LETTERS TO MY PEERS: AN AUTOETHNOGRAPHICAL APPROACH TO A MENTAL HEALTH PEER WORKER EXPERIENCE

Thesis submitted by

Elizabeth Anne Guaresi
Bachelor of Science

For the award of
Master of Applied Research

2020

Abstract

A mental health peer worker (MHPW) is one who shares their journey of recovery from mental health issues or illness in order to inspire another person on their recovery journey. This relatively new discipline of mental health is becoming more widely accepted; however, there is little research detailing the MHPW experience. This qualitative research study used autoethnography to describe the lived experience of a MHPW working in a rural area of Queensland. Introspection, sociological imagination, and reflexive writing methods, are used by the researcher to convey what the MHPW is experiencing, from the emotions encountered to the fear of exposing vulnerabilities. This research study explores the actions, thought processes, and decisions made by a MHPW peer whilst assisting individuals who they are supporting on their recovery journey to better mental health in order to answer the research question: ‘What is the lived experience of a mental health peer worker?’ This research examines the process used to build working relationships, how their relationship differs to that of other mental health workers, and the contribution of MHPW to the recovery process for people with mental health concerns.

Certification of Thesis

This Thesis is the work of Elizabeth Guaresi except where otherwise acknowledged. The work contained in this thesis has not been previously submitted to meet requirements for an award at this or any other higher education institution. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made.

Student and supervisors' signatures of endorsement are held at the University.

Principal Supervisor: Dr Melissa Carey

Acknowledgements

This research has been supported by an Australian Government Research Training Program Scholarship.

I would like to firstly thank the most important man in my life to date, my late husband Joe. Although completing my Masters was a goal of mine, prior to our marriage, he wholeheartedly supported and encouraged me with my journey. I wish he could be here to see the final chapter, but sadly his final chapter has been written sooner than mine.

I wish to thank my children, Jade, Matt, Ellie, Jack and Billy and their partners, for their love and strength during my turbulent times after the death of Joe, and for their consistent support with my studies. I am not sure that they were exactly aware what I was trying to achieve; but they encouraged me anyway.

Thank you to my friends, Dita, Shirley, Priscilla, Di, Jay, Ann, Dave and others, who have provided me with constant love, concern and support during my grief journey. Their love has been a constant for me, and provided the stability to continue this research project.

Thank you to the seven focus group participants, whose input was so incredibly valuable. To all the other people who have contributed and supported me along my journey, thank you.

Finally, I would like to give a huge thank my Principal Supervisor Dr Melissa Carey, who has provided me with an incredible amount of patience and support whilst travelling with me on this thesis journey, during which, included the death of Joe.

Table of Contents

List of Figures

List of Tables

List of Abbreviations

MHPW	Mental health peer worker
AE	Autoethnography
LTP	Letter to Peers

Chapter 1: **Defining the Work**

This thesis is the story of my research journey of exploring and discovering the mental health peer work skills that I use when supporting others. Drawing upon reflective journals, I reveal private parts of my life, uncover the emergence of these skills, explore their creation, implementation, and utilisation to benefit people that I support. I also explore how these skills affect interactions with other peers, and professionals.

I state here that the thoughts expressed in this research are only mine, I have aimed to take care of you as the reader of this thesis yet, if what I have written causes a reaction, I apologise, however please consider the words that my mentor Robyn Brownlee constantly speaks "*If you have the feeling, then you have the problem*". These are words that I live by. The very nature of this work is provocative and there will be times when this may move you to action. Sometimes this is a timely process, to work through what troubles us, but it is part of my healing, and has helped me enormously.

1.1 THESIS OVERVIEW

This Chapter provides an overview of the research starting with a statement of the problem (1.2), position of the researcher (1.3), the purpose (1.4), definitions (1.5), significance of the research (1.6), summary of the research process (1.7), limitations and delimitations (1.8), and finally conclusion (1.9).

Chapter Two provides a scoping review of the background literature, and Chapter Three will describe the methodology and methods used to conduct this research. Chapter Four, will position myself as the researcher, giving a rich and detailed description of the events that I have experienced, bringing me to Mental Health Peer Work (MHPW). Chapter Five will portray the lifestyle and unhealthy relationships that I was exposed to as a child, recounting the early years of my life and the role of peer relationships, whilst Chapter Six will look at the skills and relationships that I have built, and relationships that I encounter as a peer. Chapter Seven describes what I have learned as a Mental health Peer Worker, and in Chapter Eight, I will conclude my research journey.

1.2 STATEMENT OF THE PROBLEM

Peers are being employed more and more within Australian health systems (Queensland Health, 2019). Numerous studies have been done on the benefit of this practice, and methods including evaluation research, literature reviews, case-study projects and in-depth interviews (Shiner, 1999), and Jacobsen et al. (2012) used interviews, activity logs and focus groups. Even amongst all of this, there is little research detailing the experiences of a MHPW (Ahmed, Hunter, Mabe, Tucker, & Buckley, 2015).

As a MHPW I have qualifications other than my lived experience, but it is my experience that there is lack of understanding in how a MHPW's lived experience is used in the way they support the people they work with. This research addresses the paucity of knowledge about Mental Health Peer Work from the Peer Workers perspective, providing insight into the world of mental health peer work from the inside.

Although MHPW's may have been consulted during research for government publications, and perhaps have been involved in third party research, there is still no research that is written purely from the perspective of the MHPW reporting on their experiences of their practice and how they work to support the recovery process for others.

1.3 POSITION OF THE RESEARCHER

The areas of trauma, recovery, shared experiences, culture and stigma, and qualifications are topics that are directly linked to myself as a MHPW and the work that I undertake. As a MHPW, I use my story of recovery from traumatic life events, mental illness, the impact of stigma, and my lived experience of this as the basis of my shared experiences with those I support. My qualifications and training that I have undertaken assist my understanding of trauma and the correlation with mental illness. This current training permits me to share my experiences in order to best benefit those whom I support. Jacobson, Trojanowski, and Dewa (2012), found role conflict and confusion made it difficult for MHPW and non-peer staff to work together, and concluded that although poorly defined roles make it difficult for MHPW's, they still need more skills than just the lived experience. I have found this to be true in my employment, and my findings in this research lead to questioning of the perspectives of non-peer professionals.

1.4 PURPOSE

The aim of this research is to add to the current literature on Mental Health Peer Workers (MHPW's), and by using autoethnography, uncover the lived experience of a MHPW. This research firstly aims to extend the literature by reporting interactions from the perspective of the peer worker, thereby bringing forward a unique perspective and understanding to a relatively new discipline of mental health peer work. Secondly, this research will examine some of the actions, thought processes, and decisions made by a MHPW whilst assisting individuals who they are supporting on their recovery journey to better mental health. Finally, this research will address the lived experience of a MHPW, their working relationships, highlighting the peer worker contribution, and the assistance offered to those with mental health issues. The findings will present rich data exploring what it means to be a peer worker in the mental health field; thus answering the research question: What is the lived experience of a peer worker in mental health care?

1.5 DEFINITIONS

It was discovered that there are many names used to describe MHPWs including: peer support providers (Asad & Chreim, 2016), peer specialists (Ahmed, Hunter, Mabe, Tucker, & Buckley, 2015; Cabral, Strother, Muhr, Sefton, & Savageau, 2014; Silver, & Nemec, 2016), peer support specialists (Gidugu et al., 2015; Johnson et al., 2014), peer providers (Moran, Russinova, Yim, & Sprague, 2014; Naslund, Aschbrenner, Marsch, & Bartels, 2016), or peer supporters (Scott, Doughty, & Kahi, 2014). Other studies have used the title peer support workers (Gray, Davies, & Butcher, 2017; Jacobson, Trojanowski, & Dewa, 2012; Lawn, Smith, & Hunter, 2008; Nestor, & Galletly, 2008; Repper, & Carter, 2011; Scott, 2015; Simpson et al., 2014). The titles of mental health peer workers are numerous and varied. For this research Mental Health Peer Worker (MHPW) will be used throughout the thesis and will encompass all other titles or roles described in other research where a peer is providing support through the use of their recovery and lived experience, to another peer with mental health issues.

As shown in Table 1, the Australian Institute of Health and Welfare summarises previous descriptions by the key concept of a mental health consumer worker. Consumer or Carer, also described in Table 1.1, are considered 'Peers' in a mental health setting, however for this research if they are not employed in a paid position for their expertise and lived experience, will not be considered as a MHPW.

Table 1.1

Australian Institute of Health and Welfare Key Concepts of a Mental Health Consumer Worker

Key Concept	Description
Consumer	A consumer is a person who is currently utilising, or has previously utilised, a mental health service. Mental health service consumers include persons receiving care for their own, or another person's mental illness or psychiatric disability.
Mental health consumer worker	Mental health consumer workers are employed (or engaged through contracts) on a part-time or full-time basis specifically due to the expertise developed from their lived experience of mental illness (METeOR identifier 450727). Mental health consumer workers include the job titles of, but not limited to, consumer consultants, peer support workers, peer specialists, consumer companions, consumer representatives, consumer project officers and recovery support workers. Roles that mental health consumer workers may perform include, but are not limited to, participation in mental health service planning, mental health service evaluation and peer support roles.
Carer	A carer is a person whose life is affected by virtue of a family or close relationship and caring role with a mental health consumer.

1.6 SIGNIFICANCE OF THE RESEARCH

The Australian Government Department of Health (2020) report that up to half of the population aged 16-85 will suffer with a mental health issue including anxiety, depression, bipolar, schizophrenia, or substance use disorders sometime during their life. Furthermore, anxiety will affect at least one quarter of the population in this age group. The statistics on the Black Dog website factsheet (2020), inform us that six Australians will complete suicide daily, and that depression has the highest burden of all diseases in Australia. Globally depression is the third highest, and expected to be the number one health concern by 2030 (Black Dog, 2020).

From these statistics, it can be inferred that mental health issues are not going away any time soon. Currently clients engage with MHPW's in order to compliment traditional medical treatment or as a stand-alone treatment (Barr et al., 2020), but as the rate of mental health diagnosis increase, it is suggested that this increase will have a flow on effect for the need for MHPW's. Therefore being able to better support MHPW's in order to support the growing number of Australians with mental health concerns, will allow better support for those requiring assistance.

Ahmed et al. (2015), reported on the increase of peer led services, but that little knowledge exists of the experiences of these peers within these roles. They identified several challenges for MHPW which included little support for peers in the mental health system, and many conflicts with providers that may have negative attitudes about people with mental illness. Likewise, Cabral et al. (2014), also informed on the increase in peer workers, the lack of clarification for their role, which impacted on the expectations, guidance and training provided by supervisors. It is anticipated that the findings of this study will have the potential to assist in the future training of peers and will serve as a basis for future research. This new knowledge also has the opportunity to create better workplace training, generating a better understanding of the needs required in MHPW management, and to generally assist all of those working within the mental health sector.

As the benefits of MHPW's are becoming more widely accepted, there are more MHPW's being employed in the mental health workforce. The study by Gray, Davies, and Butcher (2017), was undertaken in an Australian rural based community health service. The difficulties reported by Gray, Davies, and Butcher (2017), were that MHPW's were employed to fill gaps, the relationships formed between worker/client were seen by other staff as risky, and that MHPW's were poorly understood by non-peer staff. The MHPW's also reported low wages, lack of training and development, stigma and unreasonable expectations. In this study, there was a perceived risk by non-peer staff that the role may have a negative impact on the MHPW's mental health. There was acknowledgement of this by the MHPW, who reported having complex, sophisticated, and in-depth understandings of their own triggers, and coping strategies in order to manage exposure.

The coping strategies I use will be explored, because as a peer, I too, have found it necessary to build this in-depth knowledge for my own safety and longevity within the mental health arena. Furthermore, Gray, Davies, and Butcher (2017) found there was a general lack of understanding of recovery principles and once again, the role of a MHPW was not clearly defined nor was it understood by other staff. Their study did however pose the question about how different relationships might affect the different outcomes of recovery for the person receiving support.

In this research, different relationships such as peer to peer, peer to client, peer to professional, are discussed, along with the different approaches and attitudes to these relationships. One of my major values in peer work is simply treating the person being supported as I would expect to be treated by another human when struggling in life, that is with inclusion, respect, dignity and empathy. This a component of my work ethic allowing me to thereby make strong connections, in order to support their recovery. This will contribute to the question 'What is the process by which a MHPW builds working relationships with individual's seeking support?'.

The questions being addressed in this research, will add to current literature by a) bringing to light new information, b) presenting a different perspective, c) supporting the MHPW workforce, and d) assisting with the training of the non-peer staff. The lived experience of a MHPW will address the proposed research questions in order to assist with broadening the knowledge base that currently exists.

1.7 SUMMARY OF THE RESEARCH PROCESS

Autoethnography will be used as the methodology and underpinned by sociological imagination, sociological introspection, and reflexivity. A more in-depth description of these methods will be discussed in Chapter Two. By using this methodology, it will enable myself as the researcher, to dig deep into my emotions, thoughts and feelings, and then with careful reflection and analysis, describe it to the reader. My aim is to take the reader on a journey with me, for them to witness, experience, and to feel included in the whole research process.

Data will be collected through personal journals, artwork, conversations, emails, all pertaining to the work that do in supporting others, interpreted within the culture of mental health. During a focus group, seven reflective journals titled ‘Letter to Peers’ were read out, and more data was captured via voice recordings, and artifacts from the participants. All the data was analysed and coded for themes surrounding the research question.

1.8 LIMITATIONS AND DELIMINATIONS

Autoethnography was used as the methodology for this research, and while it generates a depth that is not captured with other methods of qualitative research, this methodology is it may not be as readily generalisable to other areas of mental health or support work. The benefit of presenting unique data from a new personal perspective will outweigh limits to generalisability.

In addressing this gap, it is foreseen that my research will be a significant addition to the literature. By using an autoethnographical method, the researcher became the researched, and it is foreseen that the data ensuing from historical documents such as reflective journals, conversations and intensive interviews will have the potential to contribute towards a better knowledge of the qualities needed in a MHPW. This need for better understanding was reflected in the studies by Ahmed et al. (2015), and Cabral et al. (2014).

1.9 CONCLUSION

This thesis aims to introduce a different perspective on mental health. The data is not based on the numbers, facts and figures of quantitative data, but the data of reality, real life, real events, real thoughts, real feelings equating to the lived experience of a Mental Health Peer Worker. The topic of mental health is a growing concern for all Australians, and even more so on a global scale, and with this growth, the need for extra supports is required. Support from MHPW's is understood to be beneficial, however there is still a lack of understanding of recovery principles and of the MHPW's position. If this lack of understanding with regards to peer work is not addressed, there will be limited headway into the reduction of symptoms for those seeking alternative or extra support, thereby placing more of a burden on the already overloaded medical system.

Chapter 2: **Literature Review**

In this chapter, my beginnings of peer work, and issues surrounding peer work such as the impact of trauma, recovery, shared experiences, culture and stigma, and the qualifications of peers are all discussed.

2.1 BEGINNINGS OF MY PEER WORK

Growth of MHPW's is reported as increasing, however, during my time as a MHPW, in a rural town of Queensland, there is no notable growth yet. Until I commenced work, there was no other peer, there were case managers called 'peers' however there were no peers working under the peer principles or sharing their story of recovery. In the very early stages of my employment, I had a conversation with a service provider, who expressed their opinion that the MHPW program won't be around for long. I am still here, still going, and have built quite a strong reputation for the work that I do. Ahmed et al. (2015), reported on the increase of peer led services, but that little knowledge exists of the experiences of these peers within these roles. They identified several challenges for MHPW which included little support for peers in the mental health system, and many conflicts with providers that may have negative attitudes about people with mental illness. Likewise, Cabral et al. (2014), also informed on the increase in peer workers, the lack of clarification for their role, which impacted on the expectations, guidance and training provided by supervisors. However, participants in their study conveyed the overall benefits of interacting with a MHPW and aspired to becoming employed in this field.

When I started my employment, I am not sure whether it was lack of guidance, lack of role clarification, or my lack of understanding of the role, but I can say that I felt there was a distinct 'go and do your thing', but in a very supported manner. I made the role my own within the guidelines of the organisation and created relationships in the community that are still just as strong today. Role ambiguity, difficulty with integration into teams, timing of disclosure, and challenges with client/worker boundaries were reported by Asad, and Chreim (2016), whilst Davidson, Bellamy, Guy and Miller (2012), described common concerns of practitioners such as peer staff being too “fragile” to handle the stress of the job, relapse of MHPW’s, not being able to handle administrative demands, breaking confidentiality, doing harm to the clients by saying the ‘wrong’ things, and making the non-peers job harder, not easier.

2.2 CULTURE AND CONNECTIONS

Culture in this research is defined as the culture surrounding those with mental health issues, and in particular, pertaining to the MHPW workforce. Culture refers to a shared set of beliefs and meanings, values and norms, acquired through learning and shared between groups of people (Bhugra, 2006). Bhugra (2006), notes that culture defines what is abnormal, deviant, and how illness is defined, thereby perpetuating illness by defining it as abnormal. According to Bhugra (2006), culture will underpin the symptoms, assessment and management of an illness, and a service will only be considered acceptable when the needs of the patient are clearly defined and understood.

Impacting on this understanding is our construal of whether we consider ourselves independent or interdependent, which is determined by either our separation from or our connection with others (Kashima, Koval, & Kashima, 2011). Both perceptions of the self, and how we see others, are also impacted by our culture (Markus & Kitayama 1991). Our lives are complex, and it is not easy to separate self from others, culture, or society, which are all interwoven together.

Culture defines what is abnormal (Bhugra, 2006), and stigma is a mark of shame leading to rejection of others (World Health Organisation, 2018). As a person diagnosed with a mental illness, I certainly felt that shame, the rejection, the feeling that I was ‘abnormal’ and that I did not ‘fit in’ within society.

My feelings of inferiority are reflected by Singer (2019), who fought the injustice of the social welfare system for thirteen years. During this time he was labelled as ‘non-compliant, and stated “American culture necessarily relies on a philosophical underpinning that able-bodiedness is vastly better than being Disabled. The result of such castings of disability is that Disabled people feel like pariahs, internalizing the message that they are inferior" (p.503).

This inferiority can perpetuate the vicious cycle of disability, but people such as Singer, are the ones who are brave enough to use their story to create changes in the system that creates more disability. Before starting on this autoethnographical journey, I did not understand how we could use our stories as data for research, but now, like Singer, I am using my story to drive change. My feelings of rejection, shame, being 'abnormal', and not fitting in with society, are the areas that impact on myself as a MHPW and inform my practice, consequently, they are looked at during this research, with other topics such as human connections.

In their study Soler-Gonzalez, San-Martín, Delgado-Bolton, & Vivanco (2017) report that it is important for healthcare professionals to foster human connections due to the social support that this represents for their patients. Similarly, a study by Thomas, Kaiser, and Svabek (2017) reported on the importance of building human connections, asserting that it is critical to receive advice from those with lived experience and that "people don't care how much you know until they know how much you care". One participant of their study stated, "When we share life experiences, we see each other as human". Like the family connections that were strengthened when I was in hospital, I did not know how much my family cared until it was imperative. This event, and the traumatic death of Joe, has certainly bought our family closer together, and given us all a clearer understanding on how serious human connection is.

As a MHPW we are required to make connections with other peers, colleagues, clients, however, it is my lived experience, the Australian culture, and the stigma of mental illness, that together all impact on my beliefs and day-to-day decisions at the professional level. It is this current culture of mental health, the stigma and shame, that I found myself navigating in this research journey.

2.3 STIGMA

Stigma as described by the World Health Organisation (2018) “Stigma can be defined as a mark of shame, disgrace or disapproval which results in an individual being shunned or rejected by others” (Factsheet No. 218). The myths, misconceptions and negative stereotypes surrounding mental illness, are the driving factors of stigma which increase as a person’s behaviour varies from societal norms (WHO, 2018). Within the culture surrounding mental health, stigma plays a major factor and is detrimental not only due to rejection, and denial of equal participation in society, but the isolation and humiliation felt impacting on one’s recovery (WHO, 2018). An example of this is in the study by Tzouvara and Papadopoulos (2014). They reported that Greek people sampled in their survey were of the view that people with mental illness were inferior and should be closely controlled in society. Knifton (2012), found that stigma remains the largest barrier for people with mental illness when it comes to social inclusion. People with mental illness are heavily stigmatised, and culture is a large contributing factor to the stigma felt by the individual who is experiencing mental health challenges (Knifton, 2012).

Community Speech 1 *Stigma*

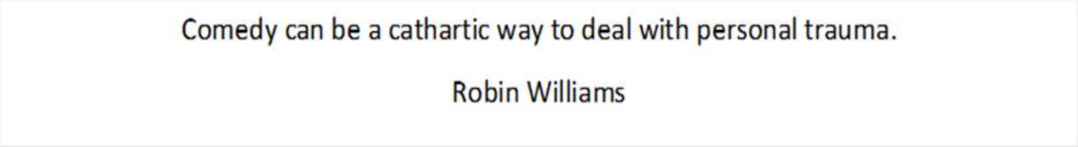
> “The one thing that I hid, the shame, the embarrassment, no-one knew, only my family, now was going to help me get a job. The interview was the first time I had admitted to anyone outside of my closest friends and family about my illness, even my kids didn’t know”

The feeling of stigma when one has mental illness is common, even though as a nation we are trying to reduce stigma surrounding mental illness, it remains. The stigma that I created for myself (self-stigma), was far worse that what I experienced within the community. My thoughts of what other people were saying and thinking about me, were mostly false, but I found that hanging out with other people with mental health issues, even to this day, is a ‘safe’ place for me. It is a place where I know people are genuine, do not judge, and simply accept you as you are. I have noticed however, not all the mental health community are like this, some wear facades, perhaps linked to the trauma(s) they have experienced.

Community Speech 2 *One of them*

> So, I ventured into the messy world of Peer Work and bought with it a nativity which enabled me to discover “a whole new world of attitudes, ones that I had been hiding from. Guess I had a fear of being labelled as ‘one of them”.

2.4 TRAUMA



Comedy can be a cathartic way to deal with personal trauma.

Robin Williams

Trauma is said to be a common experience of individuals diagnosed with mental illness (Morrison, Frame, & Larkin, 2003). Neuropsychological research has shown that a traumatic event can impede brain region development, thereby compromising cognitive functioning leading to a susceptibility to mental illness (Cook, Carcieri, Varker, & Devilly, 2009). Cook et al. (2009) reported the neural networks of those adults with no trauma accounts, and adults with trauma accounts occurring during adulthood, were the same, indicating that effects of trauma on neural networks occurring at a younger, more sensitive age of development had a greater impact.

For myself, trauma occurred from the abuse as a very young child, and then continued in different forms through my life. Likewise, the people that I support, have all experienced trauma as young children or young adults. Similarly, other research identifies traumatic experiences accumulating during childhood, increases the chance of severe mental illness (Turner & Lloyd, 1995). Lombardo and Motta (2008) report secondary trauma in children of parents with mental illness positively correlated with depression and anxiety. In addition to this, Mueser, Rosenberg, Goodman, & Trumbetta, (2002), report increased incidences of common forms of trauma and violent victimization such as rape, assault, the witnessing of, or being threatened with bodily harm, will be inflicted upon those who are already suffering with severe mental illness. These events bring forward strong emotions impacted on mental health.

As a peer, I have needed to overcome the challenges of dealing with strong emotions that lead to the thought processes that drive mental illness. As a child I was not given the skills or taught how to protect myself against strong emotions by any caregiver. This then left me prone to mental illness, struggling to cope with these emotions. It was during my recovery that I learnt to deal with these emotions, learnt to deal with the thought processes that plagued, and still plague my mind. My recovery has meant that I have now learnt to re-create healthier thoughts, to change my way of life to that of a mentally, physically and emotionally healthier lifestyle.

2.5 RECOVERY

The literature review undertaken by the New South Wales Consumer Advisory Group (NSW CAG) & Mental Health Coordinating Council (MHCC) (2009), reports that the recovery movement started in the USA around the 1970’s and describes two opposing models for recovery, the Medical Model, and the Personal Recovery Model. The Medical Model drives clinical recovery, assumes mental illness is a malady that impairs the individual’s decision-making capacity, and strives for outcomes of reduced symptomology, hospitalisation, and medication. The Personal Recovery Model uses the subjective, lived experience of the individual to drive outcomes such as hope, choice, and empowerment (NSW CAG & MHCC, 2009). This recovery model is centred around, and values, the lived experience of those living with mental illness. It challenges the traditional Medical Model of professional power and places the person as the expert in their own recovery (NSW CAG & MHCC, 2009).

According to the Australian Government Department of Health (2010), there is currently no single definition for recovery used in Australia. However, “being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues” is used as the definition in the National Framework for Recovery-Orientated Mental Health Services Guide for Practitioners and Providers (p.2). This publication illustrates (Figure 2.1), that the lived experience is placed at the centre of the concept of recovery with peer specialists being equally positioned with services, and practitioners. This indicates that MHPW are beneficial, valued, and are an important part of a person’s recovery journey. Part of my recovery journey included addressing my fears about mental illness, and the stigma associated with it..

Figure 2.1 *National framework for recovery orientated mental health services guide for practioners and providers (p.2.). Concept of recovery*

2.6 SHARED EXPERIENCES

Scott et al. (2014) state “the philosophy of peer support is one of empowerment, mutuality and the honouring of the peer’s experience” (p.199). The experience of peers is unique to each individual, however there are shared patterns of experience that emerge between peers on their recovery journey. The participants in the study by Gidugu et al. (2015), reported a sense of normality, that of not being alone, not being different, being heard when they were assisted by someone with a lived experience of mental illness. Other benefits reported by Johnson et al. (2014) included that 87% of the participants in their study reported that being a peer worker helped their own recovery process. Adding support to this finding are the results of the study by Bracke, Christiaens, & Verhaeghe, (2008), who found that those providing peer support received a greater benefit from the interaction, than those who received the support. These studies have strengthened my belief that it was in fact my employment as a MHPW, and these shared experiences that sped up my recovery process. The impact that it had on me was profound. I went from struggling with daily thoughts of suicide to finally getting a clearer understanding of my illness from my interactions with others who had also experienced the similar thought processes.

There is insufficient information about the experiences of MHPWs in their interactions with peers who are currently struggling mental illness (Ahmed et al., 2015). Likewise, Repper and Carter (2011) suggest that a future area of research is not only whether MHPW makes a difference, but under what circumstances or in which context. Gidugu et al. (2015) stated “The values and principles underlying peer support have been explored, but we lack an understanding of its mechanisms of action” (p.445). Gidugu et al. aimed to explain the workings of peer support from the viewpoint of the recipient and to determine what makes peer support effective. This research has provided a point of difference by including the perspective of the MHPW. By using an auto-ethnographical approach, I have described the process of peer support from my perspective, and the ‘mechanism of action’. This will bring more detail and understanding of the actual interactions that take place between MHPW and their clients and to answer the first research question 'What is the process by which a MHPW builds working relationships with individuals seeking support with mental illness?'. It is suggested that the data presented in this current research can increase the current knowledge, and address gaps in the literature regarding MHPWs roles, and the impact of peer support on recipients.

Question two of this research is 'How does the MHPW's working relationship differ to other non-peer mental health workers (e.g. support workers, service co-ordinators)?'. Unlike the unequal traditional 'power over' relationships that occur with customary services, it is the shared experiences allowing the benefits of MHPW support to be reciprocal. This working relationship of a MHPW can only be uncovered by firsthand direct accounts of what is experienced, such as an autoethnographical description not by a third-party perception as is normally reported in research. Training to best reveal these shared experiences, and other aspects of peer work, will enhance any relationship that needs to be built.

2.7 QUALIFICATIONS

There has been some concern expressed that MHPWs health or behaviours could bring this new aspect of mental health support into disrepute (Scott, 2015). Initially those people with a lived experience, some evidence of recovery, and with enthusiasm for the role were employed as MHPWs (Nestor & Galletly, 2008). Gradually more qualifications and specific training have become available to support and legitimise this role. Nestor and Galletly (2008) report that in South Australia, professional qualifications, tertiary level certificate courses and a two-year diploma program are available for MHPWs. According to Ahmed et al (2015), MHPWs receive training in the person-centred recovery model and certification to become MHPWs; however, the participants in the study by Scott felt that academic qualifications are not necessary to be an effective MHPW. Scott et al. (2014) reported that MHPW's trained in a certified mental health course, were more risk aversive than those trained in methods such as the Intentional Peer Support (IPS) courses. One of the peer workers in the study suggested that this risk averse qualification could be lowering the confidence of the role of the MHPW. Numerous training organisations Australia wide are now promoting the Certificate IV in Mental Health Peer Work. After six months as a MHPW, and no training whatsoever, I had a strong opinion of the work that we do as reflected in Community Speech 3.

Community Speech 3 *Breaking down the barriers*

> "Peers are exceptional and given the right opportunities, can provide an immense contribution to breaking down the barriers that people with mental illness face. We dance between the black and white, mixing it up to form shades of grey".

2.8 SUMMARY AND IMPLICATIONS

The literature is very clear that peer workers are beneficial, and these benefits are conveyed, but it is not clear why it is that their interactions, the shared experiences have such a great impact or how this is undertaken. Challenges for the peer worker include negative attitudes, stigma, lack of role clarity, lack of understanding about peers in general, and have also been considered as too fragile to undertake the role.

These challenges can be somewhat allayed as there are qualifications available now. This brings about mixed feelings from that it is not necessary; we only require lived experience, and others stating it makes the peer worker more risk averse. Regardless of the possibilities of the risk averse worker, the role of a MHPW includes being able to share your lived experiences, from the traumas faced to the recovery journey.

Trauma during childhood increases the chances of mental illness, so for me, my mental health journey started whilst I was very young, and the introduction and journey into the world of Peers started after my hospitalisation. From this event I have set about exploring, gaining knowledge, and understanding mental illness more intimately. It is the findings from this research that will present a rich data exploring what it means to be a peer worker in the mental health field; thus, answering the research question: “What is the lived experience of a peer worker in mental health?”

2.9 RESEARCH QUESTIONS

Prior to my decision to undertake this research, I had previously attended a Brook Red Dialogue conference for the lived experience workforce (MHPW’s). It was during the conference that I joined with others at a presentation regarding research for the lived experience workers, questioning the attendees as to what their thoughts were about what needs to be done, and how it can be achieved. Bipolar symptoms allowed my mind to start racing, and I grew excited at the prospects of undertaking research in this area. I knew though, that this would be just one of those things that I get excited about, it is way out of my area of expertise, not having the skill set to know where to start, let alone complete it. However, in saying all of that, this Brook Red Conference presentation was the inspiration for my thesis.

It is from reflection of my personal journey as a MHPW, and searching the literature that I am led to ask more questions. If we are to be able to better support MHPW’s, we have to understand where they fit within the system, how they build relationships, what’s different, and how do they help those they are supporting. From the thought processes driving these questions, I am putting forward the following questions in order to gather a richer knowledge base regarding MHPW’s.

1. What is the process by which a MHPW builds working relationships with individuals seeking support with mental illness?
2. How does the MHPW’s working relationship differ to other non- peer mental health workers (e.g. support workers, service co-ordinators)?
3. What does the MHPW contribute to the recovery process for people with mental health issues?
4. How do MHPW’s fit within the mental health system?

Chapter Three will introduce the methodology of autoethnography for this research, and the methods that were used in obtaining the data and the ethics required.

Chapter 3: **Research Process**

This chapter of the thesis will outline the methodology and research design. A description of the design adopted by this research to best achieve the aims and objectives will also be stated in this chapter. Section 3.1 discusses the use of autoethnography as the methodology, being underpinned by sociological imagination, sociological introspection, and reflexivity. This is followed by a discussion on data analysis (3.2), the interpretation of data analysis (3.3), the method used to collect data (3.4), and finally ethical considerations of the research (3.5).

3.1 METHODOLOGY AND RESEARCH DESIGN

3.1.1 **Autoethnography**

Autoethnography, has been chosen as the methodology for this research, because as the researcher, I am also part of the mental health peer work culture, therefore my perceptions and thought processes are part of the data collected for the research. It is this perspective that brings a totally unique and individualised depth to the research. McIlveen (2008), noted that autoethnography (AE) as a qualitative method of reflexive enquiry specifically addresses the stories of the scientist and the practitioner. As humans, we experience a range of emotions and therefore, Buckley (2015), explains that anyone experiencing emotions, cannot truly describe these emotions to another person unless they have experienced it themselves.

Buckley records that emotions such as joy, triumph, fear, relief, sadness experienced during events or situations will all be firsthand experiences culminating in a variety of artefacts and rich data. It is with the use of AE that the researcher can analyse and describe any emotion or feeling (Buckley, 2015). I am researching myself, and my work as a MHPW, so it is expected that by using this methodology the results will uncover new realities, reveal differing perspectives, and expose personal vulnerabilities in order to describe the working relationships and lived experience of MHPWs.

Autoethnography is used to describe a first-hand account of a life, the personal experience of participating in cultural life, and it is through these personal experiences the person will make sense of the culture (Adams & Manning, 2015). Farrell, Bourgeois-Law, Regehr, & Ajjawi, (2015), concurs reporting that the goals of AE are to enable a broader reflection among readers by providing new insights into the culture. Likewise, Liggins, Kearns, and Adams (2013), suggest that AE connects personal experience to cultural process and understanding, allowing the researcher to get as close as possible by being involved in the social process, thereby creating greater depth and understanding. Spry (2001) asserts that AE makes us acutely aware of our own self constructed reality and that the main defining feature of AE is for the reader to be able to interpret culture through self-reflection and cultural diversions of individuality. According to Hoppes (2014), there is a unique perspective created as AE places the writer in dual roles as the researcher and research participant and within this situation the researcher is required to be an active participant of the culture and will record, and reflect on interactions (Farrell et al., 2015). As the researcher I have exposed personal thoughts and actions, revealed personal vulnerabilities whilst writing about my own perspectives and emotions (Farrell et al., 2015), culminating in the data for this research.

There are numerous methods in which a researcher can collect data with AE. The data collection of James (2015) consisted of audio recordings of meetings, field notes, personal reflective log, and participant reflective diaries to capture what he and his team members were experiencing. Pufahl (2012), used participant observation, audio recordings, ethnographic interviews, field notes, student notes, yearbooks, and graffiti as his methods of collecting data. James (2012) used data collection methods that included documented discussions, meetings and reflections recorded in research journals. Reflections are relied upon as the main interpretation of what was experienced, however incorporating the voices of others such as supervisors, participants, or literature can add extra perspective on the culture (Farrell et al., 2015).

I am part of the MHPW culture, I have my own lived experience of mental illness, and these experiences are a part of the research, and although AE appears perfect for my research, it is not without limitations.

3.1.2 Benefits and limitations of Autoethnography

Farrell et al. (2015), state that there are limited descriptions of medical cultures, and these are often limited to interviews or questionnaires. There are many benefits to using AE as a research method for mental health; however, according to Muncy (2010, as cited in James, 2012), "you would not subject yourself to this unless there was a strongly held belief that the purpose was legitimate" (p. 556). Similarly, Ellis and Bochner (2006) record that autoethnography needs the researcher to be not only vulnerable, but intimate. I am exposing my thoughts, my beliefs, and placing myself in a situation open to criticism and at risk of jeopardising my own mental health in the process. However, I believe that this perspective needs to be put forward, needs to be relayed to the mental health community in general, and as James (2012) stated "any risk related to personal exposure is outweighed by the possible benefits" (p.556).

Grenier and Collins (2016), report that AE is subject to the ideas that it is unscientific, biased and not generalisable. This can influence the researcher to feel 'self-indulgent' (Grenier & Collins, 2016; Farrell et al., 2015), or not scholarly (Grenier & Collins, 2016). However, it is still the experience of myself as the researcher (Farrell et al., 2015). I understand that limitations also arise from the lack of generalisability to other areas, but AE studies may encourage readers to expand their own knowledge and perceptions of the work environment which may then contribute to positive change (Farrell et al., 2015).

By collecting the data for this research, I have found that AE is the precise tool to allow learning about oneself, interpersonal skills and challenges which are all intrinsic to personal development (Hoppes, 2014). Research by Hoppes, found that in teaching AE to a group of occupational therapy students, the students began by addressing questions regarding their strengths and weaknesses, challenges that arose, what hopes they had have been dashed, or realised, and how personal history influenced the therapist they are becoming. The AE researcher may encounter situations that hit with such a force that they can become ‘stuck’, unsure of what this encounter means. By asking themselves a few questions to assist in moving around the story, this use of “inward–outward/backward–forward” storytelling method will bring to light meanings that would normally not be available (Hoppes, 2014; Liggins et al., 2013).

This story telling method allows the opportunities to provide improvements to society which come with such a rigorous and creative methodology (Grenier & Collins, 2016). Farrell et al. suggests that AE acknowledges the subjective and continuously changing realities, while allowing for the exploration of subjective knowledge, understanding that there is more than one single underlying reality. In addition to this Dauphinee (2010), states that there is a possibility of us uncovering the ignored, questioning why it is ignored and what can we do about it.

Other benefits from personal experience of culture by the researcher may provide the opportunity for unique insights to advance education (Farrell et al., 2015). Grenier and Collins (2016), posit that autoethnographic methods allow individuals to share stories that are valued by not just their team or department, but by industry. Likewise, with this research, the reader will be able to enter other lives using AE. These shared experiences, sharing of stories using this methodology will remind the reader of the importance of the shared interactions between peers which assist in the mental health recovery journey of both peers.

Spry (2001) writes that profound healing took place when she took on the position of a woman of strength rather than accepting the victim status when she re-wrote about her life experiences. She posits that the primary goal for AE is through reading of others’ experiences encourages the reader to explore and uncover the fractures in their own lives. As the researcher, I have revealed not just my vulnerabilities, but my own identity created within a culture where the disabling stigma of mental health is widespread. One goal of this research is for new ways of knowing to be revealed.

I believe that through AE, exposure can be done and in a manner that will not only benefit my own professional development, but to assist with my commitment to the development of peer work in general. By exposing my vulnerabilities, this may be perceived as a limitation, and there is the distinct possibility of leaving myself to be judged by others. I may also have the feeling of being ‘self-indulgent’ (Grenier & Collins, 2016). These are limitations that will be offset against the multiple benefits of this type of research to mental health in general, and to the wider community.

This qualitative research project will be underpinned by a sociological imaginative, introspective, reflexive, and interpretive framework (Figure 3.1).

3.1.3 Sociological Imagination

According to Puga (2017), C. Wright Mills (1959) in The Sociological Imagination allows the imagination of a person to create a relationship and will be determined within specific historical, social context and structures. Empathy is a ‘major factor’ (Bousalis, 2017) when developing sociological imagination, and by incorporating stories from other individuals, similarities in societal dilemmas can be distinguished, and compassion can be cultivated.

Within this research, the story-telling, the ‘to-ing and fro-ing’ of looking at history, the looking at the present day social dilemmas for those living with the stigmas of mental illness, and similarities between the individual peer workers of today, will create an experience for the reader that encompasses both compassion and empathy in order to bring more understanding in this field of mental health.

3.1.4 Sociological Introspection

Ellis (1991) argues that even though researchers can be studying emotions, they ignore what it feels like, and how it is experienced. However, Ellis also suggested that the technique of introspection will permit access to the chosen private experience and allows the exploration of the complex nature of emotional experience. This technique encourages the active thinking of external stimuli, the bodily responses, and the social interactions that impact on the thoughts, and feelings of the person. Sociological introspection provides a way for the researcher to look at, recognize, and study, their own lived experience of emotions.

This research is looking at the lived experience of myself as a MHPW, drawing on my own lived experience of mental illness, and my own emotions when supporting others, so this introspective method best supported myself as the researcher and the aims of this research.

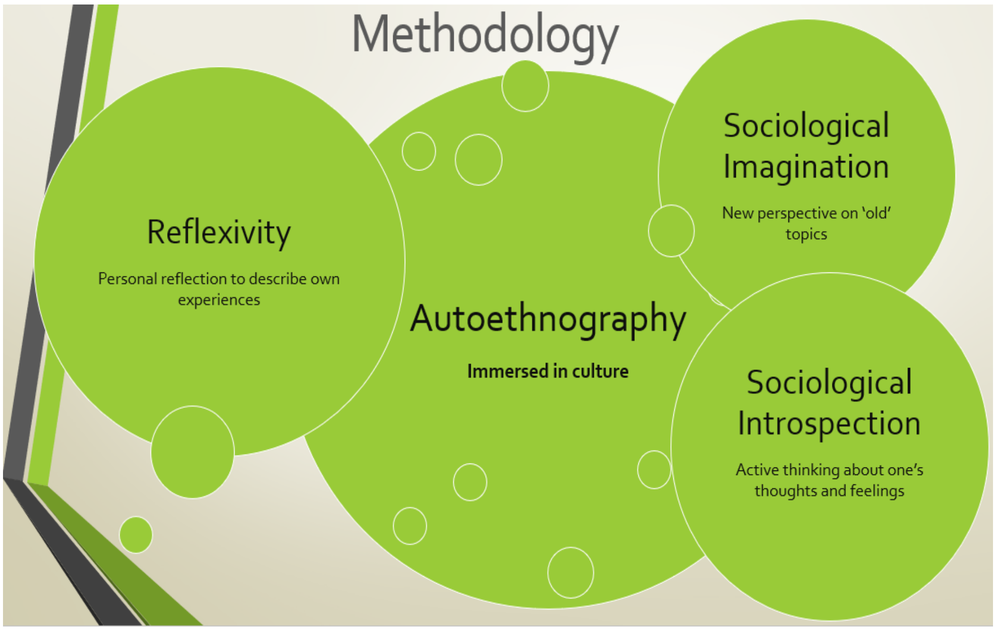
3.1.5 **Reflexivity**

The use of reflexivity in autoethnography will enable the discovery of life changes, unearthing of the mundane, the repetitions and patterns, the confusion, and the personal meaning of events (Adams & Manning, 2015). McIlveen (2008) reports that reflexivity in research offers the ability for new understandings and actions and it is this process that then permits transformation. According to Farrell et al. (2015), reflexivity for a researcher is the ability to utilise personal reflection to describe their own experiences, allowing the researcher to study themselves and create a reflexive dialogue with the readers.

This socially constructed knowledge is dependent on the researcher’s background, what and how they chose to write, their relationship with others, the environment, and other influencing factors that arise at the time (Farrell et al., 2015). Farrell et al. reflects that AE goes beyond personal experience and permits one to analyse and describe what is understood about a culture; their story must resonate with readers while exploring how it fits into daily life, and expanding upon what is already known. AE is a powerful tool for the purposes of reflection and expression of identity (Hoppes, 2014), allowing narrative self-reflection, and analytical examination of relationships between self and others (Farrell et al., 2015). It has been found that by using AE as a vehicle for reflexivity, this allows and improves the rigor of the critical thought process required by researchers and practitioners alike (McIlveen, 2008).

Through reflective journaling James (2015) was able to externalise his inner dialogue, to clarify implicit knowledge, and understand the values and principles that underpin his practice. As a peer worker, reflective journaling is a tool that I use, one that helps not only clear my mind, but put into perspective the thoughts, the events and feelings that arise from the day’s events. My reflective journals were the basis for the “Letter to Peers”.

Figure 3.1 *Methodological framework of research*

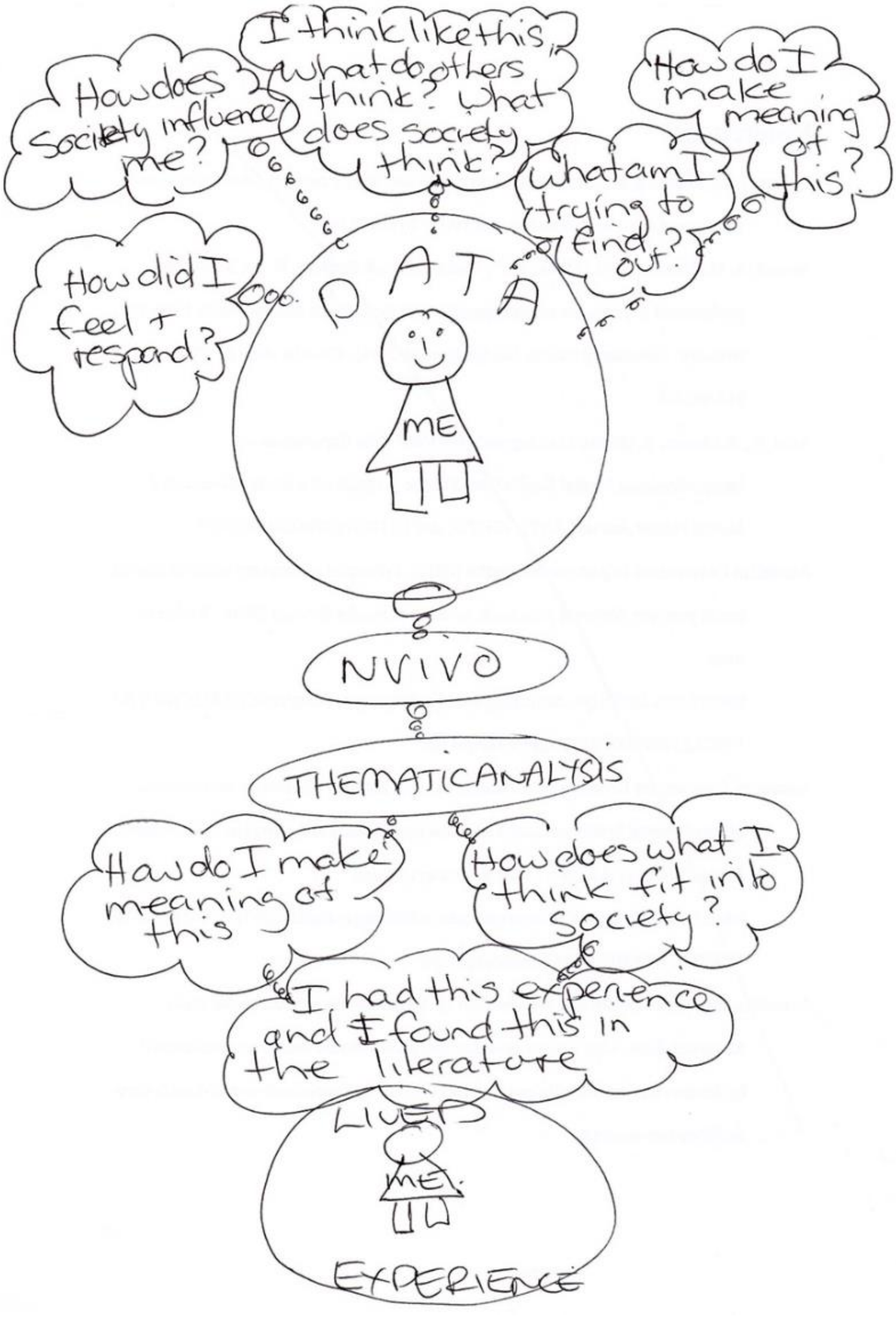


3.2 DATA ANALYSIS COLLECTION

The chosen methods for data set collection with this project was historical data through reflective journals, ‘Letters to Peers’, and artefacts created by the researcher. Information from approximately 12 months of historical journals which included details of memories and past experiences all considered important data for the research. These experiences were reflexively explored and ‘Letter to Peers’ were written. These pieces were originally created to assist the students when I was co-facilitating the Certificate IV in MHPW in our region. Before the start of each session, I would read the letters that I had written from my perspective, my experiences, that were pertaining to the topic that the students were discussing on that day. Ellis and Bochner (2006) argue that reflexive writing is more than just writing about experiences. For my journey it was about showing the passion and the struggle as I made sense of situations (Ellis & Bochner, 2006), as I completed the cycle of talking, thinking, writing, looking inwards, looking outwards, recognising and interpreting the culture (Spry, 2001).

For data collection, I had planned to undertake intensive interviewing with key cultural informants. However, due to the length of time for ethics approval and then the death of Joe, it was decided to conduct a single, two-hour focus group. In this focus group, 'Letter to Peers' were read to seven participants, and participants were encouraged to freely express their thought and ideas on A3 size paper, and other photocopied artifacts. After transcribing the two hours of recorded data, I reflected on my own thoughts, testing my own theories against these reflective conversations, the artifacts created by the participants, thereby enabling me to complete my own interpretation of the data.

Artifacts 1 *Data analysis – my perception*



3.3 INTERPRETATION OF DATA ANALYSIS

According to Braun and Clarke (2006), within thematic analysis, data corpus refers to all data such as the artifacts journals, documented conversations collected, the data set is the particular data for analysis and will include all data that is relevant to that topic. A data item will be an individual conversation, or piece of artwork and a data extract will include individual coded chunks of data, extracted from a data item. Only a selection of these data extracts will feature in the final analysis (Braun & Clarke, 2006). Using the chosen theoretical framework and methods of the research as the guide, I chose specific themes of interest to the topic, and explicitly reported choices and the decision-making process to the readers (Braun & Clarke, 2006).

Three data sets used for this research are described in Table 3.1. Data was interpreted and analysed thematically according to the type of data collected. By looking inwards at the data that I have created (how does this affect me, what does this mean to me?), then looking outwards (what does

Table 3.1 *Data set for research*

Data Set	Description
Private	Private journals and artifacts not shared with anyone.
Public	Data shared with others – Personal Reflections Community Speech 'Letter to Peers' Personal artwork Participants' artwork Participants' data Photographs, images Transcription of focus group recordings Interpretation of data Participants' artwork
Social	Data given to me - gained through social interactions Telephone conversations Emails

this mean to others, how does this fit within society?), looking at how each piece informs and links together, themes extracted informed the meanings in order to create concepts, and the story of the lived experience (Artifacts 1).

Thematic analysis allowed myself as the researcher to identify themes that arose from the data and were used when I reported experiences, being utilised to reflect reality (Braun & Clarke, 2006). The advantages include being flexible, relatively easy to do for those with little research experience in qualitative research, offers a ‘thick description’ of the data set, and can highlight similarities and differences across the data set (Braun & Clarke, 2006). By using thematic analysis, this research is authentic and trustworthy for the reader to feel like a genuine participant (Quicke, 2010).

3.4 METHOD

Whilst undergoing her PhD research journey, Carey (2018) experienced a total cultural immersion. Carey attended lectures, seminars, performances, museums, libraries to visiting the natural environment of waterways, bushlands, mountains, took photos and shared experiences, and used other methods of technology in order to obtain research data. From all of this, Carey then used a reflexive writing process to capture these experiences and by “looking inwards at self, and looking outwards at society, and backwards at history and forward to the future” (p.4.) she created the story of the lived experience of Maori cultural recovery.

As shown by Carey, autoethnographical research can encompass numerous data collection methods, however the chosen methods for raw data collection with this project were historical data through reflective journals by myself as the researcher. Data from reflexive diaries of work experiences written by myself, detailed the journey of supporting people/clients and the thought process used to better understand the values of peer work encountered. The reflexive work undertaken, allowed the examination of relationships, culture and the principles that underpin practice. These experiences were reflected upon and reflective pieces ‘Letter to Peers’ were written. In keeping with the methodology, and the ability to ‘look outwards’ as part of the data gathering process, an audio recorded focus group was formed to discuss the ‘Letter to Peers’.

Convenience sampling was used to invite seven informants to the focus group. The invited informants were people over the age of 18, and currently employed as a peer in either in a paid or voluntary position within the mental health sector. Potential informants were contacted as a group invite via the Cert IV Mental Health Peer Work Facebook group. They were requested to contact myself by email and to provide their contact details. I then provided the informant with an invitation (Appendix A), details, and objectives of the focus group (Appendix B).

The venue was a conference room at the University of Southern Queensland. As participants came in, they were required to fill in and sign a consent form (Appendix C), and prior to commencement, the group was reminded that the session was to be audio recorded, that they were free to leave at any time, and have their data withdrawn at any stage without prejudice. The participants chose to put some tables together and sit as a group, rather than spread out around the room. Morning tea, tea and coffee were provided and during the time allocated, participants were free to help themselves to refreshments, move around the room, or even leave the room to take phone calls.

The recording was started from the moment I started reading the first ‘Letter to Peers’. The seven letters each had a title reflecting the contents; Letter one – Triggers (Appendix D); Letter two – Perspectives (Appendix E); Letter three – Holding the hope (Appendix F); Letter four – Trauma Informed Care (Appendix G); Letter five – Trees (Appendix H); Letter six – Spikey balls (Appendix I); Letter seven – The power of connection (Appendix J).

Each of the letters bought forward lengthy discussions about peer work, the effect it had on them individually, the impact their illness had on their family, the stigma created by general lack of understanding of mental illness and the detrimental effect it had on those with it. At one stage, the room went quiet as they asked me how I was doing after the death of Joe. I gave a brief answer and recalled an art group where I made Joe’s bicep out of clay. No one was quite sure where I was going with this story or why I had done this. I made mention of the fact that when Joe and I sit on the couch together, I snuggle into him, leaning my head on his right shoulder, and put my right hand, holding his bicep. So, I made Joe's bicep for myself to hold. Other personal stories were shared, other analogies, stories about wellness, recovery stories, all making the focus group very rich with data for this thesis. These are the stories we take for granted, we think nothing of them as we share around the room, and yet here I am gathering their words and using it as data for what I see as important research.

The recording was stopped after the two hours and all discussions had ceased. Blank paper and coloured markers were provided and placed on the tables for the participants to use in order to capture more data. I requested that they not put their names on the top, just the name or number of the letter for future identification. When I had finished reading a Letter, participants were free to discuss what had been said, how they felt, or what they have previously experienced pertaining to the Letter. They then chose when to start the next Letter by getting the next sheet of paper or asking to start. All of this data was captured on the recording.

Copies of artifacts were also placed on the table pertaining to the particular Letter to Peers that was being read. The informants were encouraged to draw or write anything that came to mind on any of the paper provided, as the stories were read. One participant found that writing was too difficult, so they chose to draw patterns on the paper and then colour this in.

The focus group was audio recorded and pseudonyms were used during the transcription. As the data will be re-identifiable, individual data will be able to be withdrawn if requested by the participant. The transcriptions were translated and added to the rich collection of data which was then analysed for emerging key themes.

In keeping with my data management plan, copies of artwork, Letter to Peers, consent forms, transcriptions and other data have been uploaded to USQ secure sites. MS One Drive is the primary site, and MS Teams, and Cloudstor as the two required secondary sites. The data and electronic files are also stored on the non-USQ, password protected, researchers' personal laptop, per USQ ethics requirements.

Copies of the historical data, consent forms, and other data collected are stored in a locked filing cabinet at the premises of the researcher and will remain there for a period of seven years.

With any type of research that involves human emotions, there is the possibility of psychological, or social risks. For this research, these risks have been considered low, as the information gathered in the focus groups is purely voluntary. To keep the time imposition risk low, the focus group ran for approximately two hours, and members of the group were able to leave and/or withdraw at any time without prejudice. To allow all informants to view the data prior to publication, a presentation of the de identified research data collected and details will be held for all members of the focus group that participated.

It is possible that the informant can be at risk of feeling emotional upset, stress, depression or anxiety after participating in the focus group so it was written in the information letter that if they felt that they were suffering psychological harm in the way of psychological distress from the storytelling, they were to contact their GP or Lifeline on 13 11 14. As the researcher, I have access to professional supervision as part of my normal work schedule, allowing for exploring any discomfort that has been experienced throughout the research process and then dealing with the feelings that may arise while this study was being conducted.

3.5 ETHICAL CONSIDERATION

Ethical considerations must be given to people with a mental illness that are not only entitled to, but willing to participate in research. (National Statement on Ethical Conduct in Human Research 2007, (Updated 2018). This research was undertaken by and involved persons with a lived experience of mental illness. Keeping this in mind, the research was informed by the eight principles of the Australian Code for Responsible Conduct of Research. (2018); honesty, rigour, transparency, fairness, respect, recognition, accountability, and promotion of responsible research practices.

This responsibility flows onto our social networks which include not only friends and families, but those who we work with, colleagues' or other professionals. Through research, we have no choice but to implicate others in our work as we speak on behalf of others, and this is extremely true for AE. The location of my community may be identifiable as will some of the informants in this research. These relational ethics (Ellis, Adams, & Bochner, 2011) were addressed within this research. It is obvious to me that even though I may change names, or situations, people will be implicated and identifiable in my research, and this was kept at the forefront of my thoughts during the research and writing process.

3.6 ETHICS APPROVAL

Ethical clearance for this research (H19REA132) was granted 12th May, 2019 prior to any invitations to participants. Interested Cert IV Mental Health Peer Work Facebook members were invited to participate via email however, a signed informed consent form was required from all informants prior to the start of the focus group. Informants were advised verbally of a) the conversations being audio recorded for use in this research; b) that names will not be used in transcribing of the data, however pseudonyms will be used for coding of the data, and c) at any stage they may withdraw, and have their data withdrawn from the group, without prejudice. Prior to submission of the thesis, participants were given the option to look at the work and allowed to respond or express how they feel about what has been written.

Details of the situations in the de-identified historical data will be kept to a minimum and as brief as possible perhaps even changed, so that it is only my thoughts and words of any conversation to be collated for this research. The protective strategies themselves may impact on the integrity of my research, and as pointed out by Ellis et al. (2011), we must all still be able to live within these relationships after the research is complete.

3.7 MEMBER CHECKING

At the end of the research, all focus group members were invited to view the thesis and provide feedback on what was about to be submitted. Through a Facebook chat group, the participants were sent the document and invited to a Zoom meeting to so they could put forward and discuss their feedback with others in the group.

Participants said that they were each able to recognise some of their contributions, and the group chat bought back memories of the day as sentiments were once again shared. One participant recalled the stories that they told on the day, which bought back a range of emotions for them once again. Positive comments were made about the lovely food provided, their seating arrangements and how they were allowed to leave the room if upset, take phone calls, or just go for a break. These comments surprised me, as it reminded me of how the little things are so important when treating people with dignity. In fact, one participant made that exact comment "You treated us with respect and dignity". For me, I treated them the way I would want to be treated. With regards to the document, the participants were pleased with what they had read, with one eloquent comment "I feel heard. You have given a voice to the voiceless".

Chapter 4: **The Researcher**

This chapter explores the sensitive topic of my journey as a mental health consumer, beginning from just after my first attempt at suicide and continuing through my hospital stay, where I get my first glimpse at MHPW's. Hospital became a very safe and secure place for me. I did not want to leave, but what was unknown to me at the time, this was the start of my journey to becoming a Mental Health Peer Worker. As this research is being conducted at the time of COVID-19, the impact of this on the people I support and myself, will also be included.

4.1 INTRODUCTION TO MY JOURNEY

Hospitals can sometimes be considered a not so nice place to have to stay, due to the separation from loved ones, but for myself, and possibility numerous other patients, the isolation and loneliness that surrounds us in the outside world, allows the hospital ward to become a safe place. For myself, this is where I was introduced to peers and my recovery journey began. Data from personal reflections including 'Breaking Point' to 'Recovery' (below), are used to describe the surrounding events and time I spent in hospital.

As an autoethnographic account, I need to create for the reader, an understanding of the perspective of my values, my morals, my ethics and how they drive my life, and how they are integrated into my work as a peer worker. To be a peer means that you have a lived experience of mental illness, or at very least mental health issues. Likewise, for me to successfully gain employment as a peer, I was required to have a lived experience of the public health system, which was something I certainly had. As I have always loved to write, it is the journaling of experiences during my stay in the Acute Mental Health Unit, that I will reveal in order for the reader to capture some of the emotions, some of the situations that I have encountered that have led me to peer work. All the following excerpts are taken from Personal Reflections. I will describe my hospital events and the thought processes that I had during this time.

4.2 BREAKING POINT

This story starts from when the ambulance and police arrived on the scene and removed me from the vehicle. I forgot to lock the car doors. I saw them and I started to sob, I had no will left to fight, no energy to stop them. They carried me to the ambulance, put the oxygen mask on me, and did their best to console me. However, this was futile, there was nothing anyone could say that was going to ‘make me feel better’. At the beginning of this research journey, I started to write my story looking backwards, before I could look forwards. I wrote from the heart, and the soul as I reviewed my old journal entries from when I was unwell (Personal Reflections 1).

Personal Reflections 1 *Breaking point*

"Com'on, life can't be that bad" said the voice as I was lifted out of the car, my whole body wracked with sobbing. How would they know, that they had no idea of what I had been through in my life, and the efforts that I went to, to do the right thing no matter what, to be fair, to be a good mother, and yet I had failed. I just couldn't go on anymore, it had to end. What was the use? I was tired of fighting, I had no strength left. I had used every ounce within me. They had intervened and stopped my plan. Yet another thing that I had failed at.

It was his week of the holidays to have the kids. He always said he would end up with the kids, and like he had said two nights ago in our last conversation, 'I will get the kids, one by one, and you will end up a lonely old lady'. The kids were with him, they were safe, and they didn't need me. I wanted the pain, the loneliness to end. I wanted to end the fighting. I got off the phone and made my decision, I knew what I had to do. I sometimes wonder whether I made this phone call in order to drive my decision, pre-empting the outcome. Nothing ever changed with these phone calls, so what was so different this time? Was I already subconsciously getting ready? Did I just want that final push?

Journal entry on this day "My life has been hell from woe to go, need to end it and start again…….I love my children, but the fighting is not worth it….. I don't belong on this earth……this is for the best, it's the only way".

Terror Management theory states that thoughts of death are inevitable when one has no meaning in their life.

The trip to the hospital I continued to sob, and for three days after admittance I continued to sob, and my voice was barely audible. The psychiatrist informed me that I was one of the saddest cases he had ever seen.

After a few days in hospital, another attempt. Moved to High Dependency Unit (HDU). Journal entry this day;

"After 22 years he has won the round, and the fight. His favourite saying is if you throw enough mud it will stick. I am now so heavy with mud, I can't move. The sun has baked the mud and suffocated any life underneath, the wind has eroded it and the rain has washed away what is left. Touché my friend".

4.3 HOSPITAL REFLECTIONS

Things that I recall the most from my short time in High Dependency Unit (HDU), include, that for our own safety, we were locked in our rooms at night-time, and were only to use plastic cutlery and crockery. I stayed in my room for the period I was in there, although I could hear a young lady, and although I didn't ever see her, who sounded very upset, yelling all the time.

I had no understanding of her diagnosis, no understanding of her thoughts, but she was just screaming as if she wanted to be let out. This upset me greatly, and I was already sad, so it only made me sadder. Even through my sadness, all I wanted to do was help her (Personal Reflections 2).

Personal Reflections 2 *Wanting to help others*

> “My heart goes out to the ones in pain, I wish I could do something for them, but I can’t…….Oh just heard (x)-off she goes. Feel like laying down in front of her door and talking gently to her. Her throat is going to be red raw in the morning. Nice nurses here…..Poor (x) I just want to hug her but I don’t know her”.
> “Don’t know that you can do much to help most of the people in here. It’s very sad.”

Due to my immense sadness, they started my medication as an antidepressant. Apparently, this medication set of a manic episode, which is how they confirmed the diagnosis of Bipolar.

Personal Reflections 3 *Mania*

Visit with the hospital psychiatrist. The medication was working, I could not stop talking now. My voice was still barely above a whisper but apparently, I was the ‘loudest’ on the ward. Bipolar?? I chuckled on the inside, perhaps ADHD, but not bipolar.

Cyclothymia, rapid cycling bipolar, a mania and depression in fairly rapid succession. Yes, that would explain why during a phone conversation with a friend several years earlier, there was no understanding of what I was talking about

“You know that time of month when you have so much energy and can do anything?”

“No?”

“Oh, well, um…. Ok, well…..”

I thought everybody was like that, bit confusing for me, still thought that perhaps it was just her.

On entry to the ward, the psychiatrist was gathering information from me, asking all sorts of questions to get an accurate diagnosis. I was not going to play their game, fearful of the consequences (Personal Reflections 4).

Personal Reflections 4 *Stigma*

“Do you hear voices?” You have got to be kidding, even if I did I wouldn’t tell you, no way am I getting labelled as schizophrenic. The truth of the matter was that I did hear voices. On ‘the day’, a gruff voice came into my head “We’ll show ‘em.” I feebly tried to protest, but this voice was too strong, I had absolutely no will left to fight, so I resigned myself to what was being prepared. My body was being driven by another force, I had the urge to get things done, to get things sorted, however I just knew that it was not me. Just like how the voice had taken over, so too had my body been invaded by a person that just went about and got things ‘done’ as if it was all matter of fact, almost as if they had done it before and knew exactly what to do.

More stigma. Entries from my hospital journal read;

“Always imagined Bi-polar people to be crazy, not like me at all”

“I am different, I am not afflicted totally like all of them here”

My family eventually heard the news that I attempted to take my life (Personal Reflections 5). Two of my brothers had both rung the ward, but I could not speak to them. Unsure of whether it was embarrassment and shame, or simply just wanting to be left alone due to the fragility of my life at that point in time. More likely the later.

Personal Reflections 5 *Family and friends*

Family friends soon found out that I had been hospitalised. I could not bring myself to speak to my family for quite a few days. They did ring and showed their concern. Journal entry "……have both now rung. Can't speak to them yet, if they say the wrong thing unintentionally then I might start terrible thoughts up again and start crying".

"Thought I might ring and tell him what happened…..being such a wacko now. Probably better that I don't say anything coz he will tell everyone and I will end up very embarrassed. I don't think I will be seeing the kids too often

In Personal Reflections 6, I describe how basically over night, I had gone from being a person that was full of energy, confident, a full-time university student, working part-time, mother of five, to a person that was institutionalised, frail, unable to function, and one who was scared to face the world, for now the world and what it contained was simply a terrifying place.

Personal Reflections 6 *Coming off a mania*

I was learning about Bi-polar. I didn't know what was going on. I was feeling sad, and the doctor said that when coming off a mania, I will feel like I am depressed however I will be coming down to a 'normal' level.

In these times my journal entry reflected my feelings of failure that had eventuated to me ending up in hospital;

I feel like I have f….ed up my life, f…ed up my kids life and I pretty much feel lost and useless. I have thoughts of suicide, wish it had worked…….I don't want to be like my mother and abandon my children. I feel like I have failed my children and let them down and their father has been the saviour for them. Maybe I will feel different tomorrow. I hope I feel happy one day. There is no privacy here, no quiet place to just cry, wish there was".

I had a friend visit towards the end of my stay and she said that I was still 'not right'. My journal reflection states "I thought I was normal. That makes me cry today. I thought I was doing well……I think I am going through a natural depression after a mania….Feel like crap, not my usual bubbly self".

Medication was something that I struggled with. For the initial three or four days, I spat the medication out, I didn't want to 'get better'. But I succumbed.

Personal Reflections 7 *Medication*

Medication played a large part at the start of my recovery "Started the day with racing thoughts of all the things that I have to do, then that settled after tablets. Bit of anxiety, but no bad thoughts……The medication is working well and I have had no side effects apart from the fact that it slows me down in the brain department".

With the medication starting to work, I was beginning to look towards the future. Resilience has always been a strength of mine. When I was younger, I would say that I could put in the middle of the Sahara Desert and I would create a life that I would be happy with. Yet here I was, I had been knocked down again, and somehow had the strength to get up and fight another day. As for my resilience, this time was no different (Personal Reflections 8).

Personal Reflections 8 *Hope*

"Maybe I can leave here soon, I am keen to do cross-stitch and start a vegie garden"

At the start of my hospital journey, I picked up a book from the patients' bookshelf on cross stitch. Throughout my journal this cross-stitch book played a major part of what I wanted to do when I was to leave hospital. One entry I appeared quite excited about the prospects of this new hobby, and the things I could create for my grandchildren. My children were far from even the thought of having children at this stage, but this did not deter. At the end of the entry I wrote "can't wait!!".

It appeared from my entries that I was still hopeful and planning for a future. "So what do I want? I want a small house by myself, somewhere I can have a dog or a bird, maybe both…..I want to finish my degree. I would love for my daughter to live with me…." Having my children live with me was not something I could control, I didn't know where I was going to end up, but I knew that if I was to continue living, I had to finish what I had started. Finishing my degree was paramount to me, the one thing that I did have control over. So, I clung to this, and studying again became my sole focus, pretty much my reason for living.

One nurse said "make a list of why I should live, things that I am good at, so I can reflect on in the sad times". Never did make this list.

In the early stages of my hospitalisation, I just wanted to be by myself, but one day as I sat quietly doing a jigsaw, a patient who was sitting behind me, came up and sat in front of me. He was so kind, and gentle and spoke with a very heavy French accent. I did my best to ignore him, but he eventually broke through (Personal Reflections 9).

Personal Reflections 9 *Making friends.*

"Anyway it was nice, he made me smile, and we laughed together it was good. I don't know what the future holds, but I know that I have just made a friend, and that feels nice". That friend ended up becoming my husband two years later and played an enormous part in my personal recovery journey. He is the only person in my life that has seen me at my worst, my darkest hour. He saw me come into hospital as a sobbing, totally broken person, and has watched me grow into the person I am today. He unconditionally and non-judgementally cared for me, watched over me and guided me. He knows what it was like to be hospitalised, he knew how to listen, how to show genuine care and concern. He modelled peer work back then and still does today.

I met my husband in hospital. I absolutely adored Joe, he was the greatest man I had ever met. Tragically, he died in a horrific car crash (May, 2019), whilst I was still undergoing this research project. I finally found what I can describe as pure happiness, and then had it snatched away so incredibly quick. As if that was not bad enough, I was following him in my vehicle, he was in his vehicle in front of me, so I witnessed the whole event. Yet again, another time for resilience. I have recently told my psychologist that I hate being resilient. He was surprised and asked why, however my response was "*for me, resilience means pain*".

Although I attribute Joe being my introduction to peers in the real world, whilst in hospital, I was introduced to volunteer peers (Personal Reflections 10), that were actively employed to undertake the role.

Personal Reflections 10 *Introduction to peers*

"A lady came in today she is a consumer companion she came in and gave us some information, lovely lady". I remember having a lady come in as a peer, and paint the other female patients' fingernails. I was not interested, but I remember thinking that this was a good thing, the other ladies were interested in being around her. Activities in hospital are somewhat limited, so having a person actually choosing to come into the ward to visit the patients seemed like a pretty nice gesture. I thought it was nice to see someone who has been there as a patient coming back and showing that someone cares and understands. The nurses were good, but they were not there to do what this lady did. I had a fleeting thought that this is something that I could do later on, perhaps in my spare time, but certainly did not dwell on the prospect of becoming a 'consumer companion' as my main occupation.

I eventually had to accept the diagnosis, however in my usual style, I look for the positive and make the best of a bad situation. Prior to hospital, I didn't have a mental illness, I was just 'quirky'. Coming to terms with mental illness was not easy. As Personal Reflections 11, indicates, once I had a 'diagnosis' I suddenly believed that I was now disabled and no longer the same person.

Personal Reflections 11 *Acceptance*

Acceptance of my diagnosis came slowly. Entries from my hospital journal "Maybe Bi-polar has been my saving grace for my life?" "I think my Bi-polar is a part of my personality, it's what makes me so unique. Maybe it is also what creates tension between me and other people…..my over confidence irritates them….I guess having Bi-polar makes it easier to understand some of my quirky and irritating ways and maybe the reasons why I just don't 'get it' sometimes". Acceptance plays big part of recovery. Not just accepting your diagnosis, but learning to accept all situations, thoughts and feelings as they are, just letting them be.

Acknowledgement and acceptance of my 'people/voices' finally occurred about five years after the event, and I do consider this as part of my ongoing recovery.

Hospital gave me a feeling of security (Personal Reflections 12), a place where I did not have to think about the outside world. Meals were made for me, I had nothing to do except think about me. I tried to focus on my studies, but I read the same paragraph in my book numerous times. The positive was that at least I felt like I was studying.

Personal Reflections 12 *Feeling safe*

As recorded several times in my journal, hospital offered a feeling of safety.
"I feel safe here, it's enjoyable, and the people are nice".
"Drugs are good here, they keep me sedated and calm. I don't want to leave".
"It's so nice here, I don't want to leave and that is a sad fact".

My family members and close friends rang every day (Personal Reflections 13). When Joe got out, he also rang everyday too. I never thought of how my family actually cared until this event happened. Now I consider myself so fortunate. Before my hospitalisation, I felt very alone, I never reached out, and never created the family connection.

Personal Reflections 13 *Support*

Support from family and friends whilst in, and then when leaving hospital was plentiful. A person can feel so alone in the world, until something happens and you are forced to reach out for help. People who care about you are always willing to help, even those who don't know you. Someone who did not actually know me, when told of what happened, reported 'poor girl, she needs someone to care for her, to feed her nutritious food, and someone to show her love. I wish I could take her in and help her".

Personal Reflections 14 *Believing my own lies, playing the victim*

Hospital instilled a false sense of security. Only in there was I starting to feel 'normal', but I was still far from being out of the woods. When I was released from hospital, I would not dare tell anyone that I had a mental illness. Family knew, a few close friends, but that was it, I wanted to be seen as 'normal', I tried to act normal, but this was contradictory. Suicidal thoughts were always there, depression was constant, and this was now my new life. Great. I remember early on starting to believe that my illness was now going to drive my life and that I was now going to be of no use to anyone, and I should just accept that this was to be my life now, 'a mental case paralysed with Bipolar'. Someone remarked to me 'you didn't need medication before, why do you need it now?' and my reply was 'I have a mental illness that is why. I am not the same anymore".

Yes, I could hate humanity, the universe, or any spiritual entity for what it has put me through, for the traumas I have endured, and what I have lost, but at the end of the day, I have got to this stage, now my experiences are being utilised in a powerful manner to help others (Personal Reflections 15). My perspective today, as a Mental Health Peer Worker (MHPW) is that my lived experience has given me the etic perspective required to deeply understand the mental illness experience of others which informs my practice while working in this new area of mental health.

Personal Reflections 15 *Recovery*

I did not know what recovery was, I only knew that for some reason after two unsuccessful attempts, I was of the opinion that my life was not yet over and for some reason I was still needed on this earth.
Journal entry from hospital reports “I feel so emotionally weak, I will grow strong again but it will take time. I need to be by myself for a while to get better”. I was starting to organise a plan to keep strong “Need to organise people to take messages from him, so I have no contact, else I will go down again big time”.
I knew going down ‘big time’ was my reality.
I did not think that recovery was possible until I saw an article on the ‘Group 61’ website ‘My Recovery from Bi-Polar by Annette’. I read this and immediately I thought that this was not possible, no one recovers from mental illness, however the word recovery remained with me. My curiosity was also sparked by the thought at the question – the stranger that wanted to take me in, what did they know that I didn’t? What about being able to function without medication, was that a possibility for me?
My recovery is still on going, it will never end. I have made many deliberate changes to my life and my lifestyle. As far as I could see, I had a clean slate and I was now going to create my life the way I wanted it to be, and retain control over my well-being and mental health. That was now to be paramount, my sole focus. And as for becoming a Peer Worker, well that job was almost a gift from above. Fancy reading a job description where you had to actually have a mental illness, how bizarre is that?
My work as a peer, I now see is also part of my recovery. I have learnt more about myself, my recovery and mental illness since starting work in this field and just listening to people, than I did from all of the psychology text books and journal articles read whilst completing my degree. The people themselves, the ones with the lived experiences have been wonderful teachers. The information that I have gained from their experiences is so invaluable, so diverse and rich. I feel that sometimes this knowledge is waived over far too quick and undervalued by others that are ‘trained’ in the area of mental health. It’s a bit ironic really that those that are ‘professional’ get their information and knowledge from their clients, the ones with the lived experience!

4.4 COVID-19

> We have a pandemic of childhood trauma.
>
> Drew Pinsky

During this research the COVID-19 pandemic hit the world. The impact that it had globally was phenomenal to say the least. On a local level, the impact it had on our township, and the people I support was significant. People automatically isolated themselves, and even though we did not have it in our town, people were running scared. They were watching the news, the current affairs, and everything that came onto TV, had a strong pandemic influence. The fear that arose, the isolation, the impact of this pandemic was horrific. Clients were fearful of catching it. The Government locked down our area, in which there was no virus, and we were bombarded twenty-four hours a day with global news. You felt like it was right next door to you, and there was no escape.

Conversations with people indicated that they were feeling increasingly impacted by the restrictions, and the people that I support, as previously discussed, who do not work, who already struggle with relationships, and struggle with trust, were thrown into the middle of a pandemic, locked down in their houses. They became more fearful of the world, their anxiety increased, they were having more panic attacks, and all I could do, was play down the whole event and try to lessen the impact. I continually stressed that we did not have it in our town, and this was falling on deaf ears: these people were scared, and isolated even more than before. Two comments that stood out to me were that they felt like a caged rat, and another was ‘I am shunned at the best of times, and now I feel even more shunned’. Another client reported to me that the elderly neighbours have not left the house in months, fearful of catching the virus because they are in the vulnerable category.

And although I felt for my clients, it was worse on a national scale. According to the media, suicide rates, domestic violence, depression, and alcoholism all skyrocketed. We were all publicly made aware that because we were ‘locked down’, and isolated, there was a lack of social connection. Humans are social creatures, we thrive on connection with others, so to me, the effect of isolation was not a surprise.

As for me, I did have one night where I had a sore chest, started coughing, and then I worked myself up into a real panic where I could not stop coughing, started feeling sick and felt I was getting a temperature. I had convinced myself that I had the virus. As I have said, there was no virus in our town, and I racked my brains as to where I could have got it. I remembered that I had recently been in contact with a community member that had just come back from Brisbane, and then my fearful thoughts increased dramatically. I started thinking of all the people that I have now infected. I cried and cried, I cried myself to sleep.

I woke the next morning and realised that my chest was no longer sore, and I reflected with amazement on the way I had reacted. I do not watch the news, I was deliberately downplaying the whole pandemic, and yet my reaction was over the top. Perhaps I had a panic attack, I do not know. But if that was the affect it had on me, I can see why other vulnerable members of the community, like those with mental health issues, are so scared. This life experience, as a MHPW, allows me to better empathise with those that are struggling on a daily basis with their COVID-19 fears.

Chapter 5: **The Role of Relationships in Peer Work**

This chapter explores the theme of relationships in peer work, this theme has emerged through the interpretation of the personal and social data throughout the research journey. Successful peer work relies on therapeutic and safe relationships between peers and others. Little is understood about how peer workers build and maintain relationships to be successful in their work. This chapter explores the elements of peer work relationship building providing insight into the complexities that peer workers must navigate.

5.1 THE IMPORTANCE OF HUMAN RELATIONSHIPS.

The importance of human relationships in peer work is something I realised I had ‘taken for granted’. I recognised early in the research journey that I had assumed that everyone in peer work held the same understanding about the work. Through this research I began to recognise that there were many assumptions about client-peer relationships, and there was little evidence that could provide guidance or enable a deeper understanding of the skills and attributes required to maintain such complex relationships. I realised that as a mental health peer worker there was so much that I thought was common knowledge, that every peer worker would have the same understanding. This research has opened up greater questioning about what is understood about the different human relationships required to become an effective mental health peer worker. As Soler-Gonzalez et al. (2017), report human connections are central to the promotion of health and wellbeing. However, these connections can be significantly impacted by illness, which can be important to remember when working with people during mental health deterioration or chronic illness.

Other literature concurs with Soler-Gonzalez et al. (2017), that genuine social connection is beneficial, and social isolation is detrimental (Hojat, 2016; Stallard, 2015). Stallard reports on the beneficial neurobiological chemicals that are released into the blood reducing stress levels when human connections are made. During human connection, the release of dopamine, serotonin and oxytocin have the benefits of enhanced attention and pleasure, reduction of fear and worry and increasing trust in others (Stallard, 2015). During timers such as the COVID-19 pandemic, isolation has the opposite impact on our health.

As this research is being conducted around the time of COVID 19, I have noticed an increase in the depressive and anxious state of those that I am supporting. They are no longer attending their regular groups, or outings and are struggling immensely with the lack of connection, consequently having a detrimental impact on their already compromised mental health. This is the real effect of social isolation. The literature clearly states that connection is beneficial, and that social isolation is detrimental, and the effect on those whom I am supporting attests to that.

It is noted though, that some people like myself can be quite happy with social isolation. I choose to be isolated for the few days over the weekend, happy to spend my time away from the human race, but ready to recommence that human connection on Monday morning. But the difference is that I choose to isolate, and I choose to reconnect. Some do not get the choice.

Research has established that connection improves our wellness, enhances the quality and length of our lives, that we are biochemically hardwired for connection and, that we have evolved requiring connection for our own survival (Hojat, 2016). As in other relationships, the early beginnings of a relationship in peer work set the foundations for the future working relationship. When I look back at myself and my experiences of relationships', I begin to explore the foundations of relationship building that we take into our adult lives.

5.2 THE FOUNDATIONS OF MY HUMAN CONNECTIONS

When I think back and reflect upon my early years in life it seems as though it was full of mixed experiences. As part of the research, I began to write about my early connections and an excerpt is provided below.

Personal Reflections 16 *Early connections*

My story really starts from the day I was born into the family. A family of three older brothers, one younger brother and two alcoholic parents. My memories of this time are limited but traumatic. My brothers and I only remained in the family home until I was of the age of three when our mother had left once again, this time for the last time, and as told to me by my brothers, our father left us on the steps of the church with a bottle of coke and a packet of chips and said 'I'll come back later to pick you up'. He never did.

The personal file of my eldest brother given to him by the Welfare Department when he turned 18, indicates that the Family Welfare Department were always on the scene in those early days. My early childhood history is in writing, just black and white, letters and documents, no emotions, just facts, no mother or father to ask questions of, just a thick history file from the Welfare Department. In many ways I see that as a blessing, there is no 'he said, she said', just the plain facts of what was done and how. If you don't look at it and be grateful, you would start to feel sorry for yourself.

Human connection starts when we are born, we rely on our mothers, or primary caregiver to provide us with our emotional and physical needs. Bowlby and Ainsworth (cited Stallard, 2015) undertook research to show that healthy emotional growth is dependent on having positive interactions early on with our primary caregiver. It is from these early attachments that forms the basis of our future relationships and connection with other humans (Stallard, 2015). I was born into a family where the primary caregivers were unable to emotionally or physically care for myself or my brothers, we were shuffled off to group homes for the Salvation Army to provide basic food and shelter. I realise now looking back, that survival mode for me started early. There were no pre-schools back in those days, so consequently, my recollection is that I was fairly sheltered from the outside world until I came of school age (Personal Reflections 17). That is when my understanding of human connection outside of the family and caregivers became my reality.

According to the Australian Institute of Family Studies (2015), 1970 was the start of de-institutionalisation for children in care of the government, and brought about returning children to their homes, being placed in foster care or smaller group homes. A report by the Parliament of Australia (n.d.), concluded that it is difficult to be accurate with the number of children in care over the 19th and 20th centuries however it is estimated that there have been upwards of 500,000 children placed in care over this period.

By the time I was placed into care, deinstitutionalisation had started and numerous children like myself were placed into non-government group homes and orphanages run by churches. Our Salvation Army group home contained myself and my three brothers as long-term placements, and over the years we saw the coming and going of numerous children residing there for the short term.

Personal Reflections 17 *School relationships*

Life was good, until I went to school. I liked school, I was shy, but social. I had a very special friend called Adam. I was so fond of him, perhaps in my own childlike ways, he was my 'first love'. In a world that contained not much goodness, here was a young boy that bought light into my life. But going into the second year of school, Adam did not return. This is where I started to realise that life and I were not going so well. This is the year that I realised I was different from everybody else. I had no Adam there to talk to or laugh with, no Adam to shelter me from the judgement of the other children. Then I realised that I just did not fit in, I was not the same and I really felt it. This 'not fitting in' caused me great distress to the point where I had my first attempt at suicide. At the age of 6, one night as I lay in bed, I justified the 'not fitting in' due to the fact that I came from Mars, that is why I was so different. I then pushed the pillow into my face and tried to suffocate myself. Of course, it didn't work, I did not have the knowledge to succeed, but how sad is it that at this age, I already wanted to die, to end my life.

5.3 IN THE BEGINNING

From the early years of the group home in Perth, where I consider now, I was fairly safe and secure, life soon moved in a different direction where abuse became daily life. Deinstitutionalisation was not always a good thing for the children. My mother decided that she wanted us all back, so she collected us from the group home, and shifted us across the country to a small dry and dusty place called Whyalla, South Australia. The time spent at pubs, the abuse of alcohol, the fighting, the domestic violence against my mother, all that came with these days, and so the emotional, physical, and sexual abuse for me started and became the ‘norm’. One event I will never forget, the sheer terror that I felt, at the young age of seven, was having my life threatened with a knife by my mother. This was probably the most frightening event of this time in my life, and probably the most terrified I have ever felt in my life since that day.

Living with my mother lasted less than one year when she and her new husband took off again, taking with them my oldest brother and their new baby daughter. The rest of us were once again placed in care, this time in foster care, and although it was different type of abuse, it still continued for all of us. Once in the foster care system, I was grateful that I had a place to stay. The abuse continued and although I really wanted to speak out about it and what I was experiencing, I didn’t. I wondered if I would even be believed, child versus adult, in my world, adult always won. My empathy also kicked in at an early age, and I was questioning myself – how would they feel if I ‘told on them’? I knew that they wouldn’t like me, they would be angry and upset, it would cause them pain, and thereby making my life more difficult. Either moving or staying it didn’t matter, so for the young me, it was a case of ‘better the devil you know’, opting to never say anything.

I did finally move from this home to another at the age of 14, however I jumped from the frying pan into the fire. Although the abuse did not now come from the foster home, it was ramped up ten-fold by a member of the community, someone that I ‘trusted’ but someone who was showing me how adults ‘loved’ each other. I had never been taught about healthy relationships, did not have a role model, never saw a healthy relationship in action. As a child that was starved for love and affection, when someone paid me attention, good or bad, I went with it. Once I was old enough to realise it was in actual fact paedophilia, I was in too deep to get out. This situation did eventually end at the age of 20, and afterwards I jumped from one unhealthy relationship to another.

Life, bad relationships, and a marriage ending in divorce eventually wore me down to the point where further attempts at suicide. The idea of suicide was a theme that rippled through my early life which led to me having a stay in the Acute Mental Health Unit. I had hit rock bottom and I knew it. At this point in my life, I felt so alone, and truly believed that I had no one who cared about me. I didn't care about myself or what happened to me, so why should I care about what others were thinking or feeling?

As mentioned previously in Chapter Two, I had my introduction to peer workers in the hospital. The nurse explained that there were some people coming around that were Consumer Companions, and that I could chat to them. I didn't actually know what it was that they were there to do, but right from the start I realised that there was something special about them. A participant in the study by Gidugu et al. (2015), stated that when they were with their peer worker, they felt were made to feel that they were the only person in the world that mattered, and as I watched these peer workers interact with the patients, that is exactly what emanated. These hospital peer workers were making the patients feel special, like they were worth caring about. Empathy oozed from every pore of their being. These peer workers did not have to be there (after all who really wants to visit a psych ward?), and yet here they were, spending their own valuable time to be with us, making us feel important, making us feel cared about, so patient and caring, all amongst the hurried behaviour of the nursing staff, and the other professionals that came to see us doing their daily rounds.

Although I was curious about them, I did not interact with them, I was not interested in painting my fingernails, but as I watched them, I noticed how soft, how kind they were, how they had a genuine care and empathy for the people in the ward. I made a mental note that when I got better, I wanted to do something like that, to come in and volunteer to be with these people that had now become my friends.

In searching through the literature, I found that being inspired to become a peer worker is not uncommon. Research indicates that the interactions between peer and peer worker does in fact lead to the peer receiving inspiration to become a peer worker (Cabral et al., 2014). I have also reflected upon and found that during my stay, making friends with the other patients, being able to sit and empathise with them regarding their situation is no different to what I do today as a MHPW. In fact, what I did in the hospital to make new friends, is exactly what I do in being employed as a peer worker. The ability to build a relationship built on mutuality, respect and hope, creating deeper bonds during this process is what peer workers undertake (Cabral et al., 2014).

During my stay in the Acute Mental Health Unit, I made everyone my friend, I really enjoyed being with them, however I formed long lasting relationships with two of the people. One I still talk to regularly, the other one I married. However, this was no ordinary marriage. Joe saved my life simply with a lengthy pursuit of me, and finally the wholesome, caring, nurturing and unconditional love that he gave me. Something I had never experienced in my life. Joe not only loved me unconditionally, but he believed in me totally. It is his belief and love for me that is the major factor in me being here today to write this. Human connection in its purest form.

So, we were now married, and I once again shifted towns to start my new life, but this time it was without my children. Apart from the dreadful loneliness of missing my children and having to drive once a fortnight to see them and then the return drive home where I cried and sobbed my heart out for the whole 170km journey, life was wonderful. I had my perfect man, and could not have asked for anything else, except maybe a job. Well as luck would have it, my new job was not far away. The job requirement that you needed a tertiary education, I had already had that, but I could not believe my eyes when I saw that you had to have a mental illness and experience with the state mental health system. I fit the bill in all those departments, I applied, and was successful in obtaining employment as a Peer Worker.

I was new to this small town, and as I proceeded with my position, I could not help but notice the stigma, and predominantly the self-stigma around mental health was severe. I myself had previously not wanted anyone to know that I was a ‘mental case’ diagnosed with mental illness, a typical case of self-stigma. I found difficulties and resistance hindering my start into building relationships within the peer world, but I needed to reveal my darkest secret. Consequently, this was not exactly a smooth or comfortable pathway, after all I was still new to the world of building healthy relationships. Below is a section taken from a speech that I made to the community regarding the first six months of my experience as a Peer Worker.

Community Speech 4 *My beginnings of peer work*

> Some people were weary to start with, suspicious to say the least, and because they did not understand what a 'peer' was, I had to explain that I had a lived experience of mental illness, here I was again, telling perfect strangers, something that belonged to me, and only to me.
>
> Once they understood, I was then accepted, welcomed, and very open to telling me their stories. 'You're one of us, not like them….You really do understand'
>
> It left me with the feeling that "we" were so completely different from the rest of society.
>
> I had jumped right into the middle of this, another community within the community, that the black and white really was an us and them situation.
>
> I had never experienced this, in the years of hiding my illness, now here I was revealing it to strangers, this really bought it home to me how it impacts upon the individual.

Despite the difficulties, I jumped head first into this 'peer work', loving every minute of it. I was making connections left, right, and centre. Moran et al., (2014) argue that the motivation for connection is due to the loneliness felt as a direct result of the mental illness. There is always a level of loneliness, and self-isolation, when you have been diagnosed with a mental illness, so being able to connect on some level with another 'lonely' self-isolating person has the possibilities of a beneficial experience for both parties. On reflection, these early peer connections became important both ways, I was assisting them with providing hope and understanding of recovery, whilst they were assisting me with understanding the symptomology of mental illness and thereby speeding up my recovery.

According to the helper-therapy principle, Riessman (1965) argues that there is much emphasis on the person receiving help and the benefits, however it is the person that is providing assistance that improves the most. Schutt and Rogers (2009) concur reporting on the helper-therapy principle where the 'helper' improves their own understanding by helping others. Likewise, the mattering principle identified by Taylor and Turner (2001) shows that women experienced higher levels of mattering than men, and that depressive symptomology, was inversely related to mattering.

Perhaps it is because of the mattering principle, that in a study by Johnson et al., (2014) 87% of participants reported that being a peer worker helped their own recovery. Similar research indicates clearly that for a peer worker, it is more beneficial for the worker than those receiving it (Asad & Chreim, 2016; Bracke et al., 2008; Gray et al., 2017; Johnson, et al., 2014; Moran, et al., 2014; Repper, & Carter, 2011; Schutt, & Rogers, 2009). As much as a benefit it was to the clients, I noticed a few months into my position that the constant thoughts of suicide I had experienced were reducing for me, becoming far less severe, far less frequent. As I pondered this, I came to the conclusion that through these new connections with people that I understood, and likewise people that understood me, plus my new life with Joe, my recovery was becoming more noticeable, more rapid. It was only through these connections with other peers, that I truly started to understand my illness.

With regards to my recovery, research concludes (Taylor & Turner, 2001), that being a female and 'mattering' to someone, was extremely beneficial to my personal recovery. The relationship formed with clients did matter to both, and I came to understand the difference between what was me, my personality, and what were the symptoms of my diagnosis. Once I could see the difference, I started to work towards understanding my triggers and allowing myself to undertake a holistic healing of the traumas which were the cause of the symptoms.

During my personal recovery and increase in knowledge, Joe watched my every move, and noticed any change in my behaviour. I trusted him; I knew he would not tell me that I was becoming unwell if I wasn't. I also knew that he was not going to just blame strange behaviour on my illness (Gray et al., 2017), and thereby making me feel worse. Although I didn't understand it at the time, Joe really was my introduction into the world of Peers.

The longer I was employed as a peer, the more I learnt about the impact of genuine and positive human connection. In my role, I was using my own feelings of shame, stigmatisation and my behaviour of deliberately hiding my diagnosis, in order to not only benefit others, but to find connection. These behaviours are reflected in the literature by Moran et al., (2014).

> Thus the use of one's lived experience as a source of knowledge transforms that which was most stigmatised into an asset. This allows mental health peer workers to shift from feeling shame and concealment about their past experiences to carrying out positive dialogues about the illness that generate new meaning and identity (p.38-39).

This new community of my peers, were very trusting and inclusive of me. I came to understand the boundaries which separates the 'us and them', them being the clinical side of mental health. The peer world was once described to me as 'messy'. This messiness is the fuzzy boundaries occurring between client and peer worker. Boundaries in professional roles are the norm, however the boundaries between peer worker and client get blurry through the sharing of intimate stories (Repper & Carter, 2011). Asad and Chreim (2016) argue that peer workers are able to stretch boundaries and are required to be more flexible than other clinical services. As peers, we are the same, we feel the same, and sometimes we probably even have the same behaviours. We have a relationship that can only be understood by another peer, and yet at the same time we need to remain professional and keep ourselves safe with healthy and respectful relationship boundaries.

One thing I have questioned in regard to boundaries, what if the professionals are the ones that have got professional boundaries wrong? What if them being less open to connecting through emotions and feelings, and instead trying to impose how knowledgeable they are, what if that is what is doing the damage, making us feel less worthy as humans, even more second-rate citizen because we are not the 'expert'? We have been treated badly by humans, thereby leading to a life subjected to mental illness, and perhaps they are adding to it with their lack of connection and 'professional boundaries'.

I understand now about denial and using ‘facades’ as protection. My questioning about human nature is constant. Do the professionals with mental health issues use their superior position as a façade? Are they in fact denying to us that there is a possibility they are living with mental illness, because it will reveal that they are not superior, not better or more important, and in fact just like us? Are they scared of revealing this?

To be working as a peer indicates that you have travelled further along the path of recovery than the peers we serve. I utilise the terminology ‘serve’ because this keeps me humble and grounded to my own life’s experiences. As I am a peer, I must remember not to become the expert in another peer’s life. My life’s experiences are mine, and I take ownership of those experiences. We can babble on all we like about our trauma and life to our clients, trying to prove that we understand, however, my growing trauma knowledge and peer experience has taught me that in the early stages of a relationship, clients are actually not capable of listening, as they are still caught up in their own severe and distressing pain, and just want to be heard.

Clients need to be heard; they are constantly in flight or fight mode. As I enter the relationship, I expect that they are ready to brush me off, waiting for me to make a mistake so they can label me as ‘one of them’, and say that I am the same as those others who don’t listen and don’t really care or understand about their pain. This behaviour is clarified by the International Society for Traumatic Stress Studies (2016) “Anger and aggression may also arise because, after traumatic experiences, a person may feel threatened very easily”. With the respect that I have for their stories and pain, I know how important it is to be there, to listen, to actually ‘sit’ with them, creating a connection where they feel heard, validated, and that their feelings and pain are normal for the experiences they have encountered. It is all about the client and their experiences, until they felt heard and is reflected by Scott, Doughty, and Kahi (2014) “The philosophy of peer support is one of empowerment, mutuality and the honouring of the peer’s experience” (p.199).

I have a deep understanding that in order for the relationship to grow, my experiences must take a back seat, only being bought out as a tool in a precise moment to develop the shared experience. It is this shared experience that is described by Jacobsen, Trojanowski and Dewa (2012) of the peer worker sitting with the client, demonstrating in a calm and respectful manner, that it is all about the client, showing genuine concern, actively listening, paying attention, and with kindness validating the client. Like in any relationship, this first connection will either make or break any future trust the client will place in me.

In a private conversation with Michael Burbank regarding peer work, the complexities, and the necessity of connection I was informed that peer work had its basis deriving from connections, shared experiences. I have asked myself numerous times why is it that I can connect on numerous levels to all of the people I support? Michael quoted "I need to connect with something in me in order to connect with something in you" me during this conversation. I question whether it is just the trauma or all of life experiences encountered that enables us to make these connections, the more life experiences the better, however the conclusion came from the understanding that we need to be able to connect to our pain in order to connect with another person's pain. It is how we do that which varies and makes us all unique as peer workers. I discovered that the longer I am a peer, in order to strengthen and assist in building relationships through trust and shared understanding, I needed to be in touch with my feelings and pain, and not denying it. Having received and now having knowledge of the benefits of peer work, I feel sad for those mental health workers that hide behind their facades, denying that they are a peer, not wanting to reveal their story, or their pain, and thereby not experiencing the benefits of true peer work.

For me though, I need to be able to express these feelings and pain in words. I explored how I communicated this, and found that during conversations with clients, I had immediate access to a large collection of pictures in my head. It was these pictures that assisted me in the building of shared understanding and stronger relationships.

5.4 PEER WORK RELATIONSHIPS AND VISUALISATION

It is hard to put feelings into the spoken word, that is why metaphors and analogies, are so powerful for me. I have found that I firstly use visualisation, then attaching metaphors and analogies to it, often to get my point across to people. I thought I was unique; however, the literature explains, it has all been done before. The results of a study by Casarett et al. (2010) found that physicians were able to communicate more effectively with seriously ill patients, when metaphors and analogies were used in conversation. For me visualisation is a powerful tool that I use. The power comes from the use of words to describe the everyday images, converted into emotional scenarios. For me the words may fade, but the feelings associated with images stay in my head, just like the quote by American poet Maya Angelou “I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel” (as cited in Goalcast, 2017). It is these strong and powerful images that I share with others, in hope of making connection.

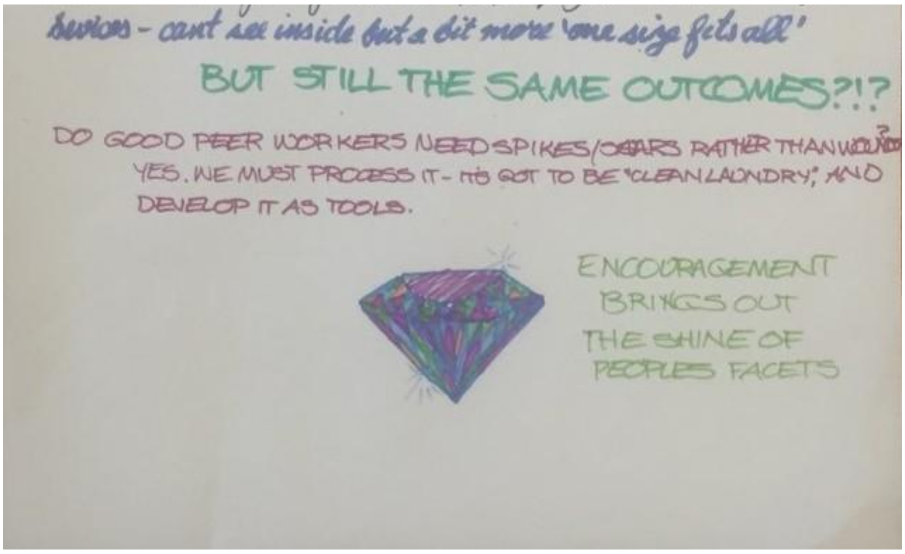
During the time spent translating these pictures, I am constantly reflecting and asking myself is the client able to recognise and feel what I am feeling? Am I portraying it in a manner that they will comprehend that I ‘get it’? As I grapple with an understanding of peer connection, I have likened each one of our painful life experiences, our healed traumas, to the spikes on a massage ball. The excerpt below was a lightbulb moment for me in my journey of understanding what makes peers so unique.

Artifacts 2 *Spikey balls*

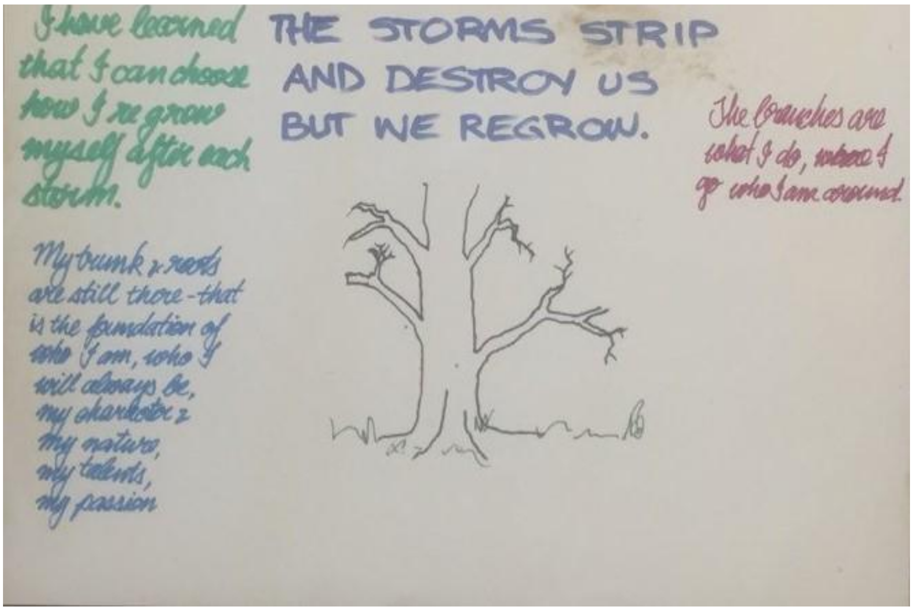
So, I was thinking about Peer Work and a picture of this (massage) ball came into my head. That is it! Peer workers are like this! Yes! Each one of the spikes is a scar, our past hurts, wounds, and traumas that have now healed. And it is our past scars that connect with the hand that holds it. The spikes massage and soften the hand, they massage the soreness of the person, bringing relief. The more 'spikes' the more connection to the person that holds it, the more relief is bought. The depth of the spikes going into the person depends on how hard the person squeezes, it is in their control, not the balls control, they control how 'deep' or how 'hard' the spikes are pushed to bring relief. And over time the spikes can go deeper as the areas become less 'sore'. I see the spikes on the massage ball as my scars, these are my connection points with clients. I do not try to hide them, they are there for anyone to see, or utilise. I have so many 'spikes' that I have gained over the years of life experiences. I have so many connection points that I am able to connect on numerous levels.

Below is a participant's artwork created whilst the letter regarding the spikey balls, and one about the storm was being read. Interestingly, the participant has questioned whether clinical services and peer workers still have the same outcomes. I feel that we are all working towards achieving the same outcomes, however our paths do not cross, they run parallel to each other.

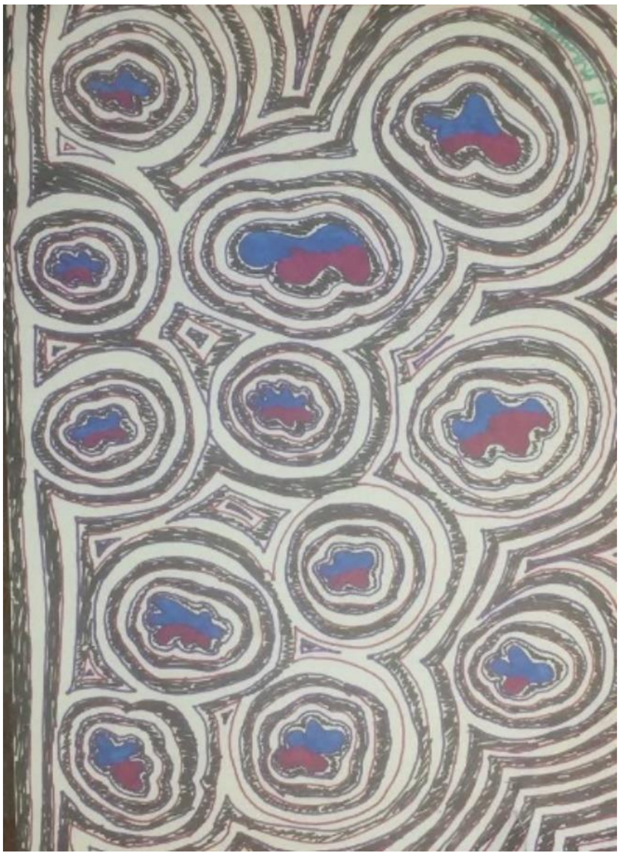
Focus Group Data 1 *Spikey balls*



Focus Group Data 2 *The storm*



Focus Group Data 3 *Participants artwork*



Whilst most participants felt comfortable to create data through words, one participant decide to create this piece of data (above).

Another example of this use of analogies is when a storm ripped through our area in October 2018. I shared with a community group, the similarities I saw with the storm, the trees stripped bare, and the cycle of mental illness. The storm, the vulnerability, the regrowth. In the focus group, this letter evoked the emotion I was striving to express.

Letter to Peers 1 *The storm*

The trees gave me a feeling that I struggle to describe, exposed and vulnerable, yet strong and powerful, a feeling of sadness but yet somehow majestic, proud, and determined to survive. An inner strength that needs to be drawn upon even though there is no strength left, but somehow ascends to fight another day.

I went to the community group later that morning, and I shared my feelings about the trees

The people in that room are like those trees, all stripped bare, but yet they commit weekly to that group. They are all struggling, yet proud enough to cry out for help, and take the help when given. Our life is like those trees, some will fall along the way. Never the strongest, only the weakest will fall, and the bravest of brave, the strongest of the strong continue to survive and face another day. And in the future, as what happens after any storm of that magnitude, the clouds will lift, the blue sky will be seen again, the grass will grow all around, trees will sprout new leaves covering the vulnerabilities that were exposed, and life will begin again. So, it is with the cycle of any mental un-wellness.

I drove past those trees several weeks later and noticed exactly that – one tree, huge, lonely tree, who had nothing left after the storm, has started to sprout new leaves right at the very tippy top, just enough to say ‘hey, I am still here, I am still alive’. Just a small amount of new growth’ to show that this tree has more life and for us not to give up on it.

Now as I drive past, you would never know there was a storm, just fits in with the scenery, but what has happened to the inside? We know that when trees are cut down, trauma that has been faced is able to be traced through the ‘rings’ that appear on the inside. So, this tree will never be the same again, even though it looks the same on the inside, it has been changed forever, just like mental health trauma survivors

Most people would drive past those trees and say – oh my – and keep on driving, others may not even notice the carnage, but those trees to me were so symbolic. It is easy to capture that image and pass it on to others, because it is a common sight. As adults with sight, we realise what a tree looks like and can imagine it with no leaves, like a deciduous tree in winter. As adults the majority of us have seen this shedding of the leaves and understand or are able to comprehend visually what this is like, so it is easy to use these trees as a metaphor for the inner strength that arises during and after a major storm has ripped through an area.

I have used the storm as a metaphor of life, the turbulence of life events that rip right through us, leaving us battered and bruised, vulnerable and exposed, and in some cases, not wanting to go on, not wanting to live another day. And after yet another one of these storms of life has passed, we feel our vulnerabilities are there yet again on show for all to see.

There are two worlds here, the first is the world of the trees, second is those travelling on the highway looking out at the trees. Vision from the safety of a vehicle passing by, making comment on the trees as they travel on the smooth black highway, continuing with their journey of life. Some like myself will know what it is like to be one of those trees and have a full appreciation for what has been encountered. Others will have no idea at all, and just zoom by, not taking too much notice, except to comment that it must have been a bad storm.

Artifacts 3 *The forest of mental health*

From this connection and the shared stories, we can learn about ourselves and it is from the learning about ourselves we are able to pass knowledge onto other peers as they journey on their recovery path.

Letter to Peers 2 *Strength*

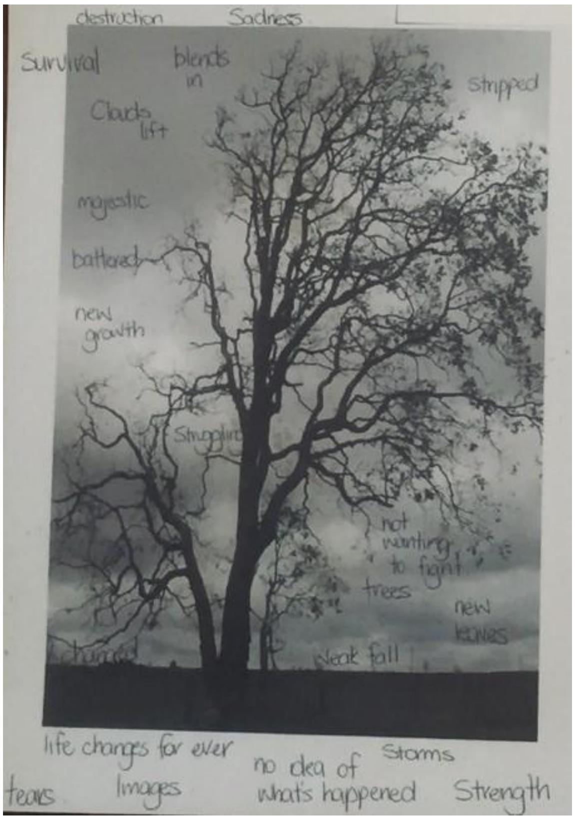
> The people in the group were appreciative of my sentiments, I told them how I was proud of them, and they had a right to be proud of themselves, after all, look at what they had been through to get to this day. One person commented that it bought them to tears, I had moved her with my words. All I can hope for is that the images that I have helped create in their mind might just give them some inner strength at a time in need. Hopefully they will remember those trees and liken their inner strength to the strength required by those trees to survive the storm.

Focus group data 4, 5, & 6 are examples of how the participants created data. Artifacts 4, 5 & 6 are examples of the copies that were placed on the tables for the participants to capture their thoughts.

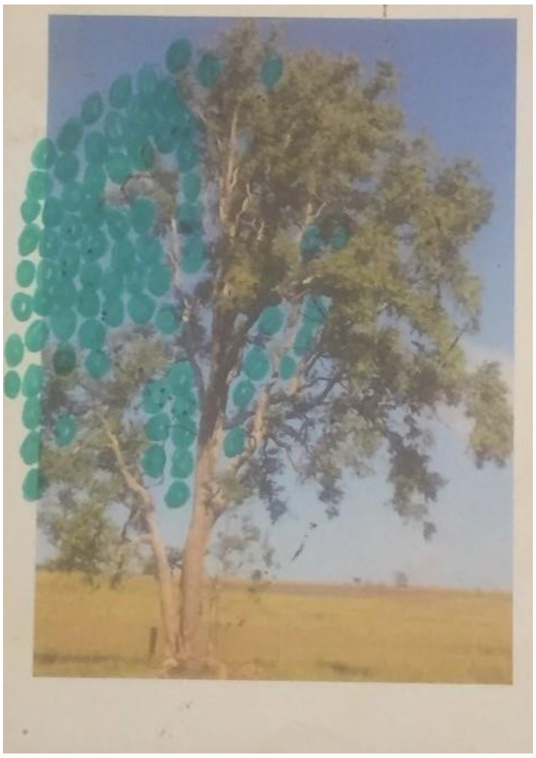
Artifacts 4 *Vulnerability*

Artifacts 5 *Recovery*

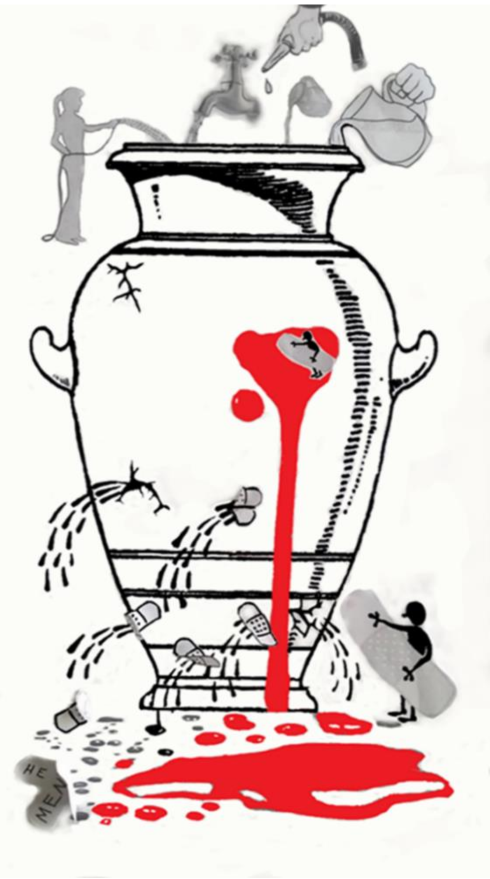
Focus Group Data 4 *Vulnerability*



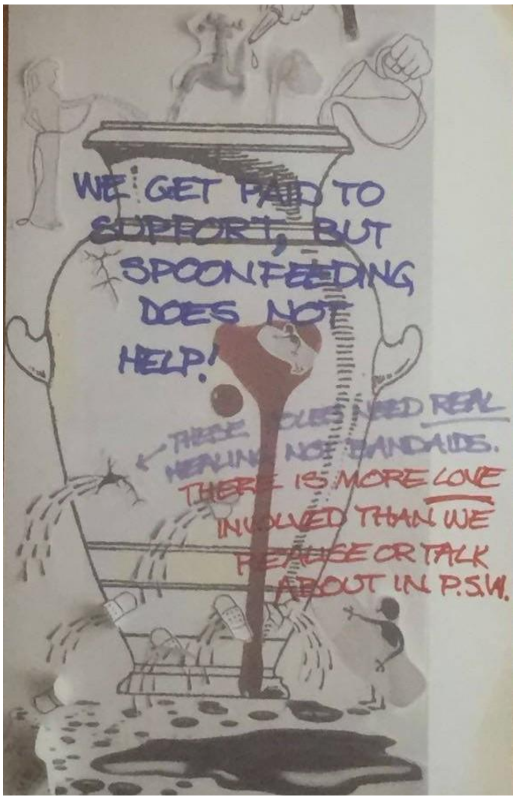
Focus Group Data 5 *Recovery*



Artifacts 6 *Cracked vase*



Focus Group Data 6 *Cracked vase*



5.5 PEER RELATIONSHIPS AND LEARNING ABOUT SELF

In order to impart knowledge onto other peers, we first have to learn about the topic to gain this information. As a peer, we share details of our life that start with our life experiences, ‘street smarts’ (Davidson, Bellamy, Guy & Miller, 2012), stress reduction techniques, advocacy (Gidugu et al, 2015), personal strengths (Lawn, Smith & Hunter, 2008) and continue through to holistic views on self-care that have come from learning about our illness and the impact that it has on our health and wellbeing. My learning gave me extra skills that I was only to happy to share in order to reduce the suffering of another individual. In looking through the literature I found numerous quotes indicating this same effect, so although I thought what I experienced was unique, it is in fact common place among peer workers and reported by Lawn, Smith and Hunter (2008).“It helped solidify my own recovery and strategies and focus on the strengths I’ve got that I can now share with others . . . I’ve learnt more about myself and I manage my overall health better. I’m much more confident”. (p.506).

> Peers draw upon their own life experiences, especially experiences of distress, poverty, and oppression, on the one hand, and experiences of recovery and resilience, on the other. (Jacobson, Trojanowski, & Dewa, 2012, p.8).

I have always loved to write, and have many journals, and diaries recording my life and experiences. It is from this journaling that I am able to express and untangle my true feelings about matters. Journaling gives me the freedom to be able to self-reflect on my thoughts at a later stage, and to clear any confusion from issues arising at that time.

Self-reflection is an important part of peer work. Sometimes when we are just starting out as peers, or even as experienced peers, we don’t handle things so well, and self-reflection can offer a unique learning opportunity.

Interpretation 1 *Trauma informed care*

Our recovery journey takes many pathways, and we are always learning. It is this learning, once learnt, we can pass this knowledge, these skills onto those that we are supporting, strengthening the relationship building process.

In the study by Repper and Carter (2011), peer workers reported that they had developed skills, increased personal growth and self-esteem through doing something worthwhile in their role of supporting others. This learning and developing of self, was also indicated by the peers from the focus group:

Focus Group LTP 1 *Participant two*

"…the more we reflect on it, at different times, re-framing things, looking at it, what did I learn, how would I do it different, what's the value that I got from that and we all do it, you know part of the 24/7 work as well"

This is a common occurrence within the peer workforce and the need to be constantly aware of our triggers, so I consider myself a 'work in progress'. In order to keep moving forward with my wellness, there are constant checks and balances on professional boundaries, and self-care. I do heaps of reflection, heaps of looking back at what I have experienced, working out what was my issue, what wasn't my issue, what do I need to work on, what can I let go. Consequently, this is what we teach others to do, but not by just telling them to do it, we model it, we can give examples of how we have used it, we live it 24/7.

It is through the use of my reflective journals that I am able to learn about myself. I feel that I need to work on myself, make myself the best I can become in order to be able to pass those skills on to other peers, other people that I am supporting.

Each time I enter into conversation in Professional Supervision, or do a reflective journal entry, I am learning about myself, how I fit into this world of peers, and how my beliefs are changing and extending. I am of the belief that once you become a peer, you can't not be a peer.

Letter to Peers 3 *Reality*

> I was at a conference once and they were talking about 'What is Peer Work and What is it Not'. Our table in the workshop said it is not 24/7, and the lady leading the conference workshop said – 'It is in fact 24/7'. We don't want it to be, but we are peers 24/7, and cited situations where this was the case.

As a peer, I never stop learning, it is an integral part of not only my recovery process, but the tools that I use to connect with the people I am supporting. It is my journey of recovery that gives me hope for others. Focus group participants reflected the same opinions.

Focus Group LTP 2 *Participants six, two and seven*

> "*yeah, you have got to learn about yourself*" (Participant Six)
>
> "*yeah we are always turning it over in our minds*" (Participant Two)
>
> "*If you can't look after yourself you can't look after others it's just a saying I got that from the saying if you can't love yourself then you can't love others*" (Participant Seven)

In a study by Asad and Chreim (2016), peer workers indicted that a difficulty arose where the clients reminded them of their own mental illness. However, the peer workers overcame this difficulty, and more felt confident with their services once they understood their own triggers and when they themselves needed help.

5.6 HOLDING HOPE FOR OTHERS

One of the valuable roles that a peer undertakes is that to provide, and increase a sense of hope of recovery whilst building relationship (Asad & Chreim, 2016; Cabral et al., 2014; Davidson et al., 2012). According to the Miriam Webster Dictionary (2020), one definition of hope is “expectation of fulfillment or success”. Holding the hope for someone on their recovery journey, is a knowing that recovery is possible and that there are numerous ways to achieve it. I believe that holding the hope is an aspect of peer work that requires reflection and is unique to each individual peer worker.

Focus Group LTP 3 *Participant seven*

> We all have obstacles we have to get through and um if we can deal through our issues and our problems then somebody, then we know that that person that we are trying to support should be able to hopefully get through their problems eventually but it takes time and might only take a few minutes or it might take years but we know that they can, that they should hopefully get through their problems.

Here, Participant Seven indicates that they will not give up on the client, and that all progress is still progress, no matter how small or slow. In working as a peer, we have an understanding, knowledge and belief that if we did it, you can too, which must be relayed to the client. A different participant (below) of the focus group uses a direct approach with their client, coming straight to the point, talking about holding their hope until they are able.

Focus Group LTP 4 *Participant one*

> *“As I say to them, on the first appointments I say look, I have a lived experience of mental health challenges, I have lived, I have been in and out of places like this for 25 years and I am a living example that there is always hope. Ok, so I don’t know exactly what you are going through but I have been through something similar and I am well enough that I am out working….. I am well enough to work now and I am well enough to hold your hope even when you don’t feel up to it, and we as a team are here for you, to help you reach your goals…….I am here to help you achieve it”.*

Each peer will have a different way of doing this, but the message is still the same – we believe in you. My own understanding of holding the hope came from a reflective journal, I didn't really understand what holding the hope was until I wrote the following journal entry:

Letter to Peers 4 *Holding the hope*

> "This morning I had a revelation. I realised that as peers we truly do carry the hope for those that are unable to carry their hope at this point in time. For the whole time however I have felt that my efforts have not been of any worth. I have felt that the words I have spoken have not been heard. This client has been a real challenge for me…… How is it that I can get this client over the line? How can I get this client to start to realise their true value and self-worth? How can I assist this client in starting to believe in themselves?.......... I could certainly see what the other person was saying and I felt most of it to be true however there was an element that left doubt in my mind. It is this doubt I have felt to be my driving force. It is this doubt that I have held onto. I knew that if I don't have the answers that does not mean that I can give up on them. This is why I have not exited this client. Is this resilience or tenacity? I believe that this doubt I felt was actually hope. I have been holding the hope for this client until they were able to hold their own hope. This client is now starting to move forward, don't know why, don't care, just thankful that they are now holding onto their own hope now. Perhaps that is the goal, that is the outcome, for the client to hold their own hope!"

As we undergo our recovery journey, someone holds our hope when we can't. If they are a peer, they will model how it is done, and then when we are able, we in turn hold it for others. Although I did not have a peer that modelled recovery, I just knew that if I was to stay on this earth, then I had to do something different, so I learnt about myself. It is through learning about myself, and undertaking my recovery journey, and watching other peers struggle, that I have come to know this journey well. It is long, it is hard, it takes so much strength, but it can be done.

As peers, we learn to hold the hope for others, we have experienced it, we know it can be done. As a peer worker I am of the belief that I am no different to you, if I did it, I know you can do it too, and I won't give up on you like others may have in the past. I have witnessed numerous people in my community of peers for whatever reason, be it lack of time or funding, put in the ‘too hard’ basket. They are passed over as being just too difficult to get through to or to deal with. This attitude does nothing to assist with one’s self esteem or recovery journey. That is not holding the hope.

There are many facets to recovery and holding the hope. One part of this hope that I instil in my clients and others around me, is that they are still valued enough as a person to make connection with others. I will ensue that they understand that I think they are valuable, and worthwhile enough to have a relationship with me, and I will hold hope for them to create or mend relationships with others.

During this supportive process, they gather more strength, more ability, more tools, more skills to overcome challenges as their recovery journey goes on. Once the client is starting to hold their own hope, I can then move more easily into the phase of creating the expert. I will empower them with skills, recovery skills, life skills, whatever it takes, so that they hold their own hope, and take responsibility for their own outcome.

We are the expert in our life, and we teach them how to become the expert in their own lives.

5.7 POWER AND PLACE IN RELATIONSHIPS

Living with a mental illness means that we usually come into contact with clinical services and individuals that have studied and worked in mental health for many years. We are the ones that apparently need this knowledge, and therefore we must listen to them, they are the experts in the field of mental health. However, whilst they may have the knowledge of the medical model which focuses on illness management and symptom reduction, recovery and its focus on health promotion sits outside of the medical model arena (Gray et al., 2017). Peer relationships were a major part of my recovery and thereby teaching me to be the expert in my own life.

From my early dealings with mental health, I felt as if I didn’t know enough about my illness, but I needed to step up and learn as much as I could as I had a burning desire to help others with their recovery journey and share what I had learnt.

From the ‘experts’, psychiatrists, psychologists, and any research that I found, there was nothing that described what I experienced. However, it was only once I started forming the new relationships as a peer worker, I was having ‘light bulb’ moments continuously. What I thought was unique to me, part of my personality, was actually a symptom, or as I believe now, a coping strategy. It was not me. Once I recognised this, I was able to start to work out where my healing should start, and what I needed for self-care. I was becoming the expert in my recovery, the expert in my life.

In my life at that stage, there was no ‘expert’ that could have taught me what I had learnt. I needed to do this myself, to put things in place for myself, and once I had a level of understanding, it was then and only then that I was able to understand, comprehend and utilise the teachings that came later from others. I had started to re-create my life, one that I wanted, with no expectations from others.

During the focus group, participants also reflected upon being the expert. The ‘ways to survive’(below), are their tools, this is the knowledge that we share with others, enabling them to survive.

Letter to Peers 5 *Participant two*

> I am more of an expert in my experience that the highest qualified psychiatrist or psychologist in the world. I have spent 45 years becoming an expert in me, and I have found some really good ways to survive.

As part of my endeavour to build relationships with other peers, I was assisting with the facilitating of the Cert IV MHPW in our area, and the upcoming component was regarding Trauma Informed Practice. I searched for any documentation and eventually found a copy of the Practice Guidelines for the Treatment of Complex Trauma and Informed Care and Service Delivery (Kezelman & Stavropoulos, 2012). The guidelines serve as a ‘best practice’ for practitioners. Professor Warrick Middleton states at the start of the guidelines “One of the last frontiers of our society is the lack of realisation about the extent of trauma” (n.p.).

As trauma has been a constant in my life, I can now see it everywhere I turn, in every person that I have dealings with, professionals and peers alike. It is this trauma framework, that I use to guide my work practices. Realising the extent of the trauma in our community, I found that I was looking at these guidelines and questioning the usefulness for myself.

Letter to Peers 6 *Trauma informed care*

> I realised that the bits that I had read, the bits that I glanced at, were (to me) simple common sense, things that were already 'what I know', and I had a good chuckle to myself, that here was a manual, this thick, on stuff that we as a community already know and take for granted, and yet they had to write a set of guidelines for practitioners in order to deal with us effectively.

I found myself thinking that these guidelines were written by the 'experts' for the 'experts', and I couldn't help questioning where has the basic sense of human connection gone if they need to write a set of guidelines on how to treat a human with what I understood as simple empathy?

Peers have their own set of unique talents that they bring to the table when supporting others. They are experts in their own lives. It is their own set of life circumstances surrounding their own mental health recovery journey, their lived experience, that they will draw upon in order to support others (Ahmed et al., 2015; Bracke et al., 2008; Cabral, et al., 2014; Jacobson et al., 2012; Kidd, Kenny & McKinstry, 2015).

However, as much as peers have extensive knowledge and can be considered 'experts', Kidd et al. (2015), argue that there is still a lack of lived experience perspectives in the development of psychiatric services.

5.8 CONCLUSION

Research indicates that we are reliant on human connection for our survival and the benefits of connection include a reduction in stress levels and an increase in our pleasure and trust in others leading to improved health. Other research specifies that the helper-therapy principle allows the helper to benefit much more than the person receiving assistance, and the mattering principle indicates that when we feel that we ‘matter’ our depression is reduced. Both of these principles apply to mental health peer support where connection and relationship is a two-way street.

As a peer, we utilise numerous tools, and sharing of stories at appropriate times is one tool that we use. For me, the use of analogies allows me to translate feelings into pictures so that a description of a situation, and therefore a description of feelings, can be bought to light. Through the use of reflective journals, my learning process is assisted, allowing for reflective thought on different situations. As I create the analogies, as I uncover the pictures, I am learning about myself, and the world of being a peer. It took me a while to learn about holding the hope for another, and now I have learned that holding hope takes immense resilience by the MHPW, and strength and courage by the client. Whilst the client may be struggling with both strength and courage, the peer worker steps in, using their resilience, they hold the hope for the client, creating a safe environment for the client to work towards the outcome of holding their own hope. In a way it is a pay it forward situation, someone held our hope once, and we in turn hold it for others, until they become the expert in their own life.

My talents and skills used to build relationships with peers are driven by the consequences of the traumas that I have encountered and the recovery path that I have travelled and my journey as a peer worker. A professional once questioned me regarding the meaning of peers, and stated that I am not a peer to those that I am supporting, as I have recovered and they have not. However, if I am not a peer to my peers, then am I really a peer? Who am I a peer to? It is this confusion of who we are peers to that will be discussed in the next chapter.

Chapter 6: Relationships within the Role of Peer Worker

6.1 INTRODUCTION

This chapter will explore the complexity of the peer concept in mental health peer work practice and the definition of peer by those working in the mental health field. As a peer, I am required to work with other professionals, other staff, other peers and of course those being supported. This calls for expertise in relationship building in order to handle the complexities and boundaries that each relationship comes with. Differing boundaries and expectations occur with each interaction. These interactions require manoeuvring in and out of each relationship, and the ability to handle each exchange with a high level of professionalism and respect for all parties.

In a conversation with a colleague, I was asked, who am I peer to? The colleague expressed their belief that I am not peer to my clients as I have recovered and they have not, and so therefore, with their understanding of the word peer, I am peer to other professionals as we are all delivering a service to help the clients.

The aim of this chapter is to reveal the complexities of the relationships with in the role of peer worker.

6.2 DISCLOSURE OF LIVED EXPERIENCE

Disclosure of life experiences, is a fundamental part of peer work (Asad & Chreim, 2016), on one hand we disclose our own life experiences of distress, and oppression, and on the other we disclose our life experiences of recovery and resilience (Jacobsen et al., 2012). It is this unique expectation of peer work that challenged me not long after commencing work in a peer role. I was informed by my manager that as a professional, personal information is not foreclosed as this is encompassed under ‘professional boundaries’. I found myself immediately comparing professionals to the peer work I had undertaken. My main goal as a peer was initially to build rapport, and to make the client feel comfortable with me. I thought about how in making my clients feel worthy, we built mutual respect, a deep level of trust, and that this was done even though they were considered on the same level as myself. I had never really thought too much about the ‘professionals’ and the way they approached things, and yet here I was being challenged, wondering why is it that they do not disclose anything about themselves? So, on one hand, the peers provide a warm and welcoming relationship environment through disclosure and on the other hand I wondered how is it that the professionals, the ‘experts’ build trust and relationship through the use of a cold, distant, and barriered attitude?

As a peer worker we are still expected to have professional boundaries, and at the same time be willing to disclose some really intimate parts of our story (Repper & Carter, 2011). It was this new experience, disclosure of my lived experience, where I felt I was stepping into completely unchartered territory. Not only had I never disclosed my story, except a brief disclosure in the job interview, but I had no formal training in this area. So, as I started into the world on Peer Work, I realised that my training was going to be ‘on the job’. In looking through the literature, it appears that we can learn through education how to share parts of our personal story to provide support for others (Nestor & Galletly, 2008), or experience will teach us when and what to reveal in order to assist the person on their recovery journey (Asad & Chreim, 2016). As I found, each situation is different, then respectfully, a different perspective should be applied to the disclosure of the story to benefit the person being supported (Asad & Chreim, 2016).

Maybe because of my age, maybe because of my early beginnings, the traumas that I have experienced, for whatever reason, I have accrued numerous ‘connection points’ (or spikes), to other humans. They are vast and varied, and so I am able to disclose a different part of me to each person and connect to many people for differing reasons. For example, there is no way I would reveal my experience of sexual abuse to an elderly gentleman who is in the painful throes of separation or divorce, it is not necessary and would be of no benefit whatsoever. However, I would certainly relate to his pain through life situations of my own relationship separations and the pain that I have experienced.

Similarly, I take care with the amount of disclosure. The amount of my story is minimal to allow for the supported person time to be genuinely heard (MacLellan, Surey, Abubakar, & Stagg, 2015), and is used simply as a communication tool, to assist in building rapport and relationship. Learning through experience, I learned very early that the timing and amount of disclosure is more important than just having something to disclose. As eager as I was to talk to other peers about my experiences, I soon realised that they were in deep pain, and unable to hear much, all they wanted was to be listened to, to feel like they mattered, to feel like someone cared about what they were feeling at that point of time. It was after I had sat with them long enough, when their pain had been validated and normalised (Gidugu et al., 2015), then would they be able to hear small bits and pieces of a story of recovery.

Disclosure of our lived experience also comes when we are engaging with professionals. I have previously engaged with a psychologist who appeared to only want to talk about themselves. After four visits, this psychologist knew very little about me, but I knew a whole heap about them. You know the type, they ask you a question, then they answer it about themselves. They asked me about my hobbies, asked me if I liked gardening, and then before I could answer, they were telling me all about their potted plants and garden. If I were a peer using this attitude, I would never be able to build relationship, rapport, or trust.

Unfortunately, this psychologist also only knows the textbook about my diagnosis of mental illness, and that is great that they know this, however, it does not capture the whole of any illness. After listening to pieces of my story, this psychologist was convinced that I did not ‘fit the criteria’ of their textbook. I have used several tactics to recover, and of course that is not possible within the medical model, text book scenario. Once again, this attitude would not work in the peer scene, as we are encouraging of our clients, not labelling and telling them they do not fit the textbook once they have disclosed their lived experience.

Professionals are in a unique position to gather data, to really listen to the clients and learn about the idiosyncrasies’ that come with mental illness. I believe that having an openness to what they are hearing during the clients’ disclosure, can give a better understanding of what has been experienced, one that is above and beyond text books.

Conversely, I had a very positive experience with a psychiatrist, who listened to my history, listened to my current symptoms, did not doubt me, or did not tell me that I ‘did not fit the criteria’. Rather, they prescribed the correct medication, which allowed the current symptoms to be managed. However, on reflection, I do now see the distant relationship, the professional boundaries. I understand that it is meant to be distant, so I do not try to build relationship through my disclosure. I talk about what needs to be said and that is it. It is a relationship of words, no emotions, little to no empathy. But it works. It does what it is meant to do, medicate me.

I am of the opinion however in observing other peers whilst attending their appointments, they want to build relationship with the professionals through disclosure, but due to professional boundaries, it is not done. The literature however, indicates that it is important for healthcare professionals to develop and foster human connections, as this will assist clients with their health, can prevent illness, and more importantly, healthcare professionals also represent social support for clients (Soler-Gonzalez et al., 2017). This may be a relatively new way of thinking; however, it appears in my community, professionals do not have the time or the intention to be there for relationship building. Perhaps that is why peer work is so powerful.

When we are disclosing our lived experience to other peers or those we are supporting, it is a useful tool to create a safe space, and to build trust in the relationship as the participants in the study by Gidugu et al (2015) indicated ”and shared a little of her story with me. And, um … that was very comfortable. Um…it made it a lot more comfortable to share back. It makes it more … more personal. Not … so clinical” (p. 449).

Peers in the focus group revealed that they only shared parts of their story, the parts that have been processed, the ones that perhaps no longer are open wounds, just scars and connection points.

Focus Group LTP 5 *Participant two*

> *"….. events that I don't share because it hasn't been processed enough".*

Focus Group LTP 6 *Participant two*

> *"…..well I really want to use my qualifications, my experience as a tool".*

Participant One disclosed that there was a possibility of them having an episode with the constant group chatter about a cat. Although this may seem strange for someone outside the peer world, when this was revealed, the group members changed the topic, and were not perturbed at all by the request. They continued on as if nothing had occurred and were respectful to the person making the appeal. A true display of unconditional positive regard for another group member. This type of acceptance is normal for peers, where disclosure is accepted without shock or horror, no strange looks as if we are weird, just total genuine acceptance. I guess, it is because we all know and have come to accept that everyone has strange little idiosyncrasies' that make them unique. This uniqueness is not shunned by peers but embraced.

Disclosure of our mental illness can also have negative ramifications depending on who it is discussed with. So, while we feel safe with other peers, other experiences have not been so nice. After getting out of hospital, I was labelled a 'mental case' and visitations with the children were withheld from me, on the basis that I was not fit to be their mother, and that this person wished that I had succeeded with my attempt at taking my life. I tell this story not for one to feel sorry for me, but to understand that this is the treatment that many people with a mental health illness or issue may have been subjected to. For me, being subjected to such emotional torment was the predominant reason for the explosion of symptoms which landed me originally in the Acute Mental Health Unit.

Ernst et al. (2016) reported on the outcomes of disclosure. It was found that whilst positive experiences increased closeness and interest in sharing, any negative experience had the reverse effect. Participants in the Ernst et al. (2016), study indicated that negative experiences reduced their future interest in sharing and thereby undertaking a re-evaluation of the process of whom to share, when to share and how much to share, however the positive effects of disclosure included self-acceptance. Attaining self-acceptance for the participants in this focus group, was achieved by firstly being accepted by others. It is then that we more readily accept ourselves. and in doing so reduce the self-stigma that we subject ourselves too (Focus Group LTP 7; Focus Group Data 7 Power of connection).

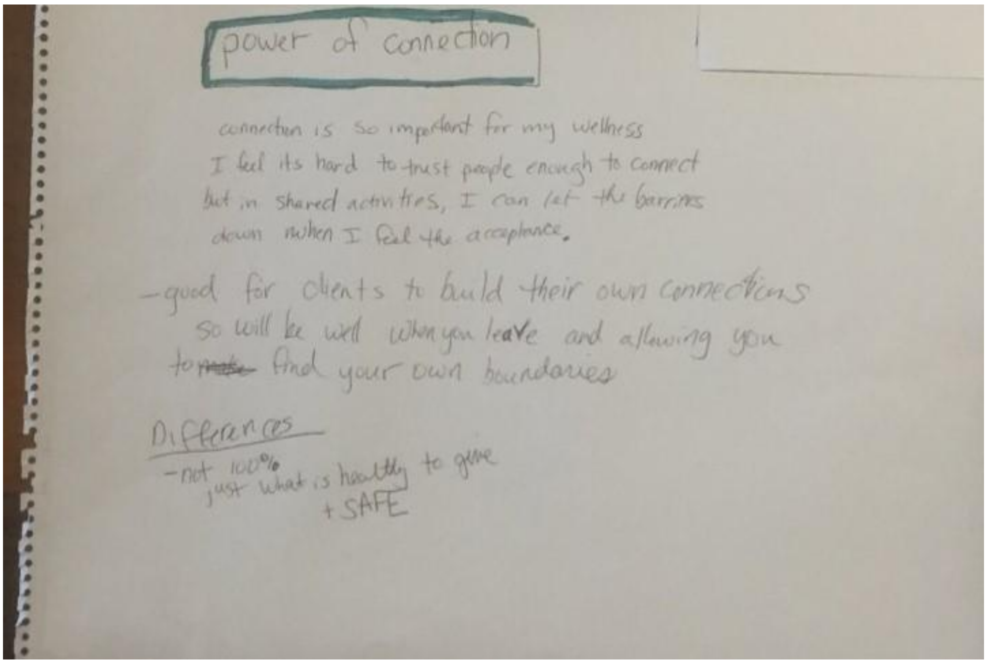
Focus Group LTP 7 *Participant one and six*

P1 –" *P7 I wanted to say that, P7 and P6 how you coped with me when I self-disclosed that I was concerned that I was going to have an episode when I was talking about your cat, and then asked to change the subject and I rode through it and I am ok*"

P1– "*just the way you guys just coped with it, that's cool, thank you"*

P6 – "*once people know that things trigger people, then they are like, ok I won't go there"*

Focus Group Data 7 *Power of connection*



power of connection

connection is so important for my wellness
I feel its hard to trust people enough to connect
but in shared activities, I can let the barriers
down when I feel the acceptance.

- good for clients to build their own connections
so will be well when you leave and allowing you
to ~~make~~ find your own boundaries

Differences
- not 100%
just what is healthy to give
+ SAFE

6.3 STIGMA

Being ‘believed’ when we talk about our experiences, not being judged (MacLellan et al., 2015), being validated, is an important tool that is used by peers. From my experience, people with mental health concerns, are constantly thinking that others ‘won’t believe me’, and that we have to fight to be heard. Along with society, these ‘text book professionals’ who do not know the little details, the little nuances of having a mental illness, are among those that create the doubt and belief that we are making it up, or not worthy of attention.

For me, it is almost useless talking to these people as they really have little to no idea what mental illness is all about. If, however it was a psychologist with their own lived experience, I believe that my treatment and experience may well have been very different. This is not by any means the only time this negative experience from disclosure happens. When we disclose that we have a mental illness, we do see the faces of people change, having them mentally step back, as if it is contagious.

My recent experience with stigma was something that I was unprepared for, I honestly did not think that people thought this way and was shocked with a question directed at me when I entered into a conversation about employment. I was having a chat to a person that worked in Aged Care, and when they enquired, I mentioned that I worked in Mental Health. The immediate response was to ask if I was scared. I was really confused, and asked why would I be scared, and they replied ‘It must be so dangerous’. Of course, my response was to say that the people I support are just like you and me, they are not dangerous at all. But my curiosity was peaked, with so much focus on mental health these days, why were we still considered ‘dangerous’?

Focus group participants made numerous comments regarding the status of mental health in the general community. Participant Seven commented “when a person hears mental illness, like you were saying, they instantly think this person could kill me”

Focus Group LTP 8 *Participant five*

> *“We need to make mental health mainstream. So I go out now and people go what are you doing, ’Oh my God how do you do it?’.....they think, they honestly think people are running around with knives…I am quite serious, they do not know what it is….like the film psycho or something”*

From the Letter to Peers (2), comments and views were similar “everybody has got mental health issues” (Participant Five) and “everybody has got something” (Participant Six). These thoughts reflect my own beliefs that there are more people with mental health issues than without in today’s society. In the mainstream outside of the mental health arena, I have not come across a single person yet that has not had some form of mental health issue such as situational depression, or even anxiety. It is everywhere, and those who deny having any experience with it, well perhaps that in itself is another form of mental health issue, denial, who knows. But people are reluctant to even admit it, and when they do talk to me about it, it comes across as if they feel they have committed a crime, they are so ashamed. I feel so sad for them.

Acceptance was felt by Participant Four, with the statement from university student colleagues “feel free to be yourself to me”. I can only hope that the younger generation are becoming more accepting of peoples’ differences and situations, thereby reducing the stigma surrounding mental health.

I question whether the stigma today is still carried on from the way we were treated back in the days of mental asylums. Diabal and Brenda (2017) report that in the past, people with mental health issues were jailed, or trialled and hung as witches. Allderidge (1979), tells of the mentally disordered being “indiscriminately exorcised, or burnt, or left to wander at will, or chained up and beaten, or all four” (n.p.). According to Diabal and Brenda (2017), mental health symptoms made it difficult to employ or shelter these people. Due to these difficulties, they were not wanted by their families and communities. Eventually asylums were created (Allderidge, 1979), and were considered a dumping ground for the mentally ill (Diabal & Brenda, 2017). These asylums were never fashioned to be therapeutic environments (Diabal & Brenda, 2017).

In more recent times, to ‘commit suicide’ was a crime and you could be jailed for it (Beyond Blue, 2019). The words – ‘commit suicide’ are still being used freely today even though the criminal associations are gone. It is now not a crime, and Beyond Blue (2019) promote the reduction of stigma surrounding suicide in society by people ceasing using the ‘c’ word. In reality, we were ‘committed’ to institutions’, had our rights taken away, treated as criminals, put into padded cells, and kept ‘under control’ by being pumped with so many drugs that just fogged our brains and dulled thought processes. Many of these drugs are still being used today and have the same effect, it’s just that we are now allowed to ‘walk free’ in society (with our knives and axes!). I do understand that there are some community members supervised under a Forensic Treatment Order, may be considered ‘dangerous’ and they are perhaps allowed to ‘walk free’, however this situation is the marginal section of mental health. In order not to be ‘tarred with the same brush’, education of the general community is required so that stigma is reduced, and there is a cessation of labelling of derogatory names for those with mental health.

My opinion of those that are ‘dangerous’ is that they have experienced severe trauma dealt out by other humans, predominantly parents in the early years. Some people have experienced absolutely horrific childhoods and situations that someone who has had a safe and secure upbringing, would never understand. I believe that it is this treatment that they have received is why they are dangerous. They have tolerated the extremes of human cruelty to their breaking point. But until trauma is recognised, stigma will still remain because people just do not understand and cannot comprehend.

There is another form of stigma, which is just as damaging, self-stigma. I certainly have self-stigmatised myself in the past. I hid what had happened, my diagnosis, I was full of shame, I was not worthy of being accepted as a regular person. Quite strange really, as up until the hospitalisation, I was considered, and I also considered myself ‘normal’, confident, outgoing, so what changed? These days I openly talk about events leading up to my hospital stay and my diagnosis without the shame or stigma of mental illness.

Brené Brown (2012) states that shame, takes on a different aspect when what we are hiding, what we are ‘ashamed’ of, is spoken about and bought out into the open. It is then no longer shame. I am no longer ‘ashamed’ of my diagnosis, in fact it has benefited me and become quite a strength. I even managed to get a job because of it.

Not all cultures shame their community members who struggle with mental health issues. A few years ago, at a cultural awareness presentation, I was informed that indigenous Australians apparently do not look at the weaknesses of a person. They look at the person as a whole, consequently they find and encourage the strengths and talents of the individual. I have often thought that our society as a collective whole, focus on the weakness of a person in order to not only make themselves feel better, but to put themselves above others. As a peer, we do the reverse, that is finding the person's strengths. We use a strengths-based approach in our work, building self-esteem as part of the relationship building process.

Jacobsen et al. (2012), reported that work done by peers in their study was predominantly experiential sharing, relationship building, and socializing/self-esteem building. Within their study, discussions around stigma were high on the agenda between peers and clients. When we are able to accept people for who they are, validate their pain, this is what changes lives. Below is the account of a focus group participant recalling an experience surrounding stigma that occurred.

Focus Group LTP 9 *Participant four*

> *"I had come out of hospital, a couple months before and my uncle was cooking a barbeques and I was like "hey uncle" and he's like "ooh, don't come over here", and I didn't go over there, like, I said "I've got bipolar, oh yeah just thought I would let you know" and he said "oh is it contagious*?"

6.4 VALIDATION

What peer workers have experienced in the way of shame, stigma, and discrimination, is commonplace in mental health, and so we are able to comfort others through validation. I remember one of my very early eye-opening moments, simply through making a connection in my role, where the person commented "oh so you do know how it feels". This person continued saying that they never felt heard or understood.

MacLellan et al. (2015), found that peer workers engage in a reciprocal relationship, and for the person being supported, this encompassed validation of the past, and acceptance of the person as a whole including their illness or history, and all undertaken with a positive outlook. Also reported in the study by Jacobsen et al. (2012), building a sense of community was the primary aim for peer workers and due to their own experiences, this allowed them to make meaningful connections.

Validating, normalising, building an egalitarian relationship (MacLellan et al., 2015), and just simply sitting with the person is what we do. I am just being human to another human. I put aside what I am supposed to achieve through the role and just sit, listen, validate and normalise what they have experienced. As peers, we build relationship first and foremost. If there is no trust, there will be resistance and they will not walk with us along the path of recovery.

In order to validate, we must first listen, truly listen to the person. Active listening is a vital part of peer work. The power of just being able to sit and listen to someone who needs to be heard. Like when I was being triggered, my professional supervisor sat and listened to me. My (non-peer) Manager couldn’t ‘get it’, and so it took another peer to be able to spend the time with me, to listen without judgement, and to recognise and understand what I was experiencing. We do this because we know what it is like to be not listened to, to not have the words to express what is going on for us, for others to dismiss us quickly. So, it is what we want, what we need, just to be heard, to have our feelings validated and normalised. You don’t have to identify as a peer to do this, but I believe that in order to do this well, to be genuine with your response, you would have to be a peer, or at the very least, a peer that does not want to reveal themselves. For the want of a better title, an ‘undercover peer’.

As peers we are required to take responsibility for our actions, even when we were unwell. Participant One revealed that they were in a lengthy relationship, and although they have been separated for over ten years, commented “it’s only now in the last nine or ten months that I am starting to realise how hard it must have been on them. Well it must have been hard on them all (the family) because I wasn’t well”. For this person, it has been ten years of carrying pain and hurt and now only in the last ten months has this person started to heal. This healing, their recovery journey is now underway since they have started to undertake the Certificate IV in Mental Health Peer Work and being supported by the other group members. Not only are they learning how to be a Peer Worker, they are getting to share stories and experiences, and to have their feelings validated and normalised, and this is obvious by the statement of “Thank God for this course….So I have to just keep going the next 25 years and I will have won, because winning is not suiciding. When I have got friends like these (Cert IV participants), anything is possible” (Participant One).

Our recovery journey takes many pathways, and we are always learning. It is this learning, once truly learnt, once understood, that is incorporated into our lives. It is this first-hand knowledge of recovery that can be passed on. We pass skills onto those that we are supporting, strengthening the relationship building process, and all the time validating their pain. This emotional support that we are constantly giving out can take its toll on anyone, so self-care is vital for the peers’ wellbeing.

6.5 SELF-CARE, HEALTH PROMOTION, AND RESPONSIBILITY

Part of our recovery journey is learning to be responsible for our behaviours which includes acceptance of our unwellness (Focus Group LTP 10), and that perhaps it is not the other person that is deliberately causing you angst. It takes a large amount of courage to face the fact that we were at fault, and that we now need to be responsible for our thoughts and behaviours. This is part of our recovery journey. This journey is what we share, not our illness story (Cabral et al., 2014). We share how to overcome stigma and discrimination, whilst modelling self-care (Davidson et al., 2012).

Focus Group LTP 10 *Participants one and seven*

“When I was in the middle of it, I was, I always thought it was someone else’s fault, someone else’s issue, they just didn’t get it” (Participant One).

“I am unwell, but actually you are the one with the problem…..That is how I felt when I was unwell, I thought everyone was against me, they’re saying I am unwell, and to me, it’s like there is nothing wrong with me…. When you are unwell you think everyone is judging you and it’s them with the problem, that is how I felt at the time” (Participant Seven).

As a peer, I realise the importance of self-care, and make this a priority in my recovery. I do have some days when the depression worsens, and I feel unworthy of self-care. I know this is only temporary, and that this knowledge, this understanding that ‘this too will pass’, is something else that I can put into my toolbox when supporting others. Mosack et al. (2013), found that peers increased their knowledge about health behaviours and were healthier at the end of their study. All jobs in the health field are stressful, so self-care should be a priority for all mental health staff, not just peers (Davidson et al., 2012). The research by Davidson et al. (2012), uncovered the thought process of other staff questioning whether peers are too fragile, and Davidson et al. (2012), so nicely responded informing the reader that peers have a substantial amount of persistence and resilience accruing from the hard work that it takes in fighting the illness, and engaging in their recovery journey. Boothroyd and Fisher (2010), report that social relationships and support are a protective factor in health, and that peer support offers emotional, social, and practical support that are essential for managing the illness and staying healthy.

From the interaction that I have had with other peers, self-care is high on their priority. In one of the Letter to Peers, I remarked that I put in 110% which caused a bit of a discussion as to whether we should even put in 100%. Below are the views of two focus group participants, and a post I found on Facebook relating to the differing levels of ‘best’ that we have depending on the day.

Focus Group LTP 11 *Participant three*

> *“with the idea of giving 100% I quite like when you originally read it to us group. I, um, don’t see it that way, I give what we can, yeah because 100% of me would be dangerous”………. not really 100% just what is healthy and safe to give”.*

Focus Group LTP 12 *Participant five*

> *"Guess it depends on how you look at it so if you are giving what you have got, that is your 100%, that is the way I look at it".*

Artifacts 7 *Facebook post – my best today*

I have learnt that it is healthy for us if we can give to others what is considered the overflow. Once our bucket is full, we give out the excess, the overflow, but we need to fill our bucket first. As peers we must constantly be mindful of keeping our bucket full for ourselves so that we can give to those who need a bit extra in their bucket today like, our clients. Our clients are so wrapped up in their own pain they can come across as 'selfish' or 'self-centred' or unable to care about others. That is because their bucket is literally empty, they have nothing left to give, they are just surviving. So, for me, self-care is vital as a MHPW. If I am not at my best, which changes daily, I am unable to give to others.

We use our recovery tools for the people we are supporting, but for me, it is something I do to and for other peers as well. What I share with my clients continues to other peers that are around me.

6.6 PEER TO PEER RELATIONSHIPS

In my May 2018 ‘Letter to Peers’, I wrote about another work colleague being a peer, but not identifying, not revealing it as it was not in their job description. Confiding in me, they revealed that they felt it was not necessary, in fact wanted no-one to know of their mental illness diagnosis. Consequently, none of the participants that they supported, no other work colleagues knew of their lived experience, or that they were in actual fact a ‘peer’. I noticed that this worker has similar traits in their work ethics to the ones I value. I questioned whether these traits are common to peers, or whether it was just coincidence that we both held high, work standards for ourselves and for the people we are supporting. I wondered whether these standards are a part of not wanting to feel ‘less than’ due to our mental health, driven by our life experiences of being harshly judged and criticised. I started to question whether we can be peers and not identify as a peer, depending on our job description? So, if it is not in our job description, does it mean that we are not peers? Are we then peers outside of work hours, and non-peers in work hours? Is this possible? Can we really switch like this? I feel like these peers that do not reveal their peer status are ‘under-cover peers’ and are not wanting to reveal that they are living with a mental health issue or illness, not wanting to be discovered or found out (Personal Communication 1). And from what I have experienced, I can see why. It is the stigma around mental health that has created these undercover peers.

Personal Communication 1 *Email to colleague*

> I am the only Peer here in this area that uses their title and does the job as a Peer actually like a Peer. I have interacted with two other 'Peers' that were employed by another organisation, however neither used their lived experience in their role. One comment made to me by one of the Peers was that they have the title of Peer, however they do not talk about themselves, are not comfortable talking about their lived experience and refer to themselves as a Case manager only.

I wonder if there were undercover peers in the study by Gray et al. (2017), who reported that 15 out of the 17 staff indicated that they had a lived experience of mental illness, either directly themselves or as a carer to a family member or friend. Disclosure of mental illness was accepted for MHPW's but others with a lived experience did not have to disclose this information (Gray et al., 2017). Even though they don't have to, do they? And if they don't, why not, what is stopping them? Even with all the publicity that it gets these days, is it the stigma of mental health that halts the revealing of this? What if they knew how beneficial it was, as reported in the helper-therapy principle, (Riessman, 1965) or the mattering principle (Taylor & Turner, 2001)?

Maybe one day those that feel the stigma and shame around mental health or illness will not only reveal, but embrace the depth of their own knowledge on recovery. Maybe one day others will not harshly judge us, but praise us for our strengths. I can only dream.

As part of my employment, I was privileged in being able to access professional supervision with another worker, and one who identified as a 'Peer' in a mental health worker role. I was lucky enough to have professional supervision with a peer mentor, Ant Gibbs. At the start if this research, I queried his version of a peer and was consequently informed that to him, a peer was "equal in having a journey of mental health challenges, equal in having life interruptions of mental health experiences, equal in having a lived experience". If we are peers, equal in having life interruptions from mental health challenges with the people we are supporting, are we still a peer if we don't reveal our lived experience?

In order for us to do our best work, we need to be supported, and professional supervision by another peer, one who recognises, understands and can assist the peer to work through the emotional and physical reaction of triggers, will create not only the best outcome for the peer worker, but for the clients they are supporting. Without professional supervision, there is the chance that peers could act 'unprofessionally', being triggered (Personal Reflections 18), and harming themselves or others, and thereby bringing peers in general into disrepute. (Scott, 2015). We have all created our own reputation which will precede us in this industry, however this can be undone quite easily with a situation arising that has not been recognised and dealt with in the manner that all peer workers should have access to.

Focus Group LTP 13 *Participant one*

> “*Help to recognise and reframe is sooo important for us….supervision and debriefing is very important but has not been available to all PSW’s in mental health*”.

As professionals, and like any other professional in the mental health sector, we require access to personal development training. I believe that professional supervision can be considered part of this development. As shown below, professional supervision with another Peer, was beneficial for my mental health and skill development. My manager at the time, could not help me get through this situation, but another peer understood perfectly what was going on.

Throughout the whole focus group, I observed peer to peer interaction taking place. Some peers were comfortable enough to be able to share their vulnerability, share their emotions, share their stories. Whilst this was occurring, the compassion that flowed through the room was constant from every member and towards every member. No group member was feeling isolated, or on the outside. Such inclusivity is one of our strengths in our skill set.

Personal Reflections 18 *Triggers*

The ‘being triggered’ and having my non peer manager not understand what was going on for me, was yet another learning curve. I questioned why didn’t the manager understand, they were more ‘qualified’ than me, been ‘in the game’ much longer than me, being my manager, my upline, so why didn’t they know? Why could they not see what I saw? In this particular situation the peer was never going to be easily understood by a non-peer.
The use of reflection, and reframing through professional supervision allowed me to understand that the manager did not understand, in fact how could they as it was purely emotional based what I was ‘feeling’ and how could they possibly ‘feel’ the same? My empathy from the situational feelings created for the client arose from similar feelings that I too had encountered and I believe needed to heal from. By recognising and acknowledging this, I have created the ability to utilise my knowledge in the future to be able to pre-empt any situation like this and through selected strategies, change the direction of outcome or effect on myself again.

I liken our skill sets to any other professional. Take for instance sales people. Not all sales people are going to utilise the same strategies to sell items, similarly, peers have their own strategies, their own skill sets that they will bring to the table. Although we have our own skill set, our own tool box, we still have a responsibility to ourselves and to those we are supporting to create a safe working environment in which our actions do not harm others. As cited in Davidson et al. (2012), the skills of being gentle and humane were identified and utilised by Pussin and Pinel who perhaps employed the very first peer workforce.

> *“As much as possible, all servants are chosen from the category of mental patients. They are at any rate better suited to this demanding work because they are usually more gentle, honest, and humane*” – Jean Baptiste Pussin, in a 1793 letter to Philippe Pinel. Pussin was serving as the governor (i.e., superintendent) of the Bicêtre Hospital in Paris, where he had himself been a patient. Pinel had been assigned to become the chief physician there, and had asked Pussin to describe how the hospital was functioning prior to his arrival. As noted above, one of Pussin’s key management strategies was to hire as many staff for the hospital as possible from among recovered patients. In addition

> to being “gentle, honest, and humane”, Pinel found these former patients recruited by Pussin to be “averse from active cruelty” (which was a common management strategy in the asylums of the day) and “disposed to kindness” toward the patients in their care (p.123).

6.7 PEER TO OTHER PROFESSIONAL RELATIONSHIPS

By the simple definition of the fact, I need to not only reveal, but consider that I am a peer in order to fulfil my job description. However, it was the comments about who I am a peer to that made me go and check out my job description in order to clarify that my clients were in fact, my peers. It is clearly stated in this job description that I am working with peers (Personal reflection 19). If they are not my peers, then why are they referred to as peers in my job description? If the simple definition of peers is equal, then who are they equal to if they are not equal to me?

Personal Reflections 19 *Current job description*

> Use your own experience of mental health issues to support and challenge peers to explore the possibilities of their lives.
> It is essential that the incumbent has a basic understanding of the state mental health system and how it works and an understanding of how and when to use their recovery story to support peers.

I was placed in a quandary when a professional colleague, someone that I hold in the highest regard, commented that my clients are not my peers. This colleague stated that they and I are peers, we are equal as we are both professional, and I have recovered whereas my clients although somewhere along their recovery journey, have not. I understood where this colleague was coming from, I could understand on the level that was been directed at me, I could see the truth and the value in their explanation.

Conversely, I had previously been involved in a conversation with a different professional who informed me that they employed my services to do for the client, what they could not, like taking the client out for coffee. This occurred after learning that I had referred that particular client for counselling due to heavy depression through grief and loss. I was called in for a meeting into the professional’s office, where they consequently informed me that they were the professional, not me, and made it very clear that my role in the community was only for taking clients out for coffee and definitely not to do professional tasks such as referring the client for counselling. So now I had two contradictory interpretations of how other professionals’ saw my role in the community, what my job description should entail and who I was ‘Peer’ to.

The unfortunate reality of this situation is that the professional that called me into their office, had absolutely no knowledge of my prior work experience or tertiary qualifications. They presumed that because I was a ‘peer’, my history of mental illness was my only required qualification to do the job at hand. In a study by Davidson, Chinman, Sells and Rowe (2006), they found a similar complication where the title of peer, only identified one facet of the persons previous experience.

Peers have reported that they feel there is a lack of clarity about their role and that their role is less defined than others (Cabral et al., 2014). I certainly felt a distinct lack of clarity when the question was posed to me, within my work role, who am I peer to. I had to go back and check my job description and it was this comment that made me question who are we peer to, and then started to think about the role ambiguity that comes with Peer work. Peers in the focus group (below) also relied on their job description to define their role.

Focus Group LTP 14 *Participant two*

> *“For me it comes down to what does my job description say.*
> *I am a support worker, that is one thing. If I am a peer support worker is a another. They are different roles, but being peer, we can attack it from a different level”*

6.8 ROLE AMBIGUITY

When I started my employment as a peer, I had no formal training on how to be a peer, I felt that I was expected to ‘know what to do’ and as reported by Asad and Chreim (2016), educate myself on how to be a peer. I was only too willing to undertake the role and with much gusto, and like a duck to water, jumped into the murky waters and educated myself on how to be a peer (Personal Communication 2). I did learn however, to utilise this ambiguity and the flexibility within my role (Asad & Chreim, 2016), to the advantage of those I was supporting

I had several upline managers throughout the first few years of my role, peers and non-peers. I felt that the peer upline managers came into the relationship with ease, and we had an instant bond or connection. We had something in common that our relationship was based on, a respect for each other, knowing that life had not been easy, but we had got through it to this point in time. On the contrast, I felt that the non-peer uplines, and professional supervisors struggled with my position, they had no clear idea of what I was doing or how I was doing it (Cabral et al., 2014).

Personal Communication 2 *Email to colleague*

> When it comes to my own role, I have been basically put out there by myself, with very little support, however when I have 'stuffed up' my uplines have been very accommodating with assistance. So, I do feel very supported when it is needed, however I am left to my own devices a fair bit of the time. I love the autonomy, and it suits me well, I work well by myself, but I could see numerous difficulties with someone of less work maturity.
>
> For my role to be successful, I need to think outside the box, I need to be creative, and that I am! That is why the autonomy of this job really suits me. If I had someone looking over my shoulder all the time, it may hinder my performance somewhat. This is just my perspective, I am outgoing when it comes to my peers, however I am very reserved when it comes to the people working in the industry that are non-peers. I understand about boundaries and guidelines that we all need to work by, but I believe for peers to be effective they need to be a bit more flexible, not clinical; they need to allow us to be 'real', not secretive.

I was questioned by a member of the focus group about how I felt about the colleague stating 'clients are not your peers', and did I think they (clients) were my peers? The conversation continued asking if this colleague understood that you can be a member of all different types of peer groups:

Focus Group LTP 15 *Participant one and two*

> *"It's not either or".* (Participant Two)
> *"So you can actually be her peer, but she can be my peer, and also other peoples' peer as well…… It's interesting that sometimes, it not always black and white*". (Participant One)

The colleague also explained that although they have a unique approach for clients, it is underpinned by a clinical framework. Peer work is not underpinned by a clinical framework so once again I questioned purely from the point of view from my job description, how are this particular professional and I peers? How are we equal?

It occurred to me that we are equal in the fact that we are supporting others, but not equal in the manner to which it is done, or to the level that we associated ourselves with. I consider my clients to be my peers, however this professional did not, and perhaps considered themselves on a different level; perhaps more as the 'expert'. One member of the focus group had a completely different take on the understanding provided by peers versus non-peers.

Focus Group LTP 16 *Participant four*

> "*It is a fallacy that only another peer can understand a peer. It is easier for them to do so, but a non-peer has a journey too and a way in which to understand peers.*
> *Peers means equal but non-peers can understand and empathise with peers too. Just like some psychologist, counsellors, psychiatrist, doctors, surgeons, GP, urologists and cleaners may not be a peer or have a friend or family member who is, however they can still understand and empathise with peers. And a non-peer has to work harder for it, more discipline and self-control"*

With regards to the last statement, I am left with a question - does empathy equate to actual understanding of challenges of mental health issues, or are those that empathise with true understanding, are they actually undercover peers? Is it possible that by revealing this about themselves, by removing their façade, they will expose an area of vulnerability, thereby making them feel just like us? Do they think that clients will respect them less, or their status will be lowered? In this world of the growing peer workforce, the Peer to client relationship de-emphasises the psychiatric symptoms (Ahmed et al., 2015), reduces the reliance on emergency services (Davidson et al., 2012), and enhances the ability for the client to be the 'expert' and take control of their own lives.

6.9 PEER TO CLIENT RELATIONSHIPS

One situation that all peer workers face is the client wanting to be friends. They do call us their friends, and for most, this can make the boundaries of the relationship difficult to manage (Asad & Chreim, 2016).

At the start of my journey, I was informed by my manager, that I was not allowed to be friends with clients as that is stepping outside of professional boundaries. Consequently, as a newcomer to the profession, I would then explain to the clients that I could be friendly, but we are not friends. On reflection and as part of the process of this research, I have decided that this needs a closer look. I have had several clients claim that they see me as their friend, and I have had a client introduce me to a family member as their friend. I have known these people for many years now, and see them each week/fortnight, and so yes, I understand why they believe that we are friends. I have looked at our relationship and found that we do have a friendship. It may not be the type of friendship where we go out and socialise together, but there is definitely a caring relationship, that is equal on both sides. I have thought of different things it could be called, but 'peer friendship' seems to be the best fit at this stage.

Back in 1989 Joan Berzoff, reported on the importance of women's friendships in psychological development, and more recently Cleary, Lees, & Sayers (2018), stated that friendships can be vital to our health and wellbeing. The problem with this however, is that for the people I support that are plagued with mental health issues, they hide away, live a reclusive lifestyle, and do not want to associate with society that has caused their trauma and pain. So how do they make friends? They simply don't. For companionship, they rely on their families, they rely on church members, they rely on their support workers for these pseudo friendships. Cleary et al. (2018), report that when we are born, we start to connect, then friendships are formed from our connections with other people. Friendships instil a sense of belonging, and are created from social activities such as dining out, or any other social activity. A level of intimacy may be created as we share personal information, and positive experiences can facilitate bonding, which in turn facilitates the feeling of mattering (Cleary et al., 2018). They go on to say that more friends, equates to better mental health, and fewer friends equates to poorer mental health.

Right at the start of my peer worker experience, in order to help me understand the difference, my manager told me that a friend is someone that you socialise with, and that we do not socialise with our clients. Likewise, I have been invited to birthday parties and other occasions, but I politely refuse, never once saying that I am not allowed due to professional boundaries, but feeling that it is kinder to just inform them that I have a prior engagement.

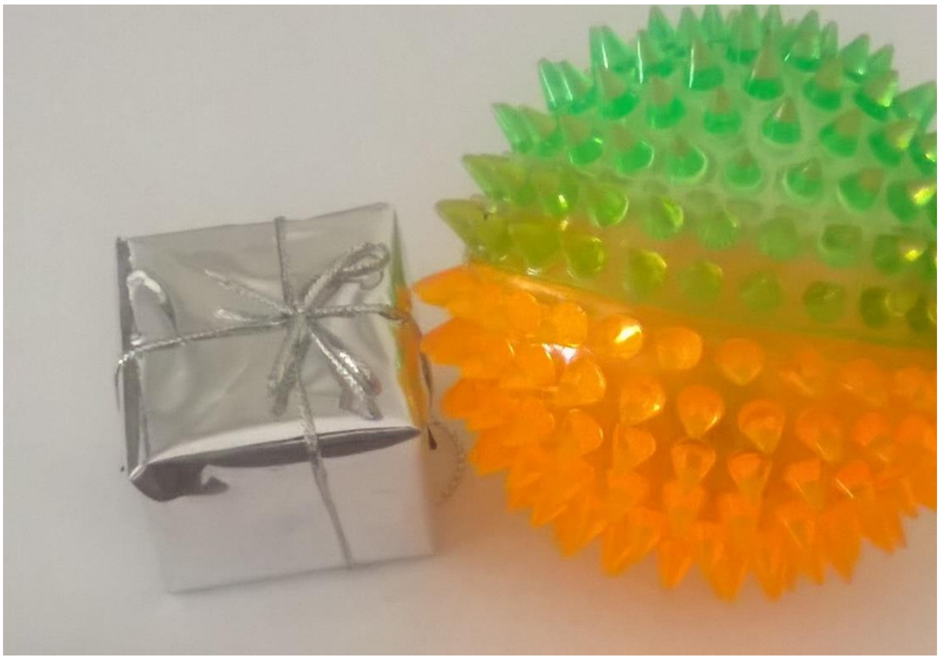
From my perspective, connection through trust is the main contributing factor for a peer to client relationship. Peers are able to connect on so many different levels, in so many different ways, this is how we build relationships. We need to build relationships in order to gain trust, and even if the client doesn't trust themselves, they will usually trust us. In fact, my experience is that people with mental health issues are extremely trusting, and it would be so easy to take advantage of them.

I talk to my clients like anyone on my ‘outer’ circle. I certainly do not divulge information of a personal, intimate nature, apart from my lived experiences appropriate for the situation, I am happy to share general information similar to those work colleagues that I share my working week with. My reasoning is that I am expecting the people I support to share with me, so why would I not be open and honest enough to share with them? How do we build a genuine trust and connection if we hold back?

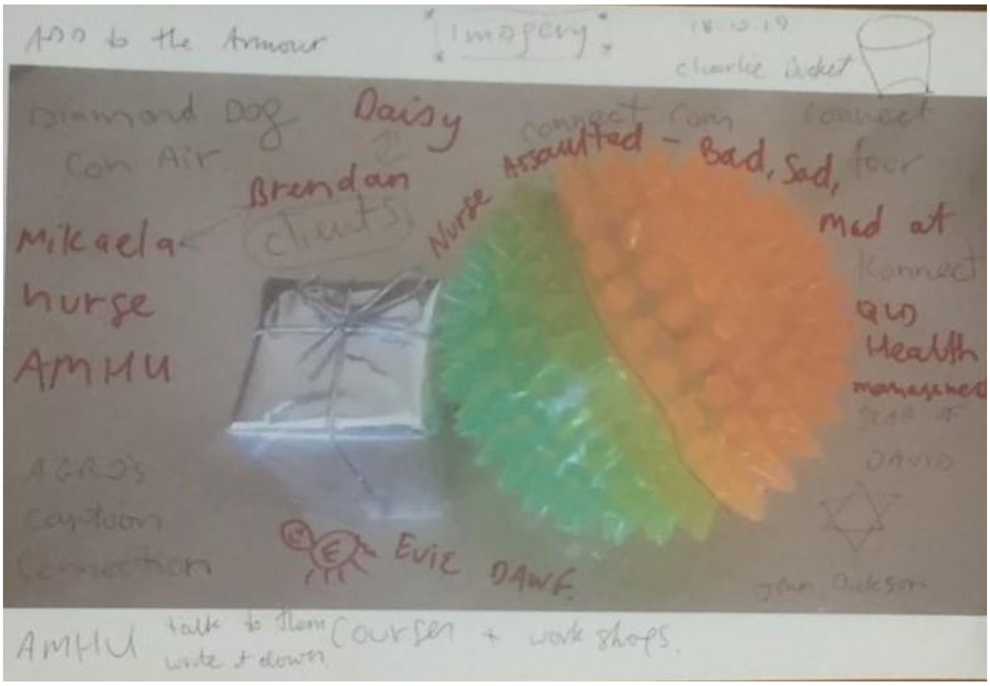
There lies the balance of power. I am just one of them, I am no different, I have just travelled a bit of a different path, and maybe a bit further along in my journey of recovery. I will never wrap myself up in a box covered with shiny paper (Artefacts 3) and a big bow and present myself as something 'secret and mysterious'. I wear my scars proudly; they are the tools of my trade.

Artifacts 8 *Clinical vs peer*

Ok, that is great, I felt wonderful at having discovered this, but what about clinical services, if we are massage balls, what are they?
Well the picture that came to me is one of a shiny little box with silver wrapping and a lovely bow tying it all together. It was coming to the end of the year, Christmas was looming, I imagined a decoration on a Christmas tree, the little shiny presents, wrapped up in silver, with a lovely little bow, all made to make the tree look 'pretty'. That is how I saw clinical services. They are the ones that are made to look all shiny, exciting, secretive and mysterious. You don't know what is inside the box, it is all kept hidden, but made to look so appealing from the outside, but who knows what is on the inside, what is it that the client is going to receive? Only the clinicians themselves know this. But it is one size fits all, one box for everyone. It is like the Santa presents at a large function, you know the one, where all the kids get the same toy, maybe a different colour, but essentially just a bulk purchase of the same item.



Focus Group Data 8 *Clinical vs peer*



In order to not create a hierarchy status, therefore being considered equal, an egalitarian relationship is required to be built. I need to instil the confidence and understanding in the person that I am not the 'expert' (MacLellan et al., 2015), that I have been where they are at this present time, even if this seems too hard for them to comprehend at that present moment.

I consider that I am 'one of them' (Personal Communication 3), and need to just be able to be on the same level as the clients, to get where they are coming from, I need to be a peer to them. That is how I feel, however other peers feel somewhat different. Varying statements from members of the focus group (Focus Group LTP 17), shows that even among a group of peers, there is still confusion as to whether we are peers to the people we are supporting.

Personal Communication 3 *Email to colleague*

> But you need to be on the ground and being with the people in the community for this to happen. The community trusts me, so therefore I have managed to become effective in this area. But if I was to not be able to use my lived experience, and just be a service provider, then I don't believe it would be as effective, it would be very hard work, for little outcome
> My groups work because I attend, I encourage, I am there with them. I am invested in them, I am one of them, they feel this, and so they are open with me and with other members of the group.

Focus Group LTP 17 *Participant one*

> *"I have a lived experience of mental health challenges, I am working with people, I have the Cert IV (Mental Health Peer Work), so have more knowledge and have got the experience, and the lived experience which is more than the people I am working with, and that is where I need to understand that when I am supporting someone, I am not their peer.*
> *I am here to help them, help them find and reach goals they have set. When I am being paid to support, to go to events, to go to shopping and to get psychosocial support, I am then their support worker, not their peer".*

6.10 CONCLUSION

For peers, disclosure of their mental illness to the person they are supporting is what sets them apart from other health professionals. It is though my experience that I have learnt to modify what I disclose, and the amount of disclosure, as each and every situation requires something different. Even in this day and age, negative connotations of people with mental illness are still rampant, leading to peers experiencing stigma from the general community. As a peer, I have also suffered with self-stigma, and shame, and it is these experiences that I am now able to share with those I support, validating their experiences in order to build trust and connection.

Validation and normalising of experiences is a powerful part of peer work. We know what it is like, we know how it felt. We didn't read it in a book, we actually experienced it. We sit, we listen, we validate, and we gain the clients' trust. We are their teachers in a way, and something we teach is self-care. We give out so much to each and every one of the people we are supporting, we need to look after ourselves. Self-care is a priority, as is professional supervision, which ultimately should be provided by another peer.

I have discovered through this research that I can be peer to many, not just other peers. However, it is this 'peer-ness' (Shiner, 1999; Silver & Nemec, 2016), that can vary depending of who we are equating it to. I can be peer to mental health peers, and I can be peer to health professionals, but it is our life experiences that determine who we are peer to, not our job title or role in the community.

I have recently become 'peer' to another group of people. After the recent death of my husband, I have started to come to understand one thing, grief. I have known people that have lost a loved one, but I have never truly understood their grief. Of course, previously I could show empathy with those that had lost a loved one, however I can now say unequivocally that I did not truly understand it. You can never have an understanding of grief unless you have experienced it first-hand. I am now a peer for those that have lost a loved one, increasing my mental health challenges with the depression and other emotions that are associated with this new grief journey.

Likewise, I can empathise with a friend that has been recently released from prison, but I have never been there. As a non-peer to this group of people, do I have a true understanding of what they have experienced? Will hard work, more discipline and self-control allow me to better understand and empathise with their experiences?

My experience has taught me that I am a peer 100% of the time, I cannot just move between roles, like a 'on-off' switch. It is my life experiences that have made me who I am, and what I stand for. My life experience determines what I value, and drives my morals, my ethics and my integrity. It also drives how I treat people and what I say to them, how I motivate them, how I inspire them. I am 100% mental health peer.

Chapter 7: Findings and Implications – What I have learned

This chapter essentially covers what I have learned along my journey as a MHPW. The themes that have been generated from the data are presented below. Section 7.1 will, cover the process of how a MHPW builds working relationships; Section 7.2 conveys the difference between working relationships of other professionals working within the mental health arena; Section 7.3 summarises what it is that a MHPW contributes to the recovery of those they support; Section 7.4 how a MHPW fits within the mental health system; and other knowledge that I discovered, in addition to the research questions will be presented in Section 7.5, Teachings.

7.1 PROCESS

7.1.1 Mutuality

I have found that there needs to be mutuality (Repper & Carter, 2011). There is an 'us and them' mentality through the mental health system, and as professionals we need to identify as one or the other. If we identify as 'us' (peer), then we will be accepted and welcomed and relationships will be built, with the opportunity for deeper connection. With these relationships, the motivation for connection will come from loneliness and isolation being felt by the person being supported (Gidugu et al., 2015).

7.1.2 Connection

My ability to create connection comes from numerous connection points, and my metaphors and analogies. People requiring support sometimes struggle with listening to lengthy amounts of words, but a picture can be recalled immediately. My experiences are shared with the person, and they share with me, so it is a learning process where we can both learn about ourselves through sharing. This helps build relationship, increases our knowledge, which in turn helps others. In order to assist with the connection, validation, normalising and building an egalitarian relationship is needed (Gidugu et al., 2015). We build relationship, we build trust.

7.1.3 **Validation**

The people we are supporting have experienced huge traumas in their life. Validation of this immense trauma and pain that they have been exposed to, they are at first unable to 'listen', and they need to be listened to. Sometimes this can take a while, but they need to felt heard before progress is made. We need to sit with them, validate and connect (Gidugu et al., 2015).

7.1.4 **Empathy**

The people that I support, have an unbelievable willingness to expose their vulnerabilities if they think the other person will listen and be able to help them. Genuine care and empathy (Gray et al. 2017), are required to listen to their story, especially as they recount their trauma. It is this story telling that can lead us to believe that we know best, they have come to us for help, so we must help them, however, with respect to the person, I have learned that I am not the expert in someone else's life. Neither is any clinician. I am only the expert in my life, and that is all.

7.1.5 **Resilience**

Persons requiring support have incredible resilience and strengths that they dismiss all too quickly. It is the MHPW's job to assist the person to identify these strengths. This can be quite a tough job as the person needing support, will continue to display negative behaviour until they find the courage to begin to trust themselves.

This trust in themselves is not easily achieved. Even though the peers that I have had the pleasure of supporting are the most genuine, honest, caring human beings, it is only once you are able to 'crack' through their outer protective layer, that the true diamond is revealed. Resilience is required by the MHPW as this can be a lengthy and emotionally challenging process to enable trust and relationship to be built in these circumstances.

Resilience is required for the difficulties that we encounter as we support others. However, if I can do it, so can you. The pathway may be different but if the person is being supported by myself as a peer worker, I will not give up. I will always praise any progress no matter how small. It’s still progress. This sometimes, long journey is where holding the hope is encountered. When the person being supported doesn’t think they are any good, doesn’t think they are capable, we step in and ‘stay’ with them, showing them that they are valuable enough for us to be with. We stay until they are able to hold their own hope, until they can see some light at the end of their dark tunnel. At the end of the day, it is the resilience bought about by the traumas the MHPW has suffered assisting them in supporting of others.

7.2 WORKING RELATIONSHIP

7.2.1 **Boundaries**

All professionals require to the use of boundaries in order to maintain longevity within the health system, however there is a difference in how they are utilised. MHPW’s require the ability to make their boundaries flexible (Asad & Chreim 2016), not rigid, as we are supporting people that quite often do not have friends, so we become their social connection (Gidugu et al., 2015). This can create confusion as to the relationship status, as there are intimate details shared, and this is mistaken as a friendship by the person being supported.

This ‘friendship’ must still have boundaries, not the ones that clinicians use, but a more flexible boundary, peer boundaries, ones that suit the relationship that has been built between the two peers (Asad & Chreim 2016).

I have watched people with mental health issues try to build a relationship with clinicians from the medical profession, but the professional stays distanced from the patient. The literature acknowledges that medical profession represents social support for clients, and suggests that due to the benefits of human connection, developing and fostering connections will assist clients with improving their health.

7.2.2 **Ability and desire to build connection**

Talking about your journey of recovery is a necessary element of being a MHPW, and the amount of intimate details revealed regarding MHPW's lived experience depends on the situation, and the person. It is possible that other staff working with services providers also have a lived experience, but not reveal it (Gray et al., 2017). In order to be considered a peer, you need to identify as a peer. However, I still believe that they can be 'undercover peers', if they do not identify. It is the ability and desire of the professional to build connection that is paramount to wellbeing of the person being supported, the feeling of connection.

We need to make time for people, we need to make time to connect, and that has been a major part of the pandemic push – connection. Why must we have a pandemic to be told to connect with one another to protect our mental health? The pandemic has hit the world hard, isolated every one of us at some stage. As an essential worker, I have felt privileged to be able to go about my normal work life and bring connection to those I support. Connections, although key to wellness, are also negatively impacted by mental unwellness.

7.2.3 **Trauma informed care**

Like Warrick Middleton (Kezelman & Stavropoulos, 2012), I feel that trauma is not recognised, understood and spoken about enough. Whenever I speak of trauma, I believe people think it has to be bigger than what they have experienced. A traumatic experienced can be anything such as separation from your parents at a shopping centre, through to a life-threatening situation. What is trauma for one, is not necessarily trauma for another.

The trauma suffered, is the reason why the people I support are constantly in flight or fight mode. They want their feelings and pain to be heard and validated. Sometimes this makes them appear 'self-centred', however they want someone else to be able to feel their pain, in order to ease theirs. I have learned this from being with them, not something that has been taught to me.

7.2.4 Qualifications

I have learned that there are more qualifications required than a mental illness and a ‘piece of paper’ to become a MHPW and do this job well, however educational qualification represent “the ability to behave professionally and maintain self-control at all times” (Scott, 2015). Furthermore, there are many traits and characteristics essential to the longevity of the MHPW position. If we are to guide people on their recovery journey, then we need to have numerous skills under our belt in order to deal with the hard times. We need to be able to teach our peers what we know, and be willing to share all of our knowledge. Some will be used, some wont, but unless we put it out there, we may just be blocking the recovery path for someone.

7.3 RECOVERY PROCESS

7.3.1 Recovery qualification

All of my life experiences get used and bought to the forefront. I have experienced so many different situations, abuse, traumas, grief, so it is these experiences that are my connection points with the people I support in my role as a peer worker.

7.3.2 Relationships

It is not only necessary, but beneficial for humans to have relationships with other humans, and more so in the recovery journey. The neurobiological chemicals that are released when we make connection with someone increases our levels of pleasure and trust. For those with mental health issues, those who commonly isolate themselves, this isolation is adding to their poor mental health, and of course is detrimental to their overall health. MHPW’s understand this isolation and it becomes part of their shared experiences (Jacobsen et al., 2012).

7.3.3 Teaching about oneself

Education about oneself, is a constant journey. I have learned that there is no reason to feel ashamed about my diagnosis, and consequently, I have used it as a strength to assist a multitude of people in my community. Peer work has a ‘strengths based’ approach, which over-rides shame, and builds self-esteem on the journey of recovery.

The lessons along our recovery journey also includes learning about and implementing self-care (Asad & Chreim, 2016). For the person who is in recovery, self-care is a difficult process, and often denied. As a role model, we need to model self-care (Jacobson et al., 2012), however we can only give out the overflow from our ‘jug’, so unless we can continuously use self-care, we will never fill our ‘jug’, and have nothing to give. If we do give from an empty jug, this is when burnout for the MHPW occurs, and the inability to intercept triggers can be heightened.

Triggers can be cleverly disguised in everyday situations. As peers we are constantly watching for triggers, and trying to be one step ahead of any situation that may be dangerous for us. We are well aware of the dangers of triggers and not being prepared for them. From what we have experienced, we are then able to pass this knowledge on to others. The knowledge continues with the symptomology of mental illness. What I learned from other peers regarding the symptomology of mental illness, and how this assisted my recovery, is now being passed back into the community as the skills and knowledge I continue to learn, thereby assisting others with their recovery. I share all of my knowledge, it is not a secret, it is given freely and willingly.

7.4 MENTAL HEALTH SYSTEM

7.4.1 How MHPW’s fit within the mental health system

Peer workers have an extremely effective part in the current mental health system (Davidson et al., 2012). As suggested in the literature, patients are wanting to build a ‘social’ relationship with clinicians which will improve the well-being of the patient. As there currently is an inability to achieve this, due to professional boundaries, the role of the MHPW, the flexibility of the boundaries allows for a social ‘peer friend’ connection to be created.

I have learned that we can be peers to numerous groups all at once. I can be peer to the professionals, and I can be peer to the people I support. All I have to do is change the skills and communication styles that I use to suit each group. However, when I am in my role as MHPW, then I am peer to the people that I am supporting, as classified by the position description. When it comes to the clinical framework, that other professionals go by, this is where the peer similarity ends.

7.5 TEACHINGS

7.5.1 Stigma and Supervision

I have learned that stigma still exists, even today, and will affect our recovery (Kidd et al., 2015). While I thought that I had a one-off situation with a person thinking my job was 'dangerous', the focus group participants all expressed similar situations and thought processes of people in their community. The stereotypes created, and labels placed on people with mental illness is not assisting in decreasing the stigma, isolation, humiliation, sense of inferiority, and rejection for anyone in the community. From this, I have also learned that self-stigma is more debilitating that cultural stigma, and that culture takes a long time to change.

Change is also needed within ourselves, acceptance of our lived experience. I have learned that not all peer workers are able to, or encouraged to feel comfortable with their lived experience. Some want the title 'Peer Worker', but don't want to, or have the ability to do the job. It is peer work and the connections that I have made, the ability to help others, and the fact that I mattered to those I was supporting (all without the knowledge of the helper-therapy principle, and the mattering principle), that increased my recovery significantly. Personally, I would like to see all of those 'under cover peers' break through their own self-stigma, acknowledge and embrace the skills that they have learned in their life. The ability to expand your knowledge from sharing stories, the ability to 'matter' or to reap the rewards from being a 'helper' severely outweigh the cost of exposing your mental health secret.

The feeling of being unworthy, flows over into other areas of our employment. We need to be able to speak out and ask for what we need, as peers, needing something specific like professional supervision with another peer. We have the need to be understood, we speak a language of emotions, and sometimes a non-peer, is not going to be able to support the peer worker seeking supervision in the best manner.

7.5.2 **Cost of Mental health**

In days gone by, people with mental health issues were segregated from society, treated badly (Alleridge, 1979). Now the mainstream through the pandemic are being treated the same way, treated like criminals as if they have a disease, shunned, if they dare cough. Society is currently being led by the fear factor, fear of catching something, fear of reprisal, fear of stepping out of line for the consequences that they will face. This fear is being driven by what? Fear of being ostracised? But at what cost? What cost to the mental health of the person, what cost to society? For each person that suffers with mental health issues, the cost flows from the person, through their family, to the community, and ends with a bigger financial cost to the government. I have learned that we need to be more human to each other, and that costs nothing.

With all that I have learned on my MHPW journey, with all that I have experienced during my life, my wish for the world is to see more peers trained to be able to utilise their recovery story to inspire hope for others. I would like to see every doctor’s surgery, every mental health service or organisation employ more MHPW’s to improve our connections, and thereby better our mental and physical health. Yes, there will be a financial cost, but the money it will save the government reminds me of the old adage ‘a stitch in time saves nine’. Invest one dollar now, and it will save you from needing to spend nine dollars later.

7.5.3 **Responsibility and Self Care**

I have learned that I am not the only peer worker that takes responsibility for their actions. Focus group members also recounted their stories of taking responsibility for their behaviours, their thoughts, their actions. We sum up the courage to face our wrong doings, face that we were at fault, for this is also part of our recovery, part of our healing process. Gray et al. (2017), informs of the complex understanding of each peer workers triggers and coping mechanisms which is necessary for our healing and recovery journey. Our healing process also includes self-care.

I have learned that although self-care is of the utmost importance for a peer or peer worker. Some of the people I support think of it as being 'selfish' thereby struggling to do anything nice for themselves. They are of the mindset that being 'selfish' is an unwanted behaviour. In days gone by, negative connotations meant that it was frowned upon, and it was considered bad. For me, not creating self-care, can be seen as self-harm. I question, if it isn't self-care, then what is it? If we know something would be good for us and we deliberately choose not to do it, is that an act of self-harm? For me, I am always wary of whether I am doing self-care or self-harm. When I am well, my self-care includes, taking my medication (until further healing takes place), going to bed early, eating reasonably well, doing something enjoyable for myself, keeping contact with my family and friends. There are times when I am unwell, and I deliberately choose to self-harm, to go to bed late, to eat badly, to disconnect from my family, to not do something nice, to not 'be kind to myself', simply because I want to punish myself. I understand this feeling, this type of 'self-harm' all too well, and so I encourage the people I support to reconsider if they feel doing something nice for themselves is a selfish act. One thing I have seen time and time again, is that even when a human is at their lowest point, and not providing any self-care for themselves, they can still have care and concern for others.

7.6 FUTURE RESEARCH & PRODUCT OF THIS RESEARCH

As I have journeyed through this research, one thing has been made very clear, and that is the amount of resilience that is gained by MHPW from the trauma they have encountered. Another area that has been pointed out in the literature, is that MHPW may put themselves into disrepute by becoming unwell. Not all people with a lived experience are going to make good peer workers, and there does not appear to be any particular skill set that is required to be employed. For me, I believe that I draw upon my resilience and that this is a major skill set. It has been pointed out to me that resilience is a complex topic, and it is definitely out of the scope of this research, however, the complexities of resilience and peer work may be an area that can be explored further.

I question the ability of being able to screen potential employees for their resilience level, and if this would benefit the workforce in general. Although I know that this is a simplistic viewpoint, perhaps future research could look at the resilience levels of MHPW that are currently employed versus the average support worker.

So what have I gained from this research? This research has enabled me to question my own professional principles of practice to ensure that I am being true to myself as a MHPW and to my clients. As mentioned at the start of the thesis, self-reflection for me is a major part of my peer work. If I am not growing as a person, then I cannot assist my clients to grow, and we will all stagnate within the symptoms of mental illness. Having the opportunity to reflect on not only my own practice though this thesis, but that of other peer workers, has given me a more confidence that I am serving those I support, well.

What are the products of this research? The beautiful data that has been created by the myself and the participants. It is unique, it is expressive, it is creative, it is unlike any other data that has been captured previously by research. I now have a deeper understanding of my talents, my knowledge, and that of the other MHPW's around me. This research and the knowledge that I have gained, has encouraged me to think more deeply, encouraging me to question the principle of professional practice, and wonder what would it be like if they changed their ways? What would it look like for those with mental health concerns if the professionals 'relaxed' their boundaries and took on a more caring, intimate approach to their patients? The people I support always talk positively about certain doctors, and these doctors are the ones that appear to 'care' more than others. The people love them, they feel safe and secure knowing that their doctor really does care, and they 'feel' it. However, even these doctors are restricted in the amount of time or 'care' that they can provide. We just need to be more human to each other.

Chapter 8: Making meaning of the work

8.1 INTRODUCTION

The inclusion of peer workers in the mental health system is gaining in popularity, and although the research it is limited, until now there has been no research from the perspective of the MHPW, with the method of autoethnography. I have used my lived experience, to bring new information to the fore in order to extend the current literature. Whilst it may be seen as only my story, the focus group included other MHPW's to extend the generalisability of the research. The use of autoethnography provided the opportunity for myself as the researcher to explore and uncover in-depth descriptions of experiences.

In order to address the research question What is the lived experience of a Mental Health Peer Worker? Several aspects must be considered. Firstly, what process that are used in building relationship, secondly what is the difference between a MHPW and non-peer worker, thirdly what does the MHPW contribute to the recovery journey, and finally how do they fit within the current mental health system? These points arising from the research are all summarised below.

8.2 BRINGING THE JOURNEY TO A CLOSE

There are many processes in which a MHPW builds working relationships with those they support. The first factor, and the most commonly thought of one is mutuality, based on the acceptance of identifying as a person with a lived experience of mental health issues. Connection will come through having mental health issues as a common denominator; however, it is the sharing of experiences that will build relationship. Validation and empathy are required to ensure that the person feels listened to, respect shown for their life choices, and that they are indeed the expert in their life. Nevertheless, it is resilience of the MHPW that is tested in order to go through this process. They are required to keep the connections, the relationship, the whole process flowing, along with ‘holding the hope’ whilst the person gathers their own strength, and creates new boundaries.

Flexible boundaries are the predominant difference in working relationship for MHPW and non-peer workers. The flexibility allows a MHPW to build relationship, or a peer to MHPW type of ‘friendship’. Due to the isolation that occurs in tandem with poor mental health, MHPW’s become a social connection, and this can create confusion in the relationship due to the intimate nature of information shared. Although research suggests it is beneficial, clinicians are unable to create a social connection, thereby utilising the MHPW’s skills is an extremely valuable asset within the mental health system.

MHPW’s bring forward unique information as a recovery journey story, which may or may not include traumas experienced. While the current Certificate IV Mental Health Peer Work qualifications are well supported, there is more than qualifications needed in order to deal effectively with guiding people on their recovery journey. The traumas we have experienced, create our connection points, which assists in building of relationship, but it is the education of oneself with self-care, triggers, and other elements on the recovery journey that is continuous. This is self-education, and there is no expert, except for the person experiencing it.

It is hoped that by revealing some of my lived experience, that this thesis will provide new information, new insight, new understandings for those entering into, those currently involved the MHPW workforce, and other clinicians and professionals within the mental health sector. It would be wonderful to think that this thesis could have some information to assist in creating new policies and procedure documents to better support MHPW’s.

Before I conducted this research, one dream of mine was to produce a tool that employers could use to screen MHPW’s before they are employed. From the outcomes of this research, I am of the opinion now that screening for resilience would be a predominant factor. It is foreseen that this screening tool would have the benefits of securing a workforce that is able to withstand the challenges of the mental health sector. Another dream from doing this research is that I would like to see every doctor’s surgery with a MHPW available to sit and listen to the patients in order to build a social network to better their health.

As we come to the end of the research journey, I hope that my passion for peer work has emanated through this research. I believe that through our life, we all search for a person that truly cares about us. To have one person that truly cares for you, can change your world. With his unconditional love and belief in me, Joe changed my world. As a 100% mental health peer worker, I know that I am a person who can change someone else's world. I have learned that my life is not yet over, and I have more to achieve, and that is why I am still here

References

Adams, T. E., Manning, J. (2015). Autoethnography and family research. *Journal of Family Theory and Review*, 7, 350-366. doi:10.1111/jftr.12116

Ahmed, A. O., Hunter, K. M., Mabe, A. P., Tucker, S. J., & Buckley, P. F. (2015). The professional experiences of peer specialists in the Georgia Mental Health Consumer Network. *Community Mental Health Journal, 51*(4), 424-436. doi:10.1007/s10597-015-9854-8

Allderidge, P. (1979). Hospitals, Madhouses and Asylums: Cycles in the Care of the Insane. *British Journal of Psychiatry, 134*(4), 321-334. doi:10.1192/bjp.134.4.321

Andresen, R., Oades, L., & Caputi, P. (2003). The experience of recovery from schizophrenia: towards an empirically validated stage model. *Australian and New Zealand Journal of Psychiatry, 37*(5), 586-594. doi:10.1046/j.1440-1614.2003.01234.x

Asad, S., & Chreim, S. (2016). Peer Support Providers' Role Experiences on Interprofessional Mental Health Care Teams: A Qualitative Study. *Community Mental Health Journal, 52*(7), 767-774. doi:10.1007/s10597-015-9970-5

Australian Government Department of Health (2010). Principles of recovery oriented mental health practice. *National Standards for Mental Health Services 2010.* Retrieved from: https://www.health.gov.au/internet/main/publishing.nsf/Content/CFA833CB8C1AA178CA2570.BF0001E7520/$File/servpri.pdf

Australian Government Department of Health (2013). A national framework for recovery-oriented mental health services. Guide for practitioners and providers. *Australian Health Ministers Advisory Council.* Retrieved from: https://www.health.gov.au/internet/main/publishing.nsf/content/67D17065514CF8E8CA257C1D00017A90/$File/recovgde.pdf

Australian Government Department of Health (2020). *Mental health in Australia* Retrieved from: https://www.health.gov.au/health-topics/mental-health

Australian Institute of Family Studies (2015). *History of child protection services.* https://aifs.gov.au/cfca/publications/history-child-protection-services

Australian Institute of Health and Welfare (2017). *Mental health services in Australia*. Retrieved from: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/specialised-mental-health-care-facilities/key-concepts

Barr, K, Townsend, M, & Grenyer, B. F. S. (2020), Using peer workers with lived experience to support the treatment of borderline personality disorder: A qualitative study of consumer, carer and clinician perspectives. Wollongong University, Faculty of Arts, Social Sciences and Humanities – Papers, 317. Retrieved from: https://ro.uow.edu.au/asshpapers/317

Berzoff, J. (1989). The therapeutic value of women's adult friendships. *Smith College Studies in Social Work, 59*(3), 267-279. doi:10.1080/00377318909517358

Beyond Blue (2019). *Why you shouldn't say 'committed' suicide.* https://www.beyondblue.org.au/personal-best/pillar/in-focus/why-you-shouldn-t-say-committed-suicide

Bhugra, D. (2006). Severe mental illness across cultures. *Acta Psychiatrica Scandinavica*, *113*, 17-23. doi:10.1111/j.1600-0447.2005.00712.x

Black Dog Institute (2020). *Facts and figures about mental health*. Retrieved from: https://www.blackdoginstitute.org.au/wp-content/uploads/2020/04/1-facts_figures.pdf

Boothroyd, R. I., & Fisher, E. B. (2010). Peers for progress: promoting peer support for health around the world. *Fam Pract, 27 Suppl 1*, i62-68. doi:10.1093/fampra/cmq017

Bousalis, R. (2017). Establishing sociological imagination before blame in historical events. *The Clearing House: A Journal of Educational*

Strategies, Issues and Ideas, 90(1), 8-11. doi:10.1080/00098655.2016.1233040

Bracke, P., Christiaens, W., & Verhaeghe, M. (2008). Self-esteem, self-efficacy, and the balance of peer support among persons with chronic mental health problems. *Journal of Applied Social Psychology, 38*(2), 436-459.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77-101. doi:10.1191/1478088706qp063oa

Brené Brown (2012) Listening to shame [Video file] Retrieved from http://www.ted.com › talks › brene_brown_listening_to_shame.

Buckley, R. (2015). Autoethnography helps analyse emotions. *Front Psychology, 6,* 209. doi:10.3389/fpsyg.2015.00209Cabral, L., Strother, H., Muhr, K., Sefton, L., & Savageau, J. (2014). Clarifying the role of the mental health peer specialist in Massachusetts, USA: insights from peer specialists, supervisors and clients. *Health & Social Care In The Community, 22*(1), 104-112. doi:10.1111/hsc.12072

Casarett, D., Pickard, A., Fishman, J.M., Alexander, S.C., Arnold, R.M., Pollak, K.I., & Tulsky, J.A. (2010). Can metaphors and analogies improve communication with seriously ill patients? *Journal of Palliative Medicine, 13(3).* doi.org/10.1089/jpm.2009.0221

Cleary, M., Lees, D., & Sayers, J. (2018). Friendship and Mental Health. *Issues in Mental Health Nursing, 39*(3), 279-281. doi:10.1080/01612840.2018.1431444

Cook, F., Carcieri, J., Varker, T., & Devilly, G. J. (2009). Changes in long term neural connectivity following psychological trauma. *Clinical Neurophysiology, 120*(2), 309-314. doi:https://doi.org/10.1016/j.clinph.2008.11.021

Dauphinee, E. (2010). The ethics of autoethnography. *Review of International Studies,* 36(03), 799-818. doi:10.1017/s0260210510000690

Davidson, L., Bellamy, C., Guy, K., & Miller, R. (2012). Peer support among persons with severe mental illnesses: a review of evidence and experience. *World Psychiatry, 11*(2), 123–128.

Davidson, L., Chinman, M., Sells, D., & Rowe, M. (2006). Peer support among adults with serious mental illness: a report from the field. *Schizophr Bull, 32*(3), 443-450. doi:10.1093/schbul/sbj043

Dlabal, S., & Brenda, M. (2017). A historical perspective of treatment and discharge planning for the seriously, chronically, mentally ill patient: A Review of the literature. *Advanced Practices in Nursing, 2*(1).

Ellis, C. (1991). Sociological introspection and emotional experience. *Symbollc Interaction, 14*(1), 23-50.

Ellis, C., Adams, T.E., & Bochner, A.P. (2011). Autoethnography an overview. *Historical Social Research, 36*(4), 273-290. doi: http://dx.doi.org/10.17169/fqs-12.1.1589

Ellis, C., & Bochner, A.P. (2006). Analyzing analytic autoethnography. An autopsy. *Journal of Contemporary Ethnography, 35*(4), 429-449. doi:10.1177/0891241606286979

Ernst, M. E., Sandberg, D. E., Keegan, C., Quint, E. H., Lossie, A. C., & Yashar, B. M. (2016). The Lived Experience of MRKH: Sharing Health Information with Peers. *Journal of Pediatric and Adolescent Gynecology, 29*(2), 154-158. doi:https://doi.org/10.1016/j.jpag.2015.09.009

Farrell, L., Bourgeois-Law, G., Regehr, G., & Ajjawi, R. (2015). Autoethnography: introducing 'I' into medical education research. *Medical Education, 49*(10), 974-982. doi:10.1111/medu.12761

Gidugu, V., Rogers, E. S., Harrington, S., Maru, M., Johnson, G., Cohee, J., & Hinkel, J. (2015). Individual peer support: a qualitative study of mechanisms of its effectiveness. *Community Mental Health Journal, 51*(4), 445-452. doi:10.1007/s10597-014-9801-0

Gray, M., Davies, K., & Butcher, L. (2017). Finding the right connections: Peer support within a community-based mental health service.

International Journal of Social Welfare, 26(2), 188-196. doi:10.1111/ijsw.12222

Grenier, R. S., & Collins, J. C. (2016). "Man, Have I Got a Story for You": Facilitated Autoethnography as a Potential Research Methodology in Human Resource Development. *Human Resource Development Review*, 15(3), 359-376. doi:10.1177/1534484316656658

Goalcast (2017), 25 Maya Angelou quotes to inspire your life. Retrieved from: https://www.goalcast.com/2017/04/03/maya-angelou-quotes-to-inspire-your-life/

Hojat M. (2016) Human Connection in Health and Illness. In: Empathy in Health Professions *Education and Patient Care.* Springer, Cham

Hoppes, S. (2014). Autoethnography: Inquiry into identity. *New Directions for Higher Education,* (166), 63-71. doi:10.1002/he.20096

International Society for Traumatic Stress Studies (2016). *Trauma and relationships.* Retrieved from: https://www.istss.org/ISTSS_Main/media/Documents/ISTSS_TraumaAndRelationships_FNL.pdf

Jacobson, N., Trojanowski, L., & Dewa, C. S. (2012). What do peer support workers do? A job description. *BMC Health Services Research, 12,* 205. doi:10.1186/1472-6963-12-205

James, J. (2015). Autoethnography: A methodology to elucidate our own coaching practice. International *Journal of Evidence Based Coaching and Mentoring* (9), 102-111.

James, M. (2012). Autoethnography: The story of applying a conceptual framework for intentional positioning to public relations practice. *Public Relations Review,* 38(4), 555-564. doi:10.1016/j.pubrev.2012.05.004

Johnson, G., Magee, C., Maru, M., Furlong-Norman, K., Sally Rogers, E., Thompson, K. (2014). Personal and societal benefits of providing peer support: A survey of peer support specialists. *Psychiatric Services, 65*(5). doi:10.1176/appi

Kashima, Y., Koval, P., & Kashima, E. S. (2011). Reconsidering Culture and Self. *Psychological Studies, 56*(1), 12-22. doi:10.1007/s12646-011-0071-4

Kezelman C.A. & Stavropoulos P.A (2012). Adults surviving child abuse. Practice guidelines for treatment of complex trauma and trauma informed care and service delivery. *Blue Knot Foundation.* Retrieved from: https://www.childabuseroyalcommission.gov.au/sites/default/files/IND.0521.001.0001.pdf

Kidd, S., Kenny, A., & McKinstry, C. (2015). The meaning of recovery in a regional mental health service: an action research study. *Journal of Advanced Nursing, 71*(1), 181-192. doi:10.1111/jan.12472

Knifton, L. (2012). Understanding and addressing the stigma of mental illness with ethnic minority communities. *Health Sociology Review, 21*(3), 287-298. doi:10.5172/hesr.2012.21.3.287

Lawn, S., Smith, A., & Hunter, K. (2008). Mental health peer support for hospital avoidance and early discharge: an Australian example of consumer driven and operated service. *Journal of Mental Health*, *17*(5), 498-508.

Liggins, J., Kearns, R. A., & Adams, P. J. (2013). Using autoethnography to reclaim the 'place of healing' in mental health care. *Social Science & Medicine*, *91*, 105-109. doi:10.1016/j.socscimed.2012.06.013

Lombardo, K. L., & Motta, R. W. (2008). Secondary trauma in children of parents with mental illness. *Traumatology*, *14*(3), 57-67. doi:10.1177/1534765608320331

MacLellan, J., Surey, J., Abubakar, I., & Stagg, H. R. (2015). Peer Support Workers in Health: A Qualitative Metasynthesis of Their Experiences. *PLoS One, 10*(10), e0141122. doi:10.1371/journal.pone.0141122

Markus, H. R., & Kitayama, S. (1991). Culture and the self: Implications for cognition, emotion, and motivation. *Psychological Review, 98*(2), 224-253. http://dx.doi.org/10.1037/0033-295X.98.2.224

McIlveen, P. (2008). Autoethnography as a method for reflexive research and practice in vocational psychology. *Australian Journal of Career Development, 17*(2), 13-20.

Miriam Webster Dictionary (2020). Retrieved from: https://www.merriam-webster.com/dictionary/hope

Moran, G. S., Russinova, Z., Yim, J. Y., & Sprague, C. (2014). Motivations of persons with psychiatric disabilities to work in mental health peer services: a qualitative study using self-determination theory. *Journal of Occupational Rehabilitation, 24*(1), 32-41. doi:10.1007/s10926-013-9440-2

Morrison, A. P., Frame, L., & Larkin, W. (2003). Relationships between trauma and psychosis: A review and integration. *British Journal of Clinical Psychology, 42*(4), 331-353.

Mosack, K. E., Patterson, L., Brouwer, A. M., Wendorf, A. R., Ertl, K., Eastwood, D., . . . Whittle, J. (2013). Evaluation of a peer-led hypertension intervention for veterans: impact on peer leaders. *Health Educ Res,* 28(3), 426-436. doi:10.1093/her/cyt004

Mueser, K. T., Rosenberg, S. D., Goodman, L. A., & Trumbetta, S. L. (2002). Trauma, PTSD, and the course of severe mental illness: an interactive model. *Schizophrenia Research, 53*(1), 123-143. doi:https://doi.org/10.1016/S0920-9964(01)00173-6

National Health and Medical Research Council (2018). *Australian Code for Responsible Conduct of Research*. Retrieved from: https://nhmrc.gov.au/about-us/publications/australian-code-responsible-conduct-research-2018

Naslund, J. A., Aschbrenner, K. A., Marsch, L. A., & Bartels, S. J. (2016). The future of mental health care: peer-to-peer support and social media. *Epidemiol Psychiatr Sci, 25*(2), 113-122. doi:10.1017/S2045796015001067

Nestor, P., & Galletly, C. (2008). The employment of consumers in mental health services: politically correct tokenism or genuinely useful? *Australasian Psychiatry, 16*(5), 344-347. doi:10.1080/10398560802196016

Parliament of Australia (n.d.) *Appendix 5 – Statistics of children in institutional care.* https://www.aph.gov.au/Parliamentary_Business/Committees/Senat e/Community_Affairs/Completed_inquiries/2004-07/inst_care/report/e05app

Pufahl, I. (2012). White Kids: Language, Race, and Styles of Youth Identity - By Mary Bucholtz. *Anthropology & Education Quarterly*, 43(1), 120-121. doi:10.1111/j.1548-1492.2011.01160.x

Puga, I. (2017). An analysis of C. Wright Mills's the sociological imagination. London, [England]: Routledge.

Queensland Health (2019). *Queensland Health mental health framework peer workforce support & development 2019*. Retrieved from: https://www.health.qld.gov.au/__data/assets/pdf_file/0039/929667/peer-workforce-support-framework.pdf

Quicke, J. (2010). Narrative strategies in educational research: reflections on a critical autoethnography. *Educational Action Research, 18*(2), 239–254

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

Riessman, F. (1965). The "Helper" Therapy Principle. *Social Work,* 10(2), 27-32. Retrieved April 11, 2020, from www.jstor.org/stable/23708219

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

Schutt, R. K., & Rogers, E. S. (2009). Empowerment and peer support: structure and process of self-help in a consumer-run center for individuals with mental illness. *Journal of Community Psychology, 37*(6), 697-710. doi:10.1002/jcop.20325

Scott, A. (2015). Gaining acceptance Discourse on training and qualifications in peer support. *New Zealand Sociology, 30*(4), 38-57.

Scott, A., Doughty, C., & Kahi, H. (2014). ‘Having those conversations’: The politics of risk in peer support practice. *Health Sociology Review, 20*(2), 187-201. doi:10.5172/hesr.2011.20.2.187

Shiner, M. (1999). Defining peer education. *Journal of Adolescence, 22,* 555-566.

Silver, J., & Nemec, P. B. (2016). The role of the peer specialists: Unanswered questions. *Psychiatric Rehabilitation Journal*, *39*(3), 289-291. doi:10.1037/prj0000216

Simpson, A., Flood, C., Rowe, J., Quigley, J., Henry, S., Hall, C., …Bowers, L. (2014). Results of a pilot randomised controlled trial to measure the clinical and cost effectiveness of peer support in increasing hope and quality of life in mental health patients discharged from hospital in the UK. *BMC Psychiatry, 14*(30).

Singer, S. (2019) Unwelfare, *Peace Review, 31*:4, 497-506, doi: 10.1080/10402659.2019.1800936

Soler-Gonzalez, J., San-Martín, M., Delgado-Bolton, R., & Vivanco, L. (2017). Human Connections and Their Roles in the Occupational Well-being of Healthcare Professionals: A Study on Loneliness and Empathy. *Frontiers in Psychology*, 8(1475). doi:10.3389/fpsyg.2017.01475

Spry, T. (2001). Performing autoethnography: an embodied methodological praxis. *Qualitative Inquiry,* 7(6), 706-732.

Stallard, M.L. (2015). Connection culture. [Books24x7 version]. Retrieved from http://library.books24x7.com.ezproxy.usq.edu.au/toc.aspx?bookid=83496.

Taylor, J., & Turner, R.J., (2001). A longitudinal study of the role and significance of mattering to others for depressive symptoms. *Journal of Health Soc Behav*. *42(3)*, 310-25. https://www.ncbi.nlm.nih.gov/pubmed/11668776?report=abstract

The National Health and Medical Research Council, the Australian Research Council and Universities Australia. *National Statement on Ethical Conduct in Human Research 2007(Updated 2018).* Commonwealth of Australia, Canberra. Retrieved from: https://nhmrc.gov.au/about-us/publications/national-statement-ethical-conduct-human-research-2007-updated-2018

The NSW Consumer Advisory Group – Mental Health Inc. (NSW CAG), & Mental Health Coordinating Council (MHCC) (2009). Literature review on recovery. *Developing a Recovery Oriented Service Provider Resource for Community Mental Health Organisations.* Retrieved from: http://www.mhcc.org.au/media/2498/nsw-cag-mhcc-project-recovery-literature-review.pdf

Thomas, G. R., Kaiser, B. L., & Svabek, K. (2017). The Power of The Personal: Breaking Down Stereotypes and Building Human Connections. *Narrat Inq Bioeth,* 7(1), 27-30. doi:10.1353/nib.2017.0010

Turner, R. J., & Lloyd, D. A. (1995). Lifetime Traumas and Mental Health: The Significance of Cumulative Adversity. *Journal of Health and Social Behavior, 36*(4), 360-376. doi:10.2307/2137325

Tzouvara, V., & Papadopoulos, C. (2014). Public stigma towards mental illness in the Greek culture. *J Psychiatr Ment Health Nurs, 21*(10), 931-938. doi:10.1111/jpm.12146

World Health Organisation (2018), Mental health problems: the undefined and hidden burden. Fact sheet N°218 retrieved from: http://www.who.int/mediacentre/factsheets/fs218/en/

Appendices

Appendix A

Participant Invitation

Dear Key Cultural Informant,

You are invited to participate in an intensive interview as part of data collection for the Masters Research project led by Liz Guaresi. The data collected will inform the development of a narrative entitled Letter to My Peers: An autoethnographical approach to a mental health peer worker experience.

We are looking to have a maximum of six persons attend this focus group. Each informant must be actively employed as a peer worker in either a voluntary or paid capacity.

As an invited informant to the focus group, please note that your information will be audio recorded and the recording will be locked in a secure filing cabinet and remain in the property of the principal researchers.

All information collected will be retained for a minimum period of five years and remain confidential. Identifiable information collected during the focus group will be de-identified prior to reporting. Individuals will not be personally identifiable and a summary of results may also be published in research journals or books at a later date.

Participation in the research is completely voluntary. You may withdraw from this study at any time, without prejudice, by contacting either principal investigator and your information will be removed. The principal investigators will not report or publish any of the information disclosed by participants who choose to withdraw from the project.

We remain thankful to you for your willingness to participate in the project and if you have any questions regarding this research project please do not hesitate to contact Liz Guaresi, Dr. Diane Duff or Dr. Melissa Carey.

We thank you for your interest in our project.

Liz Guaresi
University of Southern Queensland
u1029216@umail.usq.edu.au

Dr. Diane Duff
University of Southern Queensland

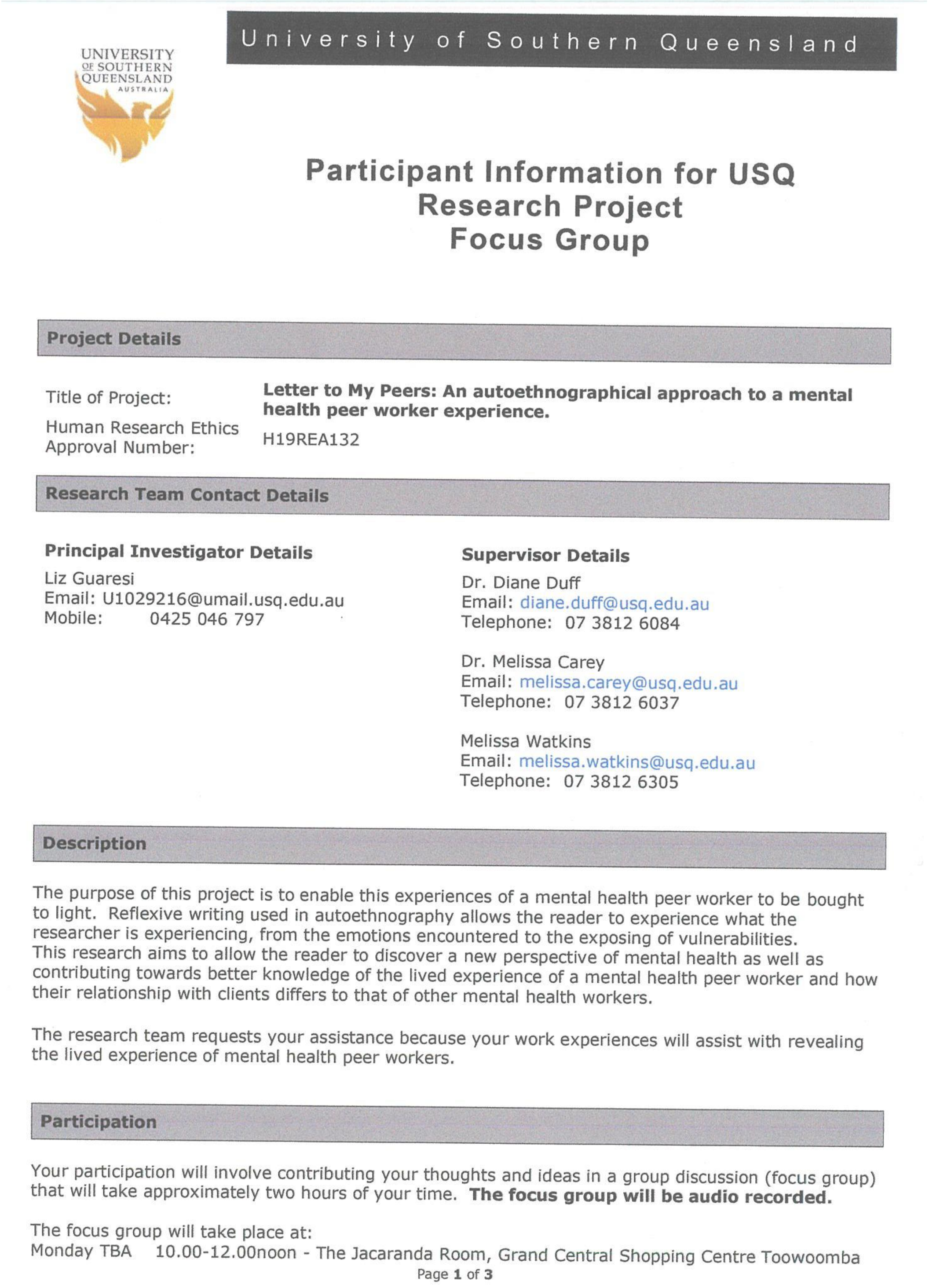
Dr. Melissa Carey
University of Southern Queensland

Melissa Watkins
University of Southern Queensland

Please note: If you have a concern regarding the implementation of the project, or if you wish to make a complaint, you should contact The Secretary, Human Research Ethics Committee USQ or telephone (07) 4631 2956. This contact is only if a parent/student has any concerns regarding “the ethical conduct of the research”, as Ethics staff are not in a position to discuss project implementation details.

Appendix B

Participant Information



University of Southern Queensland

UNIVERSITY OF SOUTHERN QUEENSLAND
AUSTRALIA

Participant Information for USQ Research Project Focus Group

Project Details

Title of Project:	**Letter to My Peers: An autoethnographical approach to a mental health peer worker experience.**
Human Research Ethics Approval Number:	H19REA132

Research Team Contact Details

Principal Investigator Details
Liz Guaresi
Email: U1029216@umail.usq.edu.au
Mobile: 0425 046 797

Supervisor Details
Dr. Diane Duff
Email: diane.duff@usq.edu.au
Telephone: 07 3812 6084

Dr. Melissa Carey
Email: melissa.carey@usq.edu.au
Telephone: 07 3812 6037

Melissa Watkins
Email: melissa.watkins@usq.edu.au
Telephone: 07 3812 6305

Description

The purpose of this project is to enable this experiences of a mental health peer worker to be bought to light. Reflexive writing used in autoethnography allows the reader to experience what the researcher is experiencing, from the emotions encountered to the exposing of vulnerabilities.
This research aims to allow the reader to discover a new perspective of mental health as well as contributing towards better knowledge of the lived experience of a mental health peer worker and how their relationship with clients differs to that of other mental health workers.

The research team requests your assistance because your work experiences will assist with revealing the lived experience of mental health peer workers.

Participation

Your participation will involve contributing your thoughts and ideas in a group discussion (focus group) that will take approximately two hours of your time. **The focus group will be audio recorded.**

The focus group will take place at:
Monday TBA 10.00-12.00noon - The Jacaranda Room, Grand Central Shopping Centre Toowoomba

Questions will be depending on the topic discussed and will include, and not be limited to:

Q1. How do you view Peer Work?

Q2. How do you utilise your recovery to assist your clients?

Q3. How important is self-care in your role?

Q.4. What is important to you in building relationships with peers that you are supporting?

Q.5. Do you feel that you participate in self stigma as a peer worker?

Q.6. What is your motivation to be a peer worker?

Q.7. How do you participate in self reflection as a peer worker?

Q.8. How do you participate in personal development with regards to your role as a peer worker?

Q.9. Have you ever 'held hope' for a person that you were supporting? How did this impact on you?

q.10. Do you feel that attitudes are changing towards peer workers?

There are no costs associated with participating in this research project, nor will you be paid for participation.

Your participation in this project is entirely voluntary. If you do not wish to take part you are not obliged to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. You will be unable to withdraw data collected about yourself after the data has been analysed. If you do wish to withdraw from this project please contact the Research Team (contact details at the top of this form).

Your decision whether you take part, do not take part, or to take part and then withdraw, will in no way impact your current or future relationship with the University of Southern Queensland.

Expected Benefits

It is expected that this project will directly benefit you by reflection of your work values and better understand the complexities involved with peer work. However, it may benefit the wider community as well, by informing of the effectiveness of mental health peer workers and add to the current body of knowledge relating to mental health.

Risks

Participants can possibly be at low risk of feeling emotional upset, stress, depression or anxiety after participating in the focus groups.

Sometimes thinking about the sorts of issues raised in the focus group can create some uncomfortable or distressing feelings. If you need to talk to someone about this immediately please contact Lifeline on 13 11 14. You may also wish to consider consulting your General Practitioner (GP) for additional support.

Privacy and Confidentiality

All comments and responses will be treated confidentially unless required by law.

The focus groups will be audio recorded for the purpose of transcription. It will be possible to participate in the project without being audio recorded.

Only the principle researcher (Liz Guaresi) and supervisory team will have access to the recording. Prior to publication, all focus group members will be invited to attend a presentation of a summary of the overall key findings. The presentation will include de-identified research data that has been collected and details will be held for all members of the focus groups that have participated.

Participant's non-identifiable data will be made available for future research purposes for similar projects in accordance with 2.5.2 of the "Australian Code for the Responsible Conduct of Research", research data should be made available for use by other researchers unless this is prevented by ethical, privacy or confidentiality matters.

Any data collected as a part of this project will be stored securely as per University of Southern Queensland's Research Data Management policy.

Consent to Participate

We would like to ask you to sign a written consent form (enclosed) to confirm your agreement to participate in this project. Please return your signed consent form to a member of the Research Team prior to participating in your focus group.

Questions or Further Information about the Project

Please refer to the Research Team Contact Details at the top of the form to have any questions answered or to request further information about this project.

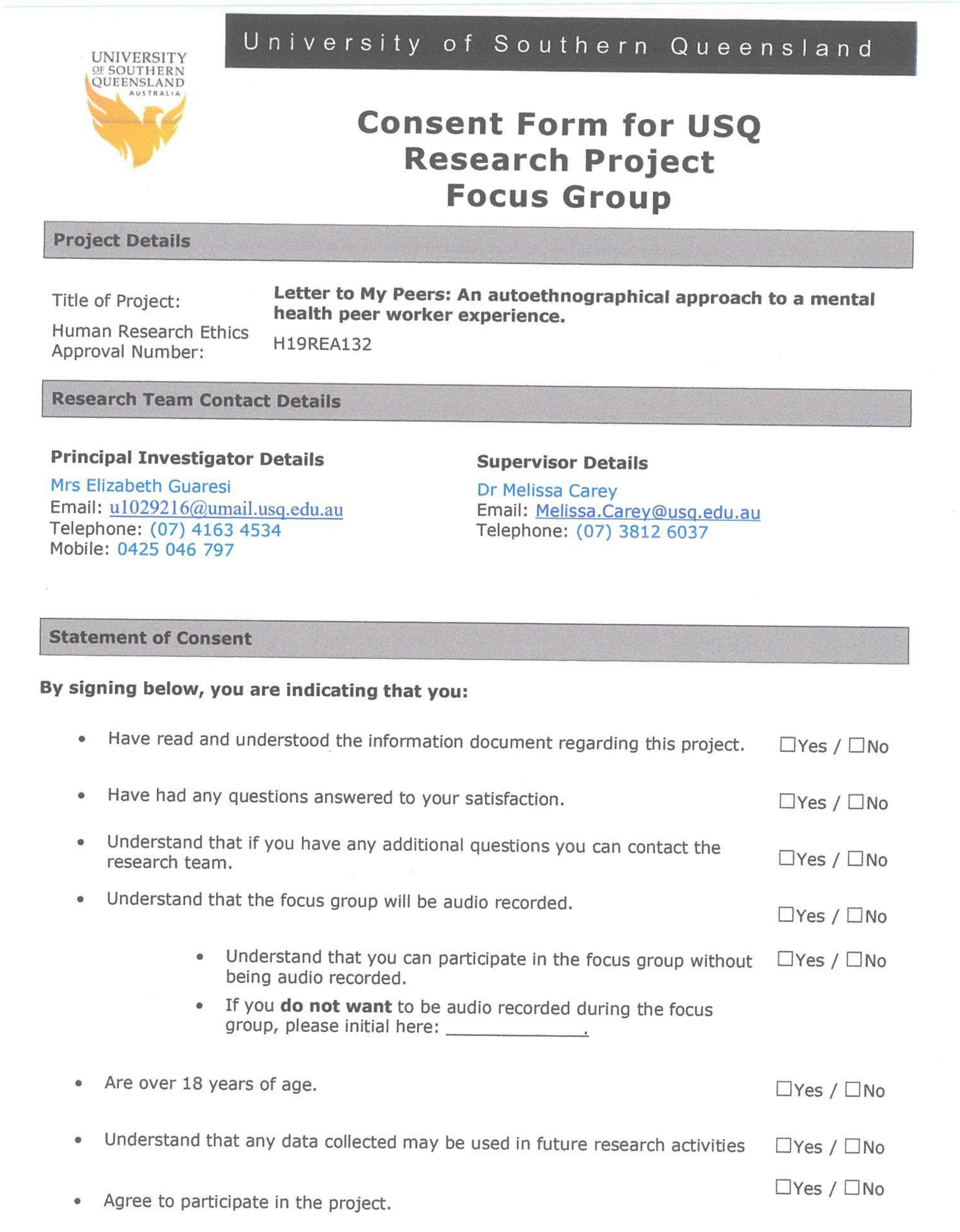
Concerns or Complaints Regarding the Conduct of the Project

If you have any concerns or complaints about the ethical conduct of the project you may contact the University of Southern Queensland Manager of Research Integrity and Ethics on +61 7 4631 2214 or email researchintegrity@usq.edu.au. The Manager of Research Integrity and Ethics is not connected with the research project and can facilitate a resolution to your concern in an unbiased manner.

Thank you for taking the time to help with this research project. Please keep this sheet for your information.

Appendix C

Participant Consent Form



University of Southern Queensland

UNIVERSITY OF SOUTHERN QUEENSLAND
AUSTRALIA

Consent Form for USQ Research Project Focus Group

Project Details

Title of Project:	**Letter to My Peers: An autoethnographical approach to a mental health peer worker experience.**
Human Research Ethics Approval Number:	H19REA132

Research Team Contact Details

Principal Investigator Details
Mrs Elizabeth Guaresi
Email: u1029216@umail.usq.edu.au
Telephone: (07) 4163 4534
Mobile: 0425 046 797

Supervisor Details
Dr Melissa Carey
Email: Melissa.Carey@usq.edu.au
Telephone: (07) 3812 6037

Statement of Consent

By signing below, you are indicating that you:

- Have read and understood the information document regarding this project. ☐Yes / ☐No
- Have had any questions answered to your satisfaction. ☐Yes / ☐No
- Understand that if you have any additional questions you can contact the research team. ☐Yes / ☐No
- Understand that the focus group will be audio recorded. ☐Yes / ☐No
    - Understand that you can participate in the focus group without being audio recorded. ☐Yes / ☐No
    - If you **do not want** to be audio recorded during the focus group, please initial here: ______________.
- Are over 18 years of age. ☐Yes / ☐No
- Understand that any data collected may be used in future research activities ☐Yes / ☐No
- Agree to participate in the project. ☐Yes / ☐No

Page **1** of **2**

Participant Name

Participant Signature

Date

Please return this sheet to a Research Team member prior to undertaking the focus group.

Appendix D

Letter one - Triggers

April, 2018

Letter to Peers

I have been working as a Peer now for a few years, since 2015, nearly three years, which is not a long time. In that time I honestly thought that I have conquered all of my triggers. I honestly did not think I had any other triggers that were going to be exposed and cause me to take notice. That was the circumstance right up until a couple of months ago.

I found myself in a position that when trying to explain to my boss the details surrounding a particular situation, I seriously and literally sounded like a raving lunatic.

Here I was trying to explain the situation as I saw it, trying to express my feelings on the situation to my manager. Pretty soon I realised that this was futile. He did not get what was upsetting to me. He just did not ‘get it’. I found that I was unable to express myself so that my manager could understand how I interpreted the situation and what I was experiencing.

Rather, what I was doing was verbally jumping all over the place, getting rather ‘passionate’ using a rather loud and raised voice, my hands were flying in all directions, and I simply did not make sense. My manager dismissed my attempts to express myself, which raised my levels of frustration even more.

Does that sound familiar? Have you ever found yourself in a situation similar to this?

On reflection, looking back now, this situation made me look like a real idiot. I was not professional, I was not thinking logically, and I was not able to ‘articulate’ what I was feeling. Why was this so? Why did this situation affect me so? After chatting with my professional supervisor (who is also a peer) for a couple of hours where he listened, reframed, I ended up coming to the understanding that I was indeed ‘triggered’ by a situation. I was able to feel the lack of power, the lack of control, and the feeling of complete helplessness felt and described by the client. This was my problem, and I had to deal with it.

So here I was finally being triggered by a situation, and it all happened so incredibly quick. To make matters worse, I did not realise that I was being triggered, until it was pointed out to me in a clear and calm manner. Once I understood and accepted what was going on for me, I could then deal with my problem, my trigger, so that if this situation arises again, I will have the knowledge to reduce the impact that it will have on me.

Why am I telling you all of this? Why is this important?

As peers, we all have buttons that are going to be pushed. We are all going to be triggered by another person. Could be a client, or perhaps another peer.

Peers have a talent, perhaps it is a unique one. We are all incredibly sensitive in certain circumstances, we pick up the most subtle of changes in tone, volume, and pitch of a voice. We are sensitive to ulterior motives, and can tell very, very, quickly when someone is being ‘fake’ or not quite true to us.

These sensitivities can heighten our reaction to a situation, and then we are told that we are ‘over-reacting’ by others. Like what I just described, I was incredibly sensitive to the situation. My manager could not understand what I saw, what I felt, he dismissed it, and although he did not say anything, I am sure he thought I was ‘over-reacting’ to what he considered a run of the mill, and simple situation.

When your buttons are pushed, when you are triggered, your reactions to the situation will come out automatically and so fast, it will leave your head spinning, and your heart racing. Fight or flight kicks in. You will feel threatened, enter into defence mode, and you will use the tools that you have always used. Without any thought whatsoever, you may react without any apparent consideration of others.

So here comes the cruncher.

Your journey as a Peer starts here in this room, not when you enter the workforce, if you haven't already.

You need to be prepared for the fact that you are going to be triggered in this room, and throughout this course. You will have your buttons pushed, and how you react will affect or impact on others.

So as a peer, you will need to start to notice these times, and work towards the control of your reactions. You may not even notice that you have been triggered, or had buttons pushed. However, if you have any sort of reaction to a situation that gets your heart racing, or any change in behaviour at all, you may question yourself as to whether you have had buttons pushed, or been triggered.

This behaviour may be noticeable to others, it may even impact on others. If so, then this is an area that perhaps you may like to have a look at or be curious about. What was it that affected you? What did you feel? You may even ask yourself 'Have I ever felt like this before?'

And what if it is another peer that has had this effect on you? Perhaps another peer in this room, whilst on this course? How will you deal with that?

There are 28-30 of you here today, that is 28-30 different personalities, and that is going to be a challenge for anyone, especially when we are all so incredibly sensitive and quick with our reactions. When you are working as a Peer, you will come across hundreds of personalities, and someone will trigger you.

So the peer work starts here. If someone does trigger you, what are you going to do? Perhaps someone says something that upsets you, how are you going to handle it?

So I have a suggestion.

What if you were to imagine that the other person was a client? How would that be? How would you handle it if it was a client that triggered you or pushed your buttons? So can we as Peers imagine that all the other Peers in this room are potential clients? Would your levels of empathy or tolerance be increased if you thought they were a client? Would you view the person differently? Would your attitude towards them be more professional? Would you have more consideration or respect for what they are feeling or experiencing?

When I was studying at USQ one of the lecturers told the class ‘If you want to work in psychology, counselling, or any other mental health area, you need to be aware of your triggers and be one step ahead of your client. Your clients will trigger you, and you need to be prepared, and fully understand your buttons and triggers, because if you haven’t worked it out, they will, and some clients will push every one of your buttons deliberately, just because they can’.

I am not saying that Peers will do this, or I really hope they won’t, but the moral stays the same. know your buttons, know your triggers, and have a plan ready for this.

You are now representing the Peer Workforce as a whole. As soon as we lay claim to the title “Peer” you are representing me, and I am representing you. We need to act in a professional manner at all times.

And to coin a favourite phrase of Robyn Brownlee

“If you have the feeling, then you have the problem”.

I really hope that this information has made you all think a bit about what makes Peers so unique, and make your journey ahead a little bit easier and more enjoyable! Thank you for listening.

Appendix E

Letter two - Perspectives

May, 2018

Dear Peers

How have you been since we last met? What have you learned about Peer Work? Remember peer work is an ongoing process, once you decide to be a 'Peer' you can't not be a peer. Are your ready for that? Sometimes it takes a level of commitment where you have to go above and beyond, you have to do what is necessary, but not necessarily within your job description. I was at a conference once and they were talking about 'What is Peer Work and What is it Not'. Our table in the workshop said it is not 24/7, and the lady leading the conference workshop said – 'It is in fact 24/7'. We don't want it to be, but we are peers 24/7, and cited situations where this was the case.

I believe that Peer work is different to conventional support work. This is how I view traditional support work – You get up, go off to work, look at your roster, see the people supporting, you do what is needed, you stay within the job description, you stay within the rules and boundaries provided by your organisation – you go home. I have never been a traditional support worker, so this is a very simplistic view!

The way I view Peer Work – I get up go to work, see the people I have organised to see, ring others I am supporting to check in on them or organising to see them. When I am supporting a person, I am always questioning myself about how I can best handle this situation, what else can I do? Can I do anything different? Can I say things in a different manner? What other supports can be put in place? Am I doing too much? Am I enabling the person? End of day - go home, self-care time, self-assess – how am I feeling, what do I need right now, am I doing too much?

This series of questions is a constant check and balance act. It does not stop. Sometimes it is very easy to get caught up in a supported persons issues and take them home with you. Beware - this is too easy to happen, simply because we care with our feelings and our thoughts. It is not just our thoughts, does that make sense? Although you can switch off thoughts (sometimes!) it is very hard to turn off feelings. Our work is feelings based, we carry our feelings with us. If someone has triggered a feeling – how do we turn that off? A bit of DBT goes a long way!! So we are constantly using skills to soothe ourselves, and what do we do with this knowledge? We pass it on to the persons we are supporting. So even when we are not at work, we are still modelling, practicing, experimenting with skills. We then say to ourselves – 'oh gosh, I must talk to so and so about this, it just might assist them with such n such'.

Some days it is not so nice. Last time we spoke, I talked about triggers. Yes, the dreaded triggers. So you might come home and be so wound up that your level of need for self-care is pretty intense. Make sure you have some self-care strategies in place and use them. If you don't this may lead to you yourself becoming unwell, and then what use are you to the persons you support?

I think that as humans that have experienced what we have, it is very easy to go above and beyond to a degree that is unhealthy. We see a situation, we want to assist that person, we know what to do, (after all we are peers), but sometimes we can do too much. This is a level that each individual must work out for themselves. An analogy for this is the oxygen mask on the plane. You must remember the oxygen mask is best given to the adults first, not the child. Likewise, the oxygen mask needs to come to you first, no good you passing out and then there is no one to assist the person needing support.

So that brings me to the topic of today. The WRAP Plan. Wellness Recovery Action Plan. I have recently been a witness to a peer colleague becoming unwell. It was suggested that this person was triggered by a client, and perhaps there were other unknown variables as well. This has been a situation where several people (peers and family), have been involved with decisions regarding this person.

As I watched over the situation, I felt that I did not have the knowledge of how to assist this person. This was a volatile situation, had to be handled with 'kid gloves' otherwise this person was not going to cooperate. I spoke to a concerned family member and they asked me ‘How long can a person be in psychosis for? Will it cause brain damage if it continues?’ I was pretty sure that psychosis didn’t cause brain damage, but I was not certain, so I said, ‘I don’t know’, and it was then that I realised this sounded pretty stupid answer coming from a ‘peer’. I felt I was expected to have all the answers. So there is a lesson in itself – get as much information as possible, don’t stop learning – explore all areas, leave no stone unturned!

So the saga continued, and as I spoke to the relative, I asked what plan should be put in place, what they thought should be done. As they expressed their thoughts, I found myself thinking ‘well I don’t really think that is such a good idea, I know they have good intentions, but I am pretty sure that is not what this person will want’.

I realised that we were all floundering, I had my ideas, the relatives had their ideas, and both were worlds apart. As a peer, I took a step back from the relative, perhaps I should have taken a step forward instead. Perhaps I should have been more assertive, perhaps I should have invested more time with this person. We will always question the amount that we do and ask, what could I have done differently or could I have done more?

So the relative took the situation into their own hands, did what they thought was the best for their family member. Consequently, that person is now in hospital, however they are wanting to be at home, in their own place, with their own surroundings. Now being ‘sanctioned’ or admitted as an involuntary patient, this person has had all their choices and control taken away. I am not saying that the relative did the wrong thing, not at all, but was it what the person wanted? Absolutely not. This person would have done anything to stay out of hospital, however for some that are not peers, hospital is the answer in every situation. Medical model rules their world. Especially when they work in a hospital. There was no other answer as far as this relative was concerned. But in a conversation with the ‘sanctioned’ person, it was stated clearly that they felt that their choice and control had been taken away.

So why is this story important? Well today you are going to learn about the WRAP plan. If this person had one of these in place, and copies distributed to supporting persons, this whole situation would have been avoided. We all would have known what to do, and would have had a better understanding of what this person wanted to happen in this situation. We could have worked together as a team. What I felt was the relatives had the power, and made the decisions with no regard or input from others that surround this person. They made the decisions, they did what they thought was best. To me it backfired. But that is my thoughts. It left me thinking - how is this person going to feel when they get out of hospital? Will they trust the relative again? I know that the first thing I will get onto is encouraging them to develop a WRAP plan. That way I won't feel helpless, powerless, and unable to assist if this situation occurs again. The persons choice and control will be retained which as peers is one thing we all believe in and fight for, and is imperative in situations like this. I do understand that once deemed 'sanctioned' or involuntary, the WRAP is no longer any use, however with a WRAP implemented prior to this all happening, this situation would not have ended the way it did. So my message to you all – this peer did not think they would ever become unwell enough to go to hospital, and yet they did. What about you? Are you so 'recovered' that you will never need to go to hospital ever again? Are you prepared to take the chance on this and have your rights, choices and control taken away? Do not take this WRAP lightly. It is an important document and should be treated with the authority that you can provide it with. Enjoy!

Here is a real life conversation between Peer and Non Peer (NP)

Peer: “This person and the relative have different realities”

NP: “If it is not real, it is not the truth. It’s not reality, it’s not real, it’s a dream it is their imagination. What’s real is what’s happened. There can only be one reality, not two. Why are you writing this down?”

Peer: “Because it is important to my research”

NP: “It’s not reality it is their imagination. How can there be two realities. If it is not the truth it is not real.”

Peer: “So what is real?”

NP: “It’s what happened”

Peer: “To you or the other person?”

NP: “Otherwise history would just be a dream. What’s happened was real. WWII was real”

Peer: “It’s their perspective”

NP: “Their perspective is not reality. It is like a big bloody fog”

Peer: “Their perspective is their perspective, it is how they see things”

NP: “That does not make it reality. Reality is what happened, and in their mind they changed everything. It’s like a false reality”

Peer: “This is your perspective”

NP: “No, no no. If you think like that everyone will have their own reality and there will be no truth at all, and that’s bloody wrong. Everything is based on the truth. So anybody that does the wrong thing can lie and say that is their reality. That is wrong. Can’t understand why you think like that. There is something wrong in their head. I think you are way too involved with that person, that is why you don’t realise they are nuts. The other day on the phone I reckon they should have gone to hospital that day. That is not the language of someone who is sharp in the head. What they are going to have to learn is to talk to people differently.”

Peer: “I think what they have is just anger. Just angry to everybody.”

NP: “I used to talk like that”

Peer: “So you understand how they feel?”

NP: “I understand how they feel, but that is not going to resolve anything. Are they Sagittarian? When they talk like that normal people will think they are crazy”

Peer: (Thinking in my head) – ‘Sagittarian, yes that is the answer!’

Peer: “I think that the medication is no longer working because the anger has built up so much.

NP: “Anger is building up, building up till you can’t control it. Looks like the only one they are not pissed off with is you”

NP: “Bet the relative is fed up with that now”

Peer: “They are exhausted”

NP: “I bet. When you start to decide for someone else you start thinking, did I do the right thing or not? I bet it was not easy for the people in the hospital the other day. Their language is a bit rough. Any kids”

Peer: “No”

NP: “Lucky them. I know some people have a bloody rough life, but in the end, you choose what you want to be”

Peer: (Thinking in head) All of this from a person who when driving will bring the car to a screaming halt to drag a dead carcass of a wallaby off the middle of the road.
Compassionate, but yet not quite understanding. I have not yet taught them enough.

NP: “Read to me what you have written. You will probably write it down in your own reality. Because I see things different to you, I am wrong.”

Peer: “No. There are multiple realities. You don’t get it. They are seeing things from their reality, their perspective”

NP: “Perspective is not a reality, it’s not what did happen. You are a funny person, it’s probably why I married you”

Appendix F

Letter three – Holding the Hope

Sunday 20th May, 2018

This morning I had a revelation. I realised that as peers we truly do carry the hope for those that are unable to carry their hope at this point in time.

This has come about from confusion in the last week or so. I have had a current client that has challenged me. I have tried to resolve these challenges through conversations with a work colleague (counsellor) and while this was useful or beneficial it did not fully resolved what I was feeling.

My confusion stems from the fact that I felt I was enabling this client and not actually supporting them in their journey of recovery.

I had previously written in a personal letter to a friend that I felt service providers were just giving out Band-Aids and when I mentioned what I had written in this letter to the work colleague they said that in fact we were the ones that were actually applying the Band-Aids to wounds for the client.

I have been questioning why I'm actually even doing this research. I need to make sure that I made a significant contribution to what is already there. What is it that I can put forward to bring light to what a peer support worker does in their business, and why they are so effective?

I have been doubting myself, I feel like I was fooling myself. Maybe what I do is absolutely no different to what anyone else does. So what do I see as being different? What do I feel I do differently to other support workers?

I started thinking about a previous experience when quite a while ago, another work colleague and I were both supporting the same client. We had both turned up on the day to support this client (hoarding issue). We hadn't been there long and we both realised how futile attempts were in assisting this client, we did not have the knowledge to support her. During the course of the conversations that we had, this colleague mentioned something I felt was very important. They mentioned that they always put in 110% to their clients. I agreed with them as I felt the same way with my clients. I wondered if this was different to other support workers. What do other support workers do? Do they just do their job and go home? Or do they actually put in 110% so that the job gets done? This colleague is a peer however they do not identify as a peer within their job description. I then realised that this is something that we both have in common, not only are we peers but we both give 110%. I started to wonder if this is a trait of peers.

I know that with my journey with this current client that I have been working with for over 18 months, I feel that I have well and truly given 110%. For the whole time however I have felt that my efforts have not been of any worth. I have felt that the words I have spoken have not been heard. This client has been a real challenge for me. How is it that I can get this client over the line? How can I get this client to start to realise their true value and self-worth? How can I assist this client in starting to believe in themselves? I believe this client is over serviced. And yet if all of these services were taken away I feel it would make no difference to the situation. This is the situation I was talking to the work colleague (Counsellor) about – we are applying the bandaids.

We spoke for 2 hours. I had previously sent an email to her outlining my thoughts and feelings regarding this client. I explained the frustrations that I was feeling. I asked this colleague for some words of wisdom.

Email to Counsellor/Work Colleague

I was wondering if you would have the time to give me some advice on how to best support a client that I feel is not helping themselves. I am feeling that I am, to a degree, enabling this behaviour. I sort of feel stuck!

I want to support and assist, but it has become very clear to me that this client wants everyone else to hand information to them, to do things for them, and I am feeling that I am caught in their web. This person after a lifetime of knowing their diagnosis, turned to me and said 'they (the psychiatrist/doctors) gave me the diagnosis and did not give me any information about it'

This client has now been handed information about their diagnosis and says that it describes them to a Tee. This is great, but this person has not taken responsibility for getting their own information, just expects it to be given to them. After a lifetime of knowing a diagnosis, surely at some stage they would have been curious? That just baffles me. That is the bit I am really struggling with. When they said 'no one gave me any information' I felt strange, but thought perhaps that they actually don't want to recover, they are in victim mode, liking it, and will not do anything to help themselves. This is the hard part for me.

Now they have another person on board, another 'counsellor' that comes to their home! They would not attend other counselling unless I made the appointment, picked them up, took them in, etc. How do I back away from this client, or in fact do I back away? I want this client to recover but I feel that no matter what I say, or do, it is falling on deaf ears.

They say no one cares, but has so many people around doing things for them!

Same with the info from my support group, wants the information but doesn't want to come.

So I have previously had a long hard talk to this client just recently, and I thought they were really going to put in an effort, but that is not happening. It’s like it is all too hard and now they are expecting this new 'counsellor' to 'fix them'.

I hold hope for this persons recovery, but I don't feel hopeful....???

When they told me about the new counsellor that comes to their house, I immediately felt shame, they wouldn't have done this or needed to seek *other support if I had been doing my job properly, felt like I had let them down. I should have been the one to give them information, I should be more supportive, I have failed them, I am not doing my job properly, I am stretched too thin, too many clients, not enough time.*

However I think I need to reassess the situation and see it for what it is. But am I seeing it correctly?

Part of me feels shame. Part of me feels anger. Part of me doesn't actually care. Part of me wants this person to fail. Part of me wants the best for them and hopes that I have been part of that journey.

Part of me hopes that the person will recognise and acknowledge my support. Part of me realises that this is not ever going to happen. Part of me wants to drop this client like a hot potato, whilst another part wants to shake them and tell them to wake up to themselves.

I care, I don't want to care. My gut hurts. I feel betrayed. I feel used. How do I face this client? Truth is they will never know any if this as I will put on my 'happy face' and continue to dance to their beat. Or will I? I don't want to, but I don't want to hurt them by walking away. Ok, think you would have to have some idea of what is going on.

As we discussed the situation a few things came to light. One was that I had not got any clear goals for this client. We knew roughly what the client wanted to achieve, however we had not written it down and I wondered if this would actually make the difference. The colleague explain to me that their approach, although it was unique with clients was underpinned by a clinical framework.

They explained to me that if there are no clear set goals this can cause confusion for the worker and the client as there is no real direction for either of them. This is an area where I have always struggled. I have found it difficult to sit down with clients and compile a list of Future goals as required by my employer. I wondered if this is actually something that other peers do?

I feel that my role or the understanding of my role has been changing. I feel that when I started this position I was acting as a peer that was putting in place other supports. When I realised that this was not working with this particular client, I feel that I have wanted to hide behind the support coordination side of my job description. Hiding behind this to me means that I am able to withdraw from the client, and simply say that my work is done. This would be very easy to do. I could simply withdraw from this client I could then simply end the working relationship.

This is how the colleague indicated to me that I could indeed deal with this situation. They indicated that if goals were not being met and there was resistance to this, I could ask the client why and perhaps when the client chooses to re-engage with achieving goals then could re-engage with the service. So basically, I would exit the client until they chose to re-engage.

However, this does not sit well with me. I feel that that is giving up on the client. I have a tenacity to me that was once described as ‘a bulldog that won't let go’. I continue to feel or hope that with this client there will eventually be progress.

In other conversations with my external supervisor we spoke about goal setting and my job description. My supervisor informed me that goal setting is what most support workers do to keep moving forward with their clients as most job descriptions are very outcome based. My supervisor also confirmed that peer work or peer support is not outcome based and therefore it is hard to set goals, so for this part I feel relieved!

In my two-hour conversation with the work colleague (counsellor) they said to me that they had trouble with the word Peer. They indicated to me that I was their peer as we were both professionals however, they believed that my clients are not my peers. This colleague talked about how I have recovered and my clients have not recovered so therefore we are not peers, as peers means equals.

I could totally understand what they were saying. On my last visit with this current client I told them that they need to surround themselves with people that also have the same disorder. They need peers with the same diagnosis, the same symptoms. I felt that there was a distance or disconnect almost between the client and myself at this stage. I realised that I didn't know enough about this disorder, however the symptoms are very similar to a lot of other mental illness.

When discussing this with my external supervisor, about the peer and being equal – he simply said that we are equal in our journey of mental health challenges, equal in having life interruptions with mental health experiences, equal in having a lived experience.

As I read the paperwork that the current client presented to me on this disorder there was a section about how a person could quite easily be seen as manipulative. I wondered about this. It had been mentioned to me by another person that they felt I was enabling the client with my actions and that the client was actually manipulating me. This other person said that the client was very good at manipulating people because they had been doing it their whole life. I tended to agree with what this other person said however for some reason it didn't quite sit right with me. I could certainly see what the other person was saying and I felt most of it to be true however there was an element that left doubt in my mind.

It is this doubt I have felt to be my driving force. It is this doubt that I have held onto. I knew that if I don't have the answers that does not mean that I can give up on them. This is why I have not exited this client. Is this resilience or tenacity? I believe that this doubt I felt was actually hope. I have been holding the hope for this client until they were able to hold their own hope. This client is now starting to move forward, don’t know why, don’t care, just thankful that they are now holding onto their own hope now. Perhaps that is the goal, that is the outcome, for the client to hold their own hope!

Appendix G

Letter four – Trauma Informed Care

September, 2018

Letter to Peers – Trauma informed care

Good morning Peers,

Today we have a wonderful topic of Trauma Informed Care. I started thinking about this topic and I looked through my workplace resources and saw a document 'Practice Guidelines for the treatment of complex trauma and trauma informed care and service delivery'. Thought to myself – 'this should be a good read'. As I began to flick through the pages, and no I haven't read it all yet, I noticed something very strange – I realised that the bits that I had read, the bits that I glanced at, were (to me) simple common sense, things that were already 'what I know', and I had a good chuckle to myself, that here was a manual, this thick, on stuff that we as a community already know and take for granted, and yet they had to write a set of guidelines for practitioners in order to deal with us effectively…to me somewhat of an oxymoron.

One good quote from Professor Warwick Middleton "One of the last frontiers of our society is the lack of realisation about the extent of trauma"

In the guidelines, I came across a section talking about Trauma Specific service delivery and there was a quote "Trauma-informed services are designed specifically to avoid re-traumatising those who come seeking assistance…" It sounds like, even though a service may be 'Trauma specific', it is not necessarily 'Trauma Informed' – I thought that was strange…

Perhaps because of the road I have travelled with my recovery, perhaps because of my thirst for knowledge and understanding of my own illness (I do liken myself to a sponge when it comes to seeking out knowledge), perhaps because I realise that no-one can 'fix me', I must do it myself, that I chuckled at these guidelines. But perhaps that is unfair, and disrespectful to the people who wrote the guidelines. They thought it needed to be done, and they were right. I have seen some attitudes out there, that I can only simply put down as what appears to be lack of knowledge, however I guess not everybody has the same quest for understanding.

This all bought me to thinking about Trauma Informed Care and how it impacts on us as Peers. If I already have this knowledge, then do the people around us? Does my husband? Does he really understand how my illness impacts on me? Is he already a 'Trauma Informed Practitioner'? For those of you who know Joe, he is indeed an 'eagle eyed' trauma informed practitioner!

When I first started working three years ago, I have a confession to make. When I wandered into this field, I was of the opinion, one that I am now actually embarrassed about, but it was pure lack of understanding on my part, that carers were not 'Peers'. How on earth could they even consider themselves a peer, it was me that had the mental illness, not them, how on earth do they think they can even be considered on the same 'level' as us…let alone a 'Peer'. Sure they care for people with mental illness, but they are not the ones with the mental illness – does this sound familiar to any of you? Is this a thought that you have had?

Over the last three years, I am truly thankful that my attitude has changed. You see, I have sat with our carers, I have listened to their stories, I have listened to the traumatic experiences that they themselves have encountered all at the hand of our mental illness.

Our traumas were been created by people, simple as that. These traumas then in turn created our mental illness, simple as that. So if our trauma has been created by people, then does a loved one watching our mental illness, standing by almost in a helpless state create a trauma for our carer? Are we as the person with the mental illness creating a traumatic event for our carer when we become unwell? Do our carers have their own mental illness? Has this been created by our mental illness and the impact that it has had on them? Just a thought.

I am not sure of your situation, and yet mine is different again, but the stories that I have heard, the anguish, the depression, the anxiety that WE have created for our carers is unbelievable. We have been traumatised, and in turn we create trauma for the ones that love and care for us, and yet we think they are not ‘peers’. I am indeed ashamed that I even had this thought. But like I said, it was pure lack of knowledge, lack of understanding on my part, and is that not what Trauma Informed Care is all about – understanding?

A quote from the guidelines

“A powerful factor in maintaining a generally calm ward environment is an emphasis on active listening. In so many scenarios involving both long and short term issues, the experience of just being listened to and heard is fundamental and far more constructive and therapeutic than medicating someone just because they are temporarily upset.”

Does anyone relate to this? Does this have meaning for you? So, do you also take time out to actively listen to your carer? If they do that for you, do you do it for them? Or because you own your mental illness, do you not have to ‘care’ for your carer, do you not have to worry because after all, you are the one with the mental illness, not them?

I see the effects of our mental illness on our carers, and in the glossary at the end of the book, is something that I thought worth bringing to your attention.

Compassion fatigue – Formerly known as secondary traumatic stress disorder; refers to the negative through predictable and treatable psychological consequences of working with, and proximity to, suffering people.”

Appendix H

Letter five - Trees

Journal entry

30th November, 2018

The South Burnett had huge storms, all of our fruit trees at home were stripped of fruit, Kumbia orchards lost all their stonefruit and avocados. Coolabunia was hit with a mini cyclone, some of the trees were uprooted and others just simply stripped bare.

I was driving to see a client in Nanango and I drove through this area in Coolabunia and thought wow- this is like mental illness/health survivors, all stripped bare after the storm, still living, almost as if they have no choice.

The trees gave me a feeling that I struggle to describe, exposed and vulnerable, yet strong and powerful, a feeling of sadness but yet somehow majestic, proud, and determined to survive. An inner strength that needs to be drawn upon even though there is no strength left, but somehow ascends to fight another day.

I went to the growth group later that morning, and I shared my feelings about the trees

The people in that room are like those trees, all stripped bare, but yet they commit weekly to that group. They are all struggling, yet proud enough to cry out for help, and take the help when given. Our life is like those trees, some will fall along the way. Never the strongest, only the weakest will fall, and the bravest of brave, the strongest of the strong continue to survive and face another day. And in the future, as what happens after any storm of that magnitude, the clouds will lift, the blue sky will be seen again, the grass will grow all around, trees will sprout new leaves covering the vulnerabilities that were exposed, and life will begin again. So it is with the cycle of any mental un-wellness.

I drove past those trees several weeks later and noticed exactly that – one tree, huge, lonely tree, who had nothing left after the storm, has started to sprout new leaves right at the very tippy top, just enough to say 'hey, I am still here, I am still alive'. Just a small amount of new growth' to show that this tree has more life and for us not to give up on it.

Now as I drive past, you would never know there was a storm, just fits in with the scenery, but what has happened to the inside? We know that when trees are cut down, trauma that has been faced is able to be traced through the 'rings' that appear on the inside. So this tree will never be the same again, even though it looks the same on the inside, it has been changed forever, just like mental health trauma survivors

'Vulnerability'

The forest of mental health'

Most people would drive past those trees and say – oh my – and keep on driving, others may not even notice the carnage, but those trees to me were so symbolic. It is easy to capture that image and pass it on to others, because it is a common sight. As adults with sight, we realise what a tree looks like and can imagine it with no leaves, like a deciduous tree in winter. As adults the majority of us have seen this shedding of the leaves and understand or are able to comprehend visually what this is like, so it is easy to use these trees as a metaphor for the inner strength that arises during and after a major storm has ripped through an area.

‘

I have used the storm as a metaphor of life, the turbulence of life events that rip right through us, leaving us battered and bruised, vulnerable and exposed, and in some cases, not wanting to go on, not wanting to live another day. And after yet another one of these storms of life has passed, we feel our vulnerabilities are there yet again on show for all to see.

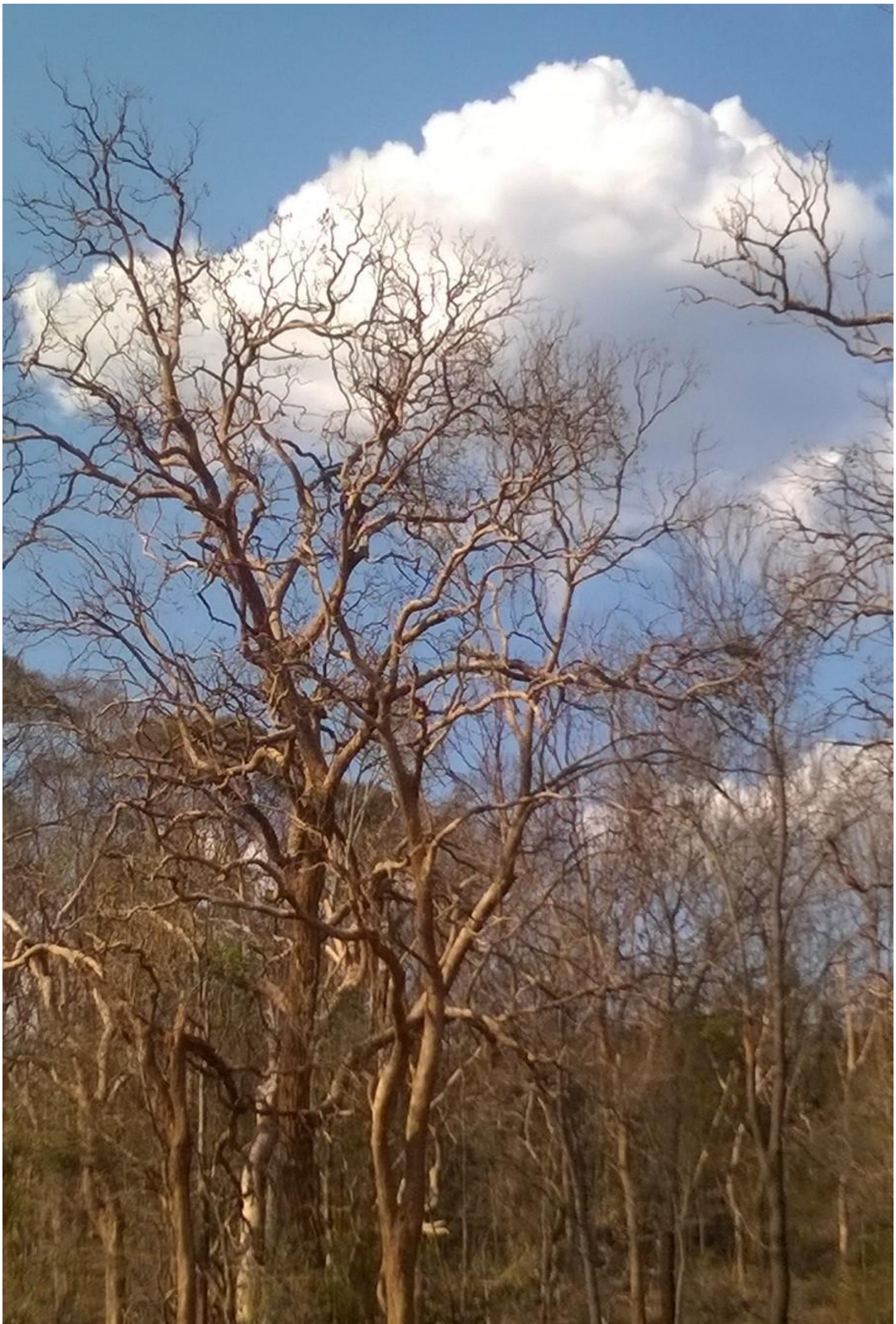
There are two worlds here, the first is the world of the trees, second is those travelling on the highway looking out at the trees. Vision from the safety of a vehicle passing by, making comment on the trees as they travel on the smooth black highway, continuing with their journey of life. Some like myself will know what it is like to be one of those trees and have a full appreciation for what has been encountered. Others will have no idea at all, and just zoom by, not taking too much notice, except to comment that it must have been a bad storm.

The people in the group were appreciative of my sentiments, I told them how I was proud of them, and they had a right to be proud of themselves, after all, look at what they had been through to get to this day. One person commented that it bought them to tears, I had moved her with my words. All I can hope for is that the images that I have helped create in their mind might just give them some inner strength at a time in need. Hopefully they will remember those trees and liken their inner strength to the strength requirRed by those trees to survive the storm.

Resilience

Weak yet strong

And yet we go on……



Appendix I

Letter six – Spikey Balls

Journal 31st December 2018

I have had many, many pictures floating through my head this year. Some of which I am about to describe. These pictures enter my head as I encounter a situation, one that I have no words for. I then get a picture, and it is from this picture that I am able to put my thoughts and feelings into words.

Most of my inspiration has come from one particular client, one that has really challenged me. For that I am thankful.

SPIKEY BALLS

I was on my way to a workshop for Peers, one that was talking about setting up a central agency/board type of thing, can't remember the name of what they were going to call it, but so it was a 'go to' for anything peer related. I was on my way there and I was thinking about my research and what makes peers so unique, what is it that makes us different, and I had a picture come into my head.

I have a spikey massage ball, it is hollow, squeezable, with numerous spikes all over it. One side has orange spikes and the other half bright green spikes. You can see through to the middle and when it is shaken there is a blue and red flashing light that goes off inside of it. I picked this up at the Brook Red Peer Conference earlier on in the year.

So I was thinking about Peer Work and a picture of this ball came into my head. That is it! Peer workers are like this! Yes! Each one of the spikes is a scar, our past hurts, wounds, and traumas that have now healed. And it is our past scars that connect with the hand that holds it. The spikes massage and soften the hand, they massage the soreness of the person, bringing relief. The more 'spikes' the more connection to the person that holds it, the more relief is bought. The depth of the spikes going into the person depends on how hard the person squeezes, it is in their control, not the balls control, they control how 'deep' or how 'hard' the spikes are pushed to bring relief. And over time the spikes can go deeper as the areas become less 'sore'.

Ok, that is great, I felt wonderful at having discovered this, but what about clinical services, if we are massage balls, what are they?

Well the picture that came to me is one of a shiny little box with silver wrapping and a lovely bow tying it all together. It was coming to the end of the year, Christmas was looming, I imagined a decoration on a Christmas tree, the little shiny presents, wrapped up in silver, with a lovely little bow, all made to make the tree look ‘pretty’. That is how I saw clinical services. They are the ones that are made to look all shiny, exciting, secretive and mysterious. You don’t know what is inside the box, it is all kept hidden, but made to look so appealing from the outside, but who knows what is on the inside, what is it that the client is going to receive? Only the clinicians themselves know this. But it is one size fits all, one box for everyone. It is like the Santa presents at a large function, you know the one, where all the kids get the same toy, maybe a different colour, but essentially just a bulk purchase of the same item.

That is where we differ. We are both aiming for the same end result, recovery or improved lifestyle for the person, but our tools are our scars and are there for the world to see, they are not hidden, they are not wrapped up to make it look all wonderful and keep you guessing. Not at all secretive. We are just spikey pressure balls that respond to touch and pressure, the more healing you want, the harder you press, and so in turn drives more connection between the spikes and the skin.

At the workshop, Michael Burbank spoke about a quote that he had heard ‘I need to connect with something in me to be able to connect with something in you’. I love this quote. I have often noticed how with the numerous clients that I have, no matter their age or gender, I am able to connect with them on some level. I have often wondered about this.

Why is it that I can connect on numerous levels to all of my clients? I realised that I have encountered so many different traumas, so many experiences that I can connect to so many people. Is it age that has done this, the older we get, the more experiences we encounter, the more connection we can make? Do we need to have experienced lots of traumas or life experiences in order to make us good peer workers? The more the better?

So we need to be able to connect to our pain in order to connect with another person's pain. What if it is not healed? Is this where triggers come into play? Peer workers are triggered if the wound is not a scar, if it is not healed? Sort of like ripping the band aid off a wound? So do good peer workers need to be healed and have scars not wounds?

I see the spikes on the massage ball as my scars, these are my connection points with clients. I do not try to hide them, they are there for anyone to see, or utilise. I have so many 'spikes' that I have gained over the years of life experiences. I have so many connection points that I am able to connect on numerous levels. Being able to identify these 'spikes' and talk freely about them and be able to utilise them in a therapeutic manner enables Peer Workers to be effective.

SUIT OF ARMOUR

I was working with a client, and I saw them, all tired, battle weary, and the picture that came to me was one of a small person was dragging a knight's suit of armour behind them. They weren't wearing their protection, they weren't using it the way it was meant, they were just dragging it behind them, and as the person continued their journey, the armour got bigger, and they got smaller.

The feeling that I had was that even though the person had skills there to protect themselves, they were not using them in the way they were meant. The person was going to heaps of courses and workshops, getting lots of information, but just not using it, but all the time feeling that they needed more armour to protect themselves, more knowledge because they didn't have enough. All they had to do was start using it the way it was meant, and it would then serve as protection for the person. They just had to turn around, open their eyes and see the tools and skills that they had accumulated, but in order for it to be effective, they had to start using it the way it was intended.

Service providers, members of the community are all helping this person, adding bits to the armour, making it thicker, heavier, but no one has helped this person put the armour on. I have been adding to this armour, now I have to somehow get this person to stop and put it on, not just carry it around with them.

FLAT VS 3D

One client that I have worked with for a while, has been slowly revealing to me bit more and more about their lifestyle. I remember saying to someone once, “No one knows everything about me, but if everyone got together, then they would discover who I was”. I never revealed myself in the whole to anyone, I was selective in what I revealed to individual people, and I see this with this client. The longer I engage with this client, the more facets I see of their lifestyle.

A picture of a diamond entered my mind. A diamond that someone once dropped, covered with bits of dirt from people stepping on it, and even hardened baked on mud from where it once sat in a mud puddle when the rain came. It now looks like a dirty stone, but the diamond is underneath, waiting to be discovered. As peers, we are able to pick up the dirty stone, we hold it in between our fingers and gently turn it around, looking at all the possibilities, knowing what can be, and gradually, and gently begin to clean and polish the diamond.

We need time to be able to remove the dirt, and to reveal different facets of the diamond. We then start exploring the light that shines through on different angles. We turn it so that we see this wonderful array of light, and we express our pleasure as we see the beauty radiating from this precious stone. This is what peer workers do.

So how do I see clinical services? They see the diamond as a two dimension flat object on a piece of paper. They do not have the time to see all the facets that there is to a person. People are complex, and it is my experience that only through taking the time to get to know someone, building rapport and trust that people will then allow different facets of their lives to be revealed.

LEARNED HELPLESSNESS

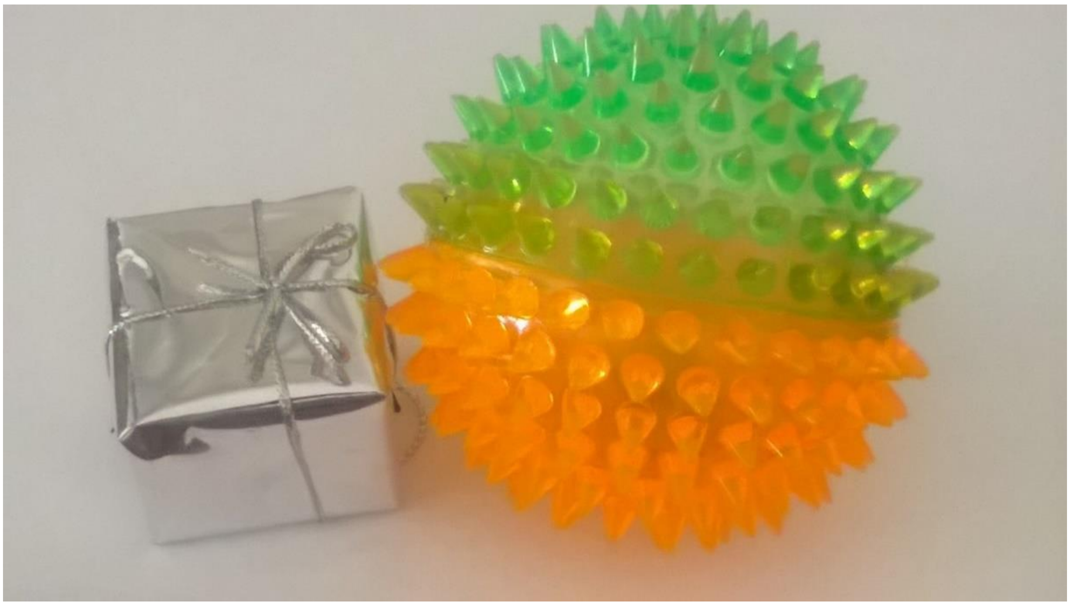
I learnt during a course at uni about learned helplessness where a dog will not leave the cage if it receives an adverse stimulus when trying to leave. The dog eventually learns not to even try.

I tested this theory on my dog. He has a chain that he gets tied to when he is let out of his kennel. He keeps taking off, so unless I am there, he is either in the kennel, or on the long chain. The other day, I got a short chain, one metre long and attached it to the handle of a bucket at one end, and then my dog at the other. My dog stays exactly where the bucket is. He could quite easily take off and drag the bucket behind him, but as he has a chain attached, he doesn't bother. Great for me!

I have a client that exhibits this behaviour. This client has all the information, resources, and services at the fingertips to start on a recovery journey, but there is a barrier – a bucket that holds them back. I am not sure whether it is that they like being unwell, like the attention they receive from being unwell, or whether they lack so much confidence in themselves they don't even try. This client does go through the motions and make it look like that they want to get better, however, there is always a barrier, a bucket that holds them back. How do we, as peer workers, identify these buckets, these barriers unless we spend time getting to know them? A diamond has numerous facets, so how many facets of the diamond must we reveal in order to find the opening to let the light start shining through? How many facets must we clean before this happens? Do we need to uncover the adverse stimulus first in order to deal with the bucket? How do we do this? Or do we get caught up in cleaning the diamond only to have them deliberately jump back in the mud puddle and get dirty again?

Peer work has many frustrations, and clients jumping back into mud puddles when life gets hard is no exception. The client needs to trust us as peer workers. They need to trust that we have been there and do know how to get out of the mud puddle, and how to clean the facets of our life. But more importantly they need to learn to trust themselves. They need to be able to sit still long enough to be cleaned, and to listen to our stories, and that comes through trusting themselves, trusting they can handle what is going to be revealed, good or bad. They need to then trust themselves with their decisions, trust that they can use the tools correctly, trust that once the armour is on, that it will protect them, and from there they will be more prepared on their journey of recovery.

Peer Work versus Clinical Services



Appendix J

Letter seven – Power of Connection

Peer Persepctives. 26th February 2019

POWER OF CONNECTION

Elderly client – sees me as her 'friend' how do I explain to her that I am not her friend, but a 'worker'?

This lady has no one that takes an interest in her, my job is to introduce her to others that are able to spend quality time as 'friends' and doing the things that friends do – socialise. She loves lawn bowls, I just happened to know someone that wants to get a team together so she is now on his team, and loving it. She is valued on this team, and my job for her is to increase that feeling of self-worth, to increase her social life in a natural way. She now also has a friend that I have introduced her to that she can ring when she is wanting to talk to someone, this other person is rather lonely too, so it benefits both of them.

I cannot do my job effectively if I am not on the ground with these people. I need to build networks of the everyday person, in order to be accepted with them, by them, to be trusted, and for me to trust them. I cannot build effective natural networks from my office or hiding behind paperwork. I have seen the power of the people, the power that connection has, and I need to be on the ground to drive it.

When I leave this position, the people will miss me, but have these networks in place so that their life will go on. There are no services or supports here that are going to help some people with their desire to connect. There is 'social support' which will take people out to groups etc, but do they build the networks?

Life is great at the moment, Bipolar high coming – I can feel my whole body is excited about life, waiting for the thump as my ego hits bottom.

It will come, and I am waiting for it.

I heard from a lady client today that she is going on a picnic with a male friend that she has made from one of my groups, next Friday, She is turning a new leaf, said that she has to be accountable, no more drugs, facing things instead of harming or suicidal thoughts….finally!!!!!

I am happy that this is happening, happy these are her thoughts now.

Spent an hour on the phone to a difficult client, trying to make her see that she needs to be the one that makes the decision as to which way her recovery goes, she is the one that needs to make the pathway. We will see how she goes, slowly, slowly.

Elderly client showed me how many times her new male friend has rung, and how many times she has called him, quite a lot of phone calls going on between those two!

List of Research Data