Mutual Support in Mental Health Recovery

Applying the evidence

Grow

A proven program for mental wellbeing

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Grow
A proven program for mental wellbeing

1. About Grow

Grow is the leading provider of mutual support, self-help for people with a mental illness in Australia. The program was originally developed nearly 60 years ago, by consumers who were drawn together by their first-hand experience of mental illness and who believed that by offering each other mutual support they could recover to good mental health and live happy, meaningful lives.

Mutual support groups provide an important gateway to wellbeing and mental health and are an essential part of today's mental health service programs.

Many people with mental illness find themselves isolated and estranged from family, friends and the community as well as being without the resources to engage in the kind of critical thinking that can help them maximise their quality of life. At each Grow meeting, members have an opportunity to share their problems and experiences and provide practical help and support to each other. This generates a sense of community, of citizenship and belonging that is unique to Grow and vital to recovery

Formal mental health services are not designed to provide the kind of social support and connection in the community that is so important to mental health recovery. Without opportunities to engage in critical thinking within a trusted group and to interact socially, it is difficult to sustain a pathway to recovery. Participation in mutual support helps develop self-esteem and a sense of acceptance in a far more intimate way then professional services. Grow's program of mutual support provides a foundation for recovery that is self-paced and self-directed.

As Australia's leading provider of mutual help, Grow has always sought to invest in research and evidence that increases the recognition of the benefits of mutual support, self-help. This literature review gathers the most recent evidence on recovery and mutual help and then summarizes it into a fidelity tool that can be used by any organisation striving to provide evidence based recovery oriented services.

Today there is around 200 Grow mutual support groups operating nationally, offering a genuine peer led experience.

About Lori Rubenstein, Researcher

For more than 30 years, Lori has worked with governments and NGOs in the U.S., Australia and Singapore to conduct social research and evaluation in education, employment, health (including mental health and Aboriginal and Torres Strait Islander Health), housing, early intervention with families and children, juvenile justice, disabilities and family policy and to provide government agencies with policy and strategic advice on these issues.

She continues to facilitate strategic planning with advocacy with service agencies and to evaluate the outcomes and impact of policy and program investments. Lori also have extensive teaching and training experience, including specially-designed strategic planning and evaluation courses for senior bureaucrats and service providers, tertiary courses in research, policy development and evaluation and workshops for practitioners across health, community services, workforce development, innovation, visioning, planning and priority setting.

Current interests include implementation of the Carmody Reforms of child protection, development of user-friendly systems and tools for measurement of outcomes, impact and social value and building momentum for change through Collective Impact.

Lori completed a B.A., with honours, in English and Education, a M.A. in Social Psychology and completed studies for a PhD in Educational Policy.

2. Executive Summary

With a commitment to engage in continuous improvement, Grow commissioned a comprehensive literature review to identify the most robust theories about what contributes to mental health recovery and evidence-based "best" practices in peer support models (e.g., the most effective organizational designs, practice principles, operational values and group practices).

Theories of Recovery

Virtually everyone agrees that mental health recovery is a process rather than a destination. It is more like a continual journey – a striving - to improve wellbeing with notable achievements and serious setbacks along the way. This is an important starting point when thinking about policy and practice. Mental health recovery does not have a definitive beginning and end. It is a way of living that is facilitated and enhanced by certain environments, relationships and modes of interaction. Following are eight models of the mental health recovery process.

HOPE is a person-centred, static model of the fundamental aspects of living with mental illness.

CHIME identifies five processes involved in mental health recovery: connectedness, hope/optimism about the future, identity, meaning in life and empowerment.

The Psychological Recovery Model identifies four psychological processes to recovery (hope, identity, meaning, responsibility/control) over five stages of recovery (moratorium, awareness, preparation, rebuilding and Growth).

Self-Righting Star combines processes and stages into five steps (passive to active, hopelessness to hope, others' control to personal control, alienation to discovery and disconnectedness to connectedness).

Socioecological Model suggests that mutual support acts as a driver of change in seven ways (correcting attachment difficulties, exhibiting altruism, developing socialisation, using imitation and adaptive learning, maintaining group cohesiveness and suffering).

The Ladder of Change presents an explicit model of the steps individuals need to take to successfully make the journey to mental health recovery (stuck, accepting help, believing, learning and self-reliance).

Critical Learning Model is about helping individuals develop new ways of thinking about themselves and their mental difficulties by asking key questions such as What happened to you? What does help look like?

Stress Vulnerability Coping Model focuses on the risk and protective factors that lead to mental illness.

After comparing models and identifying common themes, it appears that there are four basic ingredients in the recovery journey:

- Hope, optimism, a vision of a meaningful life
- Social connectedness, secure relationships, mutuality of support
- Active sense of self and positive identity, critical reflection
- Empowerment, self-efficacy, taking responsibility

Best Practice

"Best" practices in facilitating mental health recovery are extremely hard to identify because the research is still quite patchy. It is probably safer to talk about "promising" practices that appear to accord with the models of mental health recovery and evidence from disparate types of qualitative research. This review found sets of principles and standards, key components and operational guidelines that together seem to capture effective ways of working. Three elements stand out:

- the establishment and maintenance of strong social relationships;
- ensuring that everyone in a mutual support group is allowed the "tell their stories";
- shared leadership, facilitation and taking on various roles that support the continuation of the group.

Additionally, it is important to think about how to create the appropriate environment (safety, norms and values) for these three elements to operate, to use practices that appear to facilitate recovery (mutuality, socialization, modelling, buffering and protective factors) and to support core recovery elements (attachment and critical learning).

3. Introduction

The Roadmap for National Mental Health Reform, 2012-2020 sets out a clear vision for Australia (Council of Australian Governments 2012):

> A society that values and promotes the importance of good mental health and wellbeing, maximises opportunities to prevent and reduce the impact of mental health issues and mental illness and supports people with mental health issues and mental illness, their families and carers to live full and rewarding lives.

It costs a candle nothing to light another candle

An impressive range of research suggests that to achieve this vision, policymakers, service providers and others should adopt a person-centred, recovery-oriented approach. As the Roadmap document states: "This approach allows people flexibility, choice and control over their recovery pathway, and responds to each individual's unique needs, circumstances, life-stage choices and preferences" (Council of Australian Governments 2012). To make this happen requires access to a wide range of services and supports, including mutual self-help, the focus of this report.

Mental health mutual help groups (also known by many other names) have a very long history, starting with an initiative called Recovery that began in 1937 in the U.S., and Grow, which began in the 1950s in Australia and now has an international network of active groups. Mental health support groups blossomed after the de-institutionalisation in the 1970s that left large numbers of individuals with mental difficulties finding "themselves adrift in uncaring communities" (Substance Abuse and Mental Health Services Administration, 2010) or worse, in communities that "demonstrate all manner of discrimination against them" (Loat, 2011). While de-institutionalisation of mental health services has ultimately been positive, in the early stages, the mental health services available were not adequately equipped to help people manage their mental illnesses in the community. This resulted in increasing social disconnectedness. At the same time, in the face of the Growing stigma attached to mental illness, the mental health liberation movement began, resulting in people working together to fight for their civil rights as they shared their lived-experience and engaged in collective problem solving to help each other cope with daily life.

Over the years, there have been many studies of mutual help/peer support groups in metal health, most focused on simply describing how groups operated, while a few attempted to assess outcomes and impact. The studies varied in terms of methodological quality (e.g., very few randomized control studies) and clarity of results. Overall it is safe to say that the results are positive and it is clear that mutual support has a well-deserved central role in mental health recovery. However, gaps in knowledge and understanding remain, making it difficult to know to move forward.

With a commitment to engage in continuous improvement, Grow commissioned a comprehensive literature review to identify the most robust theories about what contributes to mental health recovery and evidence-based "best" practices in peer support models (e.g., the most effective organizational designs, practice principles, operational values and group practices).

A review of Australian and international research literature on mental health recovery and peer support underpins this report. The report begins by defining two key terms: mental health recovery and mutual/peer support. These definitions, then, set the boundaries for the investigation. Results are reported in three sections: Theories of Recovery (Chapter 4), Best Practices (Chapter 5) and Synthesis of Results (Chapter 6).

4. Definitions

Every field of study has its own language and the mental health field is certainly no exception. For this review, there are two terms that are of particular importance: mutual support and mental health recovery. These terms are discussed in this section.

4.1 Mutual or peer support

> *Peer support has a long and honourable history in mental health. Fellow patients and service users have always provided invaluable support to each other, both informally and through self-help and activist groups.*
>
> Jackson, 2010

There exists a dizzying array of terms referring to people with lived experience of mental illness "helping" or facilitating others during their recovery journey: mutual support, peer support, paid peer support workers, consumer-operated therapeutic programs, member-led mutual help, mutual self-help, consumer-operated service programs and the list goes on. There are also a large number of organisations and activities that come under the broad umbrella of "mental health self-help". These range from small groups meeting face-to-face to discuss common concerns, to Internet forums and phone services, consumer-run activities, self-help clearinghouses, specialist groups for people with specific diagnoses and traumatic experiences.

Two research groups put forth similar definitions of mutual help, which provide a starting point. Clinman, Kloos, O'Connell and Davidson (2002) define a mutual help group as people with similar concerns or problems meeting face-to-face regularly to share information and provide psychological support. Pistang, Barker and Humphreys (2010) define the common core of mutual help groups: "people are enabled to take charge of their own lives, and to deal with their problems with the support of others like them, without professional input. It is usually non-stigmatizing and non-pathologising, and the person with the problem stays in control of what happens to them."

In a same vein, Consumer Operated Service Programs (COSPs) are administered and operated by people with mental illness and use a self-help operational approach. They differ from other mutual help groups in that they often include employment, housing and advocacy in their work. However, at the heart of these programs is "a common set of peer structures, beliefs, and practices that are intended to recognize and nourish personal strengths and personhood and support a quality of life for participating peers" (SAMHSA, 2010). There are three common COSP ingredients (Johnsen, M, Teague, G and McConel-Herr, E, 2005):

- **Structure**: COSPs are consumer operated, participant responsive, operate in informal settings and maintain member safety from harm and coercion.
- **Beliefs**: COSPs embrace the principles of choice, hope, empowerment, recovery, diversity, spiritual Growth, and self-help.
- **Practices**: COSPs encourage participants to "tell their stories" of illness and recovery; engage in formal and informal peer support; mentor; learn self-management and problem solving strategies; express themselves creatively; and advocate for themselves and other peers.

One definition is particularly useful in capturing the way in which peer or mutual support works (MacNeil and Mead, 2003; Copeland and Mead, 2004):

> Peer or mutual support are not like clinical support, nor are they just about being friends. Unlike clinical services, peer support helps people to understand each other because they've "been there," shared similar experiences and can model for each other a willingness to learn and Grow. In peer support people come together with the intention of changing unhelpful patterns, getting out of "stuck" places, and building relationships that are respectful, mutually responsible, and potentially mutually transforming. In other words people come to a peer support program because it feels safe and accepting. By sharing experiences and building trust, peers help each other move beyond their perceived limitations, old patterns and ways of thinking about mental health. This allows members of the peer community to try out new behaviors and move beyond the "illness culture" into a culture of health and ability.

More specifically, Mead and MacNeil (2004) sum up what makes peer support unique (see Table 1):

Table 1: Factors Unique to Peer Support

Factors	Description
Not problem oriented	Work on new ways to construct personal and relational narratives.
No assessments & evaluation	People work towards mutual responsibility and communication that allows them to express their needs to each other without threat or coercion.
No medical framework	The focus is on building relationships that support learning and Growth across whole lives and challenging each other's assumptions about what it is they experience.
Full reciprocity	There are no static roles of helper and helpee; people move from one to another with ease
Systemic evolution	Conversation changes the way people "know" and knowing is malleable so that people can create possibilities that did not previously exist.
Relational safety	Emotional safety through validation, compassionate relationships, belonging, not being judged and not having to have all of the answers.

This review draws from literature covering this array of practices, but the focus is on "member-led mutual help groups," of which GROW is a prime example.

4.2 Recovery

Australia's National Framework for Recovery-Oriented Mental Health Services (Department of Health and Ageing, 2013b) says this about recovery: "The concept of recovery was conceived by, and for, people with mental health issues to describe their own experiences and journeys and to affirm personal identity beyond the constraints of diagnosis". Therefore, there is no single description or definition because recovery is different for everyone. It is generally agreed, however, that "recovery" is a social process as shown in Figure 1.

Figure 1: Social Model of Recovery

The following are some examples of how various jurisdictions or organisations have defined recovery:

- According to the Scottish Recovery Network (2013), "Recovery is being able to live a meaningful and satisfying life, as defined by each person, in the presence or absence of symptoms. It is about having control over and input into your own life. Each individual's recovery, like his or her experience of the mental health problems or illness, is a unique and deeply personal process."
- The NSW Consumer Advisory Group (2012) defines it as, "a journey that is a unique and personal experience for each individual. It has often been said to be about: gaining and retaining hope, understanding of ones abilities and limitations, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self. Essentially, the personal view of recovery is about a life journey of living a meaningful and satisfying life."
- According to the Australian National Framework for Recovery-Oriented Mental Health Services (2013), "Personal recovery is…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."
- Self-Help Queensland (East, 2009) describes recovery "as a journey as much as a destination and is different for everyone. It happens when people can live well in the presence or absence of their mental illness and the many losses (e.g., isolation, poverty, unemployment, discrimination) that may occur as a result. Recovery does not always mean that people will return to full health or retrieve all their losses. But it does mean that people can live in spite of them".

A review of mental health recovery practice in the US summarised the common conceptions about recovery (Jacobson, N and Curtis, L (2000) :

- Recovery is generally seen as a process; it is a state of being and becoming, not a cure.
- Pathways to recovery are unique. No two people will use the same benchmarks to measure their progress.
- Recovery is active and requires an individual to take personal responsibility, often in collaboration with friends, family, peers, supporters and professionals.
- Recovery involves choice, autonomous action, a range of opportunities from which to choose and increasing responsibility for the consequences of making choices.
- A key element in recovery is the discovery of meaning or purpose, which is highly personal and unique.

In a similar fashion, the national consensus statement of Mental Health America (National Framework for Recovery-Oriented Mental Health Services, 2013) argues that central to all recovery paradigms are hope, self-determination, self-management, empowerment and advocacy. Also central is a person's right to full inclusion and to a meaningful life of their own choosing, free of stigma and discrimination. More specifically, this perspective conceptualises recovery as:

- a unique and personal journey that is holistic, nonlinear and ongoing, interspersed with both achievements and setbacks.
- led and controlled by individuals who determine their own goals and path by exercising autonomy, independence, empowerment and responsibility.
- a journey rarely taken alone, but rather together with others with lived-experience of mental difficulties providing mutual support, a sense of belonging, meaningful relationships and valued roles.
- strengths-based, building on multiple capacities, resilience, talents, coping abilities and inherent worth of individuals.
- about hope and optimism that individuals can and do overcome the barriers and obstacles that confront them.

One particularly comprehensive review of recovery processes and recovery systems prepared for the US Department of Health and Human Services outlined the major evidence-based principles (Sheedy, 2009). They are summarised in Table 2.

Table 2: Principles of Recovery

Principle	Description
There are many pathways to recovery	Individuals are unique with specific needs, strengths, goals, attitudes, behaviours and expectations for recovery. Therefore, pathways are personal and generally involve a redefinition of identity in the face of crisis or a process of progressive change. Furthermore, pathways are often social, grounded in cultural beliefs or traditions and involve informal community resources. Recovery is a process of change that permits an individual to make choices and improve their quality of life.
Recovery is self-directed and empowering	Recovery is fundamentally a self-directed process, although there may be times when there is a substantial degree of direction by others. The person is recovery is the "agent" of recovery and has the authority to exercise choices and make decisions based on his or her recovery goals that have an impact on the process. The process of recovery leads individuals toward the highest level of autonomy of which they are capable. Through self-empowerment, individuals become optimistic about life goals.
Recognition of the need for change and transformation.	Individuals must accept that a problem exists and be willing to take steps to address it; this often involves seeking help. The process of change can involve physical, emotional, intellectual and spiritual aspects of the person's life.
Recovery is holistic	Recovery is a process through which one gradually achieves greater balance of mind, body and spirit in relation to other aspects of one's life, including family, work and community.
Recovery has cultural dimensions	Each person's recovery process is unique and impacted by cultural beliefs and traditions. A person's cultural experience often shapes the recovery path that is right for her or him.
Recovery exists on a continuum of improved health and wellness.	Recovery is not a linear process. It is based on continual Growth and improved functioning. It may involve relapse and other setbacks, which are a natural part of the continuum but not inevitable outcomes. Wellness is the result of improved care and balance of mind, body and spirit. It is a product of the recovery process.
Recovery emerges from hope and gratitude	Individuals in or seeking recovery often gain hope from those who share their search for or experience of recovery. They see that people can and do overcome the obstacles that confront them and they cultivate gratitude for the opportunities that each day of recovery offers.
Recovery involves a process of healing and self-redefinition.	Recovery is a holistic healing process in which one develops a positive and meaningful sense of identity.
Recovery involves transcending stigma	Recovery is a process by which people confront and strive to overcome stigma.
Recovery is supported by peers and allies.	A common denominator in the recovery process is the involvement of people who contribute hope and suggest strategies and resources for change. Peers and other allies form vital support networks. Providing service to others and experiencing mutual healing help create a community of support among those in recovery.
Recovery involves (re)joining and (re)building a life in the community	Recovery involves building or rebuilding what a person has lost or never had (healthy family, social and personal relationships). It involves creating a life within the limitations imposed by mental difficulties. Those in recovery often achieve improvements in their quality of life, obtain education, employment and housing. They also become increasingly involved in constructive roles in the community through helping others.
Recovery is a reality	It can, will and does happen.

5. Theories of recovery

There are many theories that attempt to operationalize the concept of recovery, which has traditionally been assessed with objective measures such as symptomatology, hospitalization history and functioning. In view of the new understandings of recovery discussed above, it is important to conceptualise the process using the perspective of people who have experienced it. This perspective provides some direction about how to facilitate recovery and assess outcomes in meaningful terms for consumers and others.

This section reviews key theoretical perspectives on the recovery process and the creation of recovery-oriented environments. There are many similarities among the various models, although each one also has unique elements. It should be noted, however, that this area of research is still underdeveloped and, therefore, generally unable to provide a comprehensive account of the way in which multiple factors and processes operate in practice. Consequently, it is not possible to identify the "best" model in terms of its explanatory power and operational efficacy. It should also be kept in mind that while models can help guide ways of working, they can also stifle creativity if adhered to in an uncritical way. Glover (2004) explains why there is no one best model and the reasons for retaining flexibility:

- If a model is held up as the main active change agent, then it denies the effort of the individual's agency in his/her own recovery process.
- A model places the control of what works in the hands of the external provider.
- A model assumes it applies equally to all and therefore fidelity is viewed as evidence of change.
- A model precludes numerous unique and individual ways of which people discover to reclaim their lives beyond illness and disability.
- A model infers that there is only one way in which to recover.

Note: Even though none of the models includes the role of formal psychiatric services and medications, this does not imply that they do not have important roles in mental health recovery. They do.

Recovery isn't waiting for the storm to pass ... It's learning to dance in the rain ...

5.1 HOPE

A very simple model of recovery was developed by Penumbra, an innovative Scottish mental health charity that supports people by following a person-centred model of recovery. HOPE stands for home, opportunity, people and empowerment. As Penumbra states it: "These for us are the fundamental aspects of day to day life that enable people to regain confidence and to move forward to their desired future" (Penumbra). This model presents a somewhat static view of the destination, rather than a picture of the journey as many of other models do; however, it seemed a good place to start.

- ***Home***: This means having somewhere that is safe and comfortable, somewhere where you can venture forward from but still feel firmly rooted. It is more than just shelter or a roof over your head.
- ***Opportunity***: This represents having something meaningful to do. Whether this is education, leisure, recreation, volunteering or working, we know that meaningful activity is important to people's sense of wellbeing and belonging.
- ***People***: Having people in your life as friends, confidantes and supporters is important for all of us. For many people who experience mental health problems it is important to build or rebuild social and personal networks.
- ***Empowerment***: This means always being involved in any decisions that affect your life.

Hope

Home

A safe and secure place to live

Opportunity

To pursue meaningful leisure, recreation, education and work possibilities

People

As friends, confidantes and supporters

Empowerment

Fully involved in decisions affecting own life

5.2 CHIME

A recent review of recovery practices in mental health in the United Kingdom identified five processes as central to recovery (Leamy, M, Bird, V, LeBoutillier, Williams, J and Slade; Tew, Ramon, Slade, Bird, Melton and LeBoutillier, 2012; Mancini, 2007; Nelson, G, Lord, J and Ochocka, J (2001). Table 3 on the following page summarises these processes and their characteristics, drawing on additional research that complements the REFOCUS U.K. study.

All five processes have social aspects, but *connectedness*, *identity* and *empowerment* are distinctly social concepts that have particular relevance to mutual support. Recovery, as distinct from "remission of symptoms" is about individuals being able to build meaningful lives that involve valued social roles and a positive self-identity (The Social Care Institute for Excellence, 2007). As Tew and colleagues put it (Tew, *et. al*, 2012): "Recovery may involve a journey both of personal change and of social (re)engagement – which highlights the importance of creating accepting and enabling social environments within which recovery may be supported". This emerging recovery paradigm recognizes the importance of the social within multidisciplinary mental health practice (Ramon, 2009) and that has great relevance for mutual support approaches.

Table 3: Recovery Processes - CHIME

Processes	Characteristics
Connectedness	Peer support and support groups Interpersonal relationships Support from others Being part of the community, social inclusion
Hope and optimism about the future	Belief in possibility of recovery Motivation to change Hope inspiring relationships Positive thinking and valuing success Having dreams and aspirations
Identity	Social identity Dimensions of identity Rebuilding/redefining positive sense of identity Over-coming stigma
Meaning in life	Meaning of mental illness experiences Spirituality Quality of life Meaningful life and social roles Rebuilding life
Empowerment	Personal responsibility Control over life, self-efficacy Power together with others Focusing on strengths Peer organized services

5.3 The Psychological Recovery Model

By studying personal accounts of recovery by people with serious mental illness, Andresen, Oades and Caputi (2003, 2006 and 2011) developed the Psychological Recovery Model. It shares common elements with CHIME – particularly personal responsibility and control – but does not specifically identify "connectedness" as one of the processes involved with personal recovery. The researchers describe this model as falling between the rehabilitative model (illness is incurable, but manageable) and the empowerment model (mental illness is a response to overwhelming stressors and can be overcome through understanding, optimism and empowerment).

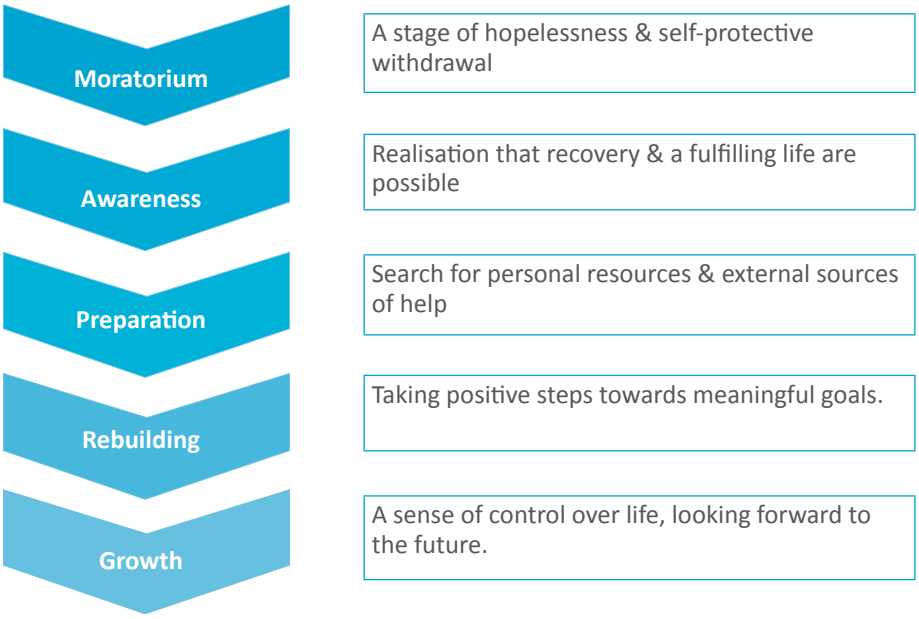
The Psychological Recovery Model captures both the internal processes (what CHIME calls components) and the stages or progression to recovery (Andersen, Oades and Caputi, 2003, 2006, 2011). Figure 2 lays out the four processes, which could be thought of as the goals or outcomes of recovery.

Figure 2: Four Psychological Processes in Recovery

Finding and Maintaining Hope	Finding and Maintaining Hope	Building a meaningful life	Taking responsibility and control
Believing in oneself; having a sense of personal agency; optimistic about the future.	Incorporates mental health issues or mental illness, but retains a positive sense of self.	Making sense of illness or emotional distress; finding a meaning in life beyond illness; engaged in life.	Feeling in control of illness, distress and life.

Once the end-points of recovery were established, the researchers identified how people described the way they moved from illness to recovery. Out of these self-reports, the five stages emerged. Understanding this progression from illness to recovery is an important contribution because it provides a platform for thinking about ways to facilitate individuals' journeys.

Figure 3: Five Stages of Psychological Recovery



5.4 The Self-Righting Star Framework

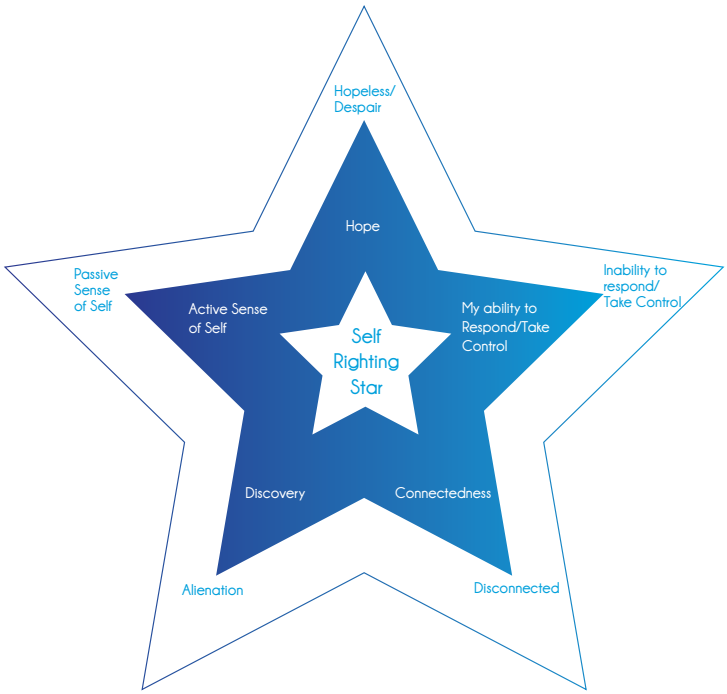


Figure 4: The Self-Righting Star

In a similar fashion to the previous two models, Glover's (2004, 2012) Self-Righting Star (Figure 4) emphasizes personal responsibility and control. It also introduces a new phrase - self-righting – to capture the essence of recovery and combines processes and stages into five steps. Glover describes the Self-Righting Framework as "a simple five point structure that attempts to articulate the efforts that individuals undertake in their processes of self-righting/recovery."

The points of the star – hope, active sense of self, discovery, connectedness and personal control – are the destinations of self-righting, if you will. Figure 5 below describes how individuals journey toward these destinations.

Figure 5: Five Processes of Recovery

From passive → active sense of self

Moving from the passive position of being a recipient of services to reclaiming one's strengths, attributes and abilities to restore recovery.

From hopelessness and despair → hope

Moving from a pessimistic view of life and feelings of desolation to one of optimism and hope

From others' control → personal control and responsibility

This model melds the efforts of individuals toward recovery with the efforts of others. Only the individual can "undertake recovery;" however, others can create environments within which the self-righting process can occur.

Glover uses the graphic below (Figure 6) to emphasise the importance of the internal journey.

Figure 6: External/Internal Recovery

External (clinical) Recovery

Absence of symptoms, return to pre-morbid functioning, outcome-focused, attainment of goals.

Everything to do with the experience of symptoms and/or distress

Internal (personal) Recovery

A process of renegotiating and reclaiming a sense of self-expertise, self-management and self-mastery within the context of life roles, relationships and opportunities.

Nothing to do with the experience of distress or symptoms.

5.5 Socioecological Model

As indicated above, most view recovery as a personal journey, but it is usually accomplished within a context of social relationships. It appears that having someone you can count on "to be there" is a key ingredient in the recovery process (Brown and Kandirikirra, 2007; Brown, Shepherd, Merkle, Wituk, and Meissen (2008).

The importance of social relationships to mental health and wellbeing goes back to the work of psychoanalyst John Bowlby and others on attachment theory starting in the 1950s (Bowlby, 1969, 1973, 1979 and 1980; Ainsworth, Blehar, Waters and Wall, 1978). Initially, Bowlby was interested in linkages between social relationships and psychopathology. Loat (2011) summarises the early conclusions of this work: "…the way we view ourselves … is dependent upon and in some way constituted by relationships with others." This starts, of course, with the attachments babies develop with their primary caregivers and continues across the lifespan as people move in and out of relationships. It is now widely accepted that our earliest social relationships and the kinds of attachments we make influence our social, emotional and psychological wellbeing and the way we view ourselves; however, there is also a Growing understanding that early dispositions are not immutable. Rather, our internal working model (IWM) or sense of ourselves is continuously modified as we experience different types of attachment relationships (Carlson, Sroufe and Egeland, 2004; Loat, 2011, Horowitz, 1979).

More specifically, there appear to be strong linkages between mental health/illness and social functioning. The two factors are interactive, mental illness leading to social exclusion and social isolation causing mental and physical health difficulties. An interesting study conducted by Mind (3004), a UK mental health charity, found that the vast majority of people experiencing mental health problems (84%) reported feeling isolated as opposed to 29% of the general public.

It is safe to say that most people want and need positive social interactions. From the perspective of this model, mutual support groups of people with lived experience of mental difficulties can serve as temporary personal communities or social microcosms that supplement or compensate for lack of natural support networks. The socially supportive interactions and sharing of experiential knowledge helps build empathy and results in increased self-esteem, feeling understood and a sense of empowerment (Pistang, Barker and Humphreys, 2010; and Helgeson, VS and Gottlieb, BH, 2000; Boydell, KM, Gladstone, BM, Crawford, ED, 2002). The mutuality appears to reduce feelings of alienation and loneliness.

Building on our understanding of the relationship between social attachments and mental health, this model suggests that mutual support acts as a driver of change as shown in Table 3 (Yalom, 1995; White and Madara, 2002, Loat 2011; Young and Williams, 1998, Finn, 2002):

Table 3: Drivers of Change

Driver	Description
Correct attachment difficulties	A cohesive group can provide help in challenging unhelpful attachment patterns and learning new ones.
Altruism	All group members receive and give help, which fosters self-esteem and contributes to feeling valued and needed.
Develop socializing techniques	The group provides opportunities to learn and practice new social skills.
Imitation	Groups allow individual to observe others and model behaviours that are more adaptive and useful.
Adaptive learning	Helps people transfer newly developed social skills to the “outside” world.
Group cohesiveness	The experience of group membership can increase a sense of belonging and acceptance and reduce social isolation and alienation and this might be the most potent driver of all.
Buffering	Social support is health and mental health protective as it acts as a buffer to stress.

Complementing the interactions and processes described above, Finn, Bishop and Sparrow (2009) describe how the social ecological model works in mutual support groups like GROW:

> Mutual help for mental health groups such as GROW can be described as offering an alternative setting and value system fostering transformation and reinvention of personal identity. This transformation can be viewed as coming about via a dynamic, interrelated and reciprocal synthesis of processes, including action and acquisition of life skills through learning by doing, together with a positive change in self-perception, where sense of self is derived from sense of community, of belonging therein and of feeling useful and valuable.

5.6 The Ladder of Change

The Ladder of Change (Figure 7) is grounded in the belief that individuals with mental difficulties are active agents in their own lives, not simply passive sufferers who need to be cured by specialist professionals. It is an explicit model of the steps that individuals take on their journey towards independence. (Triangle Consulting) Therefore, programs or services need to engage the motivation, understanding, beliefs and skills of the individuals to create change (MacKeith, 2011; Andersen, Oades and Caputi, 2003; and Prochaska and DiClemente, CC, 1982).

Figure 7: Ladder of Change

Self-Reliance	
10	No issues with self-reliance, behave in ways that work for everyone, do not need outside help.
9	Ways of doing things well established and can be maintained; in times of crisis, may need help.
Learning	
8	With support, can overcome setbacks and learn about what helps to stay on course; however, still quite difficult.
7	Gaining a sense of what helps to make progress, increased motivation and self-belief. Still need support
Believing	
6	Trying new ways of doing things, need a lot of support to manage the successes and failures.
5	Believe things could be different and have a sense of what is desirable. Understand necessity to make things happen.
Accepting help	
4	Engage more consistently, implementing agreed actions. Rely on others to drive change.
3	Want things to be different. Hesitant, but will accept help. Willingness and ability to engage still wavers.
Stuck	
2	Fed up with the way things are but still unwilling to engage in meaningful ways.
1	Cut off and not aware of problems or unwilling to talk about them.

5.7 Critical Learning Model

Mental health services and supports often focus on figuring out "what's wrong" and "fixing" it. Mead and MacNeil (2006) describe how this can skew the thinking of people experiencing mental difficulties:

> In other words, even if I have hope of moving into a better life, I have been taught to pay a lot of attention to my symptoms. This interpretation of my experiences leaves me constantly on guard for what might happen to me should I start to get "sick." Even with recovery skills (learning to monitor my own symptoms), I find myself as more fragile than most, and different than "normal" people. I then continue to live in community as an outsider, no matter what goals I have achieved.

Consciousness raising or critical learning, which are at the heart of this model, do not begin with or assume a medical definition or diagnosis. Rather, they start by asking questions that help people explore new ways of thinking about their experiences, such as:

- What is it we need to offer to help people begin to see things in a new way?
- What kinds of relationships really build community?
- How can we construct reciprocal help so that it is not attached to any particular role or interpretation of the problem?
- How do we learn to name our experiences? In what ways does naming help? Could naming keep us stuck?
- In what ways do stereotypes both within the mental health system and in the community-at-large stymy progress?

Answers to these questions then open up other potential options for moving forward, such as analyzing the many forms of discrimination practiced in communities that have nothing to do with mental disabilities, but rather are stereotypical reaction to the "unknown." Through a process of critical learning, people with mental difficulties, "learn that their feelings of isolation, inadequacy, and powerlessness were the result of real practices within the mental health system and real discrimination in the community, not by products of their 'illnesses'" (Penney and Bassman; DeJong, 1979; and Chamberlin, 1990).

A program originally designed to work with survivors of rape and sexual assault, built on a critical learning foundation, provides a snapshot of the differences between a traditional approach and a critical learning approach to trauma (National Association of State Mental Health Program Directors; Dech and Penney) See Table 4 below.

Table 4: Traditional vs. Critical Learning Approaches to Trauma

Traditional approach	Critical learning approach
Key question: **What is wrong with you?**	*Key question:* **What happened to you?**
What does help look like?	What does help look like?
Needs defined by professionals	Needs defined by "survivor"
The "helper" decides what "help" looks like	Survivors choose the help they want
Safety is defined as risk management	Safety is defined by each survivor
Relationships based on problem-solving and resource coordination	Relationships based on autonomy and connection
Help is top-down and authoritarian	Help is collaborative and responsive
Crisis must be managed.	Crisis becomes an opportunity for Growth
Common experience between peer staff and clients may be assumed and defined by the setting, i.e., common experience in a clinic is based on "illness" and coping with "illness"	Authentic relationships are emphasized, rather than common experience. Everyone recognizes that people rarely have the same experience or make the same meaning out of similar events.

Knowledge Construction

In other words, people begin to understand change and learning not as an individual process but rather one where they continuously construct knowledge from actions and reactions, conversations and the on-going building of consensus. Rather than thinking about personal symptom reduction they are talking about social change. The new version of "help" offers people the possibility for establishing true mutual empowerment.

MacNeil and Mead, 2003

Empowerment, choice and recovery become the goals and mutual support the vehicle for the critical learning that allows individuals to re-interpret the external medicalisation of their mental difficulties and internalised stigma. Perhaps, the two key features of the critical learning model are: (1) *mutuality*, in that people genuinely learn from each other (as they would in the "outside" world) in relationships of equal power; and (2) use of *language* that focuses on experiences, not symptoms.

It is also the case that "crises" are not interpreted as setbacks, but rather as opportunities for transformation. Mutually supportive relationships provide the connection and space in which "to proactively and dialogically create a plan that serves as a guideline and as a reminder to what kinds of interactions and activities will support a positive outcome for everyone. Out of this shared dynamic a sense of trust is built and the crisis can emerge as an opportunity to create new meaning around the experience…" (MacNeil and Mead, 2003).

The following interaction between a "helper" and a "helpee" demonstrates Critical Learning in action (MacNeil and Mead, 2003).

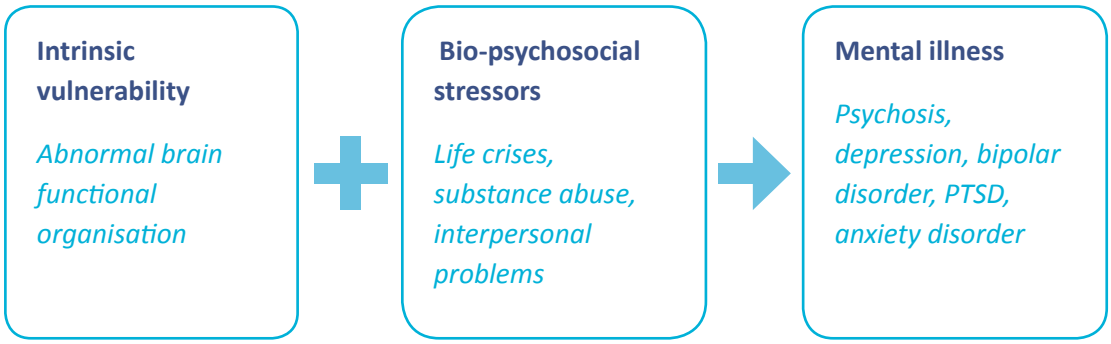
New ways of thinking	
Helpee	My depression is really acting up lately and my doctor says I need to increase my medication but I don't really want to.
Helper	What does it mean for you when you say that your depression is acting up?
Helpee	Well, I'm sleeping more and don't really feel like eating.
Helper	Boy I can remember a time when it seemed like every time I didn't feel too great I would interpret it as depression, I saw it as an illness that I had which meant, at best, that I could only learn to cope with it. I had learned to think about many of my experiences and feelings through the lens of illness and I started getting kind of afraid of my own reactions. I've had to work at thinking differently so now when I have some of those reactions I simply wonder if it's just my body's way of saying I'm exhausted or frustrated.
Helpee	But the last time I felt like this I ended up in the hospital.
Helper	Was that helpful?
Helpee	Well they changed my medications around and gave me shock treatments…at least I wasn't so depressed anymore.
Helper	I wonder if there are other ways you could think about what you might need when you're feeling tired a lot and not wanting to eat…
Helpee	Like what?
Helper	Well sometimes when I'm doing something new or uncomfortable I don't feel very confident. In the past being uncomfortable led to going to bed and not wanting to eat. Then I'd just call the doctor and they'd adjust my medication. Now I try to simply let it be ok to be uncomfortable. Instead of going to bed I go to the gym, or I ask myself how others might react if they were feeling uncomfortable about doing something new.

What stands out from this interaction is that the focus is not on a "medical" definition of the problem – i.e., depression. Rather, the discussion is about the "experience," something that can be shared between the helper and the helpee. It demonstrates how a critical learning approach can open up new avenues for thinking about what is happening.

5.8 Stress Vulnerability Coping Model

All of the previous models were about mental health recovery. This model is a bit different, but has some elements that are useful to understanding the recovery process and what might facilitate it. Originally developed to explain the onset of schizophrenia, this model is now used to understand many serious mental disorders such as bi-polar disorder, depression and psychosis (Zubin and Spring, 1977; Goh, and Agius, 2010). It starts from the premise that people, in general, have genetic and other predispositions to mental illness and proceeds to ask the question: why do some people with intrinsic vulnerabilities develop mental difficulties while other do not? The answer, according to Zubin and Spring (1977), is that the trigger involves a complex set of bio-psychosocial factors. Figure 8 shows the pathway to mental illness.

Figure 8: Pathway to Mental Illness



The usefulness of this model lies in the identification of the risk and protective factors; that is, the factors that either make it more likely that mental illness symptoms will emerge and those that inhibit the emergence of symptoms. Major risk and protective factors are included in Table 5 below.

Table 5: Risk and Protective Factors for Mental Illness

Risk Factors	Protective Factors
Family history of psychosis	No family history of mental illness
Problems with brain development	Normal development
Learning difficulties	Good physical health
Poor social skills	Good social skills
Poor coping skills	Good coping skills
Substance abuse	Medication, if appropriate
Stressful relationships	Strong family relationships
Few social supports	Adequate social support
Major life crises	Talk therapy, if appropriate

It is obvious that people have greater control over some risk and protective factors than others; however, by identifying them, it is possible to take "corrective" action such as strengthening social supports and coping skills as part of the mental health recovery journey.

6. Best Practice

The Evidence

There is now substantial evidence about some of the key social factors that may promote (or inhibit) recovery, in terms of empowerment and negotiating positive social identities, supportive personal relationships and social inclusion. However, less research has so far been conducted in relation to "what works" in terms of specific interventions that may influence these factors and, thereby enable processes of recovery.

Tew, Ramon, Slade, Bird, Melton & LeBoutillier, 2012

Individuals speak

Knowing you are not alone. Seeing that you are able to live with a mental health diagnosis and still go to school, get degrees, have a job, have a relationship and family.

If it were not for peer support, I wouldn't be alive.

Peer support got me through when I got nothing from the formal system.

It was my passage way to getting better, pretty much the only one

Beautiful, wonderful, lovely…

Peer support saves life PERIOD!

O'Hagan et al, 2010

6.1 Introduction

As discussed earlier in this document, peer support covers a range of different activities, population groups, ways of working and contexts from mutual support groups to the survivor movement to "intentional" peer support and beyond. Faulkner and Kalathil (2012) express the frustration of many that research, which often focuses on a very narrow set of practices or populations, has not been synthesised in ways that are useful for policy and practice. This lack of synthesis means that there are huge gaps between what we know and what we need to know. Much of the research has also been descriptive, exploratory and qualitative with small sample sizes, making generalisations difficult (Campbell, Curtis, Deegan, Mead and Ringwalk, 2006; Rogers, Teague, Lichenstein, Campbell, Lyass, Chen and Banks, 2007; White, 2009). So, there is good news and bad news in the search for "best practice". This Chapter will discuss the overall strengths and weaknesses of the research in best practice and will then identify principles, activities, organisational structures and processes that appear to offer mutual help group participants the best chance to make the journey to recovery.

Key Questions About Best Practice

What is it that we need to offer in order to help people begin to see things in a new way?

What kinds of relationships really build community?

How can we construct reciprocal help so that it is not attached to any particular role or interpretation of the problem?

The bad news first. A very recent systematic review and meta-analysis of peer support trials for people with serious mental illness summarised their findings in this way (Lloyd-Evans, Mayo-Wilson, Harrison, Istead, Brown, Pilling, Johnson and Kendall, 2014): "Current evidence is insufficient to conclude that peer support interventions are ineffective, but also insufficient to recommend peer support in general or any particular type of peer intervention. It is equally unclear if there are any critical ingredients that might contribute to programme success or appropriate target populations." These researchers do concede, however, that peer support has been positively assessed in qualitative literature as beneficial for service users and that there are some positive results for outcomes relating to the recovery process, i.e., self-rated recovery, hope and empowerment (Leamy, Bird, LeBoutillier, Williams and Slade, 2011; Coatsworth-Puspoky, Forchuk and Ward-Griffin, 2006; and Smith-Merry, Freeman and Sturdy, 2011).

Now the good – or at least better – news. The evidence from a huge cluster of far reaching studies does show high satisfaction as well as positive outcomes and sustainability of recovery, particularly for those who participate for long periods of time in mutual support groups and make meaningful social links. (Sheedy, 2009; and Laudet, AB, Savage, R and Mahmood, D, 2002; Loat, 2011; Timko, C and Sempel, JM, 2004; Nelson, Ochocka, Janze, Trainor, Goering, and Lomorey, 2007; Forchuk, Martin, Chan and Jensen, 2005; Lawn, Smith and Hunter, 2008; Chinman, 2001; Brown, 2009; Campbell and Leaver, 2003; Chamberlin, Rogers and Ellison, 1996; Cook, Copeland, Corey, Buffington, Jonikas, Curtis, Grey and Nichols, 2010; Doughty and Tse, 2005 & 2010; Griswold, Pastore, Homish and Henke, 2010; Humphreys, Humphreys, Wing, McCarty, Chappel, Gallant, Haberle, Horvath, Kaskutas, Kirk, Kivlahan, 2004; Lawn, Smith and Hunter, 2008; Magura, 2008; McLean, Biggs, Whitehead, Pratt and Maxwell, 2009; Norman, 2008; White, 2009; Vederhus, 2006; Forchuk, Martin, Chan and Jensen, 2005; Rogers, Teague, Lichenstein, Campbell, Lyass, Chen and Banks, 2007).

And, there is more good news. Kyrouz, Hunphreys and Loomis (2002) reviewed 45 studies of the effectiveness of mutual support for a number of different mental health difficulties. Research reviewed included randomised control trials and longitudinal studies. A diverse range of conditions showed improvement in psychosocial wellbeing, knowledge, mastery, coping and control (Loat, M, 2011).

In addition, there is some evidence that peer support is a cost effective approach (Brown et al, 2007). It has been suggested that the positive outcomes from peer support could be potentially greater for people receiving them from consumer run organisations than mainstream services (Doughty & Tse 2005).

Consumer operated services programs (COSPs) are another form of peer or mutual support and a ten-year study (1998-2008) of COSPs in the United States, including randomized control trials, revealed that they are clearly evidence-based practices: "those offered consumer-operated services as an adjunct to their traditional mental health services showed significant gains in well-being – hope, self-efficacy, empowerment, goal attainment, and meaning in life – in comparison to those who were offered traditional mental health services *only*" (SAMHSA, 2010). It is interesting to note that the greatest gains were made by those who used peer services the most. Researchers concluded that, "Most important, analyses of COSP common results established evidence of a strong relationship between key peer practices that support inclusion, peer beliefs, self-expression, and an increase in wellbeing outcomes" (SAMHSA, 2010; Rogers, ES, Teague, G, Lichtenstein, C, Campbell, J, Lyass, A, Chen, R and Banks, S, 2007).

So, in summary, there appears to be increased confidence in the effectiveness of peer support delivered by peer run organisations. In general, there is agreement that the following benefits accrue from participation in peer support:

- Increased empowerment, coping skills, self-efficacy and sense of control
- Improved life satisfaction
- Better psychosocial adjustment
- Better decision-making with regard to health
- Reduction in symptoms, less depression
- Reduced use of health & hospital services
- Greater community integration and use of appropriate resources
- Increased social support, networks and functioning
- Improvements in practical outcomes (e.g., employment, housing and finances)
- Increased quality of life
- Reduced mortality rates

While randomized control trials (the gold standard in social research) are still fairly rare in this area, together with research reviews and qualitative studies, they do provide some insight into "what works" even if the understanding of "how" is still quite frail.

The Importance of Standards

...the cumulative evidence indicates that peer support is a positive and potent recovery-oriented alternative. Peer support communities provide a safe haven for many. Peer support is quickly gaining credibility and Growing in fame. Peer programs are popping up everywhere and in every form. It is critical at this time in the evolution of peer initiatives that clear standards be established for 'What is Good Peer Support'

MacNeil and Mead, 2003

6.2 Principles/Characteristics

Before examining the evidence about best practices, it may be worthwhile to look at the basic characteristics or principles of peer support that researchers and practitioners have identified from the literature and observed experience. These can provide a foundation or touchstone for considering what works.

In "The freedom to be, the chance to dream", Faulkner and Kalathil (2012) identify two factors they believe to be essential to best practice in mutual mental health support:

- In addition to shared mental distress, peer support needs to involve other shared experiences, identities and backgrounds.
- Peer support also needs to be based on certain values, including empathy, trust, mutuality and reciprocity, quality and a non-judgmental attitude.

Expanding on these, Basset, Faulkner, Repper, and Stamou (2010) identify twelve characteristics or principles that constitute the basis of high quality peer support (see Table 5).

These principles are a starting point, but the researchers caution that they are vulnerable to compromise when peer or mutual support is provided by formal mental health services. Situating support in the voluntary, service-user led sector (as opposed to paid "peer workers" attached to statutory services and residential mutual support treatment groups) helps to maintain the integrity of these principles, which are important to achieving short- and long-term mental health recovery outcomes.

Table 5: Characteristics of Peer Support

Mutuality
Solidarity
Synergy
Sharing with safety and trust
Companionship
Focus on strengths and potential
Equality and empowerment
Being yourself
Independence
Reduction of stigma
Hopefulness
Respect and inclusiveness

6.3 Fidelity Standards

Mowbray, Holter, Teague and Bybee (2003) argue that it is very difficult to establish "best practice" standards where "there is little in the way of published literature, and the articles that do exist only describe programs, providing little evidence that the program described is a high quality or an effective one." MacNeil and Mead (2003) addressed this problem by engaging in participatory action research, during which they observed a large peer center operating over the course of a year. Using an ethnographic approach, they recorded and analysed the relational, political, moral and economic narratives embedded in participant interactions. Their research focused on the question: *how do we know when peer support communities are on track?* What resulted is a set of seven "fidelity standards" (or best practice standards), aligned with "critical learning," against which quality can be measured.

Table 6 presents a synopsis of these standards, along with potential indicators for each.

Table 6: Peer Support Fidelity Standards

Standard	Definition	Indicators - examples
1	**Critical Learning**: peers redefine who they have become, how they have become, the nature of helping relationships and what they will need to do to heal.	• Realizing you are not crazy • Redefining your roles • Taking power in relationships • Developing wellness strategies
2	**Community**: peer relationships give people a sense of security and belonging; value placed on being seen and heard and on validating, not judging, people's experiences.	• Validation and witnessing • Not told what to do, not about fixing • Acceptance of people where they are • Members are leaders and followers • Be yourself and know you are not alone
3	**Flexibility**: peers support each other around their preferences and needs; a range of supports to allow people to feel included.	• Experienced as a place to stretch your comfort zone • Encouragement to share talents and expertise
4	**Instructive**: peer support offers a chance to extend resource networks; instructive dimension is reciprocal; tensions, conflicts defined as learning opportunities	• Collective problem-solving • Genuine, inclusive feedback • Every person is teacher and learner • Value in experience & common wisdom
5	**Mutual responsibility**: respect regarding the presenting "condition"; responsibilities embedded in the relationships	• All persons considered equal • Taking charge of life and moving ahead • Building honest relationships
6	**Setting limits**: peers are clear about what they can and cannot do and say; honour each other's experiences.	• Relationship safety is negotiated • Freedom of expression • Appreciation of the "long haul" of the recovery process
7	**Safety**: emotional safety through validation; safety in compassionate interactions; safety in being able to disclose and express feelings & ideas safely	• Respecting confidentiality • Clear parameters of what is tolerable dissonance • Limits change as learning process unfolds

MacNeil and Mead (2003) sum up the importance of the Fidelity Standards in understanding the crucial ingredients in peer support that "works:"

- ***Critical learning*** leads to a shift in thinking about and describing one's experience.
- ***Community*** is about moving from focusing on individual symptom management to a safe, communal context in which to explore the journey to wellbeing.
- ***Flexibility*** acknowledges the uniqueness of every individual's experience and promotes learning from the distinctive narratives offered within the group.
- ***Instructive*** ensures that no one body of knowledge is privileged, recognizing the expertise of each individual.
- ***Mutual responsibility*** allows everyone to be both "helper" and "helpee" creating an increased sense of worth.
- ***Setting limits*** as a continuous process allows the group to build a strong sense of trust while evolving.
- ***Safety*** defined and re-defined by the collective allows people to explore new ways of thinking and doing without the constraints of potentially "dangerous risks.

These standards acknowledge the new norms, relational roles, kinds of help and support people find useful in mental health recovery, but are just the beginning (Anthony, 2003). As MacNeil and Mead acknowledge: "the process of identifying fidelity criteria is critical to launching peer support into the arena of evidence based practices. Investigating the standards of peer support will require continuing a discovery process across many different kinds of peer communities exploring different experiences, people's relationships in systems, and the kinds of things they've experienced as 'helpful'."

6.4 Common Ingredients (CI)

A ten-year study (1998-2008) of consumer operated services programs (COSPs) across multiple sites identified 46 common ingredients (CIs) and key peer practices that promote psychological wellbeing, empowerment and hope of recovery (Campbell, 2008). These ingredients and practices grew out of previous research and literature and the lived-experience of those with mental difficulties.

The 46 common ingredients were organized into three categories – Structure, Values and Processes – and then sorted into domains based on similarities in peer practice content. Called the Fidelity Assessment Common Ingredients Tool (FACIT) by the Consumer Advisory Panel for the ten-year study, it was intended to act as a yardstick against which to assess quality program implementation. Table 7 provides an overview of the CIs.

Table 7: Common Ingredients Overview

Structure Stable characteristics of providers of care, of tools and resources, physical and organisational settings.		**Values** Related to the core set of principles, standards, morals and ethics that unite the program & its membership.	**Processes** Specific and observable activities in services or in methods of delivery of services.		
Operating Structure • Consumer-operated • Responsive • Linkages	Environment • Accessibility • Safety • Informality	Belief System • Peer principle • Helper's principle • Empower-ment • Recovery • Diversity • Spiritual Growth	Peer Support • Peer support • Telling our stories • Artistic expression • Consciousness-raising • Crisis prevention • Peer monitoring & teaching	Education • Structures self-manage-ment & problem solving strategies • Informal problem-solving – receiving & providing • Formal skills practice • Job read-iness	Advocacy • Formal self-advocacy • Peer advocacy • Participant outreach

This research suggests that *inclusion* and *self-expression* are at the heart of promoting positive outcomes such as hope, empowerment, meaning in life and self-efficacy. These "best practice" common ingredients are operationalized in a very practical way in Table 8 below (Campbell, 2008; Johnsen, Teague and Herr, 2005).

Table 8: Common Ingredients (CIs) Promoting Positive Outcomes

Environment Domain (Inclusion CIs)	Peer Support Domain (Self-Expression CIs)
• Services free of charge • Program rules ensure physical safety, developed by consumers • No hierarchy • Sense of community, fellowship, mutual caring and belonging • Lack of coerciveness, tolerance of harmless behavior, emphasis on participant choice	• Opportunities for telling one's story in visual arts, music, poetry • Opportunities for sharing life experiences • Groups structured for listening, empathy and compassion based on common experience.

FACIT can act as a set of "best practice" standards, highlighting the strengths and weaknesses of a peer support program, helping formulate action plans to improve practices and outcomes, assisting participants achieve their goals and delivering peer services efficiently and effectively. As such, it is also a potential tool for measuring outcomes and impact.

6.5 Preserving User-Led Peer Support

As discussed above and demonstrated throughout this report, peer support has a long history and a plethora of organsational forms, processes, activities, values and benefits. In 2012, *Together* (a UK national charity working alongside people with mental difficulties on their journey to independent and fulfilling lives) commissioned a study to help clarify what constitutes peer support and evidence of effectiveness (Faulkner and Kalathil, 2012). Based on interviews and surveys with nine vastly different peer support projects, researchers identified the key elements of preserving user-led support, summarized in Table 9 below.

Table 9: Good Practice in User-Led Peer support

Element	Definition	User comments
Preserving the value base	Need for peer support to be based in personal experiences and seeing peers as "experts by experience"; acceptance that experience is diverse; belief in people's ability to take control of their lives, if given support, encouragement and the necessary resources.	*'…it needs human interaction… It requires relinquishing power… finding out about the ethos of working in a shared environment, where enabling people is more important than executing guidelines'*
A structure that supports organic development	Boundaries can be valuable in ensuring that everyone involved can work in a safe environment, but they need to allow for the natural, organic Growth of the peer relationship and for informal approaches to peer support to flourish.	*"We are firm about what it is: it is not counseling, not therapy."* *"Ensuring there is discussion about agreed goals/outcomes at the beginning and reviewing this regularly"*
Service users leading peer support	One of the fundamental principles of peer support is that it is user-led; those who are involved must have the right and opportunity to influence and act upon agendas and decisions regarding the delivery of peer support.	*"There is…the fear that peer support will just be fitted into the all-pervading medical models of working rather than be considered a way of exploring other models of working with mental health"*
Preserving the variety and range of peer support	Ensuring that a wide range of peer-led practice is preserved and supported and that organisations feel free to experiment with multiple ways of meeting people's needs.	*"The other kind of 'human' care, sitting and talking to you. Finding out what you need and making sure the small things that add to wellbeing are taken care of…"*

Element	Definition	User comments
Providing good support and resources.	Supporting peer supporters in their work, such as opportunities to talk to other peer supporters, issue-based training, listening skills and working with differences and diversity; adequate resourcing.	*"…every supporter should be teamed with someone more experienced who is able to act as their mentor"* *"Adequate and ring fenced financial support"*

6.6 Practical Operational Guidelines

Self-Help Queensland developed "good practice" guidelines for self-help groups based on a literature review of effectiveness and input from consumers, carers, service providers and support group facilitators in Brisbane (East, 2009). These guidelines clearly overlap with and reaffirm the "best" practice approaches discussed above. The guidelines are summarised in Table 10 below.

Table 10: Summary of Operational Guidelines

Guideline	Description
Recognised format for meetings	Group should have a set format, which is appropriate to its purpose, to the experience of its members and is conducive to participants' Growth and recovery.
Procedures ensure smooth entry	Easy access to information about the group and an agreed way to introduce new participants to the group.
Group endorsed principles	The group should develop principles around key issues such as safety, confidentiality, non-judgmental listening, taking responsibility for feelings, no coercion, voluntary participation.
Strengths-based approach	Recognition that everyone has a combination of strengths and weaknesses with a focus on reinforcing positives and no distinctions between "helper" and "helped."
Focus on problem solving	Group helps participants find solutions to their problems of living by facilitating exploration of alternatives and making choices.
Feelings expressed openly	Expression of feelings is invited, accepted, validated and legitimised.
Members progress at own pace	Group allows everyone to proceed on their journey to recovery at their own pace with no disapproval of setbacks.
High quality relationships	Group affirms all participants as valuable individuals, both as learners and potential learning resources.
Individual change celebrated	Group acknowledges participants' accomplishments, achievements, risk-taking, learning and interacting socially.
Groups vet involvement of professionals	Professionals not involved actively, but may be invited to participate in some way by the participants.
Facilitators and leaders continually supported and developed	Participants encouraged to take on facilitation and leadership roles with support and training, as appropriate. Skills reviewed regularly and enhanced by coaching, debriefing and training.
Community development principles followed	Based on principles of personal empowerment, self-help, equitable access to information, networking and self-responsibility.
Group is a living, dynamic entity	Group maintains optimism even when it is "tough" going and there is a constancy in the face of peaks and troughs.
Regular evaluation and review	Proactive evaluation on a regular basis to assess participants' satisfaction, how much positive change is occurring, what might need to be done differently.

7. Synthesis and discussion

While the focus of this report is on person-centred, recovery-oriented mental health using a mutual help approach, it was important to explore the broader territory of community-based management of psychosocial problems to identify potentially useful concepts and practices. The research is wide and deep with regard to mutual/peer support, applying theoretical models to mental health recovery and tools to measure impact on individuals and systems. However, after trawling through dozens of studies, reports, meta-analyses, outcomes of action research projects, narratives of lived-experience and papers by mental health "experts," the conclusion is that there is little consensus about the causes of mental difficulties, the dynamics of mental health recovery, the place of mutual support in mental health systems of care and the strategies for measuring individual and system impact.

Even though certainties are scarce, there are key themes and overlapping ideas embedded in the complex world of mental health research. This section will attempt to tease out these themes and ideas as a basis for recommending potential directions and actions that GROW might consider pursuing.

7.1 Achieving mental health recovery

Most researchers, practitioners and people with lived experience of mental illness and recovery agree that mental health recovery is more of a process than a destination. It is NOT like getting over the flu – very sick for a few days and then completely well. It is more like a continual journey – a striving - to improve wellbeing with notable achievements and serious setbacks along the way. This is a critically important starting point when thinking about policy and practice. Mental health recovery does not have a definitive beginning and end. It is a way of living that is facilitated and enhanced by certain environments, relationships and modes of interaction.

There are probably four basic ingredients in the recovery journey, closely reflecting the processes in the Psychological Recovery Model described in Chapter 3.3:

- Hope, optimism, a vision of a meaningful life
- Social connectedness, secure relationships, mutuality of support
- Active sense of self and positive identity, critical reflection
- Empowerment, self-efficacy, taking responsibility

Whether the journey begins with hopelessness, despair, total lack of control and/or alienation, the journey involves two intersecting and dynamic processes: (1) internal Growth in self-confidence and control (2) facilitated by relationships, valued social roles and opportunities to achieve. The journey is about the individual taking responsibility within an environment of acceptance, support and help, especially from others who have similar experiences. With this understanding as a basis, it is possible to "pick the teeth" out of the various models put forth to explain recovery.

For example, HOPE provides a broad set of goals (a picture) toward which individuals might journey, while CHIME, the Psychological Recovery Model, the Ladder of Change and the Self-Righting Framework all suggest what the processes involved in the recovery journey look like and how an individual might progress through them. The Critical Learning Model provides great insights into new ways of thinking and the Socioecological Model describes how social attachments drive mental health recovery.

> *Current evidence is insufficient to conclude that peer support interventions are ineffective, but also insufficient to recommend peer support in general or any particular type of peer intervention. It is equally unclear if there are any critical ingredients that might contribute to programme success or appropriate target populations.*
>
> Lloyd-Evans, Mayo-Wilson, Harrison, Istead, Brown, Pilling, Johnson and Kendall, 2014

7.2 Best Practices

Despite the disheartening lack of clear evidence about best practice in mutual help mental health recovery, this review discovered sets of principles and standards, key components and operational guidelines that together describe effective ways of working.

There does appear to be agreement on at least one element of best practice: the establishment and maintenance of strong social relationships. The research on impact does reveal that the longer an individual participates in a mutual support group, the better the self-reported outcomes. This suggests, then, that activities that maintain longevity of involvement are particularly important. While most studies did not look at this aspect in particular, one can infer from the characteristics of peer support, fidelity standards and common ingredients, for example, that longevity might be facilitated by establishing environments that are safe and secure, respectful and inclusive, and structured, but flexible.

Another feature that probably qualifies as "good" practice is ensuring that everyone in a mutual support group is allowed space to "tell their stories". This sharing of lived experience and listening to others' narratives benefits both the "helper" and the "helped". It is the way individuals learn to re-define their experiences, develop positive identities, feel heard and valued, envision desirable futures, solve problems and manage the challenges that come with living with mental illness. It reinforces a commitment to valuing the expertise of each individual, a part of building self-esteem and self-belief.

A third area of general agreement is that "good" practice requires shared leadership, facilitation and taking on of various roles that support the continuation of the group. This mutual responsibility plays an important role is helping participants feel valued and worthwhile, while also contributing to the development of social skills that are useful inside the group and in the wider community.

There are also "good" practice guidelines that emerge from a very wide ranging evidence base. The guidelines tend to focus on operational structures and processes that facilitate inclusion, involvement, learning and changing. For example, the summary of operational guidelines suggests having set formats for group meetings, specific procedures for welcoming new participants, ongoing support for leaders and facilitators and regular review and evaluation. More specifically, the 46 common ingredients include such things as: no fees, no hierarchies and no coercion. They also emphasise structuring groups for listening, empathy and compassion.

Figure 12 on the following page synthesizes the key components in facilitating mental health recovery.

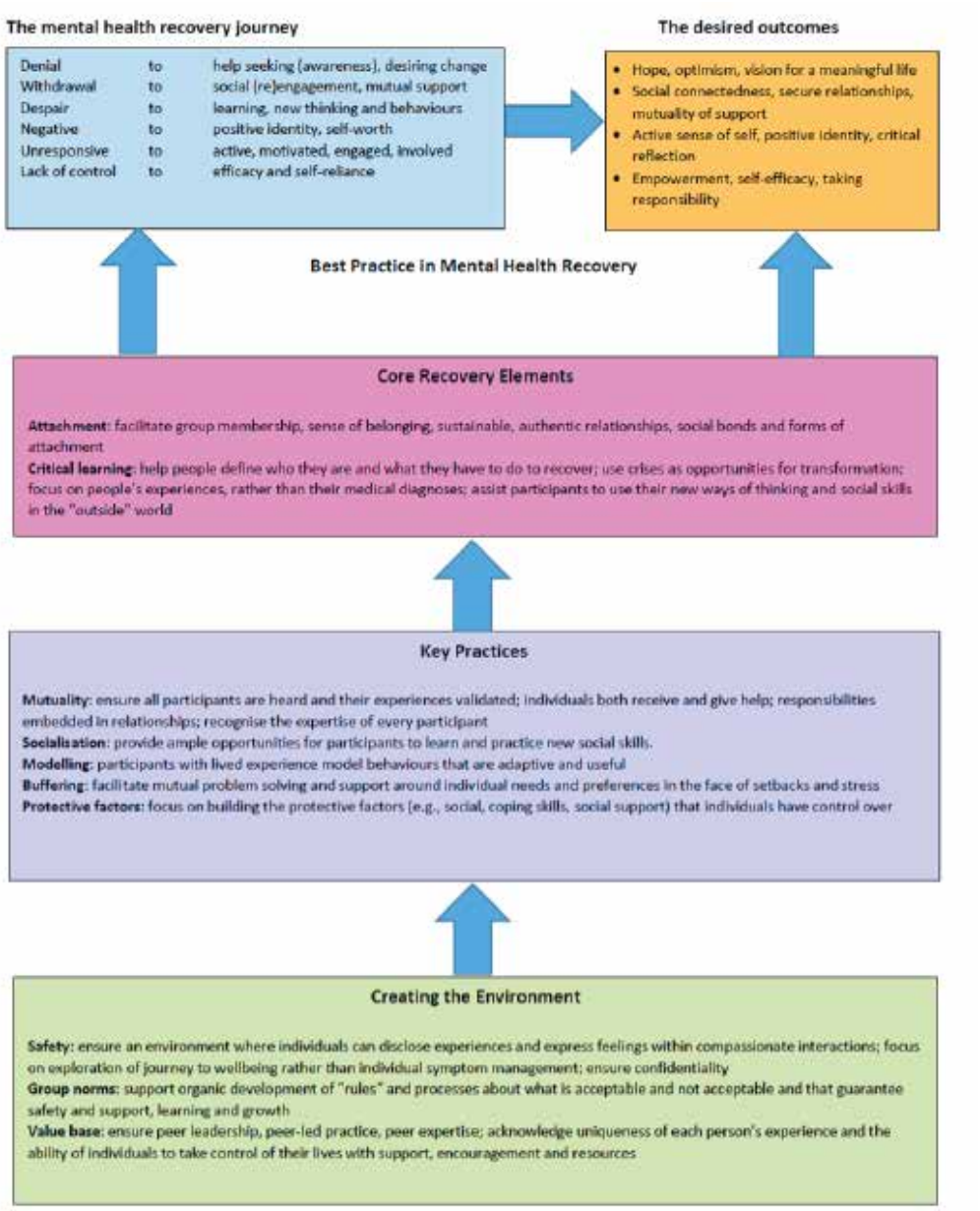
Over time, there may be more definitive research about specific "good" or "best" practices. In the meantime, it is important for organisations like GROW to continue to monitor what they are doing and the outcomes achieved for individuals and the broader systems and communities. This will contribute to the evidence base and help fill in the knowledge gaps. And, this provides the ideal segue into the next section on measurement.

With a commitment to engage in continuous improvement and to demonstrate the impact of GROW, the organization commissioned this report with four specified purposes:

- to describe the most robust theories about what contributes to mental health recovery;
- to identify evidence-based "best" practices in peer support models (e.g., the most effective organizational designs, practice principles, operational values and group practices);
- to find ways to measure the impact of mutual support groups on participants (e.g., psychological and social functioning) and the broader mental health system (e.g., service usage and cost savings); and
- to recommend activities and practices that could assist GROW in achieving its continuous improvement and measurement goals.

This final chapter will identify ways GROW might apply the evidence gathered and synthesized to the goals of continuous improvement and demonstrating impact.

Figure 12: Mental Health Recovery



7.3 Applying the evidence for continuous improvement

7.3.1 Start at the End

Identify outcomes. As always, the first task is to describe, with as much specificity and clarity as possible, the desired outcomes an organisation wants to achieve. There are many levels of outcomes, from impacts on individuals to changes in organisations, systems and communities. And, there are potentially dozens of desirable outcomes at each level. There is a temptation to include everything because it is all important to someone. However, if the desired outcomes (that will be the basis for performance improvement) are too all-encompassing, the organization may lose focus and feel overwhelmed.

In this regard, it is interesting to note that after all of the research undertaken for this report, little or no consensus could be found about what mental health services (formal and informal) want to achieve, at least not in ways that are easily measurable. Rather, it appears that many researchers and practitioners simply assume that reductions in symptomology, hospitalization and use of formal mental health services are goals shared by everyone. In addition, most also include various aspects of improved quality of life: hope, optimism, control and social connectedness. Rarely is it possible to discover a set of outcomes that fit an organization; instead, it is an organic process that emerges from thoughtful reflection and collective planning.

Some key questions to help guide this planning and reflection process include:

- What would "success" look like for participants?
- Is there a participant pathway to success? If so, what kinds of changes must happen in the short- and medium-term to achieve the long-outcomes?
- How will the organisation know if participants are making progress toward the desired outcomes?

Human Development Report

The United Nations Development Programme measures progress across the developing and developed world by using a composite index comprised on three items: life expectancy, educational achievement and per capital income. Only three measures combined into a single statistic serves as a frame of reference for both social and economic development.

Describe the problem. And, there is actually a step that should occur even before outcome identification and that is developing a concise description of the "problem" the organisation is in business to address. It is not uncommon for programs to be developed in response to a vague sense that something is missing or that we *should* do something or that someone else has one and we should too. A more productive approach involves a careful analysis of what the problem is that requires a service or program response. There are two aspects to defining the problem: (1) the dimensions and character and (2) the causes. The first helps us understand the size, urgency and reach of the problem while the second determines what strategies or actions we should take. Table 18 below summarises the components of a useful problem definition.

Table 18: Problem Definition

Problem Description	Causes
What is the size of the problem?	What are the major causes of the problem?
Is it emerging, longstanding and/or changing?	Which causes are the most important?
How frequently does it occur?	Which causes can the organisation address?
Who does it affect?	Have there been previous attempts to address the problem?
How serious are the impacts?	What has worked and not worked in the past?

Answers to these questions provide the direction and parameters for planning and developing a programmatic response to an identified problem. However, before leaving outcomes, there is another task that is necessary to monitoring, measuring and evaluating activities. Specification of indicators.

Indicators. An indicator is the key piece of information that represents what change "looks like". Indicators help us answer the two key evaluation questions:

- What does the desired change look like?
- How will we know it exists?

This is, perhaps, the most challenging aspect of monitoring continuous improvement and measuring/evaluating results. For example, a desired outcome of mutual help in mental health recovery might be *individual empowerment*. If we apply the two key questions, we must think very hard about what we mean by empowerment. What does empowerment look like in an individual? How will I know if a certain participant feels empowered? The same questions apply to *connectedness*, *optimism*, *identity* and so on. We must understand what constitutes these characteristics before we can determine whether we are achieving them individually or collectively. It is essential to know what a successful result looks like before it is possible to measure it.

This is a process that should involve all key players, but especially service/intervention participants. If we learned anything from the review of the research literature, it is that some of the richest and most useful input comes from those with lived experience of mental illness and recovery. They are ideally situated to describe what *empowerment* looks like.

7.3.2 Conduct a Stocktake

The stocktake consists of three parts: (1) assessing how well the organisation is doing in terms of achieving its desired outcomes; (2) assessing the4 organisation's values, activities, organisational structures/processes and practices against what is known about theories of recovery and the most effective ways to facilitate it; and (3) assessing the worth of the information collected about activities and results. In short, the task is to produce a picture of the *state of play* in the organization against all that we know about helping individuals with mental difficulties make the recovery journey.

It almost goes without saying that this process should also be inclusive of all key stakeholders, but again especially program participants or beneficiaries. They have the most profound knowledge about how well things are working.

7.3.3 Apply learnings

With a reasonable set of specific outcomes (and indicators) and a clear sense of where the organisation is in relation to desired results and "best" practice, it is appropriate to engage in applying this new knowledge to identifying different ways of working. The stocktake provides a gap analysis that suggests directions for change. It is important to acknowledge where GROW is "doing the right things" and "doing things right" so that effective values and practices are retained and can provide the foundation for improvements.

Change processes are not easy since they often involve alterations in the way people think as much as in what they do. Significant change is generally a long-term project and should be thought of in terms of years rather than months. That is not to say that there are no short-term actions and changes that can be made while the more challenging *reforms* are underway. We have to remember that continuous improvement is exactly that: continuous, ongoing, constant. However, organisations also benefit from setting short-and intermediate-term change goals.

As indicated above, the first *change* goal might be to establish a clear and reasonable set of desirable outcomes with specific, measurable indicators. This does not have to be a long, drawn out process; rather, it is likely that most people involved with the organisation as participants, staff and interested parties already have ideas about the kinds of results they would like to see. These need to be sifted, shaped and prioritized. Then, as a starting point, a small set of *headline* indicators can be identified; that is, a 5-10 indicators that provide a snapshot of what is happening as a result of the organisation's activities. More detailed indicators can be added as required for continuous improvement and impact reporting.

Action on measurement may be an early goal as well. With a set of desired outcomes to work with, an early action plan could involve identifying what the organisation wants and needs to know to support continuous improvement and assessment of impact. Working with stakeholders, a review of the measurement instruments can be conducted in light of what information is needed to assess performance and results. This would include finding the best fit between needs and instruments available, skills and training needed and resources required. Measurement of impact is becoming ever more important, but it still has to be supported within organizational resource constraints.

Taking the long view, but including progress milestones provides a roadmap that can serve the organization for many years. Of course, plans should never be immutable; rather they should be flexible and subject to changing circumstances. Mental health recovery obviously takes place in a dynamic environment with myriad influences both within and outside our control. It is how we respond to this dynamism that makes all the difference.

References

Ainsworth, MDS, Blehar, MC, Waters, E and Wall, S (1978). Patterns of Attachment. Hillsdale, NJ: Erlbaum.

Andresen, R., Caputi, P., & Oades, L. (2006). The Stages of Recovery Instrument: Development of a measure of recovery from serious mental illness. Australian & New Zealand Journal of Psychiatry, Vol. 40. Pp. 972-980.

Andresen, R, Oades, LG and Caputi, P (2011). Psychological recovery: beyond mental illness. West Sussex, UK: Wiley-Blackwell.

Andresen, R, Oades, LG and Caputi, P (2006). The Stages of Recovery Instrument: Development of a measure of recovery from serious mental illness. Australia and New Zealand Journal of Psychiatry. Vol. 40. Pp. 872-980.

Andresen, R, Oades, LG and Caputi, P (2010). Do clinical outcome measures assess consumer-driven recovery? Psychiatry Research. Vol. 177. Pp 309-317.

Andresen, R, Oades, LG and Caputi, P (2003). The experience of recovery from schizophrenia: towards an empirically validated stage model. Australia and New Zealand Journal of Psychiatry. Vol. 37. Pp 586-594.

Anthony, W (2003). Expanding the evidence base in an era of recovery. Psychiatric Rehabilitation Journal. Vol. 27 (1). Pp 1-2.

Basset, T, Faulkner, Repper, J and Stamou, E (2010). Lived Experience Leading the Way: Peer Support in Mental Health. http://www.together-uk.org.

Bowlby, J (10969). Attachment and Loss Volume 1, Attachment. London: Hogarth Press.

Bowlby, J (1973). Attachment and Loss Volume 2, Separation, Anxiety and Anger. London: Hogarth Press.

Bowlby, J (1979). The Making and Breaking of Affectional Bonds. London: Tavistock.

Bowlby, J (1980). Attachment and Loss Volume 3, Loss, Sadness and Depression. London: Hogarth Press.

Boydel, KM, Gladstone, BM and Crawford, ED (2002). The dialectic of friendship for people with psychiatric disabilities. Psychiatric Rehabilitation Journal. Vol. 26 (2). Pp123-131.

Brown, w, Kandinkirira, N (2001). Recovering mental health in Scotland: Report on narrative investigation of mental health recovery. Glasgow: Scottish Recovery Network.

Brown, LD, Shepherd, MC, Merkle, EC, Wituk, SA and Meissen, G (2008). Understanding how participation in a consumer-run organization relates to recovery. American Journal of Community Psychology. Vol. 42. Pp 167-178.

Burgess, P, Pirkis, J, Coombs, T & Rosen, A (2010). Review of recovery measures, Version 1.01. Brisbane: Australian Mental Health Outcomes and Classification Network.

Burgess, P, Pirkis, J, Coombs, T & Rosen, A (2010). Sharing Information to Improve Outcomes. Queensland: Australian Mental Health Outcomes and Classification Network.

Burgess, P, Pirkis, J, Coombs, T & Rosen, A 2011. Assessing the value of existing recovery measures for routine use in Australian mental health service. Australian and New Zealand Journal of Psychiatry. Vol. 45. Pp267-280.

Burns, s, MacKeith, J and Graham, K (2008). Using the Outcomes Star: Impact and Good Practice. London: Homeless Link.

Calma, N (2006). The Role of Mutual Support Self-Help in the Mental Health Sector. Unpublished internship paper, Mutual Support & Self Help Network, Victoria. MSSH__Mental_Health_Report_N_Calma_Final.pdf.

Campbell, J (2005).The historical and philosophical development of peer-run programs. In Clay, S (eds). On our own together: Peer programs for people with mental illness. Nashville, TN: Vanderbilt University Press. Pp. 17-66.

Campbell, J (2008). Key Ingredients of Peer Programs Identified. Missouri Institute of Mental Health. http://www.power2u.org/downloads/COSP-CommonIngredients.pdf.

Campbell, J, Curtis, L, Deegan, P, Mead, S and Ringwald, C (2006). Literature Review for Consumer Operated Services and Programs Toolkit (Draft v.3-1-2006).

Campbell, J and Leaver, J (2003). Emerging new practices in organized peer support. National Technical Assistance Center for State Mental Health Planning and National Association of State Mental Health Program Directors.

Campbell, J, Lichtenstein, C, Teague, G, Johnsen, M, Yates, B and Sonnefeld, J et.al. (2006).The Consumer-Operated Service Programs Multisite Research Initiative. Saint Louis, MO: Coordinating Center at the Missouri Institute of Mental Health.

Campbell-Ord, T, Chamberlin, J, Carpentar, J and Leff, HS (2005). Measuring the Promise: A Compendium of Recovery Measures: Volume II. Boston, MA: The Evaluation Center@HSRI.

Carlson, EA, Sroufe, LA and Eneland, B (2004). The construction of exerpience: A longitudinal study of representation and behavior. Child Development. Vol, 77. Pp 66-83.

Chamberlin, J (1990). The ex-patients' movement: where we've been and where we're going. Journal of Mind and Behavior. Vol. 11 (3-4). Pp 323-336.

Chamberlin, J, Rogers, S and Ellison, M (1991). Self-Help Programs: a description of their characteristics and their members. Psychiatric Rehabilitation Journal. Vol. 19 (3). Pp 33-42.

Chinman, MJ, Weingarten, R, Stayner, D and Davidson, L (2001. Chronicity Reconsidered: Improving Person-Environment Fit Through a Consumer-Run Service. Community Mental Health Journal. Vol. 37 (3). Pp 215-229.

Coatesworth-Pupoky, R, Forchuk, C, Ward-Griffin, C (2006). Peer support relationships: an unexplored interpersonal process in mental health. Journal of Psychiatric Mental Health Nursing. Vol. 13 (5). Pp 490-497.

Cook, J, Copeland, M, Corey, L, Buffington, E, Jonikas, J, Curtis, L, Grey, D and Nichols, W (2010). Developing the evidence base for peer-led services: Changes among participants following wellness recovery action planning (WRAP) education in two statewide initiatives. Psychiatric Rehabilitation Journal. Vol. 34 (2). Pp 113-120.

Copeland, ME and Mead, S (2004). WRAP and Peer Support for People, Groups and Programs. Brattleboro, VT: Peach Press.

Corrigan, P, Calabrese, J, Diwan, S and Keogh, C (2002). Some recovery processes in mutual-help groups for persons with mental illness I: Qualitative analysis of program materials and testimonies. Community Mental Health Journal. Vol. 38 (4). Pp 287-301.

Corrigan, PW and Phelan SM (2004). Social support and recovery in people with serious mental illness. Community Mental Health Journal. Vol. 40 (6). Pp. 513-523.

Corrigan, PW, Salzer, M, Ralph, RO, Sangster, Y and Keck, (2004). Examining the factor structure of the Recovery Assessment Scale. Schizophrenia Bulletin. Vol. 30 (4). Pp. 1035-1041.

Corrigan, P, Slopen, N, Fracia, G, Phelan, S, Keogh, C and Keck, L (2005). Some Recovery Processes in Mutual-help groups for persons with mental illness II: Qualitative Analysis of Participant Interviews. Community Mental Health Journal. Vol. 41 (6). Pp. 721-735.

Council of Australian Governments (20120. Ten Year Roadmap for National Mental Health Reform, 2012-2020.

Dech, E and Penney, D. Bringing Trauma-Informed Practice to Peer Support. Mental Health Empowerment Project. http://www.nyaprs.org/conferences/annual-conference/documents/NYAPRSTIPSpresentation9-10-13.pdf.

DeJong, G (1979). Independent living: from social movement to analytic paradigm. Archives of Physical Medicine Rehabilitatioln. Vol. 60. Pp. 435-446.

Department of Health and Ageing, 2013a. A national framework for recovery-oriented mental health services: Policy and theory. Canberra: Department of Health and Ageing

Department of Health and Ageing, 2013b. A national framework for mental health recovery. Canberra: Department of Health and Ageing

Dickens, G, Sugarman, P, Weleminsky, J and Onifade, Y (2012). Recovery Star: validating user recovery. Psychiatrist. Vol. 36. Pp 45–50.

Donnelly, M, et.al. (2011). Patient outcomes: what are the best methods for measuring recovery from mental illness and capturing feedback from patients in order to inform service improvement? A report. The Bamford Implementation Rapid Review Scheme. http://www.publichealth.hscni.net/sites/default/files/Patient%20Outcomes.pdf.

Doughty, C., & Tse, S. (2005). The effectiveness of service user-run or service user-led mental health services for people with mental illness: A systematic literature review. A Mental Health

Commission Report, Mental Health Commission, Wellington, New Zealand.

Doughty, C., & Tse, S. (2010). 'Can Consumer-led Mental Health Services be Equally Effective? An integrative review of CLMH services in high income countries'. Community Mental Health Journal;

DOI 10.1007/s10597-010-9321-5 (Online ahead of print, May 28 2010).

Doughty, SA, Kahi, CH, Te Pou, Whakaaro Nui (2011). National Centre of Mental Health Research, Information and Workforce Development, Aukland, New Zealand. http://www.hdc.org.nz/media/199065/peer_support_practice_in_aotearora_nz.pdf.

East, D (2009). Principles and Processes for Good Practice for Mental Health Support Groups. Self Help Queensland, Inc.

Faulkner, A., & Kalathil, J. (2012). The freedom to be, the chance to dream: Preserving user-led peer support in mental health. London: Together UK

Finn, L, Sparrow, N and Bishop, B (2007). Mutual help groups: an important gateway to wellbeing and mental health. Australian Health Review. Vol. 31 (2). Pp. 246-55.

Finn, L, Bishop, B and Sparrow, N (2009). Capturing Dynamic Processes of Change in GROW Mutual Help Groups for Mental Health. American Journal of Community Psychology. Vol. 44. Pp. 302-315.

Forchuk, C, Martin, ML, Chan, YCL and Jensen, E (2005). Therapeutic Relationships: from psychiatric hospital to community. Journal of Psychiatric and Mental Health Nursing. Vo.l 12. Pp.556-564.

Gere, J & MacDonald, G (2010). An update of the empirical case for the need to belong. http://web.psych.utoronto.ca/gmacdonald/Gere%20&%20MacDonald%20final%20manuscript.pdf

Giffort, D, Schmook, A, Woody, C, Vollendorf, C, Gervain, M (2000). The Recovery Assessment Scale. In RO Ralph and KA Kidder & The Recovery Advisory Group. Can we measure recovery? A compendium of recovery and recovery-related instruments. Cambridge, MA: Human Services Research Institute.

Glover, H (2012). Recovery, Life Long Learning, Social Inclusion and Empowerment: Is a new paradigm emerging? In P. Ryan, S Ramon and T Greacon. Empowerment, lifelonglearning and recovery in mental health: towards a new paradigm. Palgrave Publishers.

Goh, C and Agius, M (2010). The Stress-Vulnerability Model: How Does Stress Impact on Mental Illness at the Level of the Brain and What are the Consequences? Psychiatria Danubina. Vol. 22 (2). Pp 198-202.

Griswold, K., Pastore, P., Homish, G., Henke, A. (2010). Access to Primary Care: Are Mental Health Peers Effective in Helping Patients After a Psychiatric Emergency? Primary Psychiatry Vol. 17 (6). Pp.42-

45. (1082-6319)

Harris, L and Andrews, A (2013). Implementing the Outcomes Star Well in a Multi-disciplinary Environment. Victoria, Australia: The Salvation Army, Crisis Services Network.

Helgeson, VS and Gottlieb, BH (2000). Support groups. In S. Cohen, LG Underwood and BH Gottlieb (eds.). Social support measurement, and intervention: A guide for health and social scientists. Pp. 221-245. New York: Oxford University Press.

Hoffmann, N, Harrison, P and Belille, C (1983). Alcoholics Anonymous after treatment: Attendance and abstinence. International Journal of the Addictions. Vol. 18(3). Pp 311-318.

Horowitz, LM (1979). On the cognitive structure of interpersonal problems treated in psychotherapy. Journal of Consulting and Clinicial Psychology. Vol. 47. Pp 5-15.

Humphreys, K., Wing, S., McCarty, D., Chappel, J., Gallant, L., Haberle, B, Horvath, T., Kaskutas, Kirk, T., Kivlahan, D. (2004). Self-help organizations for alcohol and drug problems: Toward evidence-based practice and policy. Journal of Substance Abuse Treatment, Vol. 26, Pp 151-158.

Jackson, C (2010). Critical Friends, Openmind. Vol. 161. Pp 14-15

Jacobson, N and Curtis, L (2000). Recovery as policy in mental health services: Strategies emerging from the states. Psychiatric Rehabilitation Journal. Vol. 23 (4). Pp 333-341.

Jacobson, N, Greeley, D (2001). What is recovery? A conceptual model and explication. Psychiatric Services. Vol. 52. Pp. 482-485.

Jerrell, J, Cousins, V and Roberts, K (2006). Psychometrics o the Recovery Process Inventory. The Journal of Behavioural Health Services & Research. Vol. 33 (4). Pp. 4640473.

Johnsen, M, Teague, G and McDonel-Herr, E (2005). Common ingredients as a fidelity measure for peer run programs. In S. Clay (ed.). On our Own Together: Peer programs for people with mental illness. Nashville, TN: Vanderbilt University, 213-238.

Khanam, D, McDonald, K, and Niels, KW (2013).Measuring Recovery: A Toolkit for Mental Health Providers in New York City. The Bureau of Mental Health, New York City Department of Health and Mental Hygiene.

Killaspy, H, Boardman, J, King,M, Taylor, T, Shepherd, G and White, S (2012). The Mental Health Recovery Star: Great for Care Planning but not as a Routine Outcome Measure. Psychiatric Bulletin. Vol. 36. Pp 194.

Kyrouz, E, Hunphreys, K and Loomis, C (2002). A Review of Research on the Effectiveness of Self-Help Mutual Aid Groups. In BJ White and EJ Madara (eds). The Self-Help Sourcebook: Your Guide to Community and Online Support Groups (7th ed). Denville, NJ: American Self-Help Group Clearinghouse.

Laudet, AB, Savage, R and Mahmood, D (2002. Pathways to long-term recovery: A preliminary investigation. Journal of Psychoactive Drugs. Vol. 34 (30). Pp 305-311.

Lawn, S, Smith, A and 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. Vol. 17 (5). Pp 498-508.

Leamy M, Bird V, Le Boutillier C, Williams J, Slade M A (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. British Journal of Psychiatry. Vol. 199 (6). Pp 445-452 http://bjp.rcpsych.org/content/199/6/445.long.

Lloyd-Evans, B, Mayo-wilson, E, Harrison, B, Istead, H, Brown, E, Pilling, S, Johnson, S and Kendall, T (2014). A systematic review and meta-analysis of randomized controlled trials of peer support for people with severe mental illness. BMC Psychiatry. Vol. 14. http://www.biomedcentral.com/1471-244X/14/39.

Loat, M (2011). Mutual Support and Mental Health. London: Jessica Kingsley.

MacNeil C. & Mead S. (2003). Understanding What Useful Help Looks Like: The Standards of Peer Support. http://akmhcweb.org/Articles/PeerSupport.pdf.

Magura, S. (2008). Effectiveness of dual focus mutual aid for co-occurring substance use and mental health disorders: A review and synthesis of the “Double Trouble” in recovery evaluation. Substance Use and Misuse, Vol. 43 (12&13). Pp 1904-1926.

Mancini, M (2007).The role of self-efficacy in recovery from serious psychiatric disabilities. Qualitative Social Work. Vol. 6 (1). Pp 49-74.

McLean, J, Biggs, H., Whitehead I., Pratt, R., Maxwell, M. (2009). Evaluation of the Delivering for Mental Health Peer Support Worker Pilot Scheme. Edinburgh: Scottish Government Social Research

Mead, S and MacNeil, C (2004). Peer Support: A Systemic Approach. Family Therapy Magazine. Vol. 4 (5). Pp 28-31.

Mead, S and MacNeil, C (2006). Peer Support: What Makes It Unique? International Journal of Psychosocial Rehabilitation. Vol. 10 (2), pp. 29-37. http://www.psycholosocial.com/IJPR_10/Peer_Support_What_Makes_It_Unique_Mead.html.

Mental Health America. Position Statement 11: In support of recovery-based systems transformation. http://www.mentalhealthamerica.net/positions/recovery-systems.

Mind (2004). Not Alone? Isolation and Mental Distress. London: Mind.

Mowbray, CT, Holter, MC, Teague, GB and Bybee, D (2003). Fidelity Criteria: Developoment, Measurement and Validation. The American Journal of Evaluation. Vol. 27 (1). Pp 87-94.

Mueser, KT, Gingerich, S, Salyers, MP, McGuire, AB, Reyes, RU and Cunningham, H (2004). The Illness Management and Recovery (IMR) Scales. Concord, NH: Dartmouth Psychiatric Research Center.

Mueser, KT, Gingerich, S, Salyers, MP, McGuire, AB, Reyes, RU and Cunningham, H (2005). Illness Management and Recovery (IMR) Scales in T. Campbell-Ord, J. Chamberlin, J Carpentar, and HS Leff. Measuring the Promise: A Compendium of Recovery Measures: Volume II. Boston, MA: The Evaluation Center @ HSRI.

National Association of State Mental Health Program Directors. Chapter 8. Trauma and Peer Support Relationships. Engaging Women in Trauma-Informed Peer Support: A Guidebook. http://www.nasmhpd.org/docs/publications/EngagingWomen/PeerEngagementGuide_Color_CHAPTER8.pdf.

National Association of State Mental Health Program Directors. Chapter 1. Fundamentals. Engaging Women in Trauma-Informed Peer Support: A Guidebook. http://www.nasmhpd.org/docs/publications/EngagingWomen/PeerEngagementGuide_Color_CHAPTER1.pdf.

Nelson, G, Lord, J and Ochocka, J (2001). Empowerment and mental health in community. Journal of Community and Applied Social Psychology. Vol. 11. Pp 135-42.

Nelson, G, Ochocka, J, Janzen, R, Trainor, J, Goering, P and Lomorey, J (2007). A Longitudinal Study of Mental Health Consumer/Survivor Initiatives: Part V-Outcomes at 3-year follow up. Journal of Community Psychology. Vol. 35 (5). Pp 655-665.

Norman, J., Walsh, N., Mugavin J., Stoove, M., Kelsall, J., Austin, K., Lintzeris, N. (2008). The acceptablility and feasibility of peer worker support role in community based HCV treatment for injecting drug users.

Harm Reduction Journal. Vol. 5. Pp 8.

O'Hagan, M, Cyr, C, McKee, H & Priest, R (2010). Making the Case for Peer Support. Mental Health Commission of Canada. www.mentalhealthcommission.ca.

Penny, D and Bassman, R. The Independent Living Movement and People with Psychiatric Disabilities: Searching for Common Ground. http://www.community-consortium.org/pdfs/ILC.pdf.

Penunbra. http://www.penumbra.org.uk/about/.

Pistang, N, Barker, C and Hunphreys, K (2010). The Contributions of Mutual Help Groups for Mental Health Problems to Psychological Well-Being: A Systematic Review. In LD Brown and S. Wituk, (eds.) Mental Health Self-Help. Pp. 61-85 New York: Springer.

Prochaska and DiClemente, C. C. (1982) Transtheoretical Therapy: Towards a more integrative model of change Psychotherapy: Therapy, Research and Practice, Vol. 19. Pp 276-88.

Ralph, RO, Kidder, RO and Phillips, D (2000). Can we Measure Recovery? A Compenium of Recovery and Recovery-Related Instruments. The Human Services Research Institute (HSRI) Evaluation Center. http://www.tecathsri.org/pub_pickup/pn/pn-43.pdf

Ralph, RO (2000).Recovery. Psychiatric Rehabilitation Skills. Vol. 4. Pp. 480-517.

Ramon, S (2009). Adult mental health in a changing international context: The relevance to social work.

Rappaport, J (1993). Narrative studies, personal stories and identity transformation in the mutual help context. Journal of Applied Behavioral Science. Vol. 29. Pp 239-56.

Rappaport, J Seidman, E and Toro, P (1985). Collaborative research with a mutual help organization. Social Policy. Vol. 15. Pp 12-24.

Rogers, ES, Teague, G, Lichenstein, C, Campbell, J, Lyass, A, Chen, R and Banks, S (2007). Effects of participation in consumer operated service programs on both personal and organizationally mediated empowerment: Results of multisite study. Journal of Rehabilitation Research and Development, Vol. 44 (6). Pp. 785-800.

Scottish Recovery Network (2013). http://www.scottishrecovery.net/What-is-Recovery/what-is-recovery.html.

Scottish Recovery Network (2014). SRI 2 Guide for Services. http://www.scottishrecovery.net/SRN/View-category.html.

Sheedy, CK and Whitter, M. (2009). Guiding Principles and Elements of Recovery-Oriented Systems of Care: What Do We Know From the Research? HHS Publication No. (SMA) 09-4439. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

Smith-Merry, J, Freeeman, R and Sturdy, S (2011). Implementing recovery: an analysis of the key technologies in Scotland. International Journal of Mental Health Systems. Vol. 5 (1). P 11.

Solomon, M, Pistrang, N and Barker, C (2001). The benefits of mutual support groups for parents of children with disabilities. American Journal of Community Psychology. Vol. 29 (1). Pp 113-132.

Social Care Institute for Excellence, Care Services Improvement Partnership and Royal College of Psychiatrists (2007). A Common Purpose: Recovery in Future Mental Health Services. London: SCIE.

Substance Abuse and Mental Health Services Administration (2010). Peer Support and Peer Providers: Redefining Mental Health Recovery. http://www.promoteacceptance.samhsa.gov/.

Tew, J, Ramon, S, Slade, M, Bird, V, Melton, J and LeBoutillier, C (2012). Social Factors and Recovery from Mental Health Difficulties: A Review of the Evidence. British Journal of Social Work. Vol. 42. Pp 443-460.

Timki, C and Sempel, JM (2004). Intensity of acute services, self-help attendance and one-year outcomes among dual diagnosis patients. Journal of Studies on Alcohol. Vol. 65. Pp 274-282.

Toro, PA, Rappaport, J and Seidman, E (1987). Social climate comparison of mutual-help and psychotherapy groups. Journal of Consulting and Clinical Psychology. Vol. 55 (3). Pp. 430-431.

Triangle Consulting. The Ladder of Change. http://www.outcomesstar.org.uk/star-model-of-change/.

UK Department of Health (2009). New Horizons: A Shared Vision for mental Health.

University of Wooloongong. Measures of Recovery. http://socialsciences.uow.edu.au/iimh/stori/index.html.

Vederhus, J., Kristensen, O. (2006). High effectiveness of self-help programs after drug addiction therapy. BMC Psychiatry. Vol. 6. Pp 35.

Weeks G, Slade M, Hayward M. (2011). A UK validation of the Stages of Recovery Instrument, International Journal of Social Psychiatry, 57 (5). Pp. 446–454. DOI: 10.1177/0020764010365414

White, BJ and Madara, EJ (eds) (2002).The Self-Help Group Sourcebook: Your Guide to Community and Online Support Groups (7th edition). Denville, NJ: American Self-Help Group Clearinghouse.

White, W. (2009). Peer-based addiction recovery support: History, theory, practice, and scientific evidence. Chicago: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.

Williams, J, et.al. (2012) Measures of the recovery orientation of mental health services: systematic review. Social Psychiatry Psychiatric Epidemiology. Online First

Yalom, ID (1995). The Theory and Practice of Group Psychotherapy (4th edition). New York: Basic Books.

York Consulting (2013). Family Star Evaluation: Summary Report. London: Family Action

Young, J and Williams, CL (1988). Whom do mutual help groups help? A typology of members. Hospital Community Psychiatry. Vol. 39 (11). Pp 1178-1182.

Young, J and Williams, CL (1989). Group process and social climate of GROW, a community mental health organisation. Australian and new Zealand Journal of Psychiatry. Vol. 23 (1). Pp 117-123

Zimmerman, M, Reischi, T, Seidman, E (1991). Expansion strategies of a mutual help organisation. American Journal of Psychology. Vol. 19. Pp 251-78.

Zubin, J and Spring, B (1977). Vulnerability: a new view of Schizophrenia. Journal of Abnormal Psychology. Vol. 86. Pp 103-126.

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