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Finding the right connections: Peer support within a community-based mental health service

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Running head: Finding the right connections

Key words: community-based mental health, peer support, mental health recovery, mental health consumers, Australia

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Key Practitioner Message

- Practitioners placed high value on the peer support workers on their teams due to their unique personalised engagement with clients.
- The roles of peer support workers were poorly understood by team members.
- Organisational integration of peer support principles could improve the way *all* staff engaged with clients to reflect a recovery orientation.

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Abstract

This article reports on a qualitative study that examined the organisational enablers and barriers to implementing peer support work in an Australian, rural, community-based mental health service. Interviews with 19 peer and non-peer staff were conducted to identify attitudes towards peer support and whether there were organisational values, practices and strategies that might support the implementation of peer support. The findings revealed that peer support workers were valued for their ability to build trusting connections with clients and to accept client choice in a non-judgemental way. However, peer support workers tended to ‘fill service gaps’ within intensive, administrative case-management environments. These findings highlight the importance of an organisational-wide approach to integrating peer support, where the responsibilities for adopting new ways of working fall to *all* staff, not just the peer support workers themselves.

Keywords

Peer support, mental health treatment and services, mental health systems of care, organisational change, workforce issues in human service organisations, Australia

Introduction

With its roots in mental health consumer activism, peer support is gaining momentum in recovery-oriented practice in Australia. Within community-based mental health services, it is shifting the balance of power – at least slightly – towards people with lived experience of mental illness. The ‘consumer movement’ has long argued mental health policy would be strengthened through the input of people with lived experience of mental illness and has advocated for client involvement in decisions that affect them (Beresford & Branfield, 2006; Epstein, 2005; Lammers & Happell, 2003).

This article reports on a study of peer support within an Australian community-based, rural mental health service where peer support workers had recently been employed. First, this article describes the policy context in which peer support has been promoted in Australia and its relationship to a recovery-oriented approach to mental health. Secondly, it argues that the organisational environment should be a central focus for research if we are to better understand the feasibility and potential for peer support. The article then presents the findings from a recent study that examined the organisational facilitators and barriers to implementing peer support work in a community-based mental health service. The study sought to better understand the workplace environment into which peer support workers were expected to integrate. Interviews with 19 peer and non-peer staff were conducted to identify attitudes towards peer support and whether there were organisational values, practices and strategies that might support the implementation of peer support. In this study, peer support workers are persons with lived experience of mental illness who had been employed specifically because of their lived experience expertise, as well as their demonstration of skills in areas of project management, client work, communication and teamwork. The peer support workers in the study were employed in designated roles. Non-peer staff were those people employed as caseworkers, case managers, team leaders and senior managers, whose positions did not require them to explicitly disclose any lived experience of mental health issues or to relate to clients through lived experience expertise. The level of qualifications, experience and skills varied greatly across all the staff interviewed – peer and non-peer staff. The interviews with this diverse group of staff highlighted the challenges within this complex, multi-faceted team environment, and revealed that the peer and non-peer workers in the study adopted different approaches to relationship building, risk and recovery. Although the peer support workers offered an opportunity for enhanced client engagement, without adequate organisational change, they faced unrealistic expectations of being ‘all things to all people’. Lastly, the article discusses the implications for practice and policy, highlighting that where peer support

is implemented within an organisation-wide approach and a recovery framework, it has enormous potential to improve service delivery and connections between clinical and community-based mental health.

A policy-driven response

Peer support has been posited as a tool for enhancing the recovery of people experiencing mental illness and a means for addressing the resource limitations in mental health service delivery (Australian Health Ministers' Advisory Council, 2013). The New South Wales strategic plan for mental health highlights the benefits to be gained from employing peer support workers: 'Peer workers know what it is like to experience mental illness and can share experiences of personal recovery with consumers' (NSW Mental Health Commission, 2014, p. 100). People with experience of mental illness have fought long and hard for this recognition, buoyed by international research showing peer support results in improved self-perceptions, increased service-user involvement, a client-centred focus, expansion of social networks, access to peer role models, service flexibility, decreased service utilisation and reduced stigma for people experiencing mental illness (Bolzan, Smith, Mears & Ansiewicz, 2001; Davis, 2013; Hardiman, 2004; Hodges, 2006; McLean, Biggs, Whitehead, Pratt & Maxwell, 2009; Moran, Russinova, Gidugu, Yim & Sprague, 2012; Schön, 2010). Research suggests that peer support mentoring may correlate with reduced hospital admissions (Davidson, Bellamy, Guy & Miller, 2012), though there is limited evidence on whether or not it improves recovery outcomes (Eysenbach, Powell, Englesakis, Rizo & Stern, 2004; Lloyd-Evans et al., 2014; Pitt et al., 2013). Further, little attention has been paid to the organisational environment within the peer support literature. Challenges associated with the employment of peer workers include a lack of role clarity and professional identity and development, low pay levels, stigma and unreasonable expectations (NSW Consumer Advisory Group – Mental Health Inc., 2010). Existing service-user participation strategies

have been criticised as tokenistic. Service-user representatives report unrealistic expectations of peer support workers, where the emphasis is on their ability to adapt to workplace standards rather than the organisation's willingness to facilitate compensatory adaptive workplace practices (Davies, Gray & Butcher, 2014).

Peer support in a recovery-oriented framework

The impetus for peer support has been greatly aided by the shift to recovery-oriented practice. Recovery provides an overarching philosophy to guide *all* aspects of mental health service delivery. The National Framework for Recovery-Oriented Mental Health Services recognises the challenge of managing tensions between maximising choice, supporting positive risk-taking, the dignity of risk, medico-legal requirements, duty of care and promoting safety (Australian Health Ministers' Advisory Council, 2013).

Recovery highlights the distinction between 'clinical' and 'non-clinical' services. Clinical services rooted in the medical model, delivered within the public and private sectors, focus on illness management and symptom reduction by skilled clinicians, while recovery-influenced non-clinical services delivered within the non-government sector focus on health promotion and case management by a multi-skilled workforce. The mediation of partnerships between clinical and non-clinical service providers, and service users, is a significant focus of peer support.

Importance of the organisational environment

The shift towards a recovery model sits uneasily with an increase in corporate governance and clinical risk management envisioned in the modernisation of the clinical and community-based mental health service sectors (Clancy & Happell, 2013; Sawyer, Green, Moran & Brett, 2009). Peer support is one vehicle through which mental illness is being reframed in recovery-oriented practice. Organisations must be open to this reframing and reconstruction

of mental illness, including concepts of social and relational wellness, and lived experience knowledge as equivalent in importance to clinical knowledge.

There is the risk that peer support will be used as a means to ‘bridge the gap’ between the personal empowerment aspirations of recovery and the compliance and risk-management requirements of corporate governance. The study described herein recognises that, for peer support work to make a substantial contribution to improved recovery and service delivery outcomes, there needs to be an increased focus on the organisational environment, including the various workers’ roles and relationships, into which peer support workers are placed; further, structural changes are required to shape an environment conducive to maximising the benefits of peer support.

Organisational environment

The last 15 years has seen the increasing transfer of non-clinical mental health services from the public to the non-government sector in Australia. Originally configured around notions of ‘disability support’, these community-based services focused primarily on activities of daily living, social inclusion and enforcing compliance standards imposed by clinical mental health services. With the advent of recovery, non-government services have moved away from sole reliance on clinical planning, wellness and compliance to partnership between services and service users.

Generally, non-government mental health services are provided by case managers and caseworkers, primarily with qualifications at a certificate level. Case managers provide advocacy, daily living skills training, access to employment, social inclusion and service coordination. They also manage the interface between the service user and clinical and statutory service requirements. In this context, peer support is poorly understood as a stand-alone role. Value has been ascribed to the impact of peer support on service users, however, outside ‘consultation’, there is limited understanding of how it contributes to broader

organisational objectives. Emphasis has been on relational factors rather than the theoretical lens peer support workers use to reframe service-delivery assumptions. This lens shifts service users from the position of ‘other’ to being ‘another’ – an equal in the user-provider relationship. In this way, peer support workers are decolonising the service-delivery space, long weighted toward professionals in the helping relationship. Being ‘another’ means assuming ownership and privileging the voice of lived experience, not only of mental illness, but also of the fragmented and confusing service-delivery system.

This critical theoretical lens is also applied to research that names and labels people in terms of the mental illness thus making way for discriminatory and exclusionary practices. These colonising processes cast populations – rather than people – as passive subjects rather than informed participants (Dudgeon & Kelly, 2014; Russell-Mundine, 2012). It privileges powerful researchers as the main arbiters of mental health knowledge (Dudgeon & Kelly, 2014).

This research focused on matters of importance to peer support workers and their involvement in the broader organisational context. Based on the principles of relational recovery, the research sought an understanding of the relationships between peer support workers and their colleagues, and with their service users, in a transforming organisational environment.

The research challenged the caseworkers to undergo a process of ‘reflexivity’; to engage in a process of self-reflection to understand discriminatory processes and practices and the belief systems supporting them (Russell-Mundine, 2012). Caseworkers and peer workers alike were challenged to reflect on the meaning of lived experience in relation to the dominance of conventional mental health knowledge.

Rationale for the study

In piloting the employment of peer support workers at two of its rural sites in New South Wales, the community organisation in this study had confronted the lack of evidence to shape an effective peer-based approach and decided to undertake the work to fill this evidence gap, mindful that the effective engagement of peer support workers would require organisational change. Following a review of the literature on peer support and recovery, it became increasingly clear that structural changes would be needed and that these would fundamentally shift power relationships and perceptions of ‘expertise’ within the organisation. The starting point was not to find peer support workers who would ‘fit’ into the organisation, but to shape the organisational culture to fit the requirements of people with lived experience of mental illness.

Methods

The University of Newcastle undertook an exploratory study to examine the organisation’s introduction of peer support work into its community-based mental health services in regional, western New South Wales. The community organisation which participated in this study is one of Australia’s largest non-government organisations, and delivers a range of community-based programmes to address issues ranging from homelessness to mental illness, youth development, and drug and alcohol dependency. Given the organisation’s plans to expand this programme, this preliminary, exploratory qualitative study considered the organisational context into which peer support work had already been introduced to ascertain the changes needed to ensure its effectiveness in the future. Semi-structured interviews with peer and non-peer staff gathered data about the relationships, perceptions and experiences of integrating a peer-work model into the service. The research was structured using a case-study methodology, whereby the examination of the organisational context at this one

community-based organisation was intended to provide an illustrative, bound case for examining the implementation of peer support, but it was not intended to be representative of the diverse contexts into which peer support workers might be integrated.

Between September and November 2014, 19 staff members involved in the delivery of the organisation's community-based mental health services took part in face-to-face, individual interviews to discuss their understandings of peer support, recovery and the organisation's employment environment. All staff involved in community-based mental health programmes at two sites selected for the study were invited to participate in the interviews, and all who were available during the time of the study agreed to participate. Participants took part in a face-to-face interview with a member of the research team, in a private office located within the organisation's premises. Interviews lasted between 30 to 60 minutes. All participants were asked about their understanding of peer support, its value and the ways in which lived experience expertise was used in the organisation. Peer support workers were asked about their motivations for working in the role, the support mechanisms available to them, whether and how they felt valued in their role and their most significant contributions. Non-peer staff were asked about their knowledge of peer support, the benefits of peer support, the ways in which they drew on peer support workers and the support mechanisms and processes available to peer support workers in the organisation. The staff members interviewed included caseworkers and managers (n=16) and peer support workers (n=2). The peer support workers also maintained workplace diaries for a period of two weeks to identify key tasks attached to their roles and reflect on the nature of peer support work within the organisation. Interviews were audio-recorded, transcribed verbatim, and interview and diary entries were de-identified and coded thematically using NVivo software. Given the exploratory nature of the study, an open coding process was adopted, by which the first round of coding categorised findings in broad groups pertaining to the research questions (Strauss & Corbin, 2008). Coding categories included the difference between peer and non-peer roles,

and understandings of the role, benefits, challenges and effectiveness of support mechanisms for peer support workers. From here, the findings were shaped according to the frequency with which particular ideas within the categories were reported by participants. The quotes used within the findings are those that are representative of the commonly expressed themes. Quotes are attributed only to the broad roles of manager, caseworker or peer support worker to protect the anonymity of respondents, and the term ‘client’ is used to refer to the people who use the organisation’s community-based mental health services. Participation was voluntary, with no repercussions for staff who chose not to participate. Written consent was obtained from all participants prior to the commencement of the study, which was granted ethics approval by the University’s Human Research Ethics Committee.

Findings

Research context

Two peer support workers had been employed. Each worked at a different regional office of the organisation. One peer support worker’s role primarily involved facilitating group activities for peers, while the other had taken on a small client caseload in addition to group facilitation. The peer support workers worked closely with caseworkers (community support workers) to support clients using a range of government-funded community-based mental health programmes.

Overall, the caseworkers, managers and the peer support workers saw peer support work as valuable and positive, largely because of the strong relationships peer support workers were able to form with clients. The perceived differences in the nature of caseworker and peer support worker relationships with clients revealed differences in the approach to client empowerment that were also reflected in staff member’s conceptualisations of recovery.

Knowledge and understanding of peer support

Most staff had had limited exposure to peer support and showed little understanding of the range of possibilities it offered beyond the activity/groupwork approach that the organisation had adopted. Thus a caseworker noted:

I think it's more supporting the client around social-type activities and helping them identify hobbies and interests and things like that on a more personal basis, rather than doing casework and goal planning and things like that.

Only three respondents had prior knowledge or experience of peer support. When asked what peer support meant, most respondents suggested it involved someone with experience of mental illness supporting other people with experience of mental illness and defined it in terms of what they had seen the peer support worker at their respective office doing. Most were vague about what it entailed:

Well, I've never had to think about it much because I haven't been in this industry for long. I don't know. I guess supporting clients. I've just got no idea. – Caseworker

One peer support worker with prior work experience in the mental health sector was familiar with a diverse range of peer support approaches, while the other had never heard of it before being employed by the organisation. Non-peer staff, who were employed by the organisation when the peer support workers were recruited, remembered their addition to the team as positive and exciting, although they had received scant information on what peer support work would involve and had not had any ongoing training as their roles evolved.

Peer support workers' relationships with clients were seen as unique

When asked to discuss the benefits of peer support work, the most common response from all participants was that peer support workers had a unique capacity to form trusting, open, compassionate relationships with clients. They were perceived as being friends and support workers:

... the clients seem to relate to the peer support worker as more of a friend-type thing. There's a lot of trust with the peer support worker here and the clients because they feel the peer support worker has lived that experience, they know what they're talking about. – Caseworker

There was a strong sense that the relationship between peer support workers and clients was different to that between caseworkers and clients. There were perceived obstacles for caseworkers in achieving strong client relationships, including limited time, the need to be authoritative and maintain professional boundaries, and a lack of personal connection. Peer support workers were considered highly valuable, because they could overcome some of these obstacles:

I am doing these things for the clients and possibly this is what maybe their caseworkers would like to be able to have the time to do with them but they just don't have the time ... I get a lot of feedback from them that they don't tell their caseworkers because we're close, we're very close. We're good friends and they will confide things to me that they don't confide with their caseworkers. – Peer support worker

To an extent, peer support workers were perceived as 'gateways' to clients. They often knew what clients were doing and how they were feeling, information which clients did not always feel comfortable discussing with their caseworkers. Caseworkers saw this conduit

to clients as a useful way of obtaining relevant and important information to better support clients.

Importance of lived experience

The fact that peer support workers had lived experience of mental illness was considered important in building the relationship with clients; clients were seen to be open and trusting of peer support workers because their empathy was perceived as genuine and they were completely non-judgemental. Interestingly, however, 15 out of the 17 casework and management staff interviewed indicated that they too had some level of personal experience with mental illness, whether directly themselves or as carers to a family member or friend. The major difference here was that peer support workers were acting in designated roles where disclosure of their mental illness was accepted (and even expected), whereas other workers with lived experience did not have to disclose this. Nevertheless, their experience informed their work with clients, or their motivation to work in the mental health sector in less direct ways. For peer support workers, personal experience was intrinsic to their ‘professionalism’:

... if you need someone that has lived experience and that is in the system and is at your level of understanding of mental health and you need to talk to someone, I’m here. – Peer support worker

While perceived largely as beneficial, the nature of peer support worker and client relationships was also seen as potentially risky.

Blurring boundaries and managing peer support worker health

Paradoxically, some caseworkers who saw the ‘friendship’ relationship between peer support workers as positive were also concerned about the peer support workers becoming ‘too friendly’ with clients:

Sometimes peer support workers develop a relationship that maybe isn't as professional as it should be. Not just blurring the professional boundaries or the personal boundaries, but sometimes they can be taken in by what a client says so they'll become quite defensive of clients. – Manager

There was an expectation that peer support workers would develop close personal relationships with clients, while maintaining their primary role as part of the ‘professional’ team. Caseworkers and managers used the term ‘professional boundaries’ to describe the way in which they managed their own relationships with clients to maintain their privacy and focus on programmatic goals.

There was a perceived risk that the role may have negative impacts on the mental health of the peer support workers themselves, since they were managing their own mental illness and recovery, while working in an intensive environment in which exposure to information and stories might be difficult for them. In addition, peer support workers must maintain regular (in this case part-time) employment while managing their own mental health recovery and sometimes taking medication with serious side-effects. This made peer support work particularly difficult:

... having to have a lot of people tell [the peer support worker] their story for the day. Making sure that [the peer support worker] can debrief or wash that off by the end of the day, so they don't take it home, because they might be quite vulnerable one day. –

Caseworker

Peer support workers regarded this as a very real risk, but reported having sophisticated understandings of their own triggers and coping strategies. Further, the organisation was seen to be a flexible employer, in that managers were supportive of all staff (not just peer support workers), who needed time away from work to deal with personal or health issues. A further complication was the tendency to wrongly attribute every aspect of work performance to mental illness:

If something happens, oh, it's their mental health. It's not because they're having a bad day. – Peer support worker

Compliance and choice

Many caseworkers described their role in terms of monitoring and compliance, i.e., ensuring clients fulfil the requirements of the 'programme':

... as a caseworker, sometimes you're doing things or helping them do things they don't want to do. Pushing them to where they need to be and attending appointments ... It's a lot different because [the peer support worker] doesn't have to deal with it. – Caseworker

Caseworkers felt a sense of responsibility for supporting clients to maintain their housing tenancy, keep their finances in order, attend training and employment-related appointments, engage in social and recreational outings and, in particular, comply with medication regimes:

I have had a client say to me that the meds aren't working and I don't want to take them anymore. I just explained to her she feels that way because she feels well enough, and that's because the medication's working ... I just made sure that she kept having her meds. – Caseworker

In contrast, peer support workers had open discussions with clients about the benefits and drawbacks of medication and were comfortable with the fact that clients might make decisions that others (e.g. caseworkers) might perceive as ‘high risk’, such as going off medication or choosing not to participate in employment-related activities:

If you’re under the Mental Health Act, you’re under the Mental Health Act. If you’re not and you’re choosing, say, not to take medication and it probably is a good thing – that’s your choice... But at the end of the day, it’s all about choice and giving them some informed choice. – Peer support worker

Lack of organisational recognition of the value of peer support

For some respondents it had been challenging to find appropriate ways to express to peer support workers that they were valued, important members of the team and for them to understand their own importance:

I don’t know if [the peer support worker] understands how important [his/her] actual role is to the whole group. – Caseworker

For one manager, the organisation had not sufficiently identified how to recognise the value of lived experience as a professional capability:

It is a profession and they’re professionals and we’ve got to ensure that we can support the integrity of professionalism around peer support work and the only way to do that I guess is to be consistent and look at capabilities, training, resources, etc. – Manager

This was further reflected in one person’s assessment that pay rates did not sufficiently recognise the value of peer expertise (noting that most of the staff interviewed

would not be aware of the pay rate of the peer support workers) and that a higher rate of pay would signify recognition of the professionalism of peer support workers. In addition, it was noted that, for some peer support workers, increases in wages could have detrimental effects on their entitlements, such as Disability Support Pensions or medication rebates.

Recovery has many different interpretations

The different interpretations of compliance and choice revealed in descriptions of workers' relationships with clients were reflected in their different interpretations of recovery. In general, there was consensus that recovery was highly individualised; many described it as a 'journey':

... as long as a person, at the end of the day, can be themselves and be happy again, to me, that would be recovery. – Caseworker

Peer support workers were seen as role models for how recovery might be achieved:

I think essentially a peer support worker provides a bit of hope maybe to someone who's at a place where they don't think that life's going to get much better than it is. – Manager

However, some caseworkers also described recovery in terms of compliance, where the goal was symptom prevention:

Recovering from their illness and realising their triggers, avoiding their triggers. Probably just make sure they have their meds regularly and not to think I'm well enough to go off my meds and become unwell again, but independently take their meds. – Caseworker

For peer support workers, there was a sense that they needed to advocate within the organisation about the importance of recovery and its highly individualised nature:

Whatever recovery model that individual takes on, I want to foster that. – Peer support worker

In general, the lack of a clear consensus about the principles of recovery among staff mirrored the lack of consensus about the role of peer support.

Discussion

The purpose and potential of peer support work was poorly understood among staff and there had been a lack of formal processes within the organisation to frame their particular approach to peer support and introduce the approach to staff. Despite this, through direct engagement with peer support workers, non-peer staff had come to see the value of peer support workers in relational processes, and in particular the value of lived experience in building relationships with clients.

This examination of peer support work within this organisation revealed as much about the nature of casework as it did about peer support work. While there has been a strong emphasis in Australian policy on the importance of a recovery-oriented approach to mental health service delivery (Australian Health Ministers' Advisory Council, 2013), at the level of service delivery there continues to be a tension between the ideologies of compliance and recovery. In this study, caseworkers had assumed roles more focused on compliance and minimisation of risky behaviour than relationship building, shifting away from a recovery-oriented model of practice. This is perhaps indicative of the way in which community-based mental health services must fit within specific programme guidelines for funding purposes. The caseworkers in this study were generally required to document the hours they spent working with each client; the hours for client contact were allocated according to whether a

client was assessed as having ‘high’, ‘medium’ or ‘low’ needs. Clients directed how the support would be provided, such as determining how often they would like home visits. However, information about hours of support was part of the funding bodies’ accountability mechanisms and the categorisation of clients could be at odds with a personal approach to recovery, whereby the individual determines the outcomes and clinical diagnosis is secondary to the aspirations of the person living with mental illness.

Conversely, peer support workers offered a point of resistance to the risk-management approach to relationship building. Peer support workers managed their own health and the challenges associated with the ongoing disclosure of their own mental illness and engagement with other people’s stories and issues. Further, peer support workers accepted the sometimes risky choices that clients made for themselves, offering a type of friendship and guidance that was non-judgemental and which recognised the often cyclical and fluctuating nature of mental illness. For peer support workers, the relationship with clients was central to their role, whereas for caseworkers the administration and delivery of the programme were central.

Limitations of the study

This sample size in this study is fairly small, and is not intended to be representative of the diverse people who engage in peer and non-peer mental health support and management roles. Further, peer support takes many forms, including paid, unpaid, formal and informal roles and this study is not intended to represent the full scope of peer support activities. It is also context-specific, in describing the process of implementing peer support in one particular organisation in two rural towns in New South Wales, Australia. This qualitative project was intended as an exploratory study, to begin the process of understanding how peer support fits within particular organisations, through a case study methodology. While the sample size and context-specific nature of the study presents limitations in terms of the replicability of the findings of the study, the community organisation is a large provider of community-based

health and welfare services in Australia and, as such, the findings reflect an important organisational perspective. From this exploratory study, further intervention-based research is required to test the policies, training and workplace practices that would improve connections between peer support and recovery-oriented practice within community-based mental health services.

Conclusion

Despite a limited understanding of peer support and its many potential manifestations, there was a good foundation upon which the organisation could build its peer support work model, due largely to an organisational environment which was open to change, respectful of diversity and which, in theory, if not yet in practice, recognised the value of lived experience expertise. There were, however, few mechanisms in place to maximise the contribution of peer support workers' (and potentially non-peer workers') 'lived experience expertise'. Peer support's value lay in the unique expertise of people with lived experience of mental illness. This challenged conventional workplace hierarchies, in particular, a mental health system that traditionally placed a high value on professional, medical expertise. The adoption of peer support was not just about the employment of peer support workers but also about rethinking the ways in which knowledge, skills, experience and power were constructed within the organisation. This highlights the importance of ensuring that critical evaluation takes place in the organisational and service-delivery environment, even for specialist services. Reflexivity is essential to understanding the socio-political factors that impact on people with mental illness, including power imbalances and structural inequalities. This includes an understanding of how to safeguard the uniqueness of relationships forged between peer support workers and service users. Significant consideration needs to be given to peer support as a developing area of practice that works across disciplines and professions.

The challenge, therefore, for community-based organisations seeking to integrate peer support within a community-based, recovery-oriented mental health service is to provide space in which the relational aspects can thrive, while meeting the very real demands of existing funding structures. Given that peer support and recovery have emerged from consumer-driven movements that have challenged the dominance of clinical, authoritative approaches to mental health service provision, it is important that this challenge to the traditional hierarchies is reflected organisationally through peer support and recovery-oriented frameworks, not just within the roles of peer support workers. What is needed is a stronger understanding of how different relationships affect the personalised recovery outcomes for clients: Is there a unique value to the type of non-judgemental, open relationship that peer support workers forge with clients? If so, how can this be translated back into the types of relationships clients have with caseworkers and even managers? How can the organisation change itself to better accommodate the risk implicit in a recovery-oriented approach? Is peer support the best or only way in which to do this?

From a relational ‘social connectedness’ perspective, community-based mental health services offer an important mechanism by which the challenges associated with the isolation of people with experience of mental illness may be addressed. Caseworkers seeking to maintain that connectedness undertake roles which are imbued with fear of risk and an emphasis on compliance and safety. Peer support workers offer this same opportunity for connectedness, without seeming to be mired in the fears of risk. Perhaps this is indicative of their lived experience expertise providing a more grounded, calm approach to the relationship between mental illness and harm, or perhaps it is just indicative of the different responsibilities of staff; in this study peer support workers were not expected to monitor risk and compliance in the same way as their non-peer caseworkers.

From a policy perspective, peer support work is emerging as an important strategy for translating recovery principles into practice. However, policy which promotes the

employment of peer support workers, without concurrently shaping structural changes to the ways in which mental health services are delivered, risks placing peer support workers in untenable positions as agents of change in an unchangeable landscape. Funding models and notions such as ‘success’ and ‘outcomes’ within community-based mental health services need to be more flexible to allow for client and worker (whether a peer or non-peer worker) interactions that focus on personal recovery outcomes and in which administration and compliance do not dominate.

While there is clearly much work to be done to better understand the relationship between peer support and recovery and to better embed principles of recovery within community-based mental health services, this study offers a glimpse of the exciting potential of peer support. Peer support workers offer a reminder of what community-based services should offer – a point of difference to clinical services. Community-based services should complement and collaborate closely with clinical services. However, they should not emulate clinical services and instead embrace a recovery framework that respects their clients’ choices.

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