… I'll get into a social group and just fade into the background. I don't think I'm good enough to have friends. I've got a few close friends but in the group, and I think, 'what have I go to offer?' People are usually bored with what I've got to say.*

Therefore, for many of the women a positive outcome of peer support is that it provides a sense of belonging, friendship and connection with others, and perhaps the only opportunity for social inclusion they have. Women who were consulted reported appreciating the time to socialise and "get out of the house" to relieve boredom, lethargy or loneliness. In addition, women reported that peer support provides a feeling that "you're not alone, other people are having bad days as well". One woman commented:

I never had a strong family relationship and I've never actually had that many friends. So even though I could talk to my friends or a counsellor I never felt like anyone actually really cared, [until I joined peer support when] I actually felt they cared, you can sense it.

Some peer support participants who were consulted continue their relationships outside of group time, often by phone, or as a support when a peer is struggling:

Next time I get suicidal, [another participant] said to ring her up and come around.

Peer support also offers opportunities for social connection through the powerful mechanism of mutual support. Women reported that they both receive and provide support and wisdom through listening, relating to each other, and sharing their negative experiences. According to focus group participants this proactive approach to mental health provides a meaningful job; is therapeutic and aids in recovery; provides a sense of self worth; encourages personal motivation and ambition; and is empowering. For example:

To encourage, acknowledge, back-up [each other]. There's something really healthy about tribal[ism], people coming together, exchanging ideas and relating. It's sort of nurturing in a sense… it validates who we are. 'God, my situation is bad, but… his is worse', or 'I've got so much to learn from [others]'.

It was additionally found that while women attributed positive mental health outcomes to their participation in peer support, many also accessed other supports for recovery such as counselling, psychology, meditation, spirituality and family support. These tools complement the benefits of peer support, as one woman describes:

There is nothing that I didn't like about the [peer support group] but I did also seek one-on-one support through counselling. They were different pieces of the puzzle.

Many organisations which provide peer support also provide other services such as one-on-one support, phone support, drop in facilities, and other activities.

4.5 Challenges of peer support

While peer support can result in positive outcomes for its participants, there are also challenges to this type of support. For example, many women who were consulted discussed the importance of balancing the discussion of both negative and positive stories in peer support groups. As one woman explained, "it's good to have the light and the dark together, and the shades of grey".

In addition, women have different levels of comfort when listening to and sharing traumatic, tragic stories. Some women who were consulted describe themselves as private, so feel uncomfortable

discussing personal information. Many women described feeling confronted, upset, traumatised, more depressed, and intimidated when they listen to others stories or are asked to share something personal. One woman stated, “I don’t want to have to deal with other people’s stresses”, and for some mental illnesses such as PTSD, hearing people discuss their problems can trigger a distressing episode.

The main reason why women preferred to focus on positive stories is that while it may be appropriate to share problems at the beginning of peer support programs, they mainly joined peer support to begin a new phase of recovery. For example:

> *[In this peer support program] it seemed to be that everyone who went there had really serious issues… and I’m just like, ‘man, that’s just too heavy, I don’t want to go there’. And all we focus on is how bad our lives have been, and how bad they are now, and how hard it all is. I want to be looking upwards and outwards, I want to be making connections with people in a positive environment… I can go there and have my fix of something really positive and creative and then I’m refreshed and revitalised to tackle the rest of the week.*

An additional challenge of peer support is that relationships between members can be difficult at times. The following focus group participant describes how personalities can be a barrier to feeling comfortable:

> *I went to the [peer support] and I just didn’t gel with anyone. I just didn’t like the people and I didn’t go back for six months. By then I really needed to get out of the isolation thing and that’s when I went back to [it]. By that time all the women had changed, there were all new women there, and I gelled with people and found it to be good… I know that there have been women who have come that haven’t gelled and haven’t come back.*

Several women also identified challenges for peer support in regards to its management and funding. There are positive outcomes of self-run peer support programs because they provide the opportunity for people who may have low confidence or skill levels who are looking to return to the workforce:

> *We’ve had [the Government] suggest that we have a dedicated office that could run the group for us… On the one hand it would be nice not to [have to worry]. A lot of us are pretty stressed often, and it would be nice not to have to go through the onerous grants processes. But then, it does provide lots of learning opportunities and opportunities for people to grow their confidence again.*

While committee work can provide new skills for peer support participants it can reduce the enjoyment and support they receive from the program:

> *When you are on the Committee you take it up another step and you lose some of the inherent enjoyment of being in the group, and some of the benefits, because you are there actually being the support for the others. So that's part of our worry about trying to make [the group] a mental health service provider. We actually come here because we need the service as well.*

A further issue is the necessity for succession planning to avoid burnout in peer support members:

> *We've got our key members who do stuff… I see the same people always helping, always taking on Committee roles and things like that and… a year or two ago we had problems where everyone was just burnt out.*

Funding issues can also be a challenge to peer support. Some programs are concerned about inadequate funding for the service they provide and lack of funding certainty. Women who were consulted argued funding could assist with a number of costs and provide for courses for participants. For instance:

> *[We] receive enough funding to run four sessions a term, and we have ten sessions, and are unable to pay our childcare worker a full and appropriate wage.*

Another issue is the work load of volunteers who write submissions and manage funding agreements, because this process can be time consuming and stressful:

> *There are also the concerns that come along with service funding agreements, for example reporting requirements. And service recipients are on the board of management, and therefore seen by funders as service providers, not volunteers and clients themselves… And [the people writing the grants] are the ones that need mental health first aid!*

There can also be difficulties for peer support programs to locate an appropriate venue in which to meet in terms of space, encouraging a positive environment, and capacity to welcome new members:

> *We have found that the venue is a big factor… you can only fit so many women in the room that we've got and only so many kids in the room next door… so you're caught between really promoting [the group] to keep the new people coming and the group kind of growing and vibrant, and yet if you have 40 people in the room, no-one can do anything because there's not even elbow room to lift your cup of tea… and people will go, 'well it's too crowded and I didn't get a good go', or 'I couldn't hear myself think', 'I had to have my kids on my lap because they couldn't fit in the room' and [consequently], 'I'm not coming back.' We've had that experience in the past, where… external factors have an impact on [peer support] sustainability.*

4.6 Role of gender in peer support groups

The majority of women who were consulted reported that they felt more comfortable participating in a single gender peer support group for a variety of reasons. Some women reported that they have had traumatic experiences with men, such as relationship issues, abuse or sexual assault. One woman argued that women who have experienced domestic violence would not participate as much if men were included in peer support, because men can trigger trauma responses for these women. Additional examples include:

> *If there are men present who are really unwell, because of my [sexual assault] experience, I can't really focus on anything except feeling inordinately afraid.*

> *[When issues are related to relationship break-up], how do you go to a man who you think... when you're paranoid anyway, 'you're going to be on his side?'… Whereas with a woman, you just feel that they wouldn't judge you.*

Others felt that women's only peer support is most appropriate because they have experienced or felt uncomfortable in mixed peer support groups as a result of sexual dynamics. Women described feeling some men's behaviour is influenced by their hormones, and that they felt less safe to discuss relationships or issues of a sexual nature. In addition:

> *When I was going [to mixed gender] peer support, you'd get the occasional [male participant] who was going to suss you out for a girlfriend. I had that happen.*

> *[Male participants might] get confused with the [peer support] role as to whether or not the caring is something more than a support. Will they think it is becoming personal? Confusion can occur.*

> *I do [find the men in some peer support groups] off-putting… I'm happy here where it is all women, there's no sexuality or weirdos. Sometimes [with] guys… [there are issues with] sexuality and it can be a little bit confronting… a guy drooling or staring at you. I don't like that… I do find it a bit disconcerting and there seems to be a few of them.*

> *I also think that I wouldn't be able to talk about certain issues if men were there. Like, 'man, I've been breastfeeding for six months and I so don't feel like sex!'. Someone else will go, 'oh yeah, same here!' But I couldn't say that in front of a man I don't think.*

Women who were consulted also described the freedom of being able to breastfeed in single sex peer support without men feeling uncomfortable or making them feel uncomfortable:

> *I have been to a co-ed mental health group but for me, being a part of the women's group meant that I could breastfeed quite happily. If I flashed a breast, who cares! Other women don't care.*

Women also discussed concerns about power differences between women and men and how this can affect relationship building in peer support. One woman stated that “men often control women”, another that:

> *[Separating the genders can sometimes be good] because, as I was growing up and that, it’s always the man is the stronger person. But the women’s place was in the home.*

Other women discussed that they preferred women-only peer support because there is a cultural tendency for men to feel less comfortable talking about their feelings or problems, and it is more relaxed and intimate for women to share with each other, particularly around certain issues.

> *Women generally open up more. I find it difficult to sometimes get through to a male [peer support] participant because they tend to isolate themselves. They will not talk about certain issues.*
>
> *From what I’ve seen, it’s harder for men actually, to admit there’s something wrong…. And it was of a macho type thing. You know, ‘he hasn’t suffered so if I suffer, that’s a weakness.’*

However, even for women who prefer single sex peer support, there can be stereotypes surrounding it which women who were consulted reported ‘put them off’ from joining:

> *Someone was saying that they were quite reluctant to join us because they thought it was a group of hairy lesbians. And that’s to quote her, not me!*
>
> *In [women’s groups] we talk about scones… No, not really!*

A minority of women who were consulted appreciate mixed gender peer support groups. One stated she preferred to attend groups based on their activities and the common interest of participants, rather than gender. For another, trust is more important than gender. Other women stated mixed gender peer support could be interesting and:

> *It’s very good for women to see that men can’t cope… it’s reality. It’s society that [men and women] are together.*

In the consultations others agreed that it is important for women to choose whether they join gender specific or mixed peer support, because individuals have varying needs and it is too straightforward to presume they relate better to people of the same sex. Some women pointed out that there are issues men may also not feel comfortable talking with women about, including abuse. Focus group participants also stated:

I think maybe a combined group is good but also a male group and a female group, and then people can decide.

I think it's an issue of there being a very large number of different needs for different people.

Overall findings from the women's peer support needs and experiences

The above information collected from ACT women consulted in the focus groups is summarised to highlight their needs and experiences of peer support.

Needs of ACT women in peer support

1. *More information about peer support options*
   Women felt information about options for peer support in the ACT was not accessible.
2. *Diverse group membership*
   While views were mixed, the majority of the women consulted prefer peer support not to be mental health specific, to avoid medicalisation or labelling, and to encourage a relaxing and diverse environment.
3. *Recovery focus*
   Women believed that peer support members should be on a recovery journey so that they are more able to offer hope and mutual support.
4. *Assistance to overcome barriers in participation and peer support challenges*
   Barriers to joining peer support include stigma, practical barriers such as transport and cost, and emotional barriers such as anxiety. Group challenges include managing group content and relationships, and managing the administrative functions of peer support such as funding arrangements and committees. Support is required to address these barriers and challenges.
5. *Group facilitation, supervision and training*
   While most women who were consulted value lived experience highly, many also recognise the benefits of facilitation and the need to support facilitators through supervision and training.
6. *Women only peer support*
   The majority of the women who were consulted preferred single sex peer support for a variety of reasons including women's experiences of violence, and feeling more comfortable in an environment they felt was without power, cultural differences and sexuality.

Experiences of ACT women in peer support

1. *Increased mental health and wellbeing*

Women discussed the positive impacts of peer support on their mental wellbeing, because it is an alternative to the medical model, rejects stigma, and encourages information sharing about experiences in the mental health system.

2. *Increased self esteem and confidence*
   Women who were consulted experienced increased confidence, which has resulted in an improved ability to cope with mental health and try new experiences such as finding work.
3. *Increased social connectedness*
   Women reported feeling less isolated through building more relationships and providing mutual support.
4. *Use of peer support with other supports*
   Women who were consulted outlined that they utilise peer support in combination with other supports for recovery such as counselling, family support, exercise and spirituality.

Findings: Women Supporting Women pilot

Women Supporting Women (WSW) participated in a pilot program to evaluate the effectiveness of peer support in influencing positive mental health and social connectedness.

5.1 About WSW

The WSW group began in 2009 and is run fortnightly for two hours through the Peer Helpers and Mentors (PHaMs) program at Woden Community Service (WCS). WSW is for women living with mental health issues, and aims to improve social connectivity and mental health by creating a safe and non-judgemental environment in which women meet and provide support to one another. In consultation with the facilitator, WSW participants decide on group activities including craft and cooking, and participants bring stories and activities to share with the group.

When asked to describe WSW and its purpose, participants highlighted that the group is about being supported by people who have mental illness and share similar experiences; relying on one another and friendship; sharing stories; promoting wellbeing, recovery and connectedness; and participating as much or as little as they feel comfortable with. Participants describe this open and caring atmosphere as follows:

> *WSW… is a self help peer support group. We listen to the stories that others tell, and share a cuppa and a chat. We all come from diverse backgrounds and can learn from each other.*
>
> *[WSW is] about women supporting each other but from their own perspectives, and it's about that balance in relationships… there's no power differential, we're all here, we've got issues, we all know that. They may be different, they may be the same, but we can help each other to recover.*

5.1.1 Demographic information

The women who are members of WSW share some common demographic characteristics. All of the participants who filled in the questionnaires identified having a disability or a long term or chronic health condition (n=8). The remaining demographic data (see Appendix H), "indicate that these women were on low incomes, reliant on Government pensions, and were not in paid employment. Half of them were living alone."[122]

Four out of six women currently had or previously experienced mental health issues, including different schizophrenia diagnosis, bipolar disorder, depression, anxiety and Post Traumatic Stress

[122] A Evans, *Statistical analysis report, peer support project, prepared for the Women's Centre for Health Matters,* Accordia Consulting, Canberra, 2010.

Disorder (PTSD). Five out of six women were receiving some form of mental health treatment and support including medication (n=4), psychiatric support including visits and appointments (n = 3), support from community health (n=2), and PHaMs (n=2). Four women reported that they had not misused alcohol and drugs, one reported she previously used drugs socially and one reported she had overmedicated herself when unwell. No women were receiving treatment for issues relating to alcohol or drugs.

5.2 Group facilitation

WSW is facilitated by a PHaMs worker who reported that her role is to:

- Screen prospective new participants in order to identify their expectations of the group and their suitability to the peer support model
- Welcome new members by introducing and integrating them into the group
- Monitor group interactions and facilitate activities
- Monitor participant's mental health and wellbeing
- Provide additional support, debriefing and referrals for participants as required

The WSW facilitator reported that she may encourage members to participate, navigate difficult incidents or relationships, become involved with interpersonal issues between group members if there is conflict, or encourage members to see a new perspective:

> *You need to have somebody who can pull you up if you have a perspective about somebody or some issue that just happened, and then you can say, hey have you thought about it this way? Because sometimes in this group people say things and I think 'where did that come from'? And it's just that they're having a really bad day… it's something about their mental health that makes people do things or say things that they don't usually say.*

Therefore, a key role of facilitation is to provide overall supervision for group members and interactions, to ensure the WSW environment is safe and supportive for participants.

While the WSW facilitator clearly plays a vital role in supervising the group, the peer support model simultaneously emphasises peer-led support free from power differential between members. The facilitator is aware of that balance is necessary to achieve this goal:

> *I think it's good to have a leader and the women have said to me that they appreciate having a facilitator, but my role is more in the background. When we're in the group, it's led by themselves and that was the aim when we started... When I'm there I'm not leading it, I'm the 'tweaker'…*

The WSW facilitator reported that she experiences challenges in her role. She reports that it is difficult to both participate in and lead the group when she is not feeling well herself, facilitating the

group involves understanding the fine line between “encouraging people and not being dominating yourself”, and that dealing with issues that “come out of nowhere” from group members can be difficult. Over the course of the pilot, the facilitator recorded experiencing challenges each week except for one.

To assist in managing these challenges, the WSW facilitator reports that she engages in clinical supervision fortnightly. She also reports that peer support workers should be paid to compensate their experience and skills, and that they should receive training in addition to having lived experience of an issue, because it assists in remaining impartial and distanced.

5.3 Access and participation

WSW members reported in the questionnaire that they accessed information about peer support programs in the ACT through community services (n=5) and health services (n=3), and that the most useful place to access this information is through hospitals and community mental health centres.

WSW members reported that they decided to join peer support for a number of reasons, including relaxation, enjoyment and for the fun activities; support, participation and to address isolation; and meeting women or friends who are in similar situations, who they can explore solutions to problems with. The group facilitator stated that women join because:

> *…they felt like they were in a place in their recovery where they could reach out to others, they weren’t in a place where they needed a lot of intensive support themselves.*

Some participants also indicated that they were involved in other peer supports such as creative or arts based groups which perhaps their interest and confidence in joining WSW.

WSW members reported that they would not invite friends to participate because they value the benefits of peer support as a separate social group:

> *I guess you get comfortable with your group, and then if you’ve got a friend there… it just changes the interaction… It’s sort of like you can be a slightly different person if you’re on your own I think.*

WSW members also felt that group participants should be recovering from mental health because people who are acutely unwell may find participating difficult or stressful, and WSW can play a key role in a recovery plan.

Over the course of the WSW pilot study, an average of five participants attended per group, ranging from three to eight participants. The facilitator described member’s participation levels each week,

and reflected that while women participated “actively” and “enthusiastically”, in week four, two of the members became noticeably “happier” with a “significant increase in participation, [with members] taking more interest and making decisions.”

5.3.1 Barriers to access and participation

WSW members identified factors which were barriers to their participation in the group over the pilot program including transport (n=10), cost (n=9) and confidence, disability and time (n=5 for each barrier) (see Appendix I for full results). In regards to transport and cost, the major barriers identified, one WSW participant states:

> *Transport is an issue, but having [meetings] at central places like in the community centres where there are buses is really good. It is also a cost issue, because most of [us] are on the disability support pension so really don’t have a lot of money to spend on transport.*

During the pilot some women stopped attending WSW and some members were occasionally absent. This was due to having other priorities such as childcare responsibilities, work, employment courses, preparing for life events, family commitments, or time with a carer; living closer to another support group; illness or injury including admission to psychiatric units which occurred on two occasions during the pilot study; or bad weather.

In addition, some women may stop participating in WSW because it does not suit their expectations or comfort level. The facilitator reported that:

> *We’ve had one lady who came just once, didn’t like it and so she never came back… but the group can be very confronting for people and on the particular day this lady came it probably was a bit too much for her, it’s not something that you can always control, because you can see people slightly freaking out and trying to address that within the group as much as you can. But that’s OK because it’s not for everybody…*

Week five of the pilot study saw a drop in WSW membership. However, even when WSW participation is low, women reported enjoying themselves.

5.4 Positive impacts of WSW

WSW had positive results for its members in regards to their mental health, self-esteem and confidence, and social connectedness. The group has also proved to be a success generally, with WSW participants arriving earlier than the set group time, and meeting independently of the facilitator during the off-week because they “felt it was too long with a fortnight long gap”. Reoccurring themes as to why WSW members like the group are that it offers

- Fun, friendship and companionship
- Creative collaboration, activities, outings and new skills

- Acceptance, respect, belonging and connection to others
- Opportunities to learn from others, share, talk openly and provide/receive support.

These sentiments were expressed in questionnaires, interviews and creative pieces (see Appendix J for group collage and poem).

5.4.1 Questionnaire results

No significant difference in the levels of WSW members' social connectedness and wellbeing were found between the questionnaires administered three times over the pilot study. However, participant's levels of overall health and wellbeing were high. For example, the third time the questionnaire was administered, members scored 18.6 on the K10 psychological distress scale, falling into the moderate range (as opposed to low, high or very high). The Rosenberg self-esteem scale also indicated that women were in the normal range, with a score of 21.2. The psychologist analysing these results concluded that these scores are better than would be expected given the stressors present in participant's lives, and this could be attributed to their participation in peer support.[123]

5.4.2 Mental health and wellbeing

WSW participants reported involvement in the group has impacted positively on their mental health and wellbeing through providing friendship and increasing mood by being a fun, relaxing and creative environment. For example:

> *[WSW] has given me a sense of belonging to a community, and helps relieve boredom while I am not working.*
>
> *I am accepted despite my mental health consumer status.*
>
> *It has given me some freedom and realisation that I'm not alone. It has given me back a small part of life back. It's something I can go to and enjoy.*

Another participant discussed that for her, WSW promotes wellbeing because she feels nurtured, supported, less isolated and connected with others who have experienced similar issues.

The WSW facilitator also reported positive changes in the way in which participants manage their mental health and wellbeing, due to increased awareness when their mental health is deteriorating, and increased support in their recovery journey. Group members become aware of indicators when someone is becoming unwell and the women have visited peers in hospital if they become unwell. The facilitator reports:

[123] Evans, 2010.

I think [for one of the participants] there was increased self awareness by having the opportunity to talk about [mental illness] with other women, like stuff that she'd been through, it got her reflecting on different things that helped her through her recovery, and helped her to move on.

A further positive impact of WSW on mental health is that it provides members with an opportunity to discuss issues and share information about the mental health system, including thinking of ways in which the system can be navigated and improved, with a network of people who have similar experiences.

For WSW participants, while the group results in increased mental health and wellbeing, this was seen as a 'by-product' of its atmosphere of friendship and fun rather than a specific focus on mental health. For example, the following participants outline:

I think just being out of isolation and around other people… [is beneficial], even just talking about 'how's the weather' or being in a craft group, because then you're not focussing on your mental health.

I'm assisting another woman who has been very isolated because of domestic violence and her mental health. And she's finally got to a point in her recovery where she's going, 'I don't care where I go, just as long as I'm leaving the house and going to an activity I will enjoy'. She's not asking for specific mental health activities or anything like that. [She's] just recognising that to get rid of the isolation, being out will help her with her health.

5.4.3 Self-esteem and confidence

A contributor to positive mental health and wellbeing is one's self-esteem and confidence levels. Both WSW participants and the facilitator reported increased confidence, for example women become increasingly willing to talk, use initiative and lead the group.

5.4.4 Social connectedness

Social connectedness is key to wellbeing, particularly for people living with mental illness. However, WSW members reported experiences of isolation as a result of mental illness:

I guess people kind of move away from you because they don't understand [mental illness]. And if you're a bit depressed or something you're not very good company for people.

It's hard because [with a mental health issue] you're just left very much to your own resources… because you're in such a bad space it kind of gets difficult when you're just stuck with your own thoughts and you haven't got a lot of interaction with other people.

WSW members displayed an understanding of the link between social support and good mental health and wellbeing. They stated that social support "enables participants to belong", "helps in recovery", lets people "know that they're not alone [and] that there are other people with the same sort of problems", and that "health is very much a holistic issue: physical health, mental health, socialising–they all affect each other."

Over the course of the WSW pilot study, participants identified who they relied on for support (see Appendix K for full results). On average over the three questionnaires, the highest number of women felt they were supported by members of a peer support group or social group (n=18). In addition, WSW members provided several examples of how the group has improved social connection. Women reported their personal support networks changed because they "have more friends", "feel more relaxed" and offer each other mutual support outside of group time in regards to transport and other activities.

WSW also provides a forum for members to share opportunities for community involvement. Participants reported that they were motivated to try something new to increase social connection since joining WSW such as volunteering, finding paid work, completing courses and learning new skills.

The WSW facilitator also describes that the group has had a positive impact on her own wellbeing and sense of social connectedness:

> *I've shared some really personal stuff in this group that I wouldn't normally share in a group situation, and… I've really felt supported by these women. Sometimes in the group things have happened and they've cried, and I've cried in this group and they've been very accepting of that.*

A culture of acceptance and the welcoming atmosphere of WSW is the foundation on which social connections and supportive relationships are built. WSW members respect and listen to each other's views, value openness and honesty, and provide positive feedback to one another. The facilitator reported that the women feel accepted, embrace others and want to be there for others, as "they are open to new people and interested".

While WSW participants acknowledged that creating social connections with others is a key aspect of the group, this is not straightforward. For example, individuals must be willing to give personal input:

> *[I like] making connections with people. And just the last few meetings… I've noticed we are dealing with issues a little bit more. I think when the group first started we'd cover these books, and we wrote stories, and people brought in poems. But now that it's a bit more established, it's like we're talking about stuff more.*

You have to put something of yourself in the group before reaping the reward of connectiveness and acceptance of self.

5.5 Challenges of participating in WSW

While peer support results in positive outcomes for participants, the journey also involves challenges. One of the challenges identified by WSW is managing the difference between members who are comfortable discussing and listening to serious or distressing experiences-for example around family, disability or violence-and those who are not. The facilitator reported that she uses certain techniques to manage this, such as removing women who are debriefing from the group to discuss the issue one-on-one. Another technique is to ensure that WSW members who want to debrief about traumatic experiences can gain this support elsewhere. On e member reports:

I guess it is nice to [discuss serious and not serious issues]. I've also found [another group has] given me a chance to talk about my illness. Because most of the groups I'm in don't really focus on that very much.

Managing group relationships can also be a challenge for WSW. Changes in group dynamics can be positive, for example allow others to take a leadership role or participate more. However, changes in group dynamics can also result in a less supportive environment, for instance if a member is in a bad mood or if members use poor communication.

The WSW facilitator identified that privacy and confidentiality can also be an issue in WSW. There have been incidences where group members have disclosed information that members have requested remains confidential and where the facilitator has to remind members of confidentiality.

The WSW facilitator reported a further challenge that she does not always have knowledge of the mental health issues women are experiencing or who their emergency contact is, especially if they are not in the PHaMs program. This is an issue because:

…If I noticed someone is unwell I can talk to them but not anyone else, I don't know who their mental health worker is, or their parents or husband… So who do we contact if we're worried about you?… I'm a facilitator of this group, so do I have a role to do the follow up…? There is some role, but there's a conflict that I have.

5.6 Role of gender in WSW

Gender sensitive practice is vital so that the needs of women with mental health issues are met. The majority of WSW participants agreed that women and men have different peer support needs, mainly because some women have experienced violence. Only one participant disagreed, stating that "what men and women need would be fairly similar".

The majority of WSW participants felt gender specific peer support groups are best because some women have issues with men which could make them feel uncomfortable in a mixed group, for instance women stated:

> *If you have been violated by a man, then it's hard to open up around them*
>
> *I know in the women's group sexual abuse has come up a few times. We've discussed it. And that's probably easier in a women's group.*

WSW participants also preferred women's only peer support because they reported it is easier to open up and make connections in what they perceive to be a more gentle and understanding atmosphere. For example:

> *I feel accepted by this small group. I'm able to be me!*
>
> *It is nice having the women's group and just having women. It's just a girlie thing… I guess just having women maybe it does allow a bit more freedom of what you talk about.*

Further reasons identified by WSW participants for preferring single-sex peer support are to avoid sexism and connect with women, stating:

> *I can talk about women's personal issues and there are no sexist comments*
>
> *I really like getting in touch with that feminine energy and meeting other women… I'm a bit of a feminist so it's good to get together with the girls. And in the past I haven't really connected that much with women.*

Two out of seven WSW members stated they would feel comfortable participating in a mixed gender group, as long as they were non-judgemental. Participants reported:

> *I don't have a problem with [mixed gender groups]. [Men would] probably find it quite interesting. It would give them some insight.*
>
> *In the [mixed gender] meditation group the men [were] saying, 'Oh, I don't like men's groups', and women were saying they didn't like women's groups. [The women's reason was]… they just felt that they liked having that male energy around. [Women's groups can be] a bit too girly… she was just complaining about people talking about shopping and things, and she just couldn't really relate to it.*

However, it is important to note that while the majority of women preferred women only support, members understood the importance of having men's peer support groups available, stating:

> *Men need to support men. Women need to support women.*

Findings: Women And Prisons group pilot

The Women and Prisons (WAP) group were the other peer support group which participated in the pilot program.

6.1 About WAP

WAP was founded in 2005, and is a not-for profit advocacy and support group for women with lived experience of incarceration.[124] WAP's philosophy is to:

- Focus on rehabilitation and empowerment
- Provide opportunities for members to tell their stories to peers and wider audiences
- Provide a safe, supportive and accepting community environment
- Promote self-worth, dignity, and respect
- Increase knowledge by learning from one another

WAP has three main functions: peer support for incarcerated women, peer support for women transitioning to the community from prison and advocacy about the issues facing women in the prison system. This study focused on the peer support aspects of WAP; however it was difficult to differentiate the impact from the advocacy component also.

6.1.1 Peer support for incarcerated women

Women with lived prison experience provide peer support to women in prison by listening to issues and attempting to address them through advice and emotional support. Participants reported how these visits serve a dual purpose: to provide support to incarcerated women from women with a lived experience of prison, and to establish contact, build trust and facilitate ongoing contact when they are released from prison. WAP members visit women in prison once per fortnight when possible.

6.1.2 Peer support for women transitioning to the community

Peer support is provided to women who have exited prison and are transitioning to community life, through an outreach model. Assistance may include instructional and emotional support, and accompaniment to meetings and community supports. The aim is to build women's capacity through connecting with women with lived experience, so support is maintained until the participant is established in the community with alternative supports.

A WAP participant explained the initial process of meeting with an ex-prisoner and learning their support needs as listening to their needs and letting them know how they can assist. Providing

[124] For more information on WAP go to http://www.wchm.org.au/WAP/home.

support to women when transitioning out of prison occurs at a time when women can feel very vulnerable, as one participant states:

> *You feel like you've got a neon sign on your forehead going, 'I've just got out of jail'.*

During this time of transition peer support can include assistance with a range of practical tasks and emotional issues, either face to face or by phone. At the beginning of a woman's experience exiting prison, WAP members reported that they most value practical help. This could include assistance using new technologies and adapting to other changes.

The support most commonly provided by WAP members to transitioning prisoners is accompaniment to vital appointments and assistance transitioning into accommodation. Tasks such as attending Centrelink or parole hearings, or using public transport, can be confronting for women exiting prison. WAP members explain:

> *I found the hardest part when I got out was actually going to Centrelink and banks… I actually had to have my dad come with me because I froze in Centrelink. Because everyone's staring at you and it's like, what is everybody staring at?*

> *To have [A WAP member] there listening to what my parole officer said to me, which contradicted what Housing have told me in a different way every time I've spoken to them [was helpful]. And I said to [the WAP member] afterwards, 'I'm just so lost because I don't know who to believe or what to believe'. And she could really relate to that.*

WAP peer support workers often filled gaps in the system's provision of support in the early months of the introduction of the prison and before relevant support were in place for women. For example:

> *[The WAP member] helped me with my application for housing and did a lovely support letter for me. And these are the things that should have been done for me before I even got out. [She is like] a case manager. And none of that happened. So having someone like her, able to help and support me not only emotionally or mentally but in a tangible way [was helpful]. She was able to produce a letter that supported my application for something.*

6.1.3 Advocacy

WAP members with lived experience meet monthly and ex-prisoners and community service representatives meet quarterly to support the WAP women, and to discuss issues of concern to women in prison and strategies for advocacy. The aim is to provide opportunities for participants who are women with lived experience to build their skills, develop confidence and advocate.

Participants discussed that the WAP meetings with only the women with lived experience and facilitators are vital because members debrief, problem solve and make decisions about issues

women report experiencing in prison, and discuss ideas for the development of WAP. Women who have exited prison and are receiving peer support are welcome though not required to attend WAP meetings. Instead, they can connect outside of the meeting to keep informed.

6.1.4 The WAP model

The purpose of this peer support model is that through building participant's capacity, skills and experience, women who have received WAP support will become peer support workers themselves.

Those involved in WAP feel that because the WAP peer support model involves three distinct functions, the group can provide different meaning to different participants and meet individual needs. For example WAP members report:

> *[One of the participant's] has a lot going on with her life so she gets different things out of WAP than [the others]. For her, WAP is a chance to get together with people that are interested in her, and that care and understand her for who she is.*
>
> *[WAP members are] at different stages, and they're getting different things out of it. [One of the participant's] was straight in, she loved the concept of being able to work with and support other women, but she wasn't as reliant on the group.*

In addition, WAP's peer support model is continually evolving. The vision is clarified according to needs and the model is constantly being shaped by new ex-prisoner participants who bring unique experiences to the peer support role, and new insights about the group's purpose, and:

> *Every single [participant] uses [WAP] for a different thing and they've adapted it as they've gone through. It's about where they came from. [Women] are impacted on by their experiences in prison differently… They've all adapted their roles as they've gone on.*

6.1.5 Demographic information

One of the three WAP participants reported they had experienced mental health issues (Post traumatic Stress Disorder, depression and post natal depression) and reported she was receiving treatment in the form of medication. One out of three women described previous drug usage however none were receiving treatment for issues relating to drugs or alcohol.

6.2 Group facilitation

WAP peer support is facilitated as a learning experience by members with lived prison experience, one of whom identifies as a leader. Supervision is provided through auspice arrangements with WCHM and the ACT Council of Social Services (ACTCOSS) who provide debriefing; referrals; and support ranging from access to resources, rooms, or building skills. WAP participants identified supervision as useful both "personally and professionally", because it provides access to a wide

support network of people who they can approach for support depending on the supervisor's expertise and their own preferences.

Currently debriefing and support is only utilised by WAP when necessary. One WAP participant reports that this arrangement works well because it encourages her to trust her own skill, judgement and capabilities in challenging situations, yet approach the auspicing agencies for additional support when necessary:

> *When you talk with the other women [with lived experience] you usually debrief anyway, it's good to. But if there was any problem I'd talk to WCHM or ACTCOSS, and of course using my own common sense I'd probably refer [them] to talk to someone, [whether it's] domestic violence or whatever. If they were at harm you'd just use common sense and you'd get help straight away.*

A WAP service provider member also reported that for this supervision arrangement to work auspicing organisations need to recognise when WAP members require support, and trust that they will seek advice when necessary. Further, formal mechanisms for support are less vital as WAP peer support members have become increasingly self-sufficient, including through 'in house' debriefing.

However, some members felt that debriefing should be more regular, because WAP participants may have experienced trauma and so be particularly vulnerable to stressful events.

To ensure peer leaders feel they have the skills and confidence to provide peer support, WAP members have accessed training opportunities in interpersonal communication, mental health and advocacy. After receiving mental health training, members discussed the skills they learnt, and reported they had already used techniques with family and friends with positive feedback, and reported increases in their confidence in dealing with mental health crisis, from 1/10 to 8/10 for one participant, and 4/10 to 8/10 for another participant.

6.2.1 The role of lived experience

In the context of women who have been institutionalised in prison, participants reported that having peer support with facilitators who have lived experience is vital. The majority of WAP participants report that lived experience is more important than professional training, because ex-prisoners are more easily trusted and can relate to the issues and emotions. For example, one participant stated: "there's more trust when it's ex-prisoners [providing support rather] than service providers", and :

> *[It's easier] relating to people who've been in similar situations as I have. People relate better if they've been there, because they know exactly how you feel, or pretty close to it. And that's a big thing. I mean, people can empathise with you and say that they do understand, but they don't really know. So I know that when I talk to*

[WAP peer support members], they know exactly what I'm saying… You don't even have to say the words sometimes… so when you get that you really hold onto it. And I'd like to have people like that in my life.

[It is important having someone with lived experience] because there's no point in someone sitting next to you saying 'I understand how you feel' when they don't… women who've been in jail will sit there and tell you to [get lost], 'what do you know' sort of thing, and it can really be damaging for you and them…

Alternatively one WAP member reports that while lived experience is not vital to participation in the group, it is preferable:

I feel peer support is getting support on many levels from people that can relate to your situation. Now whether they've actually experienced it or not doesn't really matter. If they're concerned enough to want to help someone that's been in that situation then that's good enough. If they've been there then that's a bit better.

It was also reported by participants that trust is more important than whether someone has lived prison experience.

6.3 Access and participation

WAP members reported that they learnt about WAP through:

- Moving from a NSW prison to the ACT
- Meeting WAP peer support members or receiving a WAP 'prison kit' with toiletries in prison
- Receiving a flyer once exiting prison
- Participating in a WAP survey

Members described their motivation to join WAP as a desire to use their experience to help others in a similar situation. For example, one participant states:

[I joined] because I don't want other women coming out of prison and having to deal with the issues I had to deal with on my own. I had no support at all when I came out. Not from the people that probably should have done a little more for me in preparing me for coming out… And I guess the only support I did get was from [WAP]… there was a lot of phone contact. I'd always maintained... when I was still in there that I wanted to be involved with [an organisation to help prisoners], so that I could do whatever needed to be done, or anything I could do to help the other women, whether I know them or not. Because I know what it's like.

Service providers who participate in WAP meetings were keen to join to support women with lived experience in their advocacy and there continues to be a good response to the advocacy meetings.

6.3.1 Barriers to access and participation

While WAP approaches membership inclusively, there are several barriers to women with lived prison experience both accessing and participating in WAP peer support. It can be difficult to stay in contact with peers met in prison as some may not have phone numbers and it is difficult to find information about their whereabouts. Where peers do have contact, a WAP member reported that it can be difficult to know whether to initiate contact or not. In addition, to join WAP women may have to overcome difficult emotions and thoughts including apprehension, independence, lack of motivation and stigma. For instance:

> *Once women get out [of prison] they're too overwhelmed. They just think, 'I don't know how to reach out', or 'I can't be bothered', or they just think, 'I'll go it alone'. There could be many reasons [why they don't connect with WAP].*
>
> *Most [women] would think that there's stigma with [joining WAP]. They sort of shut out, and just get on with it, and not deal with the issues that they have before prison or in prison…*

The most common emotional barrier WAP face in recruiting women with lived prison experience to the group is that while women are often vulnerable and not comfortable trusting others easily, the peer support model relies on supporting each other. WAP participants reported that they must invest time to build relationships:

> *[It's important to] go into the gaol regularly and building up a rapport with the women so they know who we are and we're not going anywhere sort of thing, we're not just a blow in. You've got to try and get that into their heads… because that's what they're used to. People saying, 'yeah we'll help you', and they don't.*
>
> *You start showing a girl in prison that you care, she'll know if you're full of [it] or not, and getting her confidence, knowing that you care about her, she'll begin to trust you and feel confident enough to come [to WAP], maybe.*

WAP members also reported that they respect women's choice about whether they engage in the group.

Further challenges to the WAP peer support group is that there are a small number of women prisoners in the ACT. As seen above it may take time for to feel comfortable becoming involved in WAP, and not all ex-prisoners are interested in joining because they may have other issues that are taking priority. For instance the following woman reported feelings of overwhelming anxiety when released from prison:

> *I couldn't leave my home because I was too scared, I couldn't even go to the shop for a couple of months, I just sat on the couch and just felt [like I] didn't belong.*

WAP members also reported barriers to their participation in the group (see full results in the table in Appendix L). The main barriers include cost (n=4), time (n=3), and caring responsibilities (n=2).

For example, established members may have work commitments, and when first released members may have to deal with practical tasks to organise their life outside of prison and parole commitments. For instance:

> *It's a hard thing, that trauma where suddenly you're out in the open world and you're trying to solve all these issues you've got, and it takes up all their time and capacity.*

Participants may also have health issues that take priority over WAP activities. Transport and child care are barriers, for example WAP women report that it requires confidence and know-how to catch public transport and it can be difficult with children. An additional barrier to providing peer support to women in prison are rules about how long ex prisoners must wait before being allowed to visit prison.

6.4 Positive impacts of WAP

Participation in WAP had positive results for participants of the pilot group in regards to their mental health, confidence including building skills and combating stigma, and social connectedness.

There are also positive impacts for women in prison who are receiving peer support from WAP. Each month WAP peer support members visit an average of nine out of fourteen women prisoners. Feedback about these visits from an evaluation and service provider members include that these visits provide women with information and support from someone they trust with lived experience:

> *The women [in prison] lap it up because 'it's someone who is in here and understands me'. They see a role for them, and if they don't turn up... they get really agitated because they haven't had their visit.*

> *[Women in prison] were really very positive about [peer support], stating that they trusted the advice of [WAP] and that they'd been used to hearing different things from different people depending on what silo they're in. What they got from peer support was women who knew what it was like if they were in prison, so they trusted their advice more than if they were any other provider, because they weren't consistent.*

6.4.1 Questionnaire results

The results of the questionnaire which was administered three times over the WAP pilot study did not show any significant differences between the women's levels of social connectedness and wellbeing over the course of the pilot. However, participant's levels of overall health and wellbeing were high. The third time the questionnaire was administered, WAP women scored 16.33 on the K10 psychological distress scale, falling into the moderate range (as opposed to low, high or very

high). The Rosenberg self-esteem scale also indicated that women were in the normal range, with a score of 19.33. The psychologist analysing these results therefore concluded that these scores are better than would be expected given the stressors present in participant's lives, and this could be attributed to their participation in peer support.[125]

6.4.2 Mental health and wellbeing

WAP participants confirmed that women with prison experience have mental health issues compared to women generally, stating:

> *Most women in prison have got mental health issues… [but] most of them don't know they've got mental health issues.*

Participating in WAP had positive outcomes for the mental health and wellbeing of group members. One members describes its impacts on her health:

> *I'm not as depressed, and don't cry as much… It just helps with everything, gives me a reason to get up in the morning really. [I noticed these changes] from the beginning. I remember walking away from the first meeting going 'oh my god, this is fantastic, this is good'.*

While WAP participation does not 'cure' mental health issues, it assists in the recovery journey. For example one WAP member experiences mental health issues and received support and assistance to cope, notice changes in her mental health, and share lived experience and advice. A WAP advocacy member states:

> *[The WAP member] still sees a psychologist now… and has had trouble with medications all the way through… She does still experience problems with [mental health], but she handles it better… so I attribute that to her confidence in dealing with it.*

One WAP service provider member also reports that she has noticed WAP members with lived prison experience adopting a more positive attitude generally, transforming self doubt to a 'can do' attitude.

Despite the evidence that WAP has impacted positively on member's mental health, one WAP participant sees her mental wellbeing as separate to the group:

> *I think the only sort of mental health issues I've had to deal with I speak to my psychologist about, and that has absolutely no bearing on anyone that I've met through WAP, or coming out [of prison] and being involved in this, or wanting to*

[125] Evans, 2010.

assist or help other people. They're issues that I have that are separate to any of this.

6.4.3 Self-esteem and confidence

WAP members reported experiencing increases in their self-esteem and confidence through participating in peer support and advocacy activities, also resulting in increased mental health and wellbeing. For example, WAP members gained confidence when their advocacy work was recognised with ACTCOSS's 'Little Feet Big Steps' award. Participants also reported increased confidence to participate in meetings, find work, take on leadership roles, make decisions, influence others' situations, and respond to questions about their lived experience. Service provider members also described several examples of increased confidence in women with lived prison experience, including increased confidence to participate in meetings, challenge others and make decisions, and achieve change:

[WAP participants] have been in prison and now they're demanding that people listen to their perspectives as women with lived experience, I've seen that change over their time in the group.

Another way in which WAP increases participant's confidence is building skills through involvement in WAP's advocacy and governance tasks, including understanding influencing others and advocacy processes, raising the profile of the organisation, and chairing and running meetings professionally.

In addition to learning about strategic in advocacy, WAP members have contributed to a Parliamentary Inquiry, and attended conferences, forums and meetings to share their experiences publicly. One WAP member reported her experience of assisting with a submission process, highlighting that it taught her skills, increased her confidence, and increased her understanding of and contact with WAP:

I contributed to the application for the conference, so I have a better understanding of WAP. In doing that work I feel like I've played a small part in something tangible, I've accomplished something. I've also gained more knowledge from reading, it's been very beneficial. I've also had more contact with WAP so have more understanding of the girls and where they're coming from.

Additionally, women reported feeling increasing self worth through their role in WAP, because they feel they are contributing to something useful:

[WAP] makes you feel once again that you're actually accomplishing something

This is what keeps me going. It's the only thing. When I've been away from [WAP] I'm so down. And I come home from a meeting and I'm… on top of the world. And

I'm going to change the world, I'm making a difference… It feels like you've actually got your point across and… Someone's listened to what you've got to say.

WAP participants reported that WAP increases their self-esteem through knowing that others care about them, and realising others value and share their experiences:

To have someone say, 'look, it's OK love, I know how you feel, you'll be right, what you're feeling is normal, don't fret about it'… That's all you need… Just knowing that you're not the only one. [That] you're not weird.

[WAP] just helped me to know that I'm human, and normal and capable of doing certain things, and I'm not a bad person. Because jail teaches you, it drums it into you that you're worthless, you're nothing, and it stays with you for a long time, I think it always does.

Building self-esteem and confidence for WAP members also occurs through empowering women to combat stigma towards women with lived prison experience:

[WAP] empowers women to move forward. And know that they're not stigmatised, and know that they're normal and can live a normal life after prison.

I still have [stigmatisation], but WAP helped me to get over it big time. To know that I am normal, if not, don't judge me sort of thing.

6.4.4 Social connectedness

On average over the course of the pilot study, WAP participants identified the main people they rely on for support as members of a peer support group (n=6), friends (n=6) and family members (n=3) (see Appendix M for full table of results). Only one out of three members felt that their personal support networks had changed since joining WAP, and that they were encouraged to try something new in applying for a job.

WAP women reported that they have continued friendships with each other outside of WAP activities, and discussed liking the group because they "rely on and identify with" the other women, and ""having other people around who can relate to what you've been through" is important. Another member reported that since her release from prison, her priority has been establishing herself and addressing practical issues rather than focusing building friendships.

6.5 Challenges of WAP

While the WAP group benefits the women involved, the peer support model also experience challenges. As previously discussed, a key challenge is that women who have experienced imprisonment may be less confident and trusting of those around them, meaning that peer relationships and working with others towards advocacy can be a slower process than usual.

Due to women with lived experience having low self-confidence, participating in WAP can also feel particularly intimidating. For example when describing formal processes of WAP advocacy and meetings, participants stated:

> *Planning day [was difficult], because I'm not up there with this public service stuff like big words.*

> *[WAP meetings] are quite confronting when you first get out [of prison].*

Some women reported they were also not confident they had skills to offer women if they experience mental health issues:

> *If someone put a situation on me and said, 'this is how I'm feeling. This is what I want to do about this feeling,' and then us to turn around and go, 'well… how do we go about that?' [We don't] always having the answers. We may have to say, 'OK, hang on, we'll have to get back to you on that.'*

> *We also have to be more and more careful because we're not counsellors, and we can't [provide that]. They might just be terribly freaked out about something and you try and give advice and they might ask what you did or whatever…*

A further challenge the WAP group faces is the role of peer support in supporting women to not re-offend. Some participants feel that this is a part of their role, if not directly, for instance she reported that avoiding re-offending should be a consideration when connecting peer support members together:

> *It's also important [in peer support] that you're connecting with the right people… you don't want them connecting together and getting up to mischief.*

A challenge for WAP peer support is also that women may become institutionalised after imprisonment, impacting on their confidence and willingness to contribute ideas to the group, because institutionalisation can encourage people not to voice their opinions.

WAP peer support participants also face the challenge of ensuring there are self-care mechanisms in place for members. There is some concern that working in the system women were once incarcerated in can be stressful, and that it can be difficult separating WAP and personal or work issues. For instance:

> *I think it's really hard for [WAP participants]… The positions they find themselves in can be really traumatic for them. They're working in the system and they're also trying to work in peer support, and it crosses over.*

Finally, WAP members report that WAP's meeting and advocacy processes must continue to progress and become more formalised and efficient, especially because WAP has a small membership base so is at risk of stopping due to low numbers. Women reported WAP must expand and become more structured in meetings.

6.6 Role of gender

WAP participants reported that they would prefer their peer support group to be gender specific. One reason is that there are particular gendered issues impacting on women's experience of imprisonment such as mothering in prison, affects of parental incarceration on children, the involvement of services including child protection, and the effect this has on family relationships and mental health.

Women reported that women's specific prison advocacy is also necessary because in the ACT, gender affects the services women in prison receive:

> *They can't put [programs] like this in place for the women at the AMC because they don't have the numbers that would justify the cost of it… For the men it's a different story. You're looking at a couple of hundred. But with the women you're only looking at sometimes only a dozen. You can't do anything for that few people.*

Discussion

This discussion outlines the relationship between the research findings from peer support participants of focus groups and interviews, and WSW and WAP pilot study participants. It will highlight:

- The relationship between the literature, best practice peer support and the findings
- The positive impacts of peer support on women's mental health, confidence levels and social connectedness
- The importance of and preference for gender sensitive and women-only peer support
- The ways in which peer support in the ACT requires further development and support

7.1 Summary of findings

7.1.1 Different peer support models

The literature review found that there are different models of peer support, none of which are inherently more effective, but that best practice peer support is based on a number of key principles.

Some women who participated in the focus groups and interviews felt that peer support should be mental health specific to celebrate rather than perpetuate stigma around mental illness. However, the majority of women preferred it not to be mental health specific, to avoid medicalisation and encourage a relaxing and diverse environment. Focus group participants agreed that peers living with mental health issues should be on a recovery journey so that they can offer hope and peer support to others. Both the WSW and WAP peer support models have different philosophies and purposes which the participants felt reflected their peer support needs, whether they be about belonging and creative leisure activities (WSW) or advocacy and assistance (WAP).

While in focus groups there was a general preference for peer support that is not mental health specific, the participants of the WSW group for women living with mental health issues reported enjoying this model and experienced positive impacts on their wellbeing and connectedness. Therefore, advocacy for peer support should acknowledge that a variety of peer support models are necessary to meet the diverse needs of women living with mental health issues, who have unique life experiences and preferences for support and social connection.

7.1.2 Access, participation and barriers to peer support

Women in focus groups accessed information about peer support through a range of services and organisations; however still felt that this information should be more widely available. Women reported feeling unmotivated to research peer support options themselves due to mental illness,

and reported difficulties navigating the Internet. Some women who participated in focus groups were encouraged to attend peer support by health professionals, while others participated because of negative experiences with health professionals or because traditional clinical services did not suit their needs. Barriers to accessing and participating in peer support for focus group participants include stigma about joining a peer support for mental health, entry requirements, a desire for anonymity, and a number of practical barriers and emotional barriers such as anxiety and uncertainty.

WSW members found information about peer support through community and health services, however they also felt it could be more accessible. Participants outlined that they joined WSW for relaxation, fun, to address isolation, meet friends and find solutions to problems. The lives of WSW participants are often complex, so that a range of factors can influence their participation. For instance, in line with theories about how groups function and develop some peer support participants may take time to feel confident in the group and comfortable interacting with others[126]. WSW participants identified barriers to participation in the group as transport, cost, health and wellbeing issues, caring responsibilities and having other commitments or priorities. The WSW facilitator attempts to address barriers in participation levels, although highlights that peer support is not able to suit every persons needs.

WAP participants learnt about the group through having contact with them in or outside of prison via surveys, peer support or advertising, and decided to join primarily to help others in their situation. WAP faces unique barriers in attracting participants due to difficulties maintaining contact with women released from prison, there only being a small group of women prisoners in the ACT, ex-prisoners choosing not to join the group, WAP not being suitable for all ex-prisoners, and the lengthy process of becoming involved. Once involved in WAP barriers to participation include time, cost, mental or physical health issues, childcare, transport, work commitments, priorities establishing life outside of prison when transitioning, and rules about how long they must wait before they can visit prison after exiting.

Views about the lack of information and difficulties finding information about peer support options in the ACT strengthen previous WCHM research that highlights the barriers women face in accessing information about health and wellbeing.[127] In the ACT there should be improvements in women's access to information about peer support. While the peer support contexts of the focus group and pilot study participants differ, common barriers are transport, costs involved in attending and participation and caring or childcare responsibilities. Therefore, women require support and assistance to address barriers in participation, including:

[126] MS Corey & G Corey, *Groups: Process and practice 7th ed,* Thomson Brooks/Cole, California, 2006.
[127] Women's Centre for Health Matters, A Carnovale & E Carr, *Peer support project: Evaluation framework,* Canberra, 2009.

- Improving transport options, including assistance accessing and paying for public and community transport
- Providing funding for childcare and carers where caring responsibilities are barriers
- Providing funding to cover participation expenses including facilities hire, activities and resources

7.1.3 Challenges of peer support

Further to challenges in accessing and participating peer support, there are other challenges for peer support that were outlined in the literature review. For instance, the literature review found that participating in mental health specific peer support can perpetuate a medicalised attitude towards mental illness, by reinforcing stereotypes and stigma. Some participants of the focus groups agreed, reporting that mental health specific support could create problems by reinforcing the 'sick role'.

This study found that peer support programs face challenges specific to the context in which they operate. Women who were consulted in focus groups indentified challenges including the importance of balancing negative and positive content of discussions, and the need to remain aware that traumatic stories can affect peers. For instance, many women reported that others' traumatic stories had harmful impacts on them, so they prefer groups to be recovery-focused. Further challenges of peer support were identified as managing relationships between group members; and difficulties securing funding, managing committees, succession planning, grant writing and finding an appropriate venue.

The WSW group also faces challenges in peer support practice including managing discussions about traumatic experiences and difficult group dynamics and relationships. In addition, respecting privacy and confidentiality can be an issue both amongst group members and for the facilitator who may use information about participant's mental health appropriately.

As a peer support model WAP faces several challenges. Women with lived prison experience may be less trusting, institutionalised, or experience low levels of confidence. Therefore, participating in meetings and providing peer support can be an intimidating and slow process. Additional challenges include the question of WAP's role in supporting women to not re-offend; concerns about the impacts of WAP involvement on members in regards to stress and trauma; and ensuring the WAP model continues to develop and improve.

Common themes regarding the challenges of peer support across the focus groups and WSW and WAP pilot studies therefore include balancing the 'light' and 'dark' stories, remaining aware of the impact of traumatic stories, managing relationships, and encouraging participation in a safe and supportive manner.

Peer support programs can be aided with the challenges of peer support including administration processes such as skills in grant writing, governance, and succession planning, though options such as:

- Assistance linking in and forming partnerships with community organisations which can provide support and advice
- Investment in training options for facilitators
- Allocating Government supports for peer support programs
- Provide funding for a professional officer in peer support groups who can complete administration tasks

7.1.4 Peer support facilitation, supervision and training

Due to the barriers in accessing peer support and challenges of peer support, as described above, the literature highlights that best practice peer support encompasses facilitation, supervision and training. The literature review highlighted that groups run by employed consumers are often less associated with mutuality because they are constrained by professional therapeutic boundaries. Some participants of the focus groups outlined that they feel group facilitation leads to a power imbalance. However, the majority of women felt the positive impacts of peer support facilitation, if conducted properly, outweighs this concern, although they had mixed ideas about the type of facilitation they preferred.

For example, the majority of women consulted in focus groups value the quality of lived experience over formal skills or training in a facilitator, while others suggested good quality facilitators should possess both qualities. As discussed above, although some women reported that facilitation results in a power differential amongst peers and can conflict with the idea of peer support as informal and non-hierarchical, others reported facilitators play a vital role in managing group dynamics.

In WSW facilitation plays a vital role to manage group relationships, discuss group membership with potential members, welcome women to the group, monitor the wellbeing of participants, suggest techniques for wellbeing and recovery, and plan activities and excursions with group members. However, the facilitator is also aware that her role is ‘in the background’ supporting the group rather than ‘running’ it, and peers have responsibility for shaping the group, it’s activities and discussions.

WAP peer support is provided by women with lived prison experience and is supervised through auspicing arrangements. While some participants questioned whether debriefing should occur more often because of some women’s history of trauma and possible re-traumatisation through WAP activities, other participants reported the current arrangement is appropriate because debriefing is easily accessible when needed. It was also recognised that WAP participants debrief with each

other and that for women in WAP, lived experience and trust is more highly valued than having formal training as a facilitator.

Focus group and pilot study participants agreed that peer support facilitators should be supported through supervision, debriefing and training opportunities. The WSW facilitator reported that supervision is vital for her because her wellbeing impacts on her performance as a facilitator, and she requires support because peer facilitation can be challenging. Some focus group and pilot study participants also argued that peers should be paid to operate in clinical settings and community organisations in order to recognise and value their skills.

Therefore, in agreement with best practice the majority of focus group and pilot study participants value the role of facilitation in peer support. Lived experience is highly valued in facilitators and supervision and training is recognised by all participants as important. Options for investment in training and supervision for peer support workers in the ACT includes:

- A supervision or support network for mental health peer support workers
- Investment in training for peer support workers, for example on mental health, governance, submission processes, and knowledge of community services
- Further exploration of employing paid peer support workers in traditional and clinical mental health settings

7.2 Positive impacts of peer support for focus group and pilot study participants

The literature review found that in the limited studies that have been conducted about the impacts of peer support, there is evidence for its positive impacts on people living with mental health issues. From discussions with women in focus groups and the results of the two pilot studies with WSW and WAP, peer support was found to have three key positive impacts for women living with mental health issues:

1. Peer support improves women's mental health and wellbeing through providing an alternative to the medical model, encouraging learning and information sharing, increasing awareness about stigma and assisting in symptom reduction.
2. Peer support increases the confidence levels of participants in regards to disclosing mental illness, trying new experiences and developing skills.
3. Peer support increases social connection for women who may be very isolated, by providing a sense of belonging and friendship through mutual support, and increasing their connection with the broader community through new activities such as work and volunteering.

Overall, an improvement in these areas can be interpreted as an improvement in overall quality of life and reduction in life problems for participants. In addition, women in this study reported they enjoyed participating in peer support and would recommend the group to others, and increased contact with members outside of group hours.

7.2.1 Mental health and wellbeing

Peer support impacted positively on the mental health of focus group, WSW, WAP participants in different ways. Women in focus groups attributed improvements in their mental health and wellbeing to the benefits of accessing non-medicalised support; sharing information, resources and techniques for recovery; and an increasing awareness of stigma. The WSW model promotes wellbeing through social connection and fun activities, which results in feelings of belonging and friendship, and increased awareness of mental health symptoms and support for recovery. This leads to improved mental health, without a direct focus on this as the group aim. For WAP, participants experienced improved mental health including better management of recovery and adopting an optimistic and hopeful attitude. Again, these improvements can be attributed to a broad range of experiences undertaken as a WAP member including peer support and skill building.

Where the positive impacts of peer support on mental health are attributed to information-sharing and discussing recovery, it confirms the 'experiential knowledge theory' outlined in the literature review, whereby people develop knowledge about how to work through their issues through interacting with others with similar issues.

7.2.2 Self esteem and confidence

WSW, WAP and focus group participants all discussed the positive impacts of peer support on their levels of confidence, although again this emerged in different ways. For focus group participants, improvements in their confidence emerged through feeling comfortable disclosing mental illness, trying new experiences, and increased coping with mental health issues. For WSW, while the facilitator noticed a number of changes in women's confidence in group relationships and in pursuing new activities outside of the group, this did not appear to be the key outcome of their peer support.

In contrast, the strongest positive impact WAP appears to have on its participants is increased self-esteem and confidence. Participants reported building their confidence and learning skills through contributing to advocacy, submission writing and meeting processes. Other WAP participants felt increased self worth because they belong to a group where their experiences, voices and contributions are highly valued; and they feel the stigma associated with lived prison experience is breaking down. Increased confidence has led to good outcomes for WAP participants, such as employment.

7.2.3 Social connectedness

As discussed in the literature review and confirmed in these findings, people living with mental health issues experience high levels of social isolation. Focus group participants reported increased feelings of social connectedness through friendship and belonging, and also through the

mechanism of mutual support. For WSW, the most prominent influence of peer support on participants appears to be an increased feeling of social connectedness, both with group members and with the broader community, for example through volunteering, participating in courses or finding work. For WAP, building new social relationships was not a priority for some members who were newly released from prison, although for others increased social connection was observed through new employment. Furthermore, members reported relying on each other for support outside of the formal sphere of WAP and its peer support function.

Participants of focus groups and pilot studies who felt increased social connection through providing mutual help confirmed the 'helper-theory principle' outlined in the literature review, whereby individuals who provide assistance to each other increase their own sense of competence, self-esteem and social value, leading to recognising personal strengths and increased wellbeing. Findings that women experienced increases in their social connectedness also confirms the 'social support theory', whereby interpersonal relationships and social connectedness are associated with good mental health and wellbeing outcomes.

7.2.4 Questionnaire results

Both the WSW and WAP pilot studies found that peer support had a positive impact on the participant's levels of psychological distress and self-esteem. Ann Evens, the psychologist from *Accordia Consulting* who analysed the questionnaire results, concluded there were no significant differences in the women's levels of wellbeing and social connectedness over the three points at which the questionnaire was administered, due to some limitations of the data. However, Ann reported that:

> *This does not necessarily mean that the women participating in these groups did not derive any benefits. The quantitative data analysis is simply unable to shed light on whether there were benefits, and if there were, the nature of these.*

Ann argues that the scores the WSW and WAP participants received in the psychological scales are encouraging, because other information suggests that the women may have been through periods of psychological, social and possibly financial stress. Therefore:

> *The women's scores on the scales do appear to be lower than would be expected, given their prison history, and the incidence of mental illness and other significant stressors among them.*

It was therefore concluded that peer support has a positive impact on its participants, and that qualitative data reveals more information about its effect. Furthermore, it appears that members of WSW have slightly higher levels of psychological wellbeing and self-esteem compared with WAP members. This may be attributed to potentially higher levels of and more recently experienced trauma by members of WAP.

7.2.5 Health promotion

The literature review discussed peer support as a mechanism of health promotion, through enabling participants to improve health through increased control over and knowledge of health. Findings confirm that peer support positively influences participant's health and wellbeing. It increases participant's confidence, and builds skills in advocacy and communication, empowering them to 'take control' over their health. Peer support also educates about the causes and impacts of stigma, and builds knowledge through sharing information about how to navigate the mental health system, treatment options, and increased awareness about mental health symptoms. This process supports the 'social learning theory' outlined in the literature review, where people learn behaviour through reinforcement, so that positive behaviours and skills are learnt from role models, and peers with credibility.

There should be continued advocacy for peer support because both focus group participants and WAP and pilot study participants experienced a number of positive impacts including:

- Increased mental health and wellbeing, confidence levels and social connectedness
- High levels of psychological distress and self-esteem considering the incidence of trauma in pilot study participant's lives
- Positive effects of health promotion

7.3 The importance of women centred peer support

The literature review outlined that women experience mental health differently to men, therefore best practice for peer support should include the four A's of gender sensitivity: availability, accessibility, affordability and appropriateness. Findings of the focus groups and pilot groups also suggest that women prefer women's only peer support.

While there are some negative stereotypes surrounding women's groups, the definite majority of women consulted in focus groups preferred women's peer support for a range of reasons. For example, some women have experienced violence or wish to breastfeed, and others feel more comfortable sharing their stories in contexts without power, cultural differences and sexuality. The majority of WSW participants feel women and men have different peer support needs, and that women's only groups are necessary because: some women have experienced abuse from men and the atmosphere and conversations are more open. WAP participants felt it was appropriate for their group to be gender specific because women prisoners experience different challenges, such as motherhood and fewer services.

In short, reasons for preferring women-specific support include:

- Some women have experienced violence or sexual assault by men
- Women feel more comfortable to share and discuss issues openly with other women

- Women experience different issues to men
- Sexual dynamics play a role in mixed peer support and can result in women feeling uncomfortable
- Women who are mothers want to breastfeed comfortably
- There are power differences between women and men
- There is a cultural tendency for women to be more open when discussing their problems

However, some of the women who were consulted and participated in the pilot groups reported that they would participate in mixed gender peer support because women and men can learn from each other, and trust and sharing similar interests are more important than gender. WAP also acknowledged that it would be helpful if there was a similar advocacy service or support program for men with lived prison experience.

Therefore although most women outlined they preferred to participate in women only peer support, many acknowledged that there needs to be different options available, including mixed groups and male specific groups. It is clear that choice is important so that people can decide whether single or mixed gender peer support meets their needs. Peer support that is suitable for women should be flexible; meet their needs; accessible on weekends, out of hours and on public holidays; and available across the ACT.

Conclusion

This research found a variety of good outcomes of peer support for women living with mental illness in the ACT. Benefits include improving or maintaining mental wellbeing, rejecting the medical model and stigma, information sharing, building confidence and social connectedness, and benefits for the wider community through women's increased participation and independence. The way in which peer support provides increased wellbeing and social connectivity is significant because mental illness is becoming increasingly common in the ACT community. This research therefore shows that peer support is a viable, holistic alternative to the medical model of support for people with mental illness.

The literature review found that best practice peer support utilises the recovery framework and is based on key principles of peer support practice, is gender sensitive to meet the needs of women living with mental health issues who have different experiences to men, and incorporates facilitation which is supported by supervision and training, in order to manage the challenges of peer support.

Women who participated in the focus groups reported their peer support needs include more information about peer support options; diverse group membership that is not mental health specific, a focus on recovery; assistance to overcome the barriers in participation and the challenges of peer support; group facilitation, supervision and training; and women only peer support. Women reported that they experience increased mental health and wellbeing, self esteem and confidence, and social connectedness; and that they use peer supports in conjunction with other supports for recovery.

The WSW and WAP pilot studies demonstrated that peer support has positive impacts on its participants. It emerged that for women, peer support provides improvements in mental health because it is an alternative to the medical model. The women outlined how being treated as 'normal' and 'as a person, not the symptoms' by peers is empowering. For many of the women a positive outcome of peer support was that it provides a sense of belonging, friendship and connection with others, and perhaps the only opportunity for social inclusion they have. Women in this study reported appreciating the time to socialise and 'get out of the house' to relieve boredom, lethargy or loneliness. In addition, peer support provided a feeling that 'you're not alone, other people are having bad days as well', and the sense that others care about you.

In addition, most women prefer gender specific peer support and value lived experience in facilitation. There needs to be a wide range of peer support options so that women can choose what suits their needs best.

It is important that peer support groups for women living with mental health issues in the ACT continue to grow. However, there are some barriers for women to participate in peer support and peer support can be a challenging environment, so additional support is required for peer support groups in the ACT to ensure that they continue to follow best practice and provide support and services for women in need. More needs to be done to maintain peer support for people with mental health issues, particularly in overcoming barriers in accessing and participating in peer support, and offering more support for facilitators.

This research is a contribution to the growing body of research on the effectiveness of peer support, and is unique as it highlights the context of the ACT and the importance of gender sensitive practice. It is hoped that as a consequence of this research, peer support as a means of increasing social connectivity and managing mental health will become more widely understood in the ACT community.

Recommendations

- WCHM to advocate within the ACT for the use of gender specific peer supports, including Women Supporting Women and Women And Prisons, because of the evidence of positive outcomes for both participants and the broader community.

- From identified best practice, WCHM to develop and distribute a user-friendly *Resource Kit for Mental Health Peer Support* to ensure that lessons learnt from the research are shared with stakeholders. The Resource Kit will outline best practice in peer support, gender sensitive peer support practice, options for evaluation frameworks and processes, resources for peer support programs and information about peer support in the ACT.

- WCHM to develop ways to improve ACT women's access to information about peer support including:
  - Working with the ACT Government and community sector to advertise peer support programs and improve women's access to this information
  - Providing information about peer support programs for women in the ACT in the WCHM's *Women's Health and Wellbeing Hub*
  - Educating health/mental health workers and community sector organisations about peer support availability in the ACT, and the benefits of peer support through the distribution of the *Resource kit for Mental Health Peer Support*

- WCHM to advocate to ACT Government to improve women's participation in peer support by addressing barriers to participation, with a focus on transport, childcare and caring responsibilities, and monetary support.

- WCHM to explore opportunities for the ACT mental health sector to invest in training and supervision options for peer support facilitators, so that peer support practice continues to be supported, safe and sustainable.

- WCHM to work with the ACT Health Directorate and Community Services Directorate in relation to their role in providing support to peer support programs seeking funding.

- WCHM to continue working with and supporting the ACT Women And Prisons group to seek support and funding, as the peer support model addresses a need in the community and achieves positive outcomes for the health and wellbeing of women with lived prison experience.

Appendices

Appendix A: Organisations that participated in focus groups and interviews

- Brindabella Women's Group
- Inanna Inc.
- Mental Health Consumer Network
- Mental Health Foundation
- Mental Illness Education ACT (MIEACT)
- Picking up the Pieces
- Poppy playgroup
- Post and Anti Natal Depression Support and Information (PANDSI)

Appendix B: Semi-structured interview guide

1. What do you think peer support is? i.e., models, practical examples, theories, principles
2. What do you think the purpose of peer support is?
3. What kinds of peer support have you been involved in? i.e., support groups, activities/exercise/craft groups, one-on-one, hospital-to-home, advocacy/political consumer-run organisations.
4. Why did you decide to participate in this peer support group?
5. Did you experience any difficulties or barriers in accessing peer support, including your peer support group model?
6. What do you like about your peer support group model?
7. Is there anything you don't like about your peer support group model?
8. Would you recommend it to other people? Why?
9. In your opinion, what kind of people would suit the peer support model/group?
10. In your opinion, what kind of people do you think would benefit from peer support?
11. What kind of impact did peer support have on you/your mental health and wellbeing?
12. What was your doctor/psych's response to you participating in peer support? If applicable.
13. In your opinion, what kind of principles/characteristics/critical ingredients are essential to the functioning of peer support?
14. In your opinion, do women and men have different needs for peer support?' i.e., caring/parenting responsibilities, domestic/sexual violence etc.
15. In your opinion, are there enough peer support options for women in the ACT? Why? Why not?
16. In your opinion, where do you get information about peer support options in the ACT?
17. What kind of peer support options should be available to women in the ACT?
18. Where should they be available?

19. What kind of risks or issues do you think are associated with peer support?
20. What have been the highlights in peer support?
21. Has there been any challenging moments in peer support? Tell me more.
22. What would assist you/encourage you to take up/continue participating in peer support in the future?
23. What are your views on peer support in a hospital/medical setting?
24. What are your views on ‘professional’ peer support workers? i.e., people who have received ‘training’ and are paid to provide peer support.
25. What are your views on peer support being ‘externally supervised’ by mental health professionals? i.e., psychiatrists, psychologists, counsellors, social workers etc.

Appendix C: Comparison of the WSW and WAP peer support models

Pilot group	Access/referral pathway	Type of contact	Frequency and length of formal contact	Activities undertaken	Supervision and support arrangements
Women Supporting Women	Self-referral or referral from Woden Community Service (WCS). Participants are screened by Peers Helpers and Mentors (PHaMs) worker.	Fortnightly group meetings with PHaMs worker, fortnightly meetings without worker, and informal contact.	Fortnightly meeting, two hours in length.	Talking, excursions, activities, journaling, art and craft etc.	Facilitated by WCS PHaMs worker who receives supervision and debriefing from WCS team.
Women And Prisons	Self-referral.	Bi=monthly WAP advocacy meetings, bi-monthly meetings with women with lived prison experience, and informal/unplanned peer support contact.	Monthly meeting, two hours in length.	Discussing issues in the prison, providing practical and emotional support to peers.	Auspiced by Women's Centre for Health Matters and ACT Council of Social Services (ACTCOSS) who, with WAP members, provide supervision and debriefing as required.

Appendix D: Questionnaires

Evaluation Questionnaire 1

About You

1. I am a woman who lives or works in the ACT or Queanbeyan region.
   - ☐ Yes
   - ☐ No

2. My age is:
   - ☐ 15 – 24
   - ☐ 25 – 44
   - ☐ 45 – 64
   - ☐ 65+

3. I am of Aboriginal or Torres Strait Islander descent.
   - ☐ Yes
   - ☐ No

4. I am from a culturally or linguistically diverse background.
   - ☐ Yes
   - ☐ No

5. I have a disability or a long-term/chronic health condition.
   - ☐ Yes
   - ☐ No

6. My highest level of completed education is:
   - ☐ No schooling
   - ☐ Year 8 or less
   - ☐ Year 10
   - ☐ Year 12
   - ☐ Advanced diploma, diploma, certificate or trade qualification
   - ☐ Bachelor's degree or higher
   - ☐ Other (please specify)

7. I am:
   - ☐ Working full time
   - ☐ Working part time/casual
   - ☐ Not currently in paid employment
   - ☐ Retired
   - ☐ Other (please specify)

8. My main source of income is:
   - ☐ From paid employment
   - ☐ A full government pension
   - ☐ A part government pension
   - ☐ From superannuation
   - ☐ Other (please specify

9. My total household income per year (before tax) is:
   - ☐ $12,999 or less
   - ☐ $13,000 to $25,999
   - ☐ $26,000 to $41,599
   - ☐ $41,600 to $88,399

- ☐ $88,400 to $129,999
- ☐ Prefer not to say

10. My current living situation is:
    - ☐ Privately owned accommodation
    - ☐ Rented accommodation
    - ☐ Public accommodation
    - ☐ Other (please specify)

11. My household composition is:
    - ☐ Living alone
    - ☐ Living with a partner
    - ☐ Living with a partner and other family members (i.e., dependent children)
    - ☐ Living with other family members
    - ☐ Other (please specify)

12. How many dependent children under the age of 25 do you have?
    - ☐ 0
    - ☐ 1
    - ☐ 2
    - ☐ 3
    - ☐ 4+

Mental Health and Wellbeing

13. Are you currently or have you ever experienced mental health issues?
    - ☐ Yes
    - ☐ No

    If yes, please specify:

14. Are you currently receiving some form of mental health treatment?
    - ☐ Yes
    - ☐ No

    If yes, please specify:

15. Aside from peer support, have you recently been involved in other activities that have noticeably affected your mental health (positively or negatively), i.e., counselling, other groups hospitalisation?
    - ☐ Yes
    - ☐ No

    If yes, please specify:

16. Are you currently or have you ever misused alcohol and/or other drugs?
    - ☐ Yes
    - ☐ No

    If yes, please specify:

17. Are you currently receiving treatment for issues relating to alcohol and/or other drug usage?
    - ☐ Yes
    - ☐ No

    If yes, please specify:

18. Please indicate how often in the past month you have felt (responses are none of the time, a little of the time, some of the time, most of the time, all of the time):
    - Tired out for no good reason
    - Nervous
    - So nervous that nothing could calm you down

- Hopeless
- Restless or fidgety
- So restless you could not sit still
- Depressed
- That everything was an effort
- So sad that nothing could cheer you up
- Worthless

19. Please indicate the response which best shows how you feel about yourself most of the time (responses are strongly agree, agree, disagree, strongly disagree):
- I wish I could have more respect for myself
- All in all, I am inclined to feel I am a failure
- I certainly feel useless at times
- I feel that I do not have much to be proud of
- At times I think I am no good at all
- I feel that I have a number of good qualities
- I am able to do things as well as well as most other people
- I feel that I am a person of worth, at least on an equal plane with others
- On the whole, I am satisfied with myself
- I take a positive attitude towards myself

Social and Community Support

20. Please indicate how the following statements describe your current relationships with other people (responses include strongly agree, agree, disagree, strongly disagree):
- There are people I can depend on to help me if I really need it
- I feel that I do not have close personal relationships with other people
- There is no one I can turn to for guidance in times of stress
- There are people who enjoy the same social activities as I do
- Other poeple do not view me as competent
- I feel personally responsible for the wellbeing of nother person
- I feel part of a group of people who share my attitudes and beliefs
- I do not think other people respect my skills and abilities
- If something went wrong, no one would come to my assistance
- I have close relationships that provide me with a sense of emotional security and wellbeing
- There is someone I could talk to about important decisions in my life
- I have relationships where my competence and skill are recognised
- There is no one who really relies on me for their wellbeing
- There is a trustworthy person I could turn to for advice if I were having problems
- I feel a strong emotional bond with at least one other person
- There is no one I can depend on for aid if I really need it
- There is no one I feel comfortable talking about problems with
- There are people who admire my talents and abilities
- I lack a feeling of intimacy with another person
- There is no one who likes to do things I do
- There are people I can count on in an emergency
- No one needs me to care for them

21. Who are the main people you rely on for support? (please select all answers which apply to you)
- ☐ Family members
- ☐ Friends
- ☐ Neighbours
- ☐ Work colleagues
- ☐ Members of a peer support group
- ☐ Members of a social group
- ☐ Members of religious group

- ☐ Other (please specify)

22. Are there factors that make it difficult for you to participate in social interactions? (please select all answers which apply to you)
    - ☐ Work commitments
    - ☐ Cost
    - ☐ Transport
    - ☐ Time
    - ☐ Confidence
    - ☐ Lack of knowledge and information about options
    - ☐ Caring responsibilities
    - ☐ Disability
    - ☐ Chronic or serious health condition
    - ☐ Other (please specify)

Peer Support

23. Where did you find information on peer support programs in the ACT?
24. Why did you decide to participate in peer support?
25. What do you like best about peer support?
26. Is there anything you don't you like about peer support? Tell me more.
27. What kind of impact has peer support had on you and your mental health and wellbeing?
28. In your opinion, would it matter if men were involved in your peer support group? Tell me more.
29. In your opinion, do women and men have different needs for peer support?
30. In your opinion, what benefits have you gained from participating in a womens only peer support group?
31. Would you recommend peer support to other people? Why?

Evaluation Questionnaire 2

Same questions as above numbers 13-22 only.

23. What does social connectedness (social support) mean to you and your life?
24. Have your personal support and friendship networks changed since you joined WSW? How?
25. Have you been motivated to try something new or different, or restart something you had previously done since joining WSW? Tell me more.
26. Have you experienced any changes in your self-esteem or confidence levels since joining WSW? What has changed?
27. What is it about WSW that keeps you coming back? How is it different from other groups or social networks?

Evaluation Questionnaire 3

Same questions as above numbers 13-22 only.

23. In your own words please describe what the WSW group is, what it does, why you like it etc.
24. In your opinion, what kind of women would benefit from joining a group like WSW? What will they get out of it?
25. In your opinion, what kind of relationship exists between mental health and wellbeing and social support networks (incl. groups like WSW)?
26. Please feel free to contribute any other comments you would like to make in relation to the benefits of groups like WSW?

Appendix E: Number of questionnaires collected in the pilot studies with WSW and WAP

There were eight participants in the WSW group, however two participants filled in the questionnaire on one occasion only leaving no data for comparison, resulting in six participants. The six WSW participants filled in the questionnaires on all three occasions, although some data was missing. There were three participants in the WAP pilot study, all of whom filled in the second and third questionnaire only.

Appendix F: Number of interviews and focus groups conducted

One interview was undertaken with a participant of WSW. At the end of the pilot study an interview was conducted with the facilitator of WSW and advocacy/auspicing members of WAP at WCHM. Focus groups were undertaken with WAP across the length of the pilot at three different occasions, with three interviews with two of the participants.

Appendix G: WSW facilitator debrief form

Date:
Number of attendees:
Number of absentees:
1. Were there any reasons given for being absent today? If so, what were they?
2. Were you made aware of any significant changes in the participant's lives today? i.e., employment opportunities or health improvements. If so, what were they?
What did the women do during the session today? i.e., scheduled activity or other.
Were there any changes in the women's participation levels compared to other sessions?
What were the highlights of today's session?
Were there any difficulties or challenges in today's session?
If yes, what did you and the women do to overcome them?

Appendix H: Demographic data of WSW participants

Demographic information sought	No. of participants	Demographic information sought	No. of participants
Age		*Source of income*	
25-44	1	Full gov. pension	5
45-64	4	Part gov. pension	1
65+	1		
Aboriginal and/or Torres Strait Islander		*Income level*	
Yes	0	Up to $12,999	1
No	6	$13,000 - $25,999	3
Culturally and Linguistically Diverse		*Living situation*	
Yes	1	Privately owned	3
No	5	Renting	1
		Public housing	1
Education level		*House hold*	
Year 12	1	Alone	3
Diploma or certificate	2	Partner	2
Bachelors degree or higher	3	Other family	1
Work status		*Number of dependent children*	
No paid employment	5	0	5
Retired	1	2	1

Appendix I: Barriers to participation in WSW

This table indicates the barriers to participation in peer support WSW participants reported, on average over the three questionnaires administered.

Barrier to group participation	Number of participants
Transport	10
Cost	9
Confidence	5
Disability	5
Time	5
Caring responsibilities	2
Lack of knowledge and information about options	2
Work commitments	2
Other	2
Chronic or serious health condition	1

Appendix J: WSW collage and poem

Welcome to Women Supporting Women 2010, where all you need is yourself and, maybe a pen.
The group revolves around a writing theme, with lots of variety, candle-making, art, even scones with jam and cream.
We aim to provide support for you and your mental health, through making new friends and caring for yourself.
Providing women with an opportunity to laugh and have fun, with chocolate biscuits, cups of tea and hey, don't forget the bun!

So join with me now as we embark on a new year, prepare for learning together and maybe shedding a tear,
Which is fine 'cause sometimes it's good to cry, especially around people who care to ask why.
So with a big cheer and a mighty hoo-rah! Let's celebrate the new friendships we've made so far.

Appendix K: Supports for WSW participants

This table indicates the social supports WSW participants reported they relied on, on average over the three questionnaires administered.

Social supports	Number of participants
Friends	15
Family members	10
Members of a peer support group	10
Members of a social group	8
Neighbours	5
Members of a religious group	2
Work colleagues	0
Other	3

Appendix L: Barriers to participation in WAP

This table indicates the barriers to participation in peer support WAP participants reported, on average over the three questionnaires administered.

Barrier to group participation	Number of participants
Cost	4
Time	3
Caring responsibilities	2
Confidence	2
Work commitments	1
Chronic or serious health condition	0
Disability	0
Lack of knowledge and information about options	0
Transport	0
Other	0

Appendix M: Supports for WAP participants

This table indicates the social supports WAP participants reported they relied on, on average over the two questionnaires administered.

Social supports	Number of participants
Friends	6
Members of a peer support group	6
Family members	3
Work colleagues	2
Members of a social group	0
Members of a religious group	0
Other	0

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