

# Evaluation of a Peer-Led Education Pilot for people with psychosocial support needs in Darwin, Northern Territory

Report prepared for  
**Northern Territory Mental Health Coalition**

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## **PREFACE:**

This evaluation report presents findings from a “Peer-Led Education Pilot for people with psychosocial support needs in Darwin”. The project reflects an innovative peer-led education approach that adopts a unique multi-model collaboration process in the design, delivery, and evaluation of the Peer-Led Education Pilot (PLEP). The overarching aim of the evaluation was to describe the appropriateness and effectiveness of the *My Recovery* and Train the Facilitator programs delivered in Darwin as part of PLEP, as well as to inform (a) effective program elements, (b) potential adaptation considerations for Northern Territory (NT) rural and remote areas, and (c) considerations for scalability across the NT.

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## Executive Summary

### Summary

The Alcohol, Other Drugs, and Gambling (AODG) team within Menzies School of Health Research (Menzies) was invited by the Northern Territory Mental Health Coalition (Coalition) to undertake an evaluation of the Peer-Led Education Pilot (PLEP) in Darwin. The Coalition is the peak body for community managed mental health services across the Northern Territory (NT) and works in collaboration with a wide network of organisations, people with lived experience of mental illness, their families, and supporters across the NT. The PLEP was funded by Northern Territory Primary Health Network (NTPHN).

### Background

The contribution of mental health conditions to the total disease burden is significant nationally and is highest in the NT (Australian Institute of Health and Welfare, 2018b; Northern Territory Mental Health Coalition, 2019; Northern Territory Primary Health Network, 2016). In addition, NT residents have the second-highest proportion of mental health-related emergency department visits in Australia (Northern Territory Primary Health Network, 2016). Social and economic disadvantage, rates of homelessness, child removals, adult and youth incarceration, domestic and family violence in the NT also exceed the national average (Zhao, You, Wright, Guthridge, & Lee, 2013). These can have significant impacts on the mental health of the NT population.

Since the release of the “National framework for recovery-oriented practice and service delivery” (Australian Health Ministers' Advisory Council, 2013) all mental health services and state/territory jurisdictions have a responsibility to promote and adopt a recovery-oriented framework that is designed and informed by people with lived experience of mental health issues. In the NT, historically, psychosocial support has not had a strong peer focus, though the *Northern Territory Mental Health Strategic Plan 2019-2025* has since emphasised the importance of implementing and promoting strengths-based recovery-oriented models of care as a priority (Northern Territory Government, 2019).

### Peer focus and peer education

There is strong evidence that peer interaction and peer social support is beneficial in aiding recovery from mental health issues, and the harmful use of alcohol and other drugs. For instance, a number of studies have highlighted the benefits associated with:

- social functioning and personal empowerment (Segal & Silverman, 2002);
- hope and self-efficacy (Mancini, Linhorst, Menditto, & Coleman, 2013);
- quality of life (Castelein et al., 2008);
- self-determination and self-awareness (Bouchard, Montreuil, & Gros, 2010);
- reduced use of emergency and inpatient services (Croft & Isvan, 2013); and
- increased level of functioning and an increase in treatment satisfaction (Greenfield, Stoneking, Humphreys, Sundby, & Bond, 2008).

Peer-led education for the self-management of mental illness is an evidence-based form of psychosocial support. It offers an avenue to reduce the isolation and stigma experienced by people with mental illness, as well as increase people's capacity to understand and manage their own illness (Blixen et al., 2015; Conner, McKinnon, Ward, Reynolds, & Brown, 2015). In a peer-led program, participants are more likely to listen to, and adopt, messages since they assume that the messenger (facilitator) is similar to them and is likely to have faced similar lived experiences (Sloane & Zimmer, 1993).

There are some emerging peer-led education programs that provide psychosocial support and education across different locations in Australia. One prominent evidence-based program is *My Recovery* (described in further detail below). Yet, such programs, have not previously been implemented in the NT, with the exception of the Assisting Families program, delivered by local carer/consumer organisation.

Recognising the gap in peer-led psychosocial education programs in the NT, the Coalition engaged Wellways (an interstate not-for-profit mental health and disability support organisation), to contextualise the *My Recovery* program for delivery within an urban NT context with the support of a local Steering Group. Wellways is well known for its peer education programs that develop skills and build capacity to assist with the recovery of people living with mental health issues (Wellways, 2019a).

Currently, most psychosocial support activities provided in the NT are delivered through individualised outreach and client-centred support programs. Therefore, an opportunity existed to trial a peer-led support program, consistent with approaches adopted in other Australian jurisdictions. The PLEP project therefore aimed to:

- (1) deliver a peer-led education and recovery program to people living in Darwin with experience of mental health and/or alcohol and other drugs (AOD) issues;
- (2) establish a supported and remunerated vocational pathway for people with lived experience of mental health and/or alcohol and other drug issues; and
- (3) stimulate a vocational pathway in peer support.

### **Aims and objectives of the evaluation**

The primary aim of this project was to evaluate the delivery of the *My Recovery* and peer support Train the Facilitator program (collectively referred to as PLEP) delivered by Wellways in Darwin.

The main evaluation objectives were to assess the effectiveness and appropriateness of these programs. These included:

- (1) Describe and evaluate the *My Recovery* and Train the Facilitator program within the Darwin PLEP project;
- (2) identify current issues, challenges, and opportunities associated with the delivery of a peer-led psycho-educational program (PLEP) targeting people with psychosocial support needs in Darwin through the mental health and AOD sector;
- (3) develop a program logic model suitable for the peer-led program; and
- (4) inform the relevant service providers about evaluation outcomes.

## **Program delivery**

PLEP was implemented in two distinct phases. The first phase was the *My Recovery* program, which was delivered over 2 weeks for 3 days a week during August 2019 by Victorian-based *My Recovery* program Facilitators. The contextualisation of *My Recovery* involved adapting course delivery and materials to accommodate: (1) the local context; (2) the local needs of participants; and (3) characteristics of this Darwin pilot project such as needs and gaps in local service provision, support from local service providers, schedule of the program (total length, daily schedule), venue, transport, and logbook content. The accompanying training logbook was also amended to reflect the discussion with, and advice of, the Steering Group members, including mental health service providers, consumers and carers with lived-experience of mental illness, government and education representatives.

The second phase adopted a similar process, whereby the Train the Facilitator program was contextualised in October 2019 with advice from the Steering Group. The intent of implementing the Train the Facilitator program was to train participants who have lived experience of mental illness (primarily those involved in the first phase of PLEP) to become local facilitators of the *My Recovery* program. The intent was to build a pool of local facilitators in Darwin that can assist with the subsequent delivery of *My Recovery* over the longer-term. The training was delivered over 5 consecutive days in November 2019. This was followed by an additional 1-day co-reflection workshop; and individual co-reflection sessions.

## **Evaluation methodology**

The evaluation was qualitative in design. It involved individual pre and post program interviews with *My Recovery* and Train the Facilitator program participants, and sectoral stakeholders, namely Program Facilitators and Trainers, Steering Group members, and the Coalition representatives. The evaluation subsequently (1) contributes to building a more robust contextualisation of evidence-based information to inform mental health policy and practice in the NT; and (2) provides recommendations of possible future adaptations and scalability across the NT.

A thematic analysis of Program Participants' interview data was undertaken. Inductive thematic analysis is a data-driven method of analysing qualitative data. It allows the generation of themes that are closely related to the studied phenomenon (Boyatzis, 1998; Corbin & Strauss, 2014). This was complemented by the adoption of framework analysis, whereby interview data collected from Program Facilitators and Trainers, Steering Group members, and the Coalition representatives were compared against the themes emerging from the analysis of Program Participant data. Framework analysis typically uses pre-existing theoretical constructs (deductive approach) to code and analyse data but it also allows to include data-driven themes (inductive approach) to inform the development of the analytic framework (Ritchie & Lewis, 2003).

## **Results**

Overall, PLEP was very well-received by both Program Participants with lived experience of mental health challenges, and key local mental health service providers and the AOD sector. Interview data demonstrated a high demand and appetite for a peer-led approach to mental health and AOD recovery

in the NT. The *My Recovery* program supported Program Participants (n=17) to understand and self-manage their mental health and/or AOD issues by decreasing self-reported levels of psychological distress; improving in their coping skills; developing knowledge of, and better utilising, local social supports; and developing a deeper understanding of their mental health needs. In addition, the Train the Facilitator program also built the capacity of some of the Program Participants (n=11) to deliver the *My Recovery* program to other people in the Darwin community beyond the evaluation timeframe of the PLEP project. Interviews conducted with Program Facilitators and Trainers, Steering Group members, and the Coalition representatives, alongside those of Program Participants, enabled the identification of challenges and opportunities experienced during the pilot project delivery of PLEP.

The most important opportunities were:

- the perceived benefits of the program on participants' coping skills, confidence, resilience, trust, self-control, and self-awareness;
- the advantages of a diverse, motivated and professional Steering Group including the voice of lived experience representatives in supporting the program pilot;
- the significant role of the lived experience Project Officer in program management;
- the essential role of program contextualisation in the success of the pilot project;
- the significance of the self-nomination in the recruitment process
- the potential to develop a stronger relationship between AOD and mental health sectors, and stable referral pathways with mental health sector; and
- the need of vocational pathways for people with lived experience of mental illness that incorporate a focus on peer-support.

While the following presented some challenges:

- the distance (since the *My Recovery* program Facilitators and Train the Trainer program trainer were based in Melbourne);
- the recruitment process;
- the pilot project timeframe and budget; and
- the lack of participants' knowledge of the peer-facilitation model.

## **Conclusion**

This pilot project highlighted the importance of incorporating the perspectives of those with lived-experience of mental illness into peer-support models in aiding mental health and AOD recovery journeys for people in Darwin, NT. It also demonstrates the need for developing peer support networks and the potential to grow a peer workforce across the Darwin region, with potential for scalability and expansion across other regions of the NT.



## Recommendations

Key recommendations from the evaluation include:

- The PLEP project was reported by evaluation participants to be highly effective for people with unmet mental health needs in Darwin. There was significant support among all stakeholders interviewed for further investment in the program's sustainability, expansion and scalability across the NT.
- PLEP participants expressed a desire to focus on personal development, build self-confidence, and to connect with local support networks. It is evident there is potential to raise greater awareness among mental health consumers about personal treatment options and peer-recovery planning strategies.
- There is an unmet demand within the AOD and mental health sectors for sustained investment in peer-led psychosocial education support programs in the NT. Any future investments must incorporate the lived experiences of people diagnosed with a mental illness; and be focused on the development of explicit peer-recovery models.
- There is an opportunity for the AOD and mental health sectors to work more collaboratively with respect to the delivery of peer-led psychosocial education support.; and to further develop and build the capacity of a local workforce with relevant expertise and life experience to provide this support.
- There is an appetite within the AOD and mental health sectors to build vocational pathways for people with lived experiences of a mental illness. This should include the provision of formal Vocational Education and Training (VET) qualifications relating to health and community services (with AOD and/or mental health specialisations that incorporate a focus on peer-support and lived experience), and peer-support.
- The NT Mental Health Coalition is well positioned to co-ordinate and lead ongoing professional development and training opportunities for the AOD and mental health service sectors about emerging evidence-based peer-led psychosocial education and support models and approaches. A sector-wide forum or conference on this topic is warranted.
- Peer-led psychosocial education and support programs need to be appropriately tailored to local contexts. Due consideration of geography, cultural background, and age are particularly important, and should be considered as part of the curriculum design and delivery format. Contextualisation needs to be underpinned by appropriate governance structures, and include people with lived experience of mental illness, preferably from the intended target audience.
- Sustained efforts to strengthen the evidence-base about the effectiveness of emerging peer-led psychosocial education and support programs in the NT, such as PLEP, is vital. This should include pre and post mental health assessments.

## Introduction

### Background

The contribution of the mental health conditions to the total disease burden is well-known. Behind cardiovascular disease and cancer, mental illness, and substance use disorders represent the third - highest disease group responsible for 12% of the total disease burden in Australia (Australian Institute of Health and Welfare, 2018a). One in five (20%) Australians aged 16-85 experience a mental disorder in any year (Northern Territory Government, 2019), and 45% will experience it during their life (Australian Institute of Health and Welfare, 2018a). The most common types of mental illnesses are depression (mood disorder), anxiety, and substance use disorder, which often occur in combination (Northern Territory Government, 2019).

The Mental Health and Suicide Prevention Needs Assessment 2016 (MHSP NA) was completed by peak bodies in the NT, in conjunction with the Drug and Alcohol Treatment Needs Assessment and the NT PHN Baseline Needs Assessment. It provides an overarching description of health status in the NT. The outcomes showed that the mental health burden of disease is significantly higher in the Northern Territory (NT) than the national average, and mental health disorders are often under-reported or under-diagnosed (Northern Territory Primary Health Network, 2016). For instance, previous data showed that in the NT mental health and substance use disorders were found to be responsible for 16.3% of the total burden of disease (Aboriginal Medical Services Alliance of the Northern Territory, 2011; Department of Health and Families Northern Territory Government, 2009; Zhao et al., 2013), while nationally this was estimated to be 12% in 2018 (Australian Institute of Health and Welfare, 2018a). While the increasing amount of mental health-related admissions may relate to the increased access to services, the high rates of self-inflicted injury and suicide indicate that there is a substantial mental health burden that is not treated and detected (General Practice and Primary Health Care Northern Territory (GPPHCNT) 2007; Measey, Li, & Parker, 2005). In addition, the number of deaths from suicide is also significantly higher in the NT than the national average (Northern Territory Department of Health, 2018). The NT Government is committed to decreasing the number of suicide-related deaths aiming to halve the numbers over the next ten years (Northern Territory Department of Health, 2018). According to the outcomes of the National Psychosocial Support Measure (NPSM), health and service needs analysis, regional needs in NT were seen to be the highest within the Darwin urban area, identifying a high number of under-supported people with severe and complex mental illness (Northern Territory Primary Health Network, 2018).

In the NT, psychosocial support is primarily implemented through individualised outreach and centre-based program supports. Historically, this has not had a strong peer focus. Yet, evidence suggests that mental health care peer support and the participation of consumers with lived experience of mental health in the design and delivery of mental health services can have positive impacts on employment and mental health recovery journeys (Hayes, 2016; Health Workforce Australia, 2014). At present, the NT is the only jurisdiction in Australia where a Vocational Education and Training (VET) Certificate in Peer Support is not offered locally. In addition, there is no professional body in the NT that specifically supports the capacity building of the peer workforce, which means that it is difficult to ascertain the exact number of voluntary and employed peer workers (Northern Territory Primary Health Network, 2018)

The Coalition was funded by the NTPHN to (1) invite key regional stakeholders to participate in a Steering Group for PLEP; (2) undertake a rapid review of existing psycho-education programs; (3) engage with an external program provider in order to plan, adapt and deliver a psycho-educational program for people with lived experience of mental health issues in the Darwin and Palmerston Local Government Areas (Darwin) (Figure 1); (4) support community mental health organizations through the delivery of a psycho-educational program; (5) provide support and professional supervision for peer facilitators engaged for the delivery of the PLEP, (6) evaluate the pilot project, (7) report to NT PHN and (8) include recommendations for further implementation of peer-led education for people with psycho-social support needs in the NT. The Coalition was the Lead Agency for the Peer-Led Education Pilot (PLEP) project for people with psychosocial support needs. Wellways Australia was engaged by the Coalition to contextualize the *My Recovery* program in Darwin. Menzies (External Evaluators) was engaged to undertake a qualitative program evaluation involving pre and post-program analyses of key stakeholders associated with the planning and implementation of the Darwin-based pilot project of the PLEP.

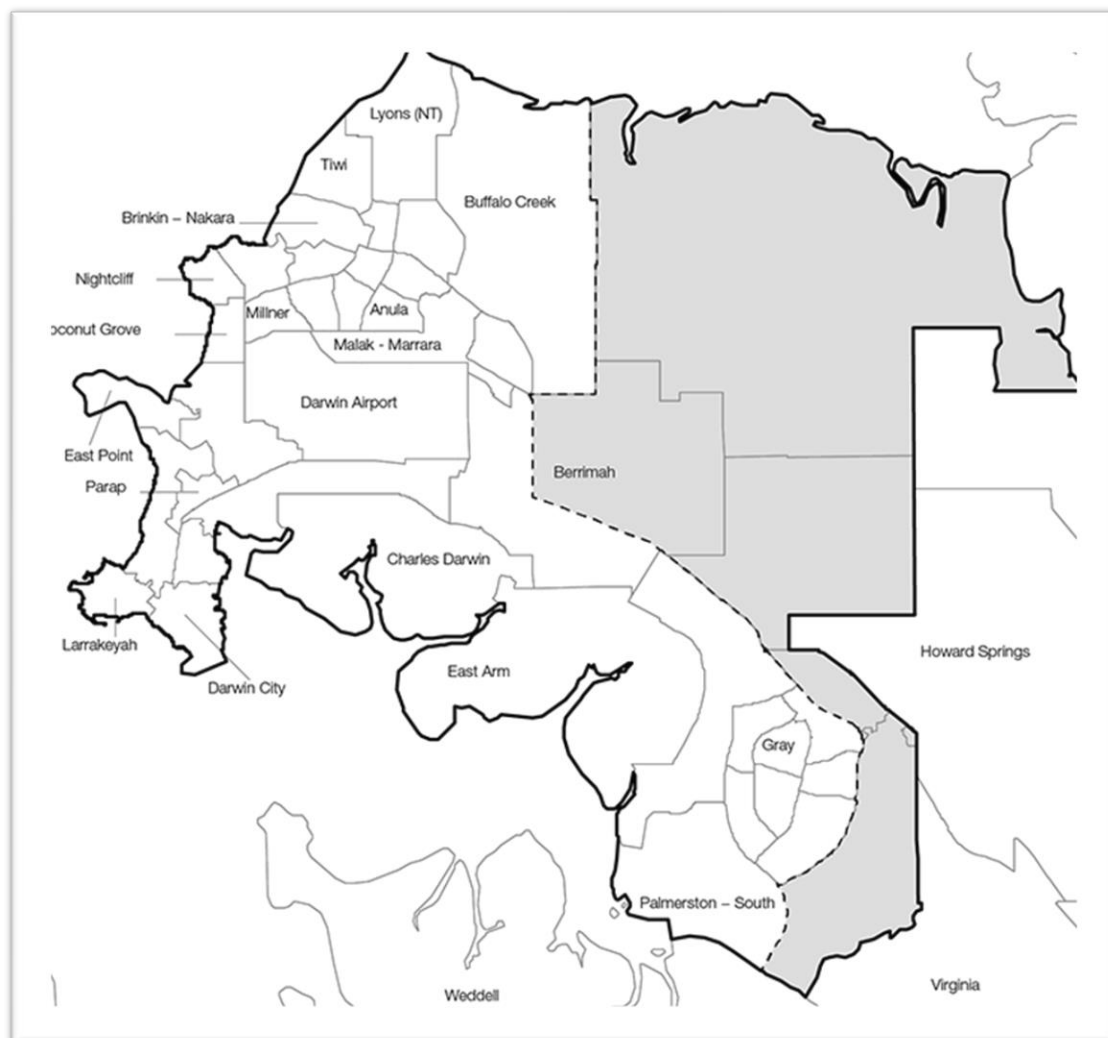


Figure 1: Darwin and Palmerston Local Government Areas (Darwin)

Source: <https://www.aec.gov.au/>

PLEP was a trial and the first of its kind in the NT. Although it has been trialed in other states, the NT context deserves specific attention to consider social, geographical, and cultural differences.

## Mental health and mental health services in the Northern Territory

Mental health conditions in the NT contribute to 16.3% of the burden disease, the highest rate in Australia (Australian Institute of Health and Welfare, 2018b; Northern Territory Mental Health Coalition, 2019; Northern Territory Primary Health Network, 2016). In addition, NT residents have the second-highest proportion of mental health-related emergency department visits in Australia (Northern Territory Primary Health Network, 2016), and young Territorians aged between 15 and 24 years are described as being the most over-represented population within mental health services, compared to other age groups, constituting 25% of all community-based clients, despite being only 15% of the population. Whilst this pilot project is not specifically Indigenous-focused, the Aboriginal<sup>1</sup> population also experience high/very high psychological distress approximately double the national average of 11.8% (Northern Territory Mental Health Coalition, 2019). In addition, there are unique considerations when considering social and emotional wellbeing (SEWB) approaches with young Aboriginal and Torres Strait Islander people (Smith, Christie, et al., 2019)

In the NT, social and economic disadvantage is well documented (Smith, Whetton, & d'Abbs, 2019). Rates of homelessness, child removals, adult and youth incarceration, and domestic and family violence, consistently exceed the national average (Zhao et al., 2013). In addition, there are lower than average rates of educational attainment and a multitude of poor health outcomes (Zhao et al., 2013). Previous research has shown that mortality and morbidity rates are significantly influenced by socioeconomic status (SES) (Zhao et al 2013). This indicates that the social determinants of health and wellbeing, which lead to poor physical and mental health, need to be addressed by service providers in order to adequately support people to improve mental health and wellbeing outcomes for Territorians (Zhao et al., 2013).

Homicide rates in the NT relating to domestic and family violence (DFV) are disturbingly high (Australian Institute of Health and Welfare, 2018c). More specifically, DFV victims and survivors excessively experience mental health issues because of the abuse they have experienced (Australian Institute of Health and Welfare, 2018c). In 2011/12 Aboriginal women in the NT were 80 times more likely to be hospitalised as a result of assault than non-Indigenous women (AIHW, 2012) and the NT reported over 20 times the rate of alcohol-related family violence than other Australian states (Miller et al., 2016). In addition, it is well documented that the social and economic costs and harms of alcohol consumption in the NT have a significant impact on the social and emotional wellbeing of Territorians (Smith, Whetton, & D'Abbs, 2019; Stephens et al., 2019). Alcohol and Other Drug (AOD) use is often cited as a means to relieve or cope with mental health symptoms. In addition, AOD intoxication and withdrawal can generate mental health symptoms and disorders like anxiety, depression, bipolar, obsessive-compulsive, and psychotic disorders (Marel et al., 2016). This infers that integrated policy responses between the AOD and mental health sector, are required to effectively address co-morbidities (Stephens et al., 2019). Historically, there is little evidence this has been achieved in the NT. However, current regional mental health and suicide prevention planning being co-led by NTPHN, NT Department of Health and the Aboriginal Medical Services Alliance NT (AMSANT) is occurring in parallel to alcohol treatment services planning being led by NT Department of Health. This provides a

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<sup>1</sup> The term of 'Aboriginal' was used to reflect Aboriginal and Torres Strait Islander, Indigenous or First Nations people for purposes of brevity

logical opportunity to achieve integrated service delivery that benefits people with both AOD and mental health concerns (Northern Territory Primary Health Network, 2017; Stephens et al., 2019).

In the NT, there are additional characteristics of the mental health and suicide prevention services system that need to be considered to provide optimum health outcomes. The NT has the highest proportion of Aboriginal and Torres Strait Islander Australians reflecting approximately 30% of the total population; in comparison to the other jurisdictions where Indigenous people make up 1-4% of the population (Australian Bureau of Statistics (ABS), 2013). It is well documented that there are high levels of trauma and disadvantage experienced by significant proportions of the NT Aboriginal population (Northern Territory Council of Social Service (NTCOSS), 2019; Northern Territory Government Department of Health, 2016; Northern Territory Mental Health Coalition, 2017b; Zhao, Thomas, Guthridge, & Wakerman, 2014). Additional service needs also relate to suicide prevention among young people and meeting the mental health needs of the NT's growing migrant and refugee populations, and the Lesbian, Gay, Bisexual, Transgender, and Intersex (LGBTI) community (Northern Territory Mental Health Coalition, 2017b)

Furthermore, the community mental health sector continues to struggle to retain suitability qualified staff considering the multitude of organisations operating in this space in the NT, such as NT Government and large national non-government organisations. They are significantly impacted by staff attrition, with the subsequent loss of sectoral knowledge, leadership skills, cross-organisational relationships, and positive organisational cultures (Northern Territory Mental Health Coalition, 2017b). NTCOSS also noted that professionals who are in contact with people experiencing challenges to their mental health needs do not always have the necessary training, experience, and expertise to recognise the early warning signs (Northern Territory Council of Social Service (NTCOSS), 2019). Since the release of the "National framework for recovery-oriented practice and service delivery" (Australian Health Ministers' Advisory Council, 2013) all mental health services and state/territory jurisdictions do have a responsibility to promote and adopt a recovery-oriented framework that is designed and informed by people with lived experience of mental health issues. In the NT, historically, psychosocial support has not had a strong peer focus though after the announcement of the "Northern Territory Mental Health Strategic Plan 2019-2025" (Northern Territory Government, 2019) implementing and promoting strengths-based recovery-oriented models of care is one of the priority areas

### **Peer interaction, peer-led education, and peer support workforce**

There are a growing number of research studies underpinning the role of peer interaction and peer social support in recovery from health conditions such as cancer (Allicock et al., 2014), mental health issues (Tracy & Wallace, 2016) and alcohol and other drug use (Tracy & Wallace, 2016). Services involving people with lived experience of mental illness have demonstrated effectiveness in supporting recovery journeys (Sax Institute, 2015). For instance, a few studies have shown that participants involved in consumer-run and/or consumer-led services, or in services supported by peer workers, have achieved better social functioning than those who only access traditional mental health services (Bell, Panther, & Pollock, 2014; Health Workforce Australia, 2014; Western Australian Association for Mental Health, 2014; Yanos, Primavera, & Knight, 2001). Moreover, 'The Safe Haven Café' - run by clinicians, peer support workers and volunteers with lived experience of mental health illness - is a specific example that showed strong evidence about the cost-effectiveness and benefits

of peer support programs, including improved patient experience and improved social connectedness (Price Waterhouse Coopers Consulting Australia, 2018). This is an after-hours drop-in centre at St Vincent's Hospital Melbourne (SVHM) that caters specifically for people seeking mental health support for people in need. Alongside this perspective, there is an increasing tendency of interest in a partnership and working in collaboration to achieve better health, social and economic outcomes (Smith et al., 2018). Intersectional collaborations are also considered to show significant contributions to several health issues such as mental health (Jalleh, Anwar-McHenry, Donovan, & Laws, 2013).

This format for providing psychosocial support has not previously been implemented in the Northern Territory. There are some emerging peer-led education programs across Australia. One of these is the Wellways *My Recovery* program (further details about this program are provided below). Wellways is an organisation widely known for its peer education programs that develop skills and build capacity to assist with the recovery of people living with mental health issues (Wellways, 2019a)

According to the Health Workforce Australia (HWA) Peer Support Workforce study, peer workers are defined as:

“People who are employed in roles that require them to identify as being or having been a mental health consumer or carer. Peer work requires that lived experience of mental illness is an essential criterion of job descriptions, although job titles and related tasks vary.” (Health Workforce Australia, 2014, p. 5)

Peer workers have an important role in the recovery process - supporting and assisting others to develop confidence and hope for their recovery journey. Previous studies have shown significant benefits of involving peers and investment in peer workforce is likely to make savings to the whole mental health service system (Kaine, 2018). This pathway also provides a legitimate form of employment for people that have often faced difficulty in obtaining and/or sustaining employment over extended periods.

In line with the national peer workforce plans and guidelines, NT policy frameworks and implementation plans also include responsibilities to establish and strengthen consumer and carer peer workforce (Department of Health, 2017; Northern Territory Government, 2019). By strengthening consumer and carer participation in this way, improvements in the quality of program and service delivery can be achieved, particularly in relation to increasing carer satisfaction with mental health services (Australian Health Ministers' Advisory Council, 2013). As mentioned earlier, there are no career pathways for people with lived experience to develop formal qualifications as a peer worker to meet the increasing demand for a skilled workforce, with a concurrent lack of VET peer-supported pathways (Kaine, 2018). The 2017 NT Mental Health and Suicide Prevention Service Review (Northern Territory Mental Health Coalition, 2017a) outlined the central role that the peer support workforce plays in improving the quality of mental health services. Recovery-oriented approaches recognise the value of adapting to the aspirations and needs of people who engage with mental health services and have the responsibility to embrace and support the development of new models of peer-run programs and services.

## Wellways: *My Recovery* education and support program

The national framework for recovery-oriented mental health services (Australian Health Ministers' Advisory Council, 2013) provides a vital new policy direction to enhance and improve mental health service delivery in Australia. This new perspective supports a range of recovery-oriented approaches developed in Australia's states and territories that are drawn from national and international research focused on complementing existing professional standards and competency frameworks. Central to this model is the lived experience and insights of people with challenging mental health needs and their families (Australian Health Ministers' Advisory Council, 2013).

In alignment with this framework, '*My Recovery*' is an education and support program led by trained people who have their own lived experience of mental health issues and recovery. *My Recovery* applies a non-clinical and holistic perspective in mental health recovery that complements existing clinical support services. The purpose of its design is so that participants can explore their recovery and build skills in a safe environment. The program design is underpinned by theories of recovery and peer support (Chamberlin, 1997; Mead, 2014). It values the diversity of experience, identity, background and culture, and differing cultural perspectives about wellbeing - expecting that participants, regardless of their world view, will ultimately connect as a peer group (Nunan, 2019).

*My Recovery* is delivered as a 10-week program by Wellways Australia in different locations across Australia. This has included delivery in the Australian Capital Territory, New South Wales, Victoria, and Tasmania. It has also been delivered by partner organisations in Queensland and Western Australia. While Wellways has different programs for families, friends, and carers, *My Recovery* is offered for individuals with mental health needs. It takes place in a supportive, structured learning environment and consists of an introductory session, followed by nine weekly sessions where information sharing, group discussion, presentations (from someone about their own mental health issues and recovery), films, and practical activities are applied. During the program, participants:

- learn about mental health and recovery;
- explore ways to improve social and emotional wellbeing (SEWB);
- develop communication and advocacy skills;
- discover ways to challenge stigma and discrimination;
- share and learn from the experiences of others; and
- develop ongoing support networks.

By the end of the program it is envisaged that Program Participants feel more positive about themselves, their place in the community, what they can achieve in life, as well as feeling motivated to take positive steps towards healing and wellbeing (Wellways, 2019a).

Multiple evaluations of the Wellways program have shown that participants leave the program feeling more empowered and more confident to challenge stigma and improve their overall health and wellbeing (Wellways, 2019a). For instance, one survey study using self-reported validated scales found significant improvements in empowerment, illness management, stigma reduction, and health status among participants post-program delivery demonstrating significant positive outcomes. Results suggested that post-program improvements were maintained at an eight week follow up period (Porter, 2012). In 2011, Wellways also invited previous *My Recovery* program participants and



facilitators to provide feedback about their subjective experiences of participating in the program. They also sought to get insight into the key learnings of Program Participants, to support continuous quality improvement in program delivery. This resulted in the following themes being identified: internalised stigma reduction, peer support, lived experience, redefining identity, self-esteem and confidence, self-efficacy and empowerment, information and choice, citizenship and belonging, and illness management. Most themes directly aligned with the theoretical and lived experience recovery factors and conditions that had been deliberately embedded in the program design (Chamberlin, 1997; Mead, 2014; Nunan, 2019).

## Wellways: Train the Facilitator program

Wellways collaborates with other organisations to train program facilitators in delivering Wellways peer education programs. There are currently more than 120 trained facilitators across Australia. In the Train the Facilitator training process, skilled and well-experienced mentors support participants to improve and develop their skills and knowledge in key areas of peer education (Wellways, 2019a, 2019b).

In most cases, the Train the Facilitator program participants have first completed the *My Recovery* Program previously mentioned, although this is not a compulsory requirement. The Train the Facilitator program applies the following training elements to build upon existing competencies: face to face training, ‘on the job learning’, co-reflection; and peer-facilitated support and mentorship (via phone, email, group teleconferences and face to face). Table 1 shows the Train the Facilitator program requirements (Wellways, 2019b).

Table 1

<b>Essential personal attributes</b>	Lived experience of mental health recovery Demonstrated leadership qualities Ability to self-reflect and discuss personal life experiences using recovery-oriented language Values live experience, respects diversity and demonstrates a willingness to explore worldviews of others Possess a drive to support positive change and transformation Exhibits personal attributes that contribute to positive role modelling and instil hope in others living with mental health challenges
<b>Essential skills</b>	Good communication skills Ability to work independently and as a part of a team Possess a current driver’s licence and have access to a vehicle or is able to secure transport with their participating organisations
<b>Essential knowledge</b>	Understand the concept of being a “peer” Understand the concept of ‘recovery’ Understand key conceptual peer education principles
<b>Desirable skills and knowledge</b>	Knowledge of adult learning principles Conceptual knowledge of stages of group development and group dynamics



	Previous experience working with peer groups Able to provide clear directions and instruction Knowledgeable of mental health legal framework Conceptual understanding of social and emotional wellbeing
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By the end of the Train the Facilitator program, participants are familiar with the following topics and modules:

- The history of *My Recovery*,
- Key recovery concepts and models that underpin the program,
- The content of the *My Recovery* program and use of the associated resources,
- Peer education concepts and techniques that support program facilitation,
- Adult learning principles, and
- The organisational structures that support program delivery.

*My Recovery* facilitators must be accredited by Wellways prior to delivering the *My Recovery* program. People attending the Train the Facilitator training are assessed based on certain elements of competency such as:

- program content;
- program manuals, session layouts, and interaction of content;
- instruction style; facilitator style and peer facilitator style;
- responsibilities of a peer facilitator; and
- correct use of the program resources and technical equipment (Wellways, 2019b).

## Project Components

### Initial Engagement

The Coalition invited Menzies to undertake monitoring and evaluation functions of the pilot project in April 2019. After further discussions between the Coalition, Menzies, Steering Group members and Wellways, the conceptualisation and implementation of the program, and evaluation scope, was discussed and finalised at a workshop on 23<sup>rd</sup> and 24<sup>th</sup> May 2019. Three members of the evaluation team attended this workshop.

### Composition of the Research Team

- Dr Noemi Tari-Keresztes, Research Fellow, Menzies
- Mr Benjamin Christie, Project Officer, Menzies
- Dr Himanshu Gupta, Research Fellow, Menzies
- Ms Tessa Wallace, Health Promotion Officer, Menzies
- Ms Donna Stephens, Project Manager, Menzies
- Ms Paris Caton-Graham, Indigenous Trainee, Menzies
- Professor James Smith, Father Frank Flynn Fellow (Harm Minimisation), Menzies

### Ethics Submission

An important part of conducting research and evaluation with a high level of integrity involves obtaining ethics approval from a certified Human Research Ethics Committee (HREC). An ethics proposal was prepared to undertake individual interviews with Program Participants (PP), Steering Group members, and Wellways Program Facilitators and Trainers. The ethics application was submitted to the NT Department of Health and Menzies School of Health Research HREC on 4<sup>th</sup> June 2019. Conditional approval was received on 4<sup>th</sup> July 2019 (HREC Ref. No. 2019-3426). A letter of response addressing ethics concerns was submitted on 24<sup>th</sup> July 2019, with full ethics approval obtained on 1<sup>st</sup> August 2019 (Appendix A). This was two weeks prior to the delivery of the *My Recovery* program.

### Sustained Engagement

Representatives of the research team have attended multiple Steering Group meetings throughout the project. Table 2 presents an outline of engagement and key activities during the pilot project. This model of sustained engagement was consistent with building trust and rapport with key stakeholders and adopting a meaningful partnership approach. These qualities are deemed important in the evaluation of mental health programs and service services, where sensitive issues may be discussed.

Table 2 – Engagement activities of the PLEP evaluation team

Dates of Engagement	Participants	Activity (purpose)
13/05/2019	Steering Group, Coalition, and Menzies research team members	Overview of the PLEP pilot project and research components
23/05/2019 – 24/05/2019	Steering Group, Coalition, Menzies research team members and Wellways	Contextualisation of the Darwin PLEP pilot project and discussion of the Terms of References (ToR)

14/06/2019	Menzies research team members and the Coalition	Introduction of the new Project Officer of PLEP pilot project
18/07/2019	Steering Group, Coalition and Menzies research team members	Meeting on project progression update
01/08/2019	Steering Group, Coalition and Menzies research team members	Preparation for PLEP implementation
05/08/2019 -09/08/2019	Menzies research team members	Conducting pre-program individual interviews ( <i>My Recovery</i> )
12/08/2019 – 23/08/2019	Wellways team	Delivery of the <i>My Recovery</i> Program in Darwin
22/08/2019	Menzies research team members	Conducting individual interviews with Wellways team
04/09/2019 – 18/09/2019	Menzies research team members	Conducting post-program interviews ( <i>My Recovery</i> )
05/09/2019	Steering Group, Coalition and Menzies research team members	Meeting on project progression update and on experiences re delivery of the <i>My Recovery</i> program in Darwin
18/09/2019 – 24/10/2019	Menzies research team members	Conduction interviews with Steering Group members
03/10/2019-04/10/2019	Steering Group, Coalition, Menzies research team members and Wellways team	Contextualisation of the Darwin Train the Facilitator program
07/11/2019	Steering Group, Coalition and Menzies research team members	Meeting on project progression update
11/11/2019 – 15/11/2019	Wellways team	Delivering the Train the Facilitator training
20/11/2019	Menzies research team members	Conducting the Train the Facilitator participant interviews
28/11/2019	Steering Group, Coalition and Menzies research team members	Meeting on project progression update
04/12/2019	Menzies research team members and the Coalition	Acceptance of Program Logic
21/01/2020	Menzies research team members	Conducting Researchers personal journey interviews
06/02/2020	Steering Group, Coalition and Menzies research team members	Meeting on project progression update
14/02/2020	Menzies research team members	Conducting the last Train the Facilitator participant interview

## Program Logic

The program logic details the flow-on effect that national strategies and inputs have as they filter down to programme level outcomes in the short to long-term. The logic describes the inputs derived from policy direction to shape programme activities, which reflects the anticipated impacts at individual, community, and service system levels. This was contextualised and approved by the Coalition, using the NTPHN Needs Assessment (2016) (Northern Territory Primary Health Network, 2016) priority areas relating to health and service needs analysis (see Appendix B).

## Aims and objectives

The primary aim of the evaluation of PLEP was to evaluate the delivery of the *My Recovery* program in Darwin. The main evaluation objectives were to address the effectiveness of *My Recovery* and peer support Train the Facilitator programs. These include:

- To describe and evaluate the effectiveness of the *My Recovery* and Train the Facilitator program within the Darwin PLEP project
- To identify current issues, challenges and opportunities associated with the delivery of a peer-led psycho-educational program (PLEP) targeting people with psychosocial support needs in Darwin through the mental health and AOD sector
- To implement the development of a program logic model suitable for the peer-led program
- To inform funding agencies and the relevant service providers about evaluation outcomes

This evaluation describes the appropriateness and effectiveness of the programs (*My Recovery* and peer support Train the Facilitator ) provided by Wellways in Darwin. The evaluation (1) contributes to a robust contextualisation of evidence-based information to inform mental health policy and practices.; and (2) provides recommendations about possible future adaptations and scalability across the NT.

## Monitoring & Evaluation Approach

### Evaluation methodology, recruitment and data collection

This evaluation project involved individual interviews with key stakeholders involved in the planning and delivery of the PLEP program (program refers to the combined *My Recovery* and Train the Facilitator programs hereafter), including Program Participants, Steering Group members, and Program Facilitators and Trainers. Initially, the research team planned to conduct observations as well (such as Program Participants-facilitators interactions, Program Participant-Program Participant interactions, and Steering group member interactions). However, after the initial consultation with the Coalition, Steering Group, and *My Recovery* facilitators, observational methods were abandoned to ensure participants felt at ease during the *My Recovery* training program.

A purposive sampling method was used, which involved the Coalition identifying people with psychosocial support needs through mental health services and AOD providers in Darwin. A Flyer and an Expression of Interest (EOI) form were developed to potential Program Participants by the PLEP Project Officer Coalition (see Appendix C). Hence, Program Participants were directly recruited by the Coalition, and evaluation interviews were carried out by the Menzies research team in Darwin, Palmerston - whichever location was most preferred by the participant. These were considered safe environments and included community centres, AOD rehabilitation centres, public areas, community, and government mental health services. The Coalition introduced the research team to Program Participants at the commencement of each interview, explaining the intent of the evaluation. It was explained that participation in the evaluation was voluntary.

The following inclusion criteria were applied to the recruitment of PLEP Program Participants:

- over 18 years;
- having lived experience of mental illness;
- resident in Darwin and or Palmerston; and
- providing informed consent.

In this qualitative evaluation project, a staged approach to the design and implementation was necessary. This involved the following phases and components, beyond the community development phase where the Coalition built relationships with relevant organisations and service providers.

#### Phase 1: Introduction to *My Recovery*

- Individual interviews with Program Participants before (n=14) and after (n=16) the *My Recovery* program delivery;
- Individual interviews with *My Recovery* Program Facilitators (n=2) after the *My Recovery* program delivery
- Individual interviews with Steering Group members (n=8) after the *My Recovery* and before the Train the Facilitator program delivery; and
- Thematic data analysis of participants' self-reported mental health status and the perspectives and experiences associated with participation in the *My Recovery* program (i.e. challenges and opportunities)

- Framework analysis of (1) the perspectives of Steering Group members and *My Recovery* program Facilitators about PLEP; and (2) perspectives of Steering Group members' roles and responsibilities

Phase 1 of the project involved individual interviews with *My Recovery* program participants (both before and after program delivery). It also involved undertaking interviews with *My Recovery* program Facilitators whilst they were completing the delivery of the program in Darwin. Participants had the option to have someone with them whilst being interviewed (i.e. an interview support person). However, only one of the Program Participants took this opportunity during the initial pre-program interview. Menzies investigators conducted all interviews face-to-face. All investigators had previous experience in undertaking research interviews with vulnerable client groups. Interviews involved a semi-structured approach that began by allowing participants to reflect on their mental health status. This was followed by targeted questions about their expectations and motivation before participating in the *My Recovery* program. This was followed by assessing their experience and viewpoints after the program was delivered (see interview guides - Appendix D).

Participants were asked to provide signed informed consent after they had understood and considered the detailed information in the form of a Participant Information Sheet (see Appendix E and F). Participation in the evaluation process was voluntary and participants were given gift vouchers for their time. While it was initially envisaged that interviews would be 45-90 minutes, most interviews were between 30-60 minutes in duration to limit the evaluation burden on Program Participants.

Interview data was recorded and transcribed verbatim by a professional transcription service. No identifying information was used. This ensured the anonymity of participants was retained. Program Participants were contacted by the External Evaluators after each interview and given the opportunity to provide feedback on their interview transcript. This was a form of member-checking. Interview transcripts were analysed using both inductive thematic analysis (for Program Participant data) and framework analysis (for Steering Group, *My Recovery* facilitator, and Train the Facilitator trainer interview data) approaches. NVivo 12 software was used to manage and organise the interview data. Data analysis was conducted by NTK, BC and TW.

An inductive thematic analysis approach was chosen for analysing the Program Participant data. Thematic analysis (TA) is a method for systematically identifying, organising, and offering insight into patterns of meaning (themes) across a data set (Braun & Clarke, 2012). It is typically a 'bottom-up' approach that is data-driven. It allows the generation of themes that are closely related to the studied phenomenon rather than linking the data back to the theory or preconceived ideas (Boyatzis, 1998; Corbin & Strauss, 2014), and thus provides unique insights into the lived experiences of the population of interest. This approach aligned with the intent to capture the unique peer-led education approach, peer-to-peer communication, and privilege of the lived experience of Program Participants, as it related to PLEP.

Framework analysis typically uses an existing structure or framework to code and analyse data (Moore et al., 2015; Parkinson, Eatough, Holmes, Stapley, & Midgley, 2016; Ritchie & Lewis, 2003). In this instance, this approach was used for the analysis of the Steering Group, *My Recovery* facilitator, and Train the Facilitator trainer interview data, whereby themes from literature and the Program

Participant interviews were used to guide the analysis process. This (a) acknowledges the existing evidence-base and (b) privileges consumer viewpoints as the primary point of reference

In addition, one evaluation team member that had not been involved in participant interviews (HG), conducted interviews with the two evaluation team members that had been directly involved in data collection processes (BC and NTK), to reflect on their experiences in being involved in the project and another team member (TW) analysed the interview transcripts. This is consistent with qualitative research that advocates for critical reflection to be incorporated as a core component of research and evaluation projects and is also deemed an appropriate way to strengthen the validity of data collected (Gardner, 2003).

### **Phase 2: Train the Facilitator (delivery of the *My Recovery* program)**

- Individual interviews with Train the Facilitator program participants after the program; (n=10)
- Individual interviews with Train the Facilitator program trainers (n=2);
- Individual interviews with Steering Group members (n=2);
- Individual interviews with Research team members (n=2); and
- Thematic data analysis of (1) participants' challenges and opportunities in the Train the Facilitator program, (2) their perspectives about the program and (3) personal journey of participants who participated in phase 1 and phase 2 phase 2 as well as well (n=5) and researchers (n=2) within the PLEP pilot project
- Framework analysis of perspectives of Steering Group members (n=2) and Train the Facilitator program trainers (n=2)

Phase 2 involved individual interviews with Train the Facilitator program participants, trainers, and Steering Group members. The same process used during Phase 1 was applied during Phase 2. The interview guides are included in Appendix G.

### **Contextualisation of the *My Recovery* and Train the Facilitator program for Darwin Urban.**

Instead of the usual 10-week program, the Darwin pilot project of the *My Recovery* program was delivered within 2 weeks, 3 days a week, Monday, Wednesday, and Friday during August 2019. The contextualisation of *My Recovery* involved adapting course delivery and materials to accommodate (1) the local context; (2) the local needs of participants, and (3) characteristics of this Darwin pilot project and identified gaps in service provision, support from local service providers, schedule of the program (total length, daily schedule), venue, transport, and logbook content. The accompanying training logbook was also amended through the contextualisation phase to reflect the discussion with, and advice of, the Steering Group members, including mental health service providers, consumers and carers with lived experience of mental illness, Government agencies and education representatives.

Adopting a similar process, the Train the Facilitator program was contextualised in October 2019. The training was delivered over 5 consecutive days in November 2019 followed by a 1-day co-reflection workshop and individual co-reflection sessions. Table 3 provides an outline of the main modules that were used in the *My Recovery* program.

Table 3 – Wellways *My Recovery* program modules

Name of the module	Topics within the module
<b>Day One:</b> Introductory session	<b>Module One:</b> Recovery Hopes and Dreams 1.
<b>Day Two:</b> Mental illness, Recovery and Identity	<b>Module Two:</b> Peer Support <b>Module Three:</b> What is Mental Illness?  <b>Module Four:</b> Mental illness and Identity  <b>Module Five:</b> Understanding and Resisting Stigma
<b>Day Three:</b> Personal Treatment and Recovery	<b>Module Six:</b> Whole Personal Health Model:  <b>Module Seven:</b> Approaching Recovery
<b>Day Four:</b> Working with Relapse	<b>Module Eight:</b> Relapse  <b>Module Nine:</b> Communication
<b>Day Five:</b> Finding a Voice	<b>Module Ten:</b> Stigma, Discrimination and Advocacy  <b>Module Eleven:</b> Vocational Skills and Strategies  <b>Module Twelve:</b> Steps to Meaningful Occupation
<b>Day Six:</b> Review and Conclusion	<b>Module Thirteen:</b> Recovery Hopes and Dreams 2.

## Evaluation project participants

### *My Recovery* program participants

The Coalition was looking for people that self-nominated and declared they have met the following criteria:

- Over 18
- Living with mental health challenges or other related issues (trauma, alcohol and/or other drug issues)
- On my own journey of recovery
- Able to access support during the *My Recovery* program
- Able and willing to commit to attending all six sessions of the program



The Coalition received 50 Expression of Interest (EOI) applications for the *My Recovery* program and interviewed and then invited 22 of those people to participate in the *My Recovery* program, which was delivered in August 2019. Of those invited, 19 people started the *My Recovery* program, with 17 completions. Two Program Participants were not able to complete the whole program for the following reasons; they were not suited to the *My Recovery* group learning environment; were not able to adhere to the group agreement established at program commencement; were considered by facilitators to be disruptive to the group process; did not clearly understand the purpose of the program; their personal goals weren't aligned with the intent of *My Recovery program*; and/or because some individuals in the group expressed a feeling of being unsafe in the program.

Some of the initial participants that completed *My Recovery* were invited to participate in info sessions (n=9) directly into the subsequent Train the Facilitator program after an assessment based on a combination of criteria that focused on the mental health status and needs of each applicant. In addition, the applicants that were not selected for the Train the Facilitator program were invited to participate in a subsequent *My Recovery* program to be delivered by the trained local facilitators. The table below (Table 4) outlines the identified source of referrals such as providers, services, and organisations that assisted with the recruitment process. It shows that AOD Rehab and Community Mental Health NGO sector provided the most, 6-6 participants, that emphasises the intersections between these sectors. However, it should be noted that the final decision to submit an EOI was facilitated through a self-referral process.

Table 4 – Referrals of Program Participants involved in the Darwin pilot project of the *My Recovery* program

Identified Provider/Service/Organisation	Frequency (N)
AOD Rehab	6
Community Mental Health NGO	6
Homeless & AOD Rehab	1
Carer NGO	3
Government Mental Health Service	1
Total (who completed the course)	17

Between 5 August - 8 August 2019 individual interviews were conducted with 14 *My Recovery* program participants before the program commenced. The remaining five Program Participants (PP) enrolled in *My Recovery* program were unavailable to participate in an interview prior to pilot project commencement. All interviews were conducted by BC and NTK. During the analysis processes, participants were denoted as PP and were also allocated a number to protect their anonymity in the presentation of evaluation findings. The numbers allocated were only re-identifiable by the evaluation team to assist them with documenting Personal Journey Participants (see the end of section). Finally, two interview participants could not start the course and the total number of the *My Recovery* program participants was 19. From the 19 participants, 17 finished the course. Between August and October 2019 (n=16) post-program interviews were carried out with 16 of the 17 participants. One participant who did not finish the course chose not to participate in the follow-up evaluation. Post-program interviews were also conducted by NTK and BC. Participants were identified in the same way as in the pre-program interviews, however, introductions by the NTHMC were no longer required as the interviewers had already established rapport with PPs. The Coalition also provided participants

\$20 Woolworths Essential voucher after the initial pre-program interview and \$40 voucher after the post-program interviews as a token of appreciation, and compensation for their time. The vouchers could not be used to purchase alcohol, tobacco, and gambling products. At the start of each interview, a short socio-demographic checklist was filled in by the participants. It included the following items: the highest level of education; current employment status; housing situation; relationship/marital status; the number of children; and satisfaction with relationship to family and to friends. Additional socio-demographic factors (such as age, gender, country of birth, main languages are spoken at home, Aboriginal and Torres Strait Islander) were also collected on a separate consent form used by the Coalition. The following table (Table 5) summarizes those participants' socio-demographic information who successfully completed the course and took part in the evaluation process (n=15).

Table 5 – socio-demographic characteristics of Program Participants involved in the Darwin pilot project of the *My Recovery* program

<b>Sociodemographic variable</b>	<b>Frequency (N)</b>
<b>Age</b>	
20-29	1
30-39	5
40-49	3
50-59	4
60-69	2
70-79	
Unknown	
<b>Gender</b>	
Male	5
Female	10
Other	
<b>Country of birth</b>	
Australia	12
Other	3
<b>Main language spoken at home</b>	
English	14
Other	1
<b>Aboriginal and Torres Strait Islander</b>	
No	12
Aboriginal	2
Torres Strait	
Aboriginal & Torres Strait Islander	1
Unknown	
<b>Highest level of education</b>	
Less than Year 10 or equivalent	3
Year 10 or equivalent	2
Year 12 or equivalent	3
Vocational Qualification	5
Bachelor's degree	2
Postgraduate degree	
Other (please specify)	
<b>Current employment status</b>	
Employed	4

Self-Employed	
Domestic duties	1
Student	
Unemployed	4
Unable to Work	1
Retired	2
Other (please specify)	3
<b>Housing situation</b>	
Owner / Mortgagee	2
Public Rental (affordable housing)	6
Private Rental	2
Unstable housing situation	1
Other (please specify)	4
<b>Relationship/marital status</b>	
Single	9
Relationship	2
Married / De facto	4
Other (please specify)	
<b>Number of children</b>	
0	5
1	1
2	2
3	5
4	2
<b>Satisfaction with relationship to family</b>	
1 (not at all)	
2	
3	5
4	5
5 (completely satisfied)	5
<b>Satisfaction with relationship to friends</b>	
1 (not at all)	1
2	2
3	3
4	
5 (completely satisfied)	9

### **My Recovery program facilitators**

*My Recovery* program was delivered by two experienced facilitators from Wellways, Victoria. A Wellways Program Manager and a Wellways Trainer (n=2). They visited Darwin before the commencement of the *My Recovery* program in May 2020 to deliver a workshop to the Steering Group and Menzies and contextualise the *My Recovery* program to the Darwin context. The evaluation team conducted individual interviews with both facilitators before the completion of the *My Recovery* program delivery in Darwin. Interviews were conducted by NTK and BC. They were identified as *My Recovery* program facilitators who delivered this program to participants. However, in the data analysis *My Recovery* facilitators and Train the Trainer program trainers and Steering Group members

were merged into a single category referred to as Sectoral Stakeholders. This helps to protect their anonymity.

### Steering Group members

The Steering Group provided governance to the Peer-Led Education Pilot (PLEP) project through engagement with the Lead Agency, the Coalition. The Steering Group and the Coalition had a mutual responsibility to each other, to ensure the effectiveness and sustainability of the PLEP project deliverables. It consisted of representatives from stakeholder organisations (presented in Table 6) that make recommendations to the Coalition to reflect the goals of the PLEP project.

Table 6 – representatives from stakeholder organisations in the Steering Group

Stakeholder Organisation	Number of representatives
AOD Peak Body	1
Mental Health NGO	4
Disability Peak Body	1
Vocational Education Training Provider	1
Government	1
Primary Health Network	1
Lived Experience Representatives	2
Industry Skills Council Association	1
Department of Social Services	1

The Terms of Reference (ToR) were developed by the Coalition and Steering Group. It was established for and endorsed by, the Steering Group. This included the purpose of the Steering Group, their duties, responsibilities, time commitments, and the composition (see Appendix H).

The key focus included:

- General governance and oversight of the pilot project
- Participate in the contextualisation of the Wellways, *My Recovery* 10 program to a 6-day Program and the Peer-Led Education Train the Facilitator program for the Darwin urban context;
- Assist in strategies to create a pool of potential candidates to undergo training as Peer Facilitators;
- Ensure there were appropriate mechanisms for the Coalition to support networking and professional supervision of Peer Facilitators engaged in the delivery of the PLEP;
- Govern engagement with a Menzies to develop a monitoring and evaluation framework for the PLEP, particularly with reference to the Northern Territory Primary Health Network's (NTPHN) internal evaluation framework and reporting requirements to the Commonwealth Government;
- Support the Coalition in ensuring data collection and reporting within the monitoring and evaluation framework is undertaken;
- Support the development of an activity plan to adapt the PLEP to rural and remote NT contexts for submission to the Coalition;
- Support the Coalition and Menzies to finalise the monitoring and evaluation of the PLEP; and
- Approve final reports and recommendations to further implementation of peer-led education projects for people with psychosocial support needs in the NT.

- While individual interviews with Steering Group members were conducted by BC and NTK between 9 September and 24 October 2019, one of them was carried out in pairs (n=8). They were identified as Steering Group members.

### Train the Facilitator program participants

The Coalition received 15 EOI applications for the Train the Facilitator program after four information sessions attended by a total of 21 people, which were held at the Charles Darwin University (CDU), the Nightcliff Community Centre and the Top End Mental Health Consumer Organisation (TEMHCO) between the 3<sup>rd</sup> and 18<sup>th</sup> of October 2019. 16 people submitted EOIs and 15 people were invited to participate in the Train the Facilitator program delivered in December 2019. Of those invited, 3 declined due to conflicting obligations, 12 started the program, and 11 completed it. Out of the 12 who started the program, 6 had participated in the August *My Recovery* program and 6 were assessed as having sufficient experiencing volunteering or working in the sector allowing them to be streamed directly into the facilitator training program. Those that were deemed suitable were invited to participate in the Train the Facilitator program and were given a Participant Logbook in advance to familiarise themselves with the program content. One Program Participant who had not completed the August *My Recovery* program was not able to complete the program due to a lack of understanding and familiarity with the Train the Facilitator program prior to starting the facilitator training. From the 11 graduated participants 4 received 'very competent', 6 'competent', and 1 'provisional competent' assessment from the trainers. Table 7 outlines the identified source of referrals for the Train the Facilitator participants. Ten people agreed to participate in this evaluation. Participation in the evaluation process was voluntary and they were given gift vouchers for their time.

Table 7 – referrals of participants involved in the Darwin pilot project of the *Train the Facilitator* program

Identified Provider/Service/Organisation	Frequency (N)
AOD Rehab	2
Community Mental Health NGO	6
Carer NGO	1
Government Mental Health Service	1
Total (participated in the evaluation)	10

Between 20 November – 21 November 2019 most of the individual interviews were conducted with Train the Facilitator program participants after they finished the course, while one was carried out later, on 14<sup>th</sup> February 2020 (n=10). Interviews were conducted by NTK. Participants were defined as Program Participants (PP).

At the start of each interview, a short socio-demographic checklist was filled in by the participants. It included the same information collated during the *My Recovery* program enrolment process discussed above. The following table (Table 8) summarises those participants' socio-demographic information who successfully completed the course and took part in the evaluation process (n=10).

Table 8 - socio-demographic characteristics of Program Participants involved in the Darwin pilot project of the *Train the Facilitator* program

<b>Sociodemographic variable</b>	<b>Frequency (N)</b>
<b>Age</b>	
20-29	3
30-39	2
40-49	3
50-59	2
60-69	
70-79	
Unknown	
<b>Gender</b>	
Male	3
Female	7
Other	
<b>Country of birth</b>	
Australia	8
Other	2
<b>Main language spoken at home</b>	
English	10
Other	
<b>Aboriginal and Torres Strait Islander</b>	
No	8
Aboriginal	1
Torres Strait	
Aboriginal & Torres Strait Islander	1
Unknown	
<b>Highest level of education</b>	
Less than Year 10 or equivalent	2
Year 10 or equivalent	
Year 12 or equivalent	1
Vocational Qualification	4
Bachelor's degree	3
Postgraduate degree	
Other (please specify)	
<b>Current employment status</b>	
Employed	7
Self-Employed	
Domestic duties	
Student	
Unemployed	2
Unable to Work	
Retired	
Other (please specify)	1
<b>Housing situation</b>	
Owner / Mortgagee	2
Public Rental (affordable housing)	3
Private Rental	1
Unstable housing situation	1

Other (please specify)	3
<b>Relationship/marital status</b>	
Single	4
Relationship	2
Married / De facto	4
Other (please specify)	
<b>Number of children</b>	
0	3
1	
2	3
3	2
4	2
<b>Satisfaction with relationship to family</b>	
1 (not at all)	
2	
3	4
4	2
5 (completely satisfied)	4
<b>Satisfaction with relationship to friends</b>	
1 (not at all)	
2	
3	4
4	2
5 (completely satisfied)	4

### **Train the Facilitator program trainers**

Train the Facilitator program was delivered by two experienced trainers from Wellways, Victoria. A Wellways Program Manager and a co-facilitator of the *My Recovery* program delivered in Darwin (Phase 1); and a Senior Peer Trainer, hereafter Program Trainers (n=2). They travelled to Darwin to meet the Steering Group and Menzies to contextualise the Darwin Train the Facilitator program. A single interview was conducted with the Program Trainers immediately after the Train the Facilitator program delivery. This was led by NTK.

### **Personal Journeys of Program Participants**

The evaluators had the opportunity to follow some Program Participants' personal journey from the beginning until the end of the delivery of PLEP. Five participants finished both courses - the *My Recovery* and Train the Facilitator programs - and all participated in the evaluation. Although they were identified as Program Participants, in the results section their perspectives are also discussed separately as well as in the conclusion where they are presented as Personal Journey Participants.

### **Learning Journeys of the two Evaluation Team Members**

In addition, the learning journeys of two evaluation team members (NTK and BC) were collected through individual interviews conducted by HG at the end of the data collection. These interview transcripts were then coded by TW. They were identified as Research Team Members (RTM) in the subsequent analysis.

### **Sectoral Stakeholders**

In the data analysis Program Facilitators and Trainers, Steering Group members, and Lead Agency representatives are referred to as a combined group - Sectoral Stakeholders. This approach was adopted to protect their anonymity.



## Results

### Phase 1: Introduction to *My Recovery* program

#### Mental Health Challenges: Background of mental health recovery journeys (pre-program interviews)

Mental health challenges were regularly described by participants. The conversations centred around drug and alcohol addiction and different types and forms of mental health illnesses and experiences such as trauma, Post-Traumatic Stress Disorder (PTSD), depression, schizophrenia, anxiety, eating disorders, and bipolar disorder:

*"...I've always struggled a lot with binge eating and kind of eating disorder behaviours.....I was at the point where I couldn't work, I couldn't feed myself, I couldn't clothe myself, I couldn't do anything. Then, I started to have suicidal thoughts, which scared the shit out of me, especially given all I know and understand about suicide." (PP 12)*

*"...my dealing with mental health issues has been considerable for about over a decade I guess, unmanaged until the last few years, not really knowing what was going on. I've got a few diagnoses, nothing that I think accurately portrays what I go through... My stuff hinges around trauma, post-traumatic stress." (PP 10)*

*"I've cared for him [brother] all that time and I was very protective of him because I knew that he was a trauma survivor but I didn't think about myself being one until I had a bit of a breakdown a couple of years ago and then they told me that I was and I realised that I was at the same time. And I had that where you remember – where something triggers you to remember something and you – PTSD or whatever you call it. I had that for quite a few times for a while but it's – it doesn't impact me as much now." (PP 14)*

One participant expressed the chronic nature and long-term presence of their mental health concerns:

*"I've had depression for many, many years. I have had suicidal ideation on numerous times." (PP 14)*

In some cases, the mental illness started during the participants' teenage years and continued into adulthood:

*"I've dealt with depression and anxiety ever since I can remember being a teenager. Just something that's always been there for me." (PP 9)*

Regardless of the cause and effect, the circular associations between mental illness and other problems were described by many participants:

*"I've had a lot of things in my life. There's been incest there, there's been - mental abuse has been there. A lot of my life, I've always tried to please others, and I've taken on a few things I shouldn't have taken on. My children, I had problems. My children felt that I wasn't a good enough mother, they're better off with someone else, with two parents. I've gone through this. I've gone through rape on top of it. Many years ago, I thought I'd dealt with it all. Now I'm finding a lot of memories are flooding back. I have found – well, a lot of people say it shouldn't affect me, but it does. Yeah, I feel for me to survive, now I have to survive, I've got to find another way to do it." (PP 15).*

In some cases, consultations incommensurate with participants' needs and misdiagnosis of their condition by health service systems led to inappropriate treatment (such as excess polypharmacy), trying different medications (polypharmacy), being detained under certain mental health act (sectioned), unnecessary and involuntary multi-institution admissions, and unsuccessful attempts to access appropriate help/care:

*"Seen many doctors. Tried different drugs.... And I haven't really realised that my drinking essentially was – it was a mask for my mental illness." (PP 9)*

*"So, I had the diagnosis of bipolar effective disorder... after I was involuntarily admitted, and I was put on a community treatment order and continued to get worse and continued to be involuntarily admitted... So, after that, that treating psychiatrist became my advocate and fought to get me off the community treatment order and fought to get me off a lot of the drugs I was on, that I didn't need." (PP7)*

Participants' mental health was also challenged by family issues, turning points, and painful events resulting in increased vulnerability. These were clearly communicated:

*"Throughout that I suffered with depression and also my partner passed away." (PP 11)*

*"But then a series of tragic events unfolded that, as I said, had started with the onset of my sister's bipolar disorder and then the repeated and continued crises and suicide attempts and self-harm and whatnot." (PP 12)*

*"Before I have my depressions, I have from workplace first, and in my family, I dealing with severe autistic adult son has aggressive in our own house [sic]" (PP 13)*

Instances were described where participants struggled with performing at school and work, as a result of mental illness. Strong terms such as "felt worthless" and "loser" were frequently used by participants to describe their emotions:

*"I grew up in Sydney... a rough area and just couldn't work it out there. I was a 10 times loser...." (PP 10)*

*"But apart from that I was always pretty driven person, very studious but my anxiety and depression that I didn't know I had, really disrupted me being able to do what I wanted to do and achieve well...." (PP 12)*

*"Tried to go back to an old job that I used to be able to do with my eyes shut and ended up making too many mistakes and getting fired and stuff." (PP 4)*

*"... I couldn't perform well. But on my workplace, they push me too far and push and push... I just feel worthless and worry, everything worry.... I can't cope so much in the workplace.... they just treat me [unwell] (sic). "(PP 13)*

Challenging mental health status had resulted in suicide ideation and suicide attempts in some cases. Loneliness (particularly social isolation) was described as a risk factor for suicidal behaviour:

*"I've always been a loner...I've always not spoke [sic] to anybody about how I feel. I've always hidden it. Always. Because I don't like to burden people with how I feel because they have their problems. Recently, things have got to a point now where suicide had been coming through...I nearly did it a few years ago. I now realise that I don't hurt myself, I hurt others. And I also realised by not talking about it, it's not helping me. But I don't want to hurt my friends, and I just feel alone with it." (PP 15)*

Supportive environments such as stable relationship, spouse, partner, and friends that helped people to cope with difficult circumstances were described as protective factors against suicidal behaviour:

*"I've sought help when that [suicidal ideation] occurred, so I haven't tried – made an attempt although I have had a plan but when I made the plan I talked to my husband and then – so he helped me not follow through on my plan I suppose." (PP 14)*

*"...I had a really isolating, horrible experience there [at the university] and went along a number of different study pathways. I'm lucky because I guess I've always been pretty good with relationships, so friends, family and romantic partners. So, I'd always kind of had a stable person in my life and I had some really good times through that." (PP12)*

A few participants also discussed issues associations between challenging mental health status with drug and alcohol addiction, homelessness and incarceration:

*"... I was homeless and had an ice addiction.... So yeah, I wasn't in a very good place and I needed help basically." (PP 8)*

*"I'm participating in the program today because I have recently been subject to a drug habit... I was recently in prison and I had a drug addiction, so I wanted to be able to stop myself from going back to that life." (PP 5)*

Some of them felt that the period after the diagnosis was very traumatic while others were relaxed since the right diagnosis gave them the opportunity for accessing appropriate help:

*"The first couple of years after diagnosis was very traumatic. I was not treated very well by the New South Wales health system." (PP 7)*

*"And once I had the bipolar diagnosis, now I haven't had any trouble accessing help. I'm fine, it's good, I'm happy, I'm looked after. But prior to that, they just said I had anxiety and to exercise, eat well and do some meditation." (PP 12)*

The current mental health status of the participants before the program started was quite different. Some of them were travelling well and others not so well. This ultimately indicated that not all participants were in the same state of health at program commencement:

*"I'm in a very difficult spot. A lot of the times, I'm able to cope.... At the moment, I'm not." (PP15)*

*"but I also think...what I've learned over the last 15 years of coping with this disorder and actually doing really well - I still have my times, but I'm actually managing it pretty damn well." (PP 7)*

### **Mental Health Opportunities: Impact of the My Recovery program on participants' mental health status immediately after finishing the program (post-program interviews)**

All participants experienced some improvement in their self-reported mental health status following their participation in the program, albeit to varying levels.

My Recovery program was perceived to help participants to develop coping mechanisms to combat the challenges they had faced. This resulted in enhanced confidence and increased level of optimism among participants:

*"My thinking, it's all changed. I'm carrying a lot more positive now than negative. I now look forward to challenges, whereas before I couldn't do that." (PP 15)*

*"There's been improvements, but I guess the biggest thing is that it's changed my focus and I guess it's given me a bit more focus again." (PP 10)*

*"I don't feel so stuck anymore. That's how I was feeling before. It was basically more around the job, when we were talking about jobs and stuff like that, that was where I have been at. So that really helped me, and I've taken steps since then to forward my progress because of that." (PP8)*

Participants also acknowledged the energy, meaning, and strengths that the program gave them:

*"[It gave you some strength too.] Yeah, because my confidence built up in there as well." (PP11)*

*"I can see now that, where I couldn't see a meaning, I can see now a meaning. I can also see why life is so important too. So, the course did make a hell of a difference for me." (PP 15)*

In the program, an instilled sense of 'hope' was also talked about as a possibility for change. For instance, a participant explained how her concept of hope changed as a result of the program:

*"I came out of the program feeling very energised and quite hopeful. I've always had a funny relationship with hope, but through the sessions, and particularly one of the facilitators, he talked about hope in a different way and I really connected with that....Talking about hope as possibilities, rather than the way that people throw around the word hope as, "You should always have hope for something positive." It was more that hope is - yeah, possibilities for change, possibilities for things to be different. To me, it was just more realistic." (PP 12)*

Social isolation was described as a risk factor contributing to suicidal ideation among some participants. However, the program provided them with an opportunity to voice their opinions and share their experiences and challenges with other participants. This was perceived to help them overcome loneliness and instilled an element of trust with each other:

*"So, I guess, coming from the program, that sense of isolation just went away. For me, I got to have a voice, I got to share my experiences and my challenges, but also the things that have been working for me." (PP 12)*

*"I'm still a loner, but my trust building is better.... I'm very careful where I put my information with anybody, and I speak to the ones that I can trust. But I'm a lot more open in mind now, a very lot more open there." (PP 15)*

The program introduced the concepts of forgiveness and acceptance to participants and thus improved their understanding of recovery from mental illness, as summarised below:

*"[I experienced an improvement] in my concept of recovery and in what a practice of recovery for me might look like. So, recovery planning, I guess, if you were to give it a word. I think I gave myself - because of the program, I gave myself a lot more compassion. Forgiveness, acceptance." (PP12)*

*"I am feeling great actually. I think the program did help. It gave me a much broader and more in depth understanding of what My Recovery was all about. So, at the beginning I didn't think I struggled with a mental health issue. I now understand that I did. Anxiety and depression." (PP 5)*

*"...a little bit [helped me with My Recovery journey]. There were some new things to learn there. I think the main thing I came away from was the difference between personal medicine and medicine." (PP 4)*

Further, understanding the signs and symptoms of illness and the ways to manage them was found to be crucial to their successful recovery:

*"...being able to identify in myself and be okay with that is what is different and the fact that I now know the signs and symptoms of when it is going to happen and what I have to do to stop it or manage it. And I can do that a lot easier now without having to worry or increase the signs and symptoms where anxiety is not a great friend to have but she is a friend of mine and I can manage her a lot easier knowing about her now. Yeah, so that's good." (PP 5)*

*"I'm feeling a lot better after I learned that to recovery, and then I find myself a lot what to do when I'm unwell. This course is very excellent in the individual persons..." [sic] (PP 13)*

Below, one participant described her program journey a "roller-coaster ride"; however, the program helped her to reflect on her feelings, learnings, and unspoken things that she could not express before taking part in the program:

*"...it was going through the program, there was a lot of ups and downs for me. So, some was really good, and some would be really bad. So, I found it was very - more of a roller coaster than a stable - if I hadn't been in there, I'd probably be more stable. But it was good in that I reflected on things that I wouldn't normally give myself time to reflect on. So, I think overall, it's beneficial for that. (PP 14)*

The program also provided participants with practical tools and methods to help deal with the common symptoms of their mental health illness:

*"I think it's helped with My Recovery journey. I mean, you know, I'm bipolar. I get manic. I get depressed. That is not going to stop. But I think the course has helped me deal with those ups and downs. I don't think it's going to stop the ups and downs. "(PP 7)*

Participants occasionally spoke about the meaning that the training gave to their life, changing their perspectives and making them more motivated in their recovery journey:

*"I definitely feel a lot better after the course and that being said, because of the motivation to go to it and then your sense of achievement of having done something and then meeting with a lot of peers that are actually quite intelligent rather than speaking with people that were not really into learning about what was wrong with them. I feel a lot better for that in that way. It's definitely better." (PP9)*

Below, one participant did not recognise her mental health issues, even though she had struggled with drug addiction in the past. However, during her program participation, she was able to recognise the anxiety and depression that she was dealing with and how that related to her drug addiction:

*"...at the beginning I didn't think I struggled with a mental health issue. I now understand that I did. Anxiety and depression.... I knew anxiety was a form of mental health and depression was a part of mental health, but I didn't see myself as a person that had*

*a mental health issue. Now I am happy to say yeah, I struggle with mental health in the form of anxiety and depression and everything that goes along with that.” (PP 5)*

The program not only built up participants’ self-confidence but also their self-awareness and resilience, through peer support:

*“I was doing more positive things and I think it’s because I had so much support around me from my peers and so many people going through the same thing.” (PP 7)*

*“[it gave me strength] my confidence built up... my son still unwell, that still happening, I think my mental health was suffering a bit. And then I have other things going on but at the same time, I didn’t fall apart, and I do believe it was because of the [program]. “(PP 11)*

### **Perspective of Program Participants about the My Recovery program**

This chapter presents participants’ perspectives both before and after their participation in the My Recovery program.

#### *Strengths of a peer-to-peer education model central to lived experience*

All participants expressed that they valued the peer-to-peer model and the way it drew on their individual lived experience. This approach provided an opportunity to reflect and discuss their unique experience of mental health in a safe environment:

*“I think it’s brilliant. I think peer programs are the way to go. I got more out of that peer program than I’ve got from any bloody program ever that’s been done by professionals.” (PP 7)*

*“Opening up about [mental health] to people that were suffering with the same kind of things made me feel warmer and comfortable about it. I now don’t feel so alone about my situation and I am happy to talk to people about it as well.” (PP 5)*

*“it’s very difficult talking about yourself and especially when it comes to mental health, to not break that person down, but giving that person a voice. And I saw people in there that I know for a fact, they wouldn’t talk before they talked.” (PP 11)*

When asked about what was most useful in the My Recovery program and if there was anything to capture about the effectiveness or benefits, some agreed that the peer-led delivery was a cornerstone to its overall effectiveness:

*“I think the peer thing really touches on something that’s wonderful and useful.” (PP 10)*

*“I think you’d lose something from it not being as intense... [a mutual understanding] and a level of comfort within a group where you can discuss whatever you want...it was formed by the rest of the group far before I became a part of it. Like I watched it happen and then I was like ‘Ooh, this is different!’ They were all chummy and laughing and giggly.” (PP 10)*

The *My Recovery* program allowed Program Participants to talk comfortably and build confidence with others that had a shared experience. Synthesising their previous experiences and knowledge and being able to talk about their lived-experiences to somebody else who was actively listening to their stories, established meaningful connections:

*"My confidence built up in there as well. Like they were things that I knew anyway. There were things that I was doing that's when I thought, oh, it's okay, I'm going to be okay. I'm not saying crying is not a good thing or anything like that, but when you're dealing with so much in your life, if you talk to somebody else about it and then somebody says to you - I was listening to the stories in there of people; they talk about what they went through and I think that was the thing about having that lived experience, you need that in the room; you have to have that in the room" (PP 11)*

*"I just think sometimes my level of English cannot do this because I don't want people asking me 'I'm stupid', 'I don't understand [where] your accent's from'. But, my experience and my knowledge to be this far, I can give my past experience to other people and bring them joy. I love it." (PP 13)*

Also, when asked about the importance of having a gendered lens to appropriate discussions about such lived-experiences, some participants commented:

*"Obviously, it's good to have a male and a female, but sometimes if you've been through trauma, you don't want a male there." (PP 14)*

*"The course was awesome, really good. I'll just say I think a lot of it's to do with the peers and I had appropriate peers – I could relate to all of them and I think that's important. If it was a group of all women and I was the only guy, I don't think it would have been as good." (PP 10)*

Participants identifying and sharing their mental health journeys formed a bond that supported, encouraged, inspired, and supported each other to grow, heal, and find confidence together. This peer-to-peer approach helped to reduce any prejudice/s by others, as each participant was understanding of, and familiar with, these issues. As stated above, the lived experience was regarded as the most important aspect for the success of the program:

*"My Recovery was the fact that we were a group. We were all bonded together. We all had similar problems, but I found that I wasn't alone. We supported each other. That's what I found with it. I also found that you've got all the encouragement, and it became like a family in the end...that's how I felt, it become like a family in the end...on two occasions I did speak, but when I did, it did help the group around." (PP 15)*

*"I'm not saying crying is not a good thing or anything like that, but when you're dealing with so much in your life, if you talk to somebody else about it and then somebody says to you - I was listening to the stories in there of people; they talk about what they went through and I think that was the thing about having that lived experience, you need that in the room; you have to have that in the room. And that particular group was quite open*



*and the facilitators as well. Not everything, because you don't share everything; I shared a little bit but not too much."* (PP 11)

### *Approaches toward supporting a safe space for recovery and treatment*

Another important theme that emerged from participants' responses was the non-clinical approach and non-judgemental delivery of the *My Recovery* program. Participants advocated for the need to create a safe space to allow an individual to express their vulnerabilities.

Personal treatment and recovery planning were also discussed and exploring these concepts assisted in learning strategies that could improve their mental health. For example, there was noticeable interest and reference to learnings, such as "personal medicines" and some mentioned this as their favourite topic. Its appeal garnered more attention as participants could relate to their own experiences with using a medication, specific complications with their medication use:

*"The other thing they shared was about the personal medicines, which when the group reflect[ed] on the feedback was very positive about that. People got really, really different things out of it, and it came up over the rest of the days, the way that people were using it...I hadn't heard about that term, "personal medicines," before. I think [it's] a good way for me to explain to clinicians of why I might not like a medication or something like that, because to say to them that when...I feel this way that means I can't do these things, and I need to do these things because they're important to me."* (PP13)

*"Trying to deal with it without having to take medication because my body just does not like the chemicals. [My favourite topic was] personal treatment and recovery planning. In that module it covered obviously things that you do for self-medication like [self-medication] being not alcohol or drugs which I used to use, but more on the lines of say going to the beach, going to a quiet beach, or going fishing, or going for a bushwalk. Just doing something that you like that calms you down. I found that was pretty good...From the recovery planning point of view when you know that you're in that bad space in your head, you just got to remember that everything is going to be all right and then you still got to plan for it to be okay because you can't just give up."* (PP 9)

*"So, in a way that kind of made me rethink about how I identify myself. Instead of just an ex-patient, just relabelling myself. So, it was just good in the way that it changed the way I think about mental illness, the words I use, also giving me more strength with combatting, say, like there's that medical perspective and then there's the patient perspective and kind of how these days it's kind of a bit of both. It's starting to get there a little bit where the patient kind of knows what's right for them after years and years of mental experience. So...to try and summarise what I learnt, was just being more self-aware with mental illness, really."* (PP 18)

It was recognised by the group that everyone was dealing with mental health difficulties that had impacted their lives, but as individuals spoke more about their own journey, the act of sharing these stories with the group was instrumental to creating an appropriate safe space for all:

*"...it gave everybody a chance – everyone in the room knew that they all had been dealing with some form of mental illness or in some form of recovery and hearing other people*

*expressing that, it really lets you open up a bit more. Again, it helps you to really hear what's being said by the facilitators because it's just a really open and warm place where you felt safe. You knew you weren't being judged by anyone because everyone felt the same. It was really helpful like that... [during the course] I didn't feel any judgment from anybody. I felt like I could say anything, and it was quite well received. I'm pretty sure that everyone else in the group would have felt [the same]."* (PP 9)

*"...because it gives others a look at it differently as well. It's not all about drugs and alcohol. It's about the mental health first. So, the drugs and alcohol come in second. It's nice for others to look at it differently as well...I think it would be good for people already in rehab because places like where we are now don't have all that here."* (PP 20)

*"The first thing that I noticed about the group itself...I found it really good in this circumstance with [Program Facilitators and Trainers], that I got to hear other people's stories and how they feel, and what they're doing in their lives that is not necessarily based around the AOD. Some of them were, some of them weren't. I just found that interesting to be a part of that. It broadened my mind to what other people are going through as well."* (PP 8)

*"it's a very nice course – like it's very gentle language and so I think it can cover a very broad scope of participant. Like I think it's gentle enough for people that are very very unwell, and I think it's strong enough for people that are feeling quite strong in their recovery and I think, again, the dynamics that such differences bring in I think are a benefit; it's suitable for anyone."* (PP 10)

A few participants expressed concerns around some issues being too sensitive to discuss openly. Concerns were also raised that some participants may have ulterior motives or use information shared outside of the immediate program environment. For example, some participants spoke about their experiences of homelessness, drug addiction, and exposure to discrimination. This resulted in some feeling unsafe initially about certain topics being discussed, a participant made challenging remarks on the first day of the *My Recovery* program, which made it difficult for some participants to (re)build trust. Nevertheless, participants appreciated the idea of a safe space to voice their opinions and experiences in an open manner:

*"...sometimes in [AOD rehabilitation], like this is a good place to be but there are people here that are just solely dealing with either just being homeless or just being addicted to a drug that they need to get off. Or they're only here because it looks better on their court bloody record or whatever. You know, there are some people like that."* (PP 9)

*"...some of the people in here aren't voluntary. They have to be here. They have a court order to be here, so you feel a lot of judgment when you talk. So, without having those people in the room thinking like what the hell is this [person] talking about?"* (PP 9)

*"...I'm a trauma survivor, it's very, very hard for me to build trust and share my experiences with people I don't know, which is what you're sort of encouraged to do in those spaces. The group was a little bit large for me, so I felt unsafe when I first got there. And then on the first day we had unfortunately a person that was judging what people were saying,*

*and that to me...made it very unsafe...there were a couple of people who when they shared their experiences also talked about people of other races than what their race was..." (PP 14)*

*"...sometimes it was group, sometimes it was individual...I just found it a bit difficult sometimes sort of getting into conversations with people..." (PP 4)*

### *Using lived-experiences to engage Program Participants respectfully and meaningfully*

In the My Recovery program, facilitators' skill and lived experiences are essential in the engagement with program participants. To create a respectful and safe space and develop a meaningful relationship, facilitators did not force participants into sharing, instead, they allow them to share at their own will. This voluntary approach empowered a sense of self-control among the participants:

*"[The facilitators] came across like they were really interested, and they really cared, and everyone started to trust each other in the end. It was really good." (PP 20)*

*"...my whole life I'd been told I was fat, ugly, useless, good for nothing and I would never amount to anything. So, here [the facilitators] were telling me that I'm this wonderful person and I'm loveable. On the other side the scales didn't balance. And it's still a hard thing for me to accept and that's where I found that by doing the My Recovery program that helped a lot, it lifted up some of that cement that I needed to lift." (PP 21)*

*"...[the facilitators were] helpful, and then because I find my accent I mentioned, English [is] a bit hard for me - my second language, but I got [support people] beside me...they are lovely, they not look at me like [I'm] stupid because sometime I'm shame...they try very much with me...because [the facilitators] really want to learn and help me...it's lovely, people comfort me." (PP 13)*

*"What I liked about the facilitator, especially the gentleman, he was very experienced...he was really okay if you didn't want to share...and you felt it... [For example] there was one particular lady, I think she only shared twice, and nothing deeply personal, about just general things. And I really respected how he didn't at any time pressure her into doing it. I think for her it was a big thing just coming, the same as me, so I could relate to her. And when she didn't speak, I always gave her that eye contact, like we had this unspoken thing that we understood each other...that facilitator's probably the best facilitator I've ever seen." (PP 14)*

The sharing of personal stories by Program Participants enhanced the mental health journeys of other participants, promoted a sense of relatability and connectedness, thus growing a support network between members of the group. By participant's sharing their stories, predicaments, feelings and mental health issues, and talking them through together, the participants were able to develop and share coping strategies that were achievable and realistic for themselves and others:

*"...very much recommend [My Recovery] to carers and family of people with mental illness. Give it to their siblings. Give it to their mums and dads. I think there were a couple of carers in that course and I definitely think it's really viable for people that are caring for*

*people with mental illness definitely because again, how do you care for other people until you know how to care for yourself.” (PP7)*

*“It was encouraging to have up here a support group, up here, and the facilitators were amazing. The fact that they knew and could understand what we were going through also helped. And the group itself, it was a good group. We felt like a family towards the end than we did just a peer group. It was good to hear the honesty and stuff coming from people as well and it helped also with us opening up to each other...the different dynamics of the group in regards to different stages of mental health and the progress of what they went through was a learning curve for everyone.” (PP 5)*

Participants stated that they felt comfortable and familiarity between participants grew with time, and the facilitators harnessed this through open discussion, relationship building, and by taking the lead personally as opposed to pushing the participants:

*“Without a doubt, you know, when faced with a lot of questions in the book I thought I was going blank. But then when someone kind of started it off it would trigger the responses from the rest of us and, you know, it actually put me in a better place of what I was doing and where I was going just listening to other people’s experiences and thoughts on things...you know, particularly when there was dead silence, you [knew]. [The Facilitators] starting the ball rolling with their own experiences really helped.” (PP 7)*

*“The facilitators were absolutely magic. Wonderful people, very approachable, calm 100 per cent of the time. Obviously in the first couple of days we were getting to know each other, but as that kind of broke that cycle, I found us all getting much more comfortable in sharing our stories...the group conversations grew day by day...I really, really enjoyed it. I really did.” (PP 8)*

*“it was good that some people in the group took it upon themselves to talk about their own personal experiences. I probably would have liked a bit more of that. But it was good to hear other people’s perspectives because there was lots of people in the class from all different age groups and different backgrounds. So, hearing people’s personal knowledge was pretty good...also the Facilitators, they definitely - they brought their own personal struggles and experiences which I felt was really rewarding. So that’s another great thing you can take from it.” (PP 18)*

Participants also stated that the program improved throughout the delivery, with initial judgements towards the structure of the program and successes subsiding as the course progressed. Participants were initially doubtful about the program but overcame this as they began to synthesise the learnings from each module over time. Some stated that the most helpful part of the program was the combination of personal and professional content:

*“...in the first week I had a bit of a bee in my bonnet of certain people taking up too much time and I thought ‘this is poor facilitation to have allowed this to happen and run’, but then by the second week the value of what these people were interjecting was apparent*

*and just so I had to let go of stuff; but then there was a big change from week one to week two, when you could see that it was working.” (PP 10)*

*“I thought it was really well delivered. The facilitators were really friendly. They explained things quite well and they were both quite intelligent in the way they spoke. They didn’t try to dumb down things, but they also didn’t try and over-jargon things as well. But again, most of the people that were in the room had probably seen doctors so much that they knew, or they know all the jargon anyway because they’re just so used to hearing it.” (PP 9)*

*“...just how friendly the presenters were, and it was very professional, which was good...they worked really well together. They were able to give some good anecdotal or professional stuff on ways to help.” PP 4)*

### *Training Provision & Course Materials*

Participants were all asked program-specific questions about the delivery of the training, schedule, educational resources, and other required logistics, for future considerations. The intent was to identify factors that could improve *My Recovery* program more broadly, and if the program was to continue. When asked about the usefulness of the information they received during the program, many provided positive feedback about the peer logbook and the provision for setting rules for all to follow:

*“The information was very good...it was the support that was there. We had a set of rules that we run by, and everyone went by the rules.” (PP 15)*

*“The group rules were very good. I thought that group rules that they put up and we basically stuck to that during the course. It really helped me with my anxiety acceptance of all our little quirks and things like that that we have.” (PP 7)*

*“I found it pretty useful. Again, I wasn’t expecting to get a module book...it’s just like a Uni textbook or something. It was good to just have everything already laid out in a really nice book and you can go back and forth throughout the class and check what you’re going to be doing. Yeah, I found it really informative. I thought it was a really great idea.” (PP 18)*

*“[The peer logbook was] actually really helpful. I was even going home and flipping through a lot of the pages at night, and even now I still go and flip through it and stuff. It’s actually set out quite well as we can go straight to each module you want to look at, and then it gives you ideas of – if you want to look at something in Google, then there’s ideas right there for you to have a look at as well.” (PP 9)*

In some cases, the peer logbook acted as a reference point for continuous self-reflection and growth beyond the program itself:

*“I can keep this book forever, and I can refer back to it, and I can remember if I’m having a bad day...” (PP 9)*

*"...[it] was really well laid out and quite professional...I've got [the peer logbook] at home...Read over it and remember some things...overall it was good, the activities were good and thought-provoking." (PP 4)*

Participants were also asked about the kind of exercises they did individually or in group activities. The individual-centred approach was considered highly effective, as it was contextualised to personal preference, need, and desire as opposed to 'one-size-fits-all' or a general application. Furthermore, the choice of either individual or group completion of tasks, dependent upon individual needs, was comforting, and reinforced a sense of empowerment and self-control:

*"it was all about me. [Laughs] You make it your own, you make it personal, and it wasn't like we were doing a test and handing it back in at the end of the day. Everything in the workbook was me related...it was a very personal experience, and you got to take it away with you. I've still got it sitting on my desk, and it's something that I will definitely be using a lot...There was lots of group discussions. You could either do it by yourself or do it as a group if you wanted to. Everything was to make you feel comfortable." (PP 8)*

*"the arts and crafts. So, you had a big piece of paper and you could cut out pictures and words and stick it on there, what your recovery looks like or what your goals want to be. Mine was all about travelling because I want to travel. Seeing it on a piece of paper it's better than just saying it. And you can keep looking at it...[it] helped us get to know each other a bit more. It was nice having groups. (PP 20)*

For some participants, discussion about psychosocial support was a highly regarded alternative to medication management of the illness. Participants mentioned it addressed the underlying causes of mental illness and offered true coping strategies to control, rather than treating it primarily as a biomedical and physiological condition that needed to be 'fixed':

*"...getting into what really was important, just learning about how to, not so much control but manage our illness in ways such as not to rely so heavily on medication. That's a big thing for me." (PP9)*

*"I did like us having to look at different aspects of why we think we do the things that we do; and our thinking and our feelings, how do we change those? I enjoyed doing that." (PP 11)*

Participants stated that the visual representation of goals and recovery assisted the depiction of what this looked like to them, and how this could be achieved. By completing these types of exercises, participants were able to solidify their thoughts more meaningfully:

*"I looked at one question and I went, ah, okay. It said, 'Goals', and I thought, wait a minute, I've never thought about goals, or strength. I had never thought seeing that set like it was...If you're struggling to find aims, struggling to find goals, all you've got to do is go back in the logbook and it's all there because it's your words." (PP 15)*

*"Learning a bit about, more about myself and putting goals in place was what I liked." (PP20)*

*"...we did another one that I really thought was fun where you had to say three statements about yourself, two have to be true; and that was good...because you're learning about someone and you're learning too for someone." (PP 10)*

One participant explained the need for recognising goals with life challenges in the family, which promoted resilience and was fundamental to their recovery:

*"I got to be encouraging each day...because I melt down, someday I [have] no energy at all, and when you [do] you can cry and lock yourself, you don't want to [be] isolated...and I don't want to become [feeling] sad because I'm happy...I will pass to...my family [who] need a goal too, because especially dealing with [an] autistic son in the home...this course [will] not only recover myself but some tips [that] can help my son...I learn it is not [about] the shame, and that we should learn to let people know...[the facilitators are] not assessing what your type of mental [is], but they focus on your recovery. So, it's quite different and I never [discovered] this skill before" (PP 13)*

Another participant who initially mentioned their dislike towards some of the program activities was challenged when realising the benefit, it brought in the home. The visual depiction of their personal expectations assisted in comprehending what it looked like to another person, triggering thoughts and conversations within the family as to how something could be attainable:

*"I can't draw, so I'm not orientated that way. We had to do paper and scissors and magazines...it was probably one of the nicest things that could have been done. Because even though I hate that stuff, you cut out like your expectations for yourself. And then I put my family; I actually drew my family because I couldn't find a family with all our different colours, so I just drew stick people. But I cut out my car; I cut out the drumming, the guitars, the singing, I did all that...then I took it home and stuck it on the fridge. And the comments, like my kids saw it, and they're like, "Oh mum, is that how you think?" And I said, "Yeah." But it's such a little thing and so that started a conversation and they said, "Oh, do you want that kind of car?" I've got my L, so, I don't have a full license. And then they go, "Mum, you've got to get yourself a license." (PP 11)*

The icebreaker activity at the beginning of the course was also regarded as beneficial, for it enabled the group to open up to each other and form a connection, thus establishing trust and relationship building. Some participants stated the icebreaker exercises assisted in cognitive motivation and initiation to prepare for the day ahead:

*"The icebreakers were really good at the start of the day, try and get the brain going. What colour do you feel like today and what animal are you today and why? I thought it was really good." (PP9)*

*"there was a lot of learning about your mate and then speak on their behalf stuff...I liked the what they called icebreakers – so like they'd say, they'd write on the board in the morning 'you're stuck on a deserted island, you can only take two things' – and I liked that, that was really insightful... (PP10)*

*"I thought it was actually quite intelligent and quite well done, especially with the fun things, the icebreakers at the start of the group. Getting to know each other within the group was actually a really good way of connecting" (PP 9)*

Key learning mentioned by most participants was the CHIME model discussed in the course (Connectedness, Hope and optimism, Identity, Meaning, and Empowerment), which was used as a

mechanism to support recovery planning. This central principle helped many to improve focus and better grasp how they could monitor important benchmarks in their own mental health journey. Some participants related this model to similar concepts introduced in mental health programs they had completed previously:

*"There's been improvements, but I guess the biggest thing is that it's changed my focus and I guess it's given me a bit more focus again. You get a bit complacent in your recovery, and it's highlighted that that's not cool. I think [CHIME is] really important to have benchmarks and a record of where you feel that you're at, so as you can monitor your journey. I like to call it a climb." (PP 10)*

*"I'm feeling a lot better after I learned [about My] Recovery...I find myself a lot what to do when I'm unwell. This course is very excellent [for] the individual persons...yeah, I like that [CHIME model] because it's told me a lot...Connected...Hope...Identity...Meaning, and E is empowerment... [I] learn about why my [mental health] got like a combination with my social, my religion and my workplace, my family and different cultures, society, that push me...so now I learn to think what is positive energy, what negative energy...I learn to not care anyone much, I do love myself more. The course learn to give me more confident...self-care and don't care what another people think, and to be yourself...open and trust." (PP 13)*

Compared with other strategies they had learned and applied before, some participants mentioned how the CHIME model provided awareness in detecting signs of anxiety:

*"I think [The CHIME model] it's a bit like the drop page in the Grow Program. It makes you start to think, be definite. Sometimes some of those little things that we are experiencing and carrying on about, they're not very important at all. It's something that is hidden, hidden in us...Sometimes there isn't anything to do. And as I said I've been in Grow for quite a few years, so it's taken me all this time. So eventually I will learn the CHIME [model], what they all stand for and how to work." (PP21)*

*"I was in [AOD rehabilitation] and they taught us nothing like [the CHIME model]. So I got more out of this Well Ways program than I did in the seven weeks I did [before]...when I found the understanding of anxiety and what sets it off, I had a bit of a moment where I was anxious about something, the court coming up and I didn't realise and I was actually having the triggers of anxiety and I had just learnt the signs of it and I actually used the CHIME process and it came out totally different but I was able to manage what I was doing." (PP 5)*

The My Recovery program delivery in Darwin was adjusted into a two-week long intensive course. Questions about the location, venue, and timing were asked of all participants. Overall, there was a significant number of participants who supported the structure of the pilot project delivery, particularly the gaps between elements of course delivery. This was important to allow time for participants to think about, and absorb, the information they had learned. It gave them time to reflect and be prepared and ready for the next day. Some participants expressed finer details about the venue and considerations of the group size to be important:



*"It was great. I really liked that they had it spread out. So, you had your day, then you had a day in between. I really like that, because it felt like there was not so much pressure, so you could actually - because it is quite intense, you had that day in between to fresh, breathe, absorb, and then did come back extra fresh, ready to go again" (PP 8)*

*"I think that was the best thing because you're intaking a whole lot in, and you need a day for it to take it in, and it gives you time to think about it. Then when you go back on the Wednesday, then you can sort of fall back and you can say, yeah, this is right, this is right, and this is how I feel...the Monday, Wednesday and Friday, it was good. [At the same time] a very lot to take in." (PP 15)*

*"The venue was great. The toilets were right there so it was good. You could go out into the garden. It was great...I think every day for five days would be too much. I think the Monday, Wednesdays and Friday group was good because you weren't [just spacing it out]. [The schedule] was perfect because you went on a Monday, you were jam-packed with information. You got to go home, you go to diagnose it...to actually filter through what happened... for me that worked really well. The fact that it was two weeks, yeah. I didn't have a problem with that." (PP 5)*

*"I actually think - I think the group size was good. So, I think if you get more people, you're probably better off having more groups of about that size, I think. About 20 people is good. I think more would be too much and a small group is too little, it'd be harder to open up I thought. You actually got it right on the actual size of the group, so I think that, you know...they said they normally do it over the 10 weeks - I really love they did it over the two weeks. I wouldn't have stuck it out if it had been over 10 weeks..." (PP 7)*

As mentioned above, the adaption of the *My Recovery* program from 10-weeks to a 2-week intensive course was shown to be highly favourable among most of the participants. The consolidation of the modules to enable delivery 3 times per week allowed sufficient time for participants to absorb the learnings and experiences, whilst building and fostering important local support networks. Both in a personal and professional sense, these trusted relationships were reportedly absent from the lives of some participants that had been experiencing mental health difficulties for a long time:

### *Approaches to deal with mental health challenges*

Participants identified their past mental health challenges, goals that were important to them, and what practical tools and strategies could be implemented to improve their mental health. There were various responses from participants that viewed mental health challenges at individual, family, and community levels. Challenges associated with mental health policy environments were also discussed:

*"I expect, like you've written on your sheet, an improvement in policy, an improvement in staffing and staff training, particularly. That's what I expect from this. I do realise that it will take a while to correlate and record and this and that and - I'm hoping that it's like planting a seed" (PP 8)*

*"Being able to have the - how would I voice it? A little bit more support I guess on getting those goals achieved of what I mentioned before on the job, the you know, my own place and my daughter. So, they're the three things that are in my mindset right now. So, like I said I was feeling a bit stuck. So, I'm hoping this will help achieve those goals." (PP 7)*

*"Learn new tools. Meet new people that are in similar things, that have experienced the same stuff. And possibly gain some insight as well into an induction into the field. It's something that I've always been interested in studying, would be either a counsellor or a mental health professional. So even something like that, like just being around people that have started their academic journey as such, or – yeah starting their career from scratch and get to know some of the ways that they started." (PP 9)*

*"It's to see if there's way that I can improve my advocacy skills...because of my lived experience I participate in lots of different meetings and to try and effect change with government departments and the [Lead Agency] and things like that. And things are very, very slow to change in the mental health area here so I don't know if I can learn – learn to say things in a different way that will affect change faster." (PP14)*

As stated above, there was a sense of urgency to reconsider how organisations and government departments approach mental health. Some participants also expressed their own ongoing struggles to seek a solution that works for them and the importance of mental health training to enhance their capacity to support others with mental health concerns:

*"I hope to have a clearer thought pattern of what triggers these problems that I have. I hope to have a clearer understanding of if I do this, this is going to trigger it and if I think this way it's going to trigger it even worse...It'll lead me back to illness, I can see that happening and I want to avoid that...[I want] to be able to see clearer where my faults lie with this mental illness...some days I can't scratch my head to get my words out right and some days I sail through it and make every appointment I need. I want to be able to balance. I want to be on a balance where I can just [work], have good thoughts, have a strong train of thought pattern and just work. And communicate in the community better." (PP6)*

*"Just trying to do something different and trying to get something going in my life that's a bit different...Possibly the Train the Facilitator thing that was mentioned. And just some strategies around mental health stuff that I may not have learnt before and may not know about...just day to day living...I want to make it through the course. And be able to get up every day and functionally get there. And as I said, one really big goal would be to get some extra training out of it. The Train the Facilitator things sounds really interesting. It's difficult getting on training courses so that would be useful." (PP 4)*

Other participants appreciated how structured and organised, yet simultaneously fluid, the program delivery was. There was a deep appreciation of the regard for autonomy and flexibility:

*"I liked the way that it was really done thoughtfully. And the structure, because I have to have structure. I'm one of those people; I like the way it was setup; I like how we went through exactly what was in the book, we didn't digress off subjects. And what they said we were going to do, we did; the time was given for each thing...we followed the plan but not only that, we were treated like adults...we were given that space. If we needed to go outside for a break...and of course, no mobiles." (PP 11)*

*"it give me energy back because I find myself that time before I attend this program I have energy and want to give up, and then when I attend this course, and then that what I find*

*myself learn[ing] is myself well what I should need, what I should do... just walk and learn and find what it can offer me, education for mental health.” (PP 13)*

### *Measures to improving confidence in mental health recovery*

Many participants expressed their ongoing struggles with their mental health status impacting their confidence and identity:

*“Working with the relapse one and identifying key things that do tend to put me into a bit of an anxious or depressive state, learning to spot them before they’re going to happen, that’s a big one. I’ve been noticing that a lot more like in situational avoidance and things like that and confrontation stuff, even though I’m not quite there yet but learning how to deal with it a lot better than I would have thought.” (PP 9)*

*“I think it’s helped with My Recovery journey. I mean, you know, I’m bipolar. I get manic. I get depressed. That is not going to stop. But I think the course has helped me deal with those ups and downs. I don’t think it’s going to stop the ups and downs...I actually was on a bit of a high when I left the course and, you know, now I’m on a bit of a low. But I think what it’s done is it’s just made me more self-aware.” (PP 7)*

Some participants were able to develop more self-confidence by recognising the previous beliefs and attitudes have limited the potential of their recovery journey. The Program assisted them to transition towards a more positive mindset:

*“So, identifying, before the program I didn’t think I had one. I knew anxiety was a form of mental health and depression was a part of mental health, but I didn’t see myself as a person that had a mental health issue. Now I am happy to say yeah, I struggle with mental health in the form of anxiety and depression and everything that goes along with that. Seeing myself before the program...I guess I was afraid to say that I was diagnosed with that. I am pretty sure the majority of people have it, they just don’t know about it.” (PP 5)*

*“...my confidence built up in there as well. Like they were things that I knew anyway. There were things that I was doing. So, when you recognise those things and it’s silly, you probably - like I know that, but I guess it was my confidence.” (PP 11)*

*“My thinking, it’s all changed. I’m carrying a lot more positive now than negative. I now look forward to challenges, whereas before I couldn’t do that. I couldn’t look forward because I couldn’t see the point in that. I believe a lot of people didn’t believe in themselves. They didn’t have the faith there, the hope. A lot of them that come out - there were still some that were still a little on that dark side, but they were a lot more open to ideas and ways. I’m learning to trust, whereas I couldn’t trust before.” (PP 15)*

*“Having the strength, a bit more to be able to step out of my safety net that I’ve got going on right now. So, it’s a bit scary and I’m feeling very safe here, but I need to find other means to help me get out there. So that’s with [Program Facilitators and Trainers].” (PP 8)*

### *Future considerations to improve and expand program development*

Participants were able to articulate areas of program improvement that could support the expansion and scalability of the My Recovery program into other parts of the NT, including regional and remote

areas. One participant mentioned the growing demand to deliver courses like *My Recovery* program in more areas across the Northern Territory:

*"The Northern Territory. It can be a very hard and rough country up here. We miss out on a lot of things up here. We've missed out on a lot of these courses, such as My Recovery. There's a lot of people out there that are sincerely trying to find a way to help themselves, but there's nothing there for them.... I believe there is a big appetite. And I believe a lot of people are going to benefit through it all - once they know what this is about, I think that then they would come in and then they'd be better people. (PP 15)*

For this pilot project, it was deemed important to consider how this peer-led education pilot project could target other population groups impacted by mental health issues. Some of these suggestions extended to in-patients in hospital settings, prison inmates, and other marginalised, disadvantaged groups living with mental illness:

*"I think where people in jail and people with mental health problems, God, there's so much crossover there. It is the fact that you have to really look at yourself and what it does is it tries to bring positive things out of that. A lot of people in jail have a very negative opinion of who they are. Anyone institutionalised so, you know, bring it into [mental health inpatient unit]." (PP 7)*

*"They've got very limited resources out there so getting out to the prison would be something and I do believe like this program could benefit a lot of people out there...when I read it my first thought was it would be great in prison because it helps people identify their issues. Most people in there don't know what their issue is, they just think oh I'm in here because I'm an alcoholic or I'm in here because I'm a drug addict or I stole ra, ra. They don't actually realise that it is an underlying issue in their behaviour...they are lacking a lot of [essential] information... [for example] they have some people come and do a barista course. Yeah, okay, giving them skills of life when they're released but you're not giving them skills of life to prevent what they've been in there for. I hope that you eventually do get the opportunity to go out there." (PP 5)*

*"I'm based out in a remote community, but since I've just come out of hospital I'm staying at a place [mental health inpatient unit] which is kind of like a halfway house for people with mental illness. So I've been living with people there with mental illness and I've recommended it to one guy who I wish he could have come along a bit earlier because he probably would have gotten a lot out of it...mainly just to give people the sense of understanding and belonging with their mental illness when they come out of hospital." (PP 18)*

As stated above, there was a strong focus on personal development throughout the program, which gave participants a greater sense of understanding and belonging. Some participants described the connections that were made over the two weeks and explained the importance of maintaining support and a sense of connection after the program delivery had finished. Signs of withdrawal and isolation were sometimes discussed:

*"I felt concerned on the last day when one of the members, when he realised that it was over and we weren't going to be meeting anymore, felt concerned that - well, I saw him*

*withdrawing and isolated himself, and I felt concerned about what would happen to him afterwards. So I don't know about the follow-up. Yeah, I think there should be [local support]. And maybe there is. As far as I know, I haven't been offered that." (PP 14)*

*"I think that there's a bond there. You share six days with people...I felt people who could have maybe connected in another way afterwards; I felt that we should maybe have something for people afterwards." (PP 11)*

Other participants suggested more attention needed to be given to describing and talking about their own relationship towards mental health illness:

*"...I felt there needed to be a day where if it's comfortable for people to talk about it, to actually have a page where in the group we actually do talk about our illness and what it means for us and to kind of go throughout and describe our personal journeys a bit more in detail in relation to the thing." (PP 18)*

### **Perspective of Sectoral Stakeholders on the first phase of the pilot project**

This chapter presents information on Sectoral Stakeholders' perspectives about the pilot project.

These stakeholders were drawn from diverse backgrounds, providing a mix of skills and expertise in guiding the pilot project development and implementation. This included representation from the community mental health and Government sector, alcohol and other drugs (AOD) sector, community mental health organisations, VET sector, people with lived experience of mental health issues, carers, nursing and health promotion backgrounds, and with expertise in early intervention, suicide prevention, program management, and health service provision.

#### *Program alignment with national and territory health priorities*

Sectoral Stakeholders were asked how well the program aligned with current health priorities in the mental health and psychosocial disability space at the territory and the national level. All suggested there was a strong alignment between the program and mental health policy priorities in the NT:

*"I think it aligns very well... particularly in the territory lack capacity, there isn't a framework. There's frameworks out there, but they're not implemented well in the territory at all, and I think developing a network for these peers, so that they are supported and also the arm of it which talks about building capacity for organisations is really key as well." (Sectoral Stakeholder)*

However, some stakeholders expressed their concern about a perceived shortfall of the implementation of national mental health policy priorities in the NT. A need for collaboration at a local level between the commissioning bodies (such as PHN and Department of Health) was also discussed:

*"It aligns beautifully at a National level. The problem is we've got some, a lack of collaboration at a Territory level between the commissioning bodies. Cohesiveness, approach, implementing National priorities, to really say that - they're not prioritising it...nationally this fits within all of the peer and lived experience movements in the fifth plan. Actually, at a Territory level this fits really well within some of the employment and*

*workforce stuff, so the stuff that sits out of the mental health and suicide prevention.”*  
(Sectoral Stakeholder)

In the NT, the need for these types of programs was visible as some Sectoral Stakeholders expressed their concerns with finding qualified trainers to deliver the training. Training people locally, and building the capacity of the local workforce, was advocated strongly:

*“Territory level absolutely.... the carer consumer engagement peer work is at the forefront.... It is vaguely there nationally but there’s no national strategy for peer workforce and frankly, workforce in general in mental health. We cannot achieve true reform without the workforce.”* (Sectoral Stakeholder)

*“...we even have trouble getting qualified trainers to do training up here or finding organisations to do any training. So, if we can train people who are already here who are passionate about it to continue it, that’s perfect, but it has to be driven by quality and standards and evaluation.”* (Sectoral Stakeholder)

### *Accessing the target population*

When asked whether the program had accessed the targeted mental health and AOD population, stakeholders responded in the affirmative; however, concerns were expressed with over-representation of some groups (notably AOD) in the program. However, they were aware of the potential presence of substance use disorders among people with mental illness, eased some of these concerns:

*“I was concerned that [the Project Officer] was out in the AOD sector for a bit there. That worried me even though we know 70 per cent of people with a mental illness also have a dual diagnosis of substance abuse disorder”* (Sectoral Stakeholder)

As mentioned earlier, participation in the program was contingent upon identifying as someone with lived experience of mental illness, and a willingness to self-nominate. This was clearly communicated to potential participants and service providers during the recruitment process. An inclusive approach was adopted wherever possible, which helped the recruitment process be successful in achieving the targeted mental health and AOD population:

*“I do think that it’s reached the intended targeted population. I think that it’s really important that we don’t discriminate because I feel that people that are so called profoundly mentally unwell and people like that – you can still be profoundly mentally unwell and have a full-time job or you can be profoundly mentally unwell and work part time but still have a very significant role in decision making in the community...”* (Sectoral Stakeholder)

*“We keep trying to say to people, you don’t send people to this pilot project..., people must self-nominate...So having the service providers on the steering committee, there’s been very difficult to get into their services to talk to their clients, right, because they feel they know their clients. We manage our clients, we know what they’re doing, we know they*

*won't be well enough to do this. Well naturally it's not about you mob, it's about people who want to put their hand up; and yes, they might only come for two hours in the morning and realise it's not theirs, but it's their choice.... So, this is really difficult to get around when you've got service providers who are very protective of their clients, okay." (Sectoral Stakeholder)*

Interestingly, there was considerable discussion about the association between mental health and AOD clients and sectors in the way the target population was conceptualised:

*"... some of the members were questioning whether AOD should have a significance, and they actually asked us in particular if we thought it was okay that they would go there and we said, "Well, yes, of course, it's meant to be inclusive for anyone." ... the content on the program it could be anyone that wants to work on their well-being, regardless of what they identify with. "(Sectoral Stakeholder)*

*"And people...who have come through an AOD pathway have talked about the realisation of their use of alcohol and/or other drugs, starting points through mental health challenges... So, there is a mental health component that is underpinning most people's introduction to alcohol and other drugs." (Sectoral Stakeholder)*

Compared with other sectors, the program had more uptake from the AOD sector than initially expected. Since many referrals from the AOD sector had a dual diagnosis of mental illness and substance misuse. At the planning stage there was a suggestion that reaching out to the AOD sector was an important recruitment strategy:

*"...the targeted population for me.... was for people who would not get an NDIS package; for people, to give them some skill to self-manage their mental illness. I think it's expanded on that a lot... because the AODs made it expand...I think it did hit the target group that we weren't expecting, so I think that was the expectation I didn't plan on... I think the implementation part of it, and what was originally planned has, sort of, it's shifted and moved really, and that's what's happened. "(Sectoral Stakeholder)*

*"I think [they] communicated well in terms of what they were looking for, and I think also made it clear that it wasn't up to organisations to make statements around whether people were prepared to do this or not, based on how well they were or where they were on their wellness journey. It was up to the individual and that was I think an important point, it was up to the individual to decide....I know that they tried to reach people through a few different avenues, and so I feel like they at least tried to reach a target market in a pretty thorough way, and it sounds like they did without actually knowing who was there". (Sectoral Stakeholder)*

Further, because of the time constraints for recruitment, there were fewer opportunities to build relationships with other organisations outside of the community mental health and AOD sector. Whereas, the AOD sector showed an immediate appetite for the program, and they were able to mobilise interest in the program among AOD clients in rehabilitation:

*"I did expect more uptake through community mental health organisations. I think my lesson from that is there was not enough time to build the relationships with staff, organise opportunities for clients to come in and hear about the program and then to sit on that knowledge and have enough time to put in an application. Like all of that actually takes quite a bit of time, whereas the AOD, we had a captive audience. It was too easy to be honest." (Sectoral Stakeholder)*

*"I think the way that services work in the NT is that the AOD sector quite open, and mental health.....they're quite closed. They don't really want to let anybody in. They're doing their own thing and that's that. So, I think that was a major barrier to accessing other people.... for mental health services themselves, I think it was really difficult for the [Lead Agency] to access clients one-on-one to be able to draw them in to a program like this." (Sectoral Stakeholder)*

*"...straight away saw that it was something that his members would benefit from. And they've been the most embracing of this than any of ... mental health services. Because... mental health services are making judgments about their clients; AOD's not...And AOD, I think, fits very well, because it's a complimentary recovery program, okay, it's not one or the other. So, they're in rehab doing AOD, and this is just a complimentary program that runs alongside. So, I think there's potential." (Sectoral Stakeholder)*

### *Implementation of the program*

Although not everyone was involved from the beginning of the program, nearly all were satisfied with the implementation, especially applauding the Project Officer for her efforts in making the program a success:

*"I think [it was implemented] very well and [the Project Officer] did a significantly great job in doing the work that she did. I understand she recruited 17 people which is absolutely amazing as far as I am concerned. I have given her lots of credit and positive feedback." (Sectoral Stakeholder)*

*"I think it's been done really well... and her [Project Officer] drive, and her energy around it. I think we've had a couple of stumbling blocks, but we've worked through those, as always." (Sectoral Stakeholder)*

Sectoral Stakeholders appeared to be satisfied with the program's framework, timeline, and the peer-led approach. It was acknowledged that some activities were deliberately adjusted to better meet program needs influenced by the project budget, timeframes, and adaptation to meet local needs):

*"I think it was implemented really well. Simple, clean, timeframe was good. Set up the dates really quickly." (Sectoral Stakeholder)*

*"The only thing that's changed is the contextualisation, that's all." (Sectoral Stakeholder)*



It was important to consider the practical provision of transport to support some participants to consistently attend the program. Therefore, the Project Officer supported Program Participants way beyond what was expected:

*"I made a big effort and was still making phone calls right up until Saturday or Sunday before the course started, to try and reach out and touch base with everyone who'd submitted an expression of interest to let them know that we'd keep them in mind for the next program. Because I'd already had 21 names by that time" (Sectoral Stakeholder)*

The following stakeholder emphasised the importance of practical provision such as transport to support some people to attend:

*"I did go out of my way to make sure participants who didn't have transport got there, to and from the program. And I think that was actually a good thing.... I got support with carrying the equipment in from the young man that I was picking up and dropping off." (Sectoral Stakeholder)*

*"I think the practical component and support was really helpful. Some of the participants I gave a voucher for fuel... And I think that was appreciated as well." (Sectoral Stakeholder)*

*"Another person lost my number, so when I rang him to – because he missed a day – to make sure he was okay, he said, "Oh, thank you for ringing. Sorry, I lost your number." He appreciated the follow-up. I think that they really they were important elements." (Sectoral Stakeholder)*

### *Training delivery and participants engagement*

The training was delivered professionally and was well received by Program Participants. From the feedback Sectoral Stakeholders received, they described the program delivery as "excellent", "safe", "supportive" and "enjoyable". They suggested that participants liked the six days duration and were extremely satisfied with the trainers:

*"From all the feedback, everybody really enjoyed it and got something out of it... So, I think that's a really good sign of something working...So I think it was really well-received and everybody really liked it...everybody felt supported and safe in the environment, and that's the most important thing. They really liked the trainers from what I've heard." (Sectoral Stakeholder)*

*"I think they really enjoyed engaging in that way, some people had never engaged with other people that have mental illness before in a group setting. So yeah, I think it was really well received by the participants... They could identify different things that helped them easily. So, I think yeah, I think it very well received." (Sectoral Stakeholder)*

*"The facilitators were both very good..." (Sectoral Stakeholder)*

Wellways Facilitators were skilled with an understanding of the NT, so they were confident in the delivery of the program. However, the Darwin 6-day program delivery differed from groups facilitated in other jurisdictions, such as Victoria. Key differences included the program in Victoria is a 10-day program and includes flexible delivery timeframes, smaller group sizes, composition of the groups, and participants' in Victoria attend information sessions delivered by the facilitators. It was not possible for the facilitators to deliver information sessions for the Darwin Program. Instead, information sessions were delivered by the Coalition as a part of the recruitment process:

*"...firstly, one of the big differences is the time. So yeah, this is truncated into two weeks. It's also a much larger group. So usually groups are between 10 and 12. This was commenced at 19 and now with a constant 17 that will finish tomorrow. We've got quite a mix of people too. And a lot of participants in the program are from the alcohol and other drug sector. And also, people not as familiar with a peer facilitation program and also a recovery peer model." (Sectoral Stakeholder)*

*"I felt fairly confident....because of my experience and I have a lot of facilitation experience and training of facilitators so I know the program... one of the things that I was concerned about that initially that I was less confident was about there's not been a strong culture around peer development in Northern Territory... if seeds hadn't been planted before it can be like you're speaking a foreign language." (Sectoral Stakeholder)*

Sectoral Stakeholders also liked the level of engagement, the learning experience, the openness and willingness to engage with participants, and the group dynamics as well:

*"What I liked the most? The level of engagement and the learning that I've had as a result..." (Sectoral Stakeholder)*

*"Highlights for me were just the genuine willingness to engage with participants. Particularly in an environment that hasn't had this – programs like this available to them... So that – there was that coming together and working together as a group, that group dynamic stuff was fantastic...." (Sectoral Stakeholder)*

Facilitators were satisfied with the participants' engagement in the *My Recovery* program, their commitment was outstanding. Through meaningful discussion the facilitators created a safe, open, and non-judgemental space and the participants applied the program principles and group agreement in their communication with each other:

*"[Their participation] is been exceptional. Because it is heavy going. And people acknowledge that it's very challenging on a personal and emotional level. But the conversations are rich, the sharing is authentic. Yeah, it's really been quite a profound experience for me. And I'm not new to facilitating things. So, I really feel quite privileged to have been part of this." (Sectoral Stakeholder)*

*"[They engaged] just fantastically. Really openly and genuinely. They've been quite compassionate with each other as well. There's been very little judgement. Sometimes*

*people have said things that have been quite offensive to another person and in any other environment it could lead to a disagreement or disengagement. And it's kind of – people have left it that that's that person's opinion because in the group agreement people talked about it's okay to disagree, and it's healthy at times to have differing points of view but they're all valid in terms of that's valid for that person, mine's valid for me. So, they really embodied the principals of the program.” (Sectoral Stakeholder)*

### *Provided information and support*

Sectoral Stakeholders were asked about their satisfaction with the support and contribution of the Steering Group in providing direction to the Peer-Led Education Pilot, and the information received from the Coalition and the Program Facilitators and Trainers.

Although the Program Facilitators and Trainers were provided with a lot of support and information, some expressed that during the contextualisation process there wasn't enough time to adequately reflect on the content due to budget and time constraints. There was a suggestion that the pilot project should have been funded longer for a longer period to support better contextualisation in any future iterations:

*“... the only limitation there is time and budget, which is something that should be fed back to the PHN, because if you don't have the time and budget to do something properly, that's an issue.” (Sectoral Stakeholder)*

*“the Steering Group supported our work in the initial phase when we were looking at the truncated design - so they were instrumental in supporting that - and also minor customising. Again, funding dictated how much we could do with that. But there was certainly the support in that. And then also the support in promoting the program to their networks and communities as well” (Sectoral Stakeholder)*

*“I was a bit challenged by that to be honest. It was what it was. We did what we had to do but I didn't feel like I had enough time to really reflect on it. Or it sort of left, here it is, now you need to sort of make a comment. It just felt rushed” (Sectoral Stakeholder)*

Early consultations with the Program Facilitators and Trainers helped the Coalition to implement the pilot project within the contractual timeframes:

*“... I'd taken into account how long we could spend on it given the financial restrictions. So, the timing – and the [Lead Agency] and I had been having conversations about this for a long time before it was actually signed off. So that was helpful.” (Sectoral Stakeholder)*

While some of them felt that the Steering Group provided less direction, the voice of lived experience was really strong especially to the contextualisation of the program, with issues raised about the training schedule, content, and transportation:

*"[a person with lived experience] was really vocal about the quality.... I like that [this person] stood up for that point and it's something that we all agreed on..." (Sectoral Stakeholder)*

*"I don't really think we did provide a lot of directions frankly. We provided feedback or comment on the content, but I don't know that that was the steering committee's real brief. "(Sectoral Stakeholder)*

*"... I think there were opportunities... for peers to contribute, which as I said before doesn't always happen. So, I think it's actually the peers that were directing a lot of things more than the service providers, because - well, they didn't verbally say it contributed much" (Sectoral Stakeholder)*

*"I'm really happy, I'm especially happy with the people with lived experience. I know it's very important to have more than one person there because they give confidence to each other and they have been good advocates. I know they have to pick their battles because we don't necessarily have the energy to maybe offer a counterpoint to everything that's said there. But I think they've chosen - they've advocated well and for what they felt really strongly about." (Sectoral Stakeholder)*

One of the Sectoral Stakeholders described the necessary need for the service provider to be engaged in discussions to support an understanding of their clients' needs, as there could have been issues with the service provider not being aware of their clients' needs during the Program. For instance, financial pressure, anxiety, not having a car or a driving license to attend the Program:

*"And I just think that service providers don't necessarily pick up on it or have it in mind that the person might be experiencing that [some barriers for example barriers with transportation, anxiety, not having car, financial pressure, not having license...]. So, it might be just something that they are unaware of or take into consideration. So, I think having conversations where you have lived experience people with service providers, but if they're not going to talk, you can't have that conversation. So yeah, getting them to be more engaged is better I think for them as well. Because there's things that you just don't learn from books" (Sectoral Stakeholder)*

One of the Sectoral Stakeholders thought that the diverse background of the Steering Group helped in securing the necessary breadth of support and expertise from this group:

*"I think the direction everybody's input has been really good because of everybody's different roles... really robust. It's diverse and it meets what we need to do..." (Sectoral Stakeholder)*

Sectoral Stakeholders were also satisfied with the information that was provided by the Coalition and Program Facilitators and Trainers but one of them emphasised that understanding the information can be influenced by previous experience, knowledge, and background:

*"I formed a good understanding about what the program was from that information [that the Program Facilitators and Trainers presented] ... I understood what was happening in the program. But for other people, that could be different." (Sectoral Stakeholder)*

*"the [Lead Agency] had lots of stats.... they did a lot of work around that, and it was really good to understand where all these potential participants are coming from, and that could also highlight a gap for continuing programs or other services..... They did a lot of good work on the information" (Sectoral Stakeholder)*

Sectoral Stakeholders liked the contribution of the Coalition and the supply of a lot of background information; documentation about the phases and funding that was necessary to understand the context of the pilot project:

*"I think that they did provide thorough background, definitely yes, I would say yes I'm satisfied with how they provided information, they gave like some formal documentation outlining the phases and who was funding it from the PHN and kind of what the background was, and I think that was really useful to get context when you went. Yeah, I think they did that well" (Sectoral Stakeholder)*

*"Very satisfied. The [Lead Agency] was really instrumental in just getting the information out there and then when the [Lead Agency] was able to step in then she's just been able to continue it. It's gone from strength to strength..." (Sectoral Stakeholder)*

Overall, the program was highly regarded - the information on the peer work and peer model was very useful; the program was of high quality; and the facilitators who delivered the 6-day *My Recovery* program were inspiring. Although, some stakeholders indicated that more information about the delivery would have been useful:

*"I think that the information they deliver is excellent, I think it's really high quality, it's really insightful. I learnt a lot about peer work and the peer framework... I think we got an overview of what My Recovery itself was... We also learnt about the peer work framework in terms of organisations and what that looks like and some of the ethics around it, and that came from peer workers themselves, which is obviously really useful. They just seemed like such great facilitators, and I just thought "wow, this is actually quite inspiring"...really strong facilitators and really intelligent, just so great articulating their story or sort of not - like so aware of the boundaries and the ethics around how to be a peer worker, which is something that I just you know, people tiptoe around a little bit, they're not sure how it's done you know?....I think for me, I felt there's a lot to be learned from those people." (Sectoral Stakeholder)*

*"In regards to the information I would have liked – when we all came together and we were contextualising the content, I would have liked to have been left with a copy of how that delivery was going to be..." (Sectoral Stakeholder)*

One of the stakeholders articulated that the local knowledge of the Steering Group was essential for the implementation of the program, but there seemed to be a misunderstanding of the role of a Steering Group:

*“It was good to have local context... that probably supported them to encourage people to come and just to see the responsiveness that we always had so they would have potentially felt more comfortable there... It’s good to have people with local context and knowledge saying, “Well this might work down there but here we need – this is stuff we need to consider” ...What was probably less helpful there seemed to be a misunderstanding of the role of a steering committee. Whereas a steering committee can provide advice, but they don’t tell you what to do... From an advisory body providing information and advice around how it would go it needs to be clear advisory only.”*  
(Sectoral Stakeholder)

They agreed that the Steering Group contribution was most useful in the contextualisation of the program, although the level of participation across sectors varied:

*“I think there was some really interesting discussions when we first had our meeting, they were invaluable around the contextualisation.... So that was really beneficial, and the Steering Group really done the best around that, that was great.... [but] they haven’t been the most boisterous group.... [the AOD sector] have been the most active.... We didn’t get that much with the mental health sector, which is fine, we just had to work through that, what that looks like...”* (Sectoral Stakeholder)

### *Perceived program success and challenges*

Based on participants’ experiences after the 6-day *My Recovery* program was completed, Sectoral Stakeholders described multiple **success factors**. The elements that contributed to the success included:

- High response and retention rates;
- Perceived immediate benefits of participation based on participant feedback;
- A high level of demand for peer models of mental health psycho-education;
- A commitment to future planning through investment in evaluation;
- Reported (health) behaviour changes among participants;
- The visibility peer role models;
- The opportunity to share personal stories and experiences;
- Recognition of new vocational pathways.

Stakeholders were satisfied with the *My Recover Program* outcomes and they felt the success exceeded their prior expectations:

*“[I am] very pleased with the outcome, it appears to be really successful the first round. Yes, in the fact that it did have 17 participants go through. So even though there was some of the governance process, clear boundaries, the project could have been better. To me*

*that's extremely successful, great outcome regardless of who the group were. (Sectoral Stakeholder)*

*"I think to the point it is now, I think yeah, they've done what they set out. I mean for me the facilitators, you know, everything came together. I didn't expect it to be as good as it was. I didn't. "(Sectoral Stakeholder)*

High response and retention rates were described as key elements to success. This reflected the demand for an ongoing peer recovery program for the Darwin community:

*"I think it was very successful, considering it was only two people that didn't finish the program, and everybody else finished.... I think it showed demand as well for a program like that." (Sectoral Stakeholder)*

*"I think the NTs pretty starved for that type of national training, and it's about, how do we do that in a way that also supports the people who have done the Train the Facilitator." (Sectoral Stakeholder)*

Improvements in participants' mental health, evidence-based form of the program, evaluation of the pilot project, and relevant future plans were also listed among the success factors:

*"I think it was successful, because I mean clearly there was a high response rate... I think it's great they did a pilot and it's been evaluated, and they've got planned phases for the future... think it's well thought out, and evidence based in terms of what these people need, based on what we know about peer workforce and people with mental illness and what they need..." (Sectoral Stakeholder)*

*"I think it was successful... the retention rate sort of shows that people kept engaging when you didn't have to. There were no consequences for not coming back... I actually think it would've been not as successful if you relied on the people that - the Steering Group meetings to engage participants. I think the better idea was to go to each service." (Sectoral Stakeholder)*

*"I think in those terms it's been incredibly successful if you look at the retention rates. The other thing that I really have noticed is the changes in people over such a short period of time has been extraordinary. [Participants] are articulating how transformational they're finding it on a personal level, but also how authentic the engagement has been for them." (Sectoral Stakeholder)*

One of the key components of the peer recovery model is increasing the visibility of peer roles to continue to develop and promote strategies that can be adopted throughout the recovery journey:

*"I think it has been successful in that it's shown that a different way of providing psychosocial support, building the capacity of people, showing them what is possible, showing them strong role models..." (Sectoral Stakeholder)*

*“... we’re modelling that, or we’re supposed to be, and we were, but it doesn’t mean that people are necessarily going to pick up and run with it. But they did and we didn’t even need to encourage it apart from we were just doing what we normally do. So that was great.” (Sectoral Stakeholder)*

One person described that even the pilot project was unique, and a first of its kind for the NT. They recognised the lack of peer support networks in the NT, and considered that the inclusion of more participants from the AOD sector worked well:

*“I was pleasantly surprised. People responded very well to it. And we also have quite a few people who have come in through an AOD pathway and that’s not normally the way this is run. So, we – for me there was – I was just curious. I wasn’t sure how that was going to go, but it’s worked brilliantly.” (Sectoral Stakeholder)*

*“...we had people who have come from a diverse range of experiences. So, people who are in a therapeutic community for AOD, being bused into a group environment. So that was – that could potentially be quite tricky where you’ve got people who are living together or a couple of groups of people who are living together can get quite clique but it wasn’t – it didn’t play out that way, they actually – majority of the time they actually were willing to expand out and hear other people. And there wasn’t judgement from people who were there from a mental health perspective on other people who come in through a different kind of focus or working on a different focus in their world.” (Sectoral Stakeholder)*

The above-listed success factors of the pilot project were considered to be strong indicators for expanding the program across other regions of the NT:

*“I think we’ll start to see movement in the community. Then when we can spread the tentacles out like that ripple effect, I think that we’ll see some really good changes in the Territory.” (Sectoral Stakeholder)*

While the Sectoral Stakeholders described the program’s success in many ways, they also highlighted some **challenges**. More specifically, there were multiple challenges the Program Facilitators and Trainers faced, which included:

- Distance from, and the local characteristics of, Darwin;
- The venue;
- The dismissal of a participant;
- Budget
- Time constraints;
- Insufficient knowledge of the peer model among participants; and
- Minimal opportunities for the Program Facilitators and Trainers to build rapport with participants prior to program commencement due to distance.



Among the described challenges for the trainers from Wellways was the distance from Melbourne to Darwin was one of the most demanding. It represented some additional travelling and working hours out of normal business hours:

*“Look, distances have proved to be a bit of a challenge just in terms of trying to prepare for the program because we were a long way away. And because this is a pilot program, there wasn’t people on the ground who understood it. So, we were needing to do a lot of education on the run with the [Lead Agency] and that was tricky at times. I think too having it truncated has meant that we probably needed to make some decisions quickly about things because we didn’t have the time in between to allow people time for things to sink in. So, where we might normally ask people to go away, think about things, try things, come back, talk about it, you can’t do that because you’d spend a day somewhere.”* (Sectoral Stakeholder)

The venue presented some challenges to Program Facilitators and Trainers, such as room size and the learning environment that did not support the small group work:

*“What we prefer... to have an environment where you can break into smaller groups... that meets people’s needs and for people to feel comfortable.... [a tertiary education campus] is a learning institution that’s often challenging... that [venue] doesn’t provide room for small group conversations without other people – intimate conversations without other people hearing... So that setting didn’t really help for that.”* (Sectoral Stakeholder)

Asking a participant to leave the program was also challenging in some instances:

*“... probably the decision we needed to make after the first day to ask one of the participants to not come back [was challenging]. And again, that was something that needed to come to a head quickly because of the truncated nature of the program. We didn’t have the luxury of time on our hands. So that was really challenging and the support we received from the [Lead Agency] was tremendous around that. It was a delicate situation and it was able to be handled as well as what it could be.”* (Sectoral Stakeholder)  
*“Because this is a group process, you need to be able to manage yourself in a group setting and you also need to be mindful of the group agreement that we came up with in consultation - everyone came up with on the first day. And this particular participant wasn’t able to honour the group agreement and was having an impact on the other participants... And we’ve had conversations with the participants since saying how they really didn’t appreciate this particular person’s behaviour. So, it was necessary to sit down and talk with them about how there could be other opportunities for him to contribute and participate, but just not in this and not right now.”* (Sectoral Stakeholder)

Although challenging, the decision about the dismissal was considered beneficial to the rest of the group considering the success of the program:

*“So, while that was a really hard thing to do, and not a clear decision to make, I think that that was really important for the rest of the group. And I don’t think actually if we hadn’t have made that decision that it would have been as successful.” (Sectoral Stakeholder)*

All participants except two finished the program. One of them was asked to leave the group because the facilitators were confident that the program was unable to meet his needs. Another participant withdrew from the program himself:

*“.... his [participant who withdrew] reasons for not attending – and weren’t directly related to the other participant, and they were more about having his expectations met about the content of the course. And he didn’t feel at his age that he wanted to be changing things about himself. He was quite happy with who he was.” (Sectoral Stakeholder)*

*“his involvement in the group and that we didn’t think that this was where he was going to get his needs met, and that I would continue the discussion with him about other ways the [Lead Agency] could support him. Now, understandably that was quite tense, and I think this person in general was triggered by talking about his mental health and recovery.” (Sectoral Stakeholder)*

*“there was a couple of challenging personalities in the group, but [the facilitators] were confident that it was all right and they could manage it. But then on the second day, when I was having a chat with one of my own participants, and he said he no longer wanted to attend, when I fed that information back to the facilitators, they then started to express their concern about another person in the course, and whether that maybe something that had happened on the first day had upset the person who withdrew from the course.” (Sectoral Stakeholder)*

While the program was intensive for both the facilitators and participants, it was considered a good introduction to the start of the Train the Facilitator program. Since the 6-day program was considered heavier with more intense involvement and requirements:

*“... there had been some concerns around delivering an all-day program and whether that would be too challenging for people. But I think given that this program was a pilot with the intention of people going on to become Facilitators, I think it was important that it was delivered like this because the Train the Facilitator Program is actually quite heavy going. So, if you found this too challenging, you actually wouldn’t be able to sit through the Train the Facilitator. And so, I think from that perspective too it’s quite good.” (Sectoral Stakeholder)*

*“Some of the challenges have been that in a condensed timeframe you’re looking at aspects of yourself in a way that potentially you’ve never done before... and you’re doing it from 10 until 4 one day, day off, come back 10 to 4 the next day, day off, come back 10 to 4.... so, people are drained. They’re now – they’re now mentally drained. Most of the people are – the energy’s really dropped off... it is really noticeable in the room at times*

*because people are just fatigued from that intense focus. So that's been a – that's a bit of a challenge.” (Sectoral Stakeholder)*

Some Program Participants were used to adapt to an instructor-based model through their previous education and training. This teaching method involves very little or no interaction with students. In contrast, *My Recovery* and Train the Facilitator programs are based on a different approach, known as the peer-facilitation model. Hence, training the local trainers to adapt to this model of training might be a challenge:

*“there's also not as much understanding and experience of being within a peer facility - not even peer - within a facilitated model. So, people are quite used to a didactic training model, an instructor model, instructor learner model, and that's not how My Recovery is done either. So that's one of the challenges that we're going to face when we look at the Train the Facilitator process...it's probably easier for people that have got no instructor training because they can just come at it with a completely open mind.” (Sectoral Stakeholder)*

Not having direct contact with the Program Participants during the recruitment process was expressed as another challenge by the facilitators as they were not familiar with the needs of the participants before the program commenced and therefore unable to check-in with Program Participants about their needs during the program delivery:

*“...that's actually one of the things that has been challenging is that we have not had direct contact details of the participants... That's actually been challenging and unhelpful at times because under normal circumstances we would be able to check-in with people and we haven't had a chance to do that... I think it's important for Facilitators to have - and with people's permission obviously - but have that opportunity to check-in directly.” (Sectoral Stakeholder)*

*“...it's been a challenge when we've had nothing to do with the recruitment of people who have come into the program... we would [usually] introduce ourselves to the participants and talk with them about the My Recovery program so that we're really clear that what they're hoping to get out of it is what the program is there to meet their needs. If they think it's something different like [one of the Program Participant] who comes Monday and then it was really clear that this wasn't going to meet his needs and that he had a misunderstanding and it wasn't going to change and it was actually going to be – it was very disruptive to the group.” (Sectoral Stakeholder)*

It was also expressed that a lack of local knowledge may be a potential challenge. However, both facilitators had previous experience of working in the NT and thus had a good understanding of the context of Darwin and the NT:

*“What's helped is that I've been working up in the Northern Territory for 10 years, so I have a good understanding of the context and some of the uniqueness that Darwin brings, and the Northern Territory bring. I think that there are challenges around that if you didn't*

*have that knowledge ... So, I think that needs to be taken into account as a potential challenge.” (Sectoral Stakeholder)*

From a partnership aspect, building trust and agreement between partners to achieve the pilot project goals presented some challenges at the beginning. However, discussion and open communication helped to overcome these challenges. The excerpts have not been included here in an effort to uphold the anonymity of evaluation participants:

*“It was a bit confusing in the beginning what their expectations were about people participating in the program. And also, a bit confusing I think was some of their expectations when we’re really trying to grow something here in a short amount of time, so there was a bit of toing and froing, but I think we got to the right - arrived at the right place.” (Sectoral Stakeholder)*

### *Feedback and messages*

Sectoral Stakeholders were asked if they received any feedback from Program Participants or if they had any feedback, thoughts, or message that they would like to share. Program Participants were requested to provide feedback after each training day and facilitators were also sought for feedback during the breaks. This feedback was included in the following training sessions ensuring continuous reflection for participants’ needs:

*“...we’ve been getting feedback constantly, both from a group perspective, but also participants coming up and talking to us in breaks. And we’ve really adopted a bit of an iterative agile design to this. So, where people have spoken to us about some of their experiences, we’ve taken that on board and tried to incorporate that. And at the end of the day we debrief, we talk about what worked well, what are some possibilities for improvements, how could we consider that for the next day. So, without changing the content per se, we’ve changed the delivery design where we could. So that’s been great.” (Sectoral Stakeholder)*

*“...at the end of each day we ask people what’s one thing you’ll take away? Throughout the day we get people coming up providing unsolicited feedback... So, there was [a Program Participant] who said, “I’m not saying much but there’s a lot going on in my world and I’m really taking this away.” (Sectoral Stakeholder)*

An outstanding feature was how Program Participants were impressed by, and reacted to, the peer recovery model in the *My Recovery* program:

*“[Program Participants] have really been blown away by that peer model and how they have responded to the peer model. One of the participants said this really is the way, the peer...also the safety that they felt within the group and the joy that they have from meeting the other people, so that was pretty powerful feedback I think.” (Sectoral Stakeholder)*

*"... the feedback has been really good, [the Project Officer] kept me informed. People feel that that really has helped their recovery, whatever level that's at, which is fantastic, which is what this is all about." (Sectoral Stakeholder)*

Program Participants also felt that what they learnt how to develop communication skills during the program which was helpful in their relationships, as well as building their knowledge about medication use:

*"Yeah, one of the participants also said to me that the communication was really key to them, and they'd be using that in their relationships at home because they didn't understand the different styles about passive, passive aggressive, aggressive, you know, it hadn't been explained in that way. And they thought it was really, really useful to them..." (Sectoral Stakeholder)*

*"you have your chemical medicines that you're given, but your personal medicines what you do in your life, so it might be your work and you have grandchildren, whatever it is.... what they were saying in the clip was that you will talk to a doctor you don't want your chemical medicines to interfere with your personal medicines. ... They are just talking about using a different language to explain things to doctors. I have to have a lot of energy to play with the child, you know, to engage with the child that I'm raising, so I don't want a medication – a chemical medication that's going to make me feel drowsy and things all the time..." (Sectoral Stakeholder)*

Sectoral Stakeholders also had the opportunity to share their feedback and thoughts about the pilot project. They wanted to see the program carry on with continued funding, a longer implementation period, and with an intent to increase the peer workforce in the NT. The skills and knowledge of this program provided were fundamental to the growth and health of Program Participants, and with some additional contextualisation the program could be extended to other community contexts:

*"I think ... the funding needed to be maybe two years, maybe a longer kind of process, more funding." (Sectoral Stakeholder)*

*"I would just like to see it continue, definitely...from all different [ages] like 0 to 7, this is what you teach kids, from 7 to 14, from 14 to 21 and then when people are having children, when people are going to the workplace for the first time... Make sure that you've got all your socks in the basket before you go out to the snow. Have I got what I need to live well? It's fundamental stuff. It's like learning to tie your shoelaces." (Sectoral Stakeholder)*

*"... we set things up, we have the conversations, we start the ball rolling, but we have no capacity to keep doing it...we've got to find the support network for those... that graduate." (Sectoral Stakeholder)*

*"I think it's more than [the Project Officer] .... I think we could do with another three of [her] just help with them get going." (Sectoral Stakeholder)*

While the venue presented some challenges to the facilitators, Steering Group members were unaware of the challenges:

*"... it had all the services that they needed in the room. It had the bathrooms there, the Chinese garden, two cafes for people to be able to just go and spend time in if they wanted to. They could go to the library if they wanted to at lunchtime. They could also go to Casuarina if they needed to." (Sectoral Stakeholder)*

*"location with the glass and the gardens I think worked well. And the buses, for the people who got the buses. It's a bit annoying that the parking was a bit far away and you had to pay for parking. We tried to be as responsive as possible for [the Program Facilitators and Trainers] in terms of their needs, food, resources, just boxes and boxes of shopping, manuals and that sort of thing." (Sectoral Stakeholder)*

Providing catering was a good idea and the Program Participants appreciated it:

*"And I do think the food – people were very grateful to know, one, it was free, and that there was catering. That was important to people." (Sectoral Stakeholder)*

The Sectoral Stakeholders said that there was a potential to expand the program across the NT more broadly, though some of them indicated that cultural considerations for Aboriginal and Torres Strait Islanders and Culturally and Linguistically Diverse (CALD) groups needed to be carefully thought through first:

*"this pilot has the potential to grow into regional areas, for sure, but ... we've got to be very conscious and culturally appropriate, and sensitive to the fact that other areas are quite different to what we're doing." (Sectoral Stakeholder)*

Stakeholders also stressed the importance of the lived experience of peers in the recovery journey:

*"...when you have a peer or someone with a lived experience talking to you as a patient as someone going through that, there's much more of a connection and understanding and that's the power from it.... they don't know my whole story, but they actually have an understanding of how hard this might be for me, whether it is mental health, suicide prevention, whichever area it is." (Sectoral Stakeholder)*

*"You are not going to be taken seriously if you are not a peer." (Sectoral Stakeholder)*

*"We're stepping outside of a biological model, outside of an illness-based paradigm...everyone in the room has their own experience of mental health challenges and it's about drawing the wisdom out of the group... we're open to what sense people make of it but also open to what sense people make of their experiences in the room... And it's also a great opportunity for people to see that they're not the only one. So, there's a real normalising and destigmatising component that comes with it... And also, the opportunity for facilitators themselves to actually grow and learn..." (Sectoral Stakeholder)*

There was some trepidation about managing peers in mental health and AOD workplaces. This underlined the need for a better understanding of the peer support model and the need for workplace strategies and training. This was important, as it was also stated that people with lived experience would like to see employment pathways into services and organisations based on their lived experiences:

*"I didn't really know how to manage it very well...I didn't really know how to guide staff and how to manage it. We had some pretty weird questions from staff, like are they allowed to drive and are they allowed to enter data on to the computer about participants? Because they might lack the formal qualification... So, people were quite confused, and it caused a little bit of anxiety in the workplace, and it's just a lack of understanding on how to work with peers." (Sectoral Stakeholder)*

*"[it shows] the interest from people, and I think people want an employment pathway based on their experience as well, it can be quite like empowering for some people I think..." (Sectoral Stakeholder)*

*"It's about making sure it's an accredited course, but also that it's value added in the workplace... but there's also a flip to this coin, it's a matter of them going through as a peer support, see this as a career pathway, get as many qualifications as they can, be quite skilled, and then go into a workplace that has no clue how to do it with them... So, there's a flip coin here, and the flip coin is, how do we build the capacity within organisations, so that they're ready for a peer support workforce." (Sectoral Stakeholder)*

*"I'd love to see a heart tick, a mental health green tag in these emails that says, here we're ready. We've redeveloped all our policies and procedures, we've looked at our strategic plan, we are now ready and value a peer support worker in our work place." (Sectoral Stakeholder)*

During the Steering Group meetings, feedback about the program and evaluation was continuously shared to assist the Steering Group to have a better understanding of the impact of this pilot project:

*"And I do try and formulate what we've done into bites of data and bites of information. Because I've gotten my further funding hat on. And I want them to understand the impact." (Sectoral Stakeholder)*

Regarding the recruitment process, it was noticeable that lived experience and having completed the care component of the program in QLD the Project Officer influenced recruitment due to a shared understanding of mental health and the intent of PLEP project:

*"...looking at the data around the expressions of interest that came out of the information sessions, and the information sessions where I, as a person with lived experience, shared the impact, this kind of program, albeit not the same program, had on My Recovery. So, the uptake was really high there. Where I didn't have access to clients, and I needed to rely on staff members socialising the program, I did create a guide for them, which included a*

*link to a promotional video... hoping that they would show that. And in sharing that video that might build some of the rapport with the clients. But the uptake was really, really low.” (Sectoral Stakeholder)*

### *Recommendation, opportunities, future plans and considerations*

Sectoral Stakeholders were asked about their recommendations and future consideration about the further development of the *My Recovery* program in Darwin and across NT, more broadly. Recommendations included inviting people from (1) remote areas, and (2) representatives from Aboriginal and Torres Strait Islander peoples and Culturally and Linguistically Diverse (CALD) background, into the Steering Group, if further iterations are targeting these population groups:

*“there was no Aboriginal Torres Strait Islander representation or remote representation and that was a major problem... so they are the two big gaps that for future need to be addressed, I would suggest....and it is not just Aboriginal and Torres Strait Islander people are remote, it’s CALD in general as well.” (Sectoral Stakeholder)*

If the *My Recovery* program was implemented in the remote areas, and among Aboriginal and Torres Strait Islander peoples, a culturally appropriate version and model would be required to use with culturally competent facilitators. According to a Program Facilitator it would not be difficult to make the program culturally appropriate:

*“I would really encourage that facilitators... who are known in the area and who are valued and trusted in the area be utilised...I don’t think that would play out as well in a rural community...there’s another great model, another fantastic model outside of the whole person health model to – that people could look at...So, if it was going to be done for indigenous communities it would be great to see if that could be included in this, so you’re not bringing in an expanded westernised model when there’s a brilliant model that would be – that is consistent with the rest of the program. And it would be easy to dovetail it in to make it much more originally culturally appropriate.” (Sectoral Stakeholder)*

*“I know remote is very hard, but maybe they could even get someone from Katherine or something. So if they’re looking to develop it, having that voice from the start might help. Or I think it can help... and having someone dedicated made it a lot better as well.” (Sectoral Stakeholder)*

To implement the program in the remote areas, program materials need to be simple, accessible, and suitable for using outdoors as well:

*“...be some simplifying of the content, more graphic design... and less reliance on using PowerPoint technology because that relies on you being indoors. You might want to be outdoors and have that flexibility so what props and learning tools are you going to use when you go outside...there would need to be how you would make the materials translatable, accessible but also have it suited so that it could be delivered outdoors, that kind of thing and your facilitators need to be local people.” (Sectoral Stakeholder)*



For further development of the *My Recover Program* it is essential to allocate the time and resources, provide support and mentoring, invest extra work to assist the facilitators, sustain interest and drive, and promote the program in a targeted way.

Maintaining the movement of the *My Recovery* program and providing opportunities for participants to improve their facilitation skills require further work and financial support:

*"...it's really important to have adequate resources to be allocated to support the ongoing facilitation of this program... We're intending to train a group of Facilitators in November. We're limited with how many people we can train in one go. And the demand will exceed that, which is great on the one hand, but has its challenges.... So, it's around how do you maintain that momentum, how do you maintain the support, how do you ensure that people get enough opportunity to facilitate, to practice at home and develop their skills without feeling alone and isolated. And that takes resources and it takes money." (Sectoral Stakeholder)*

*"...what I'm doing is applying for a heap of money which wasn't really part of my original scope but absolutely necessary...in applying for that money I'm trying to think about how we would implement this in other areas and the learnings that we can take away from here. So critically important, if we go into other areas, we need to have a precursory trip to go there and promote it and socialise it. And really get services aware of it, run some community information sessions or even come back for a second trip and run some community information sessions before we head back to do the training. So, there is quite a bit of, I think, forward work that needs to happen to make something successful in its first iteration in a new area." (Sectoral Stakeholder)*

Above the financial support, providing mentoring support and continuous opportunities for facilitators' personal development was also necessary:

*"...for the program to – for this pilot continued facilitators there really needs to be follow-up support and mentoring facilitators. It's not a train somebody and then they're free to run. You really need to have professional development and mentoring around that peer stuff so that people are able to remain as peer facilitators where we draw collective wisdom rather than get trapped into a didactic instructional load. That can be draining, and it can be tricky, particularly if you're not seeing it modelled around you. So there really needs to be support for that process ongoing." (Sectoral Stakeholder)*

*"I think the challenge going forward is to get the experienced facilitators, you know, like you'd want everyone to experience what [the Program Participants] experience with those high-level facilitators, you know, very experienced facilitators. And that will be a challenge I think going forward, is let the experience of the facilitator – because a lot of things come up and how people respond to challenging things that come up, it depends on whether the rest of the group is going to listen to you or take your advice or just think switch off or you know. Yeah, that I think it would be an ongoing challenge or a future challenge." (Sectoral Stakeholder)*

One Sectoral Stakeholder highlighted that including *My Recovery* program participants would promote the program and raise the interest and awareness of the program by sharing firsthand experience:

*“What I would like to do going into stage 3 is get some of those stage 1 participants and take me along, take them along to those sessions because now I have really good first-hand account of what the program was like and that is the best information sharing.”*  
(Sectoral Stakeholder)

To avoid issues around participants’ expectations of the program it is important to make clear about the program’s focus and the meaning of recovery and the benefits of peer-led recovery approaches, which is usually delivered during information sessions. However, an alternative model was adopted as part of this pilot project which involved the Coalition sharing generic information about the program during the recruitment phase:

*“[communicate] what the group is about and making sure that people are coming in with the full understanding of what it is, and a full expectation about their involvement.”*  
(Sectoral Stakeholder)

*“...explanation needs to happen in that first contact, about what peer-led means. They need to know it’s safe.... and it’s literally only people who, like them, identify as having challenges. That’s the important thing. I think that’s really important. Confidentiality, understanding what peer-led means, and then why peer-led is – yes. And then the focus on recovery skills – what you’ll learn that.... So, it’s breaking down peer-led, recovery. But being confident that it’s safe, and that they’re regular people like you...[and] that there’s no expectation for them to talk about their diagnosis whatsoever. So, they come in there and share as little and as much as they want. And the conversations are very recovery-focused, not deficit-focused.”* (Sectoral Stakeholder)

While the 10-week program was contextualised and condensed into and adapted to a 6-day program, two-week intensive program, delivering the 10-day program as a comparison might be advantageous. This could also provide an alternative option to deliver night classes for people unable to attend day time classes:

*“Given the facilitators have come from interstate I think that it was good to have the two-week duration, day on, day off, day on, day off.”* (Sectoral Stakeholder)

*“...from a logistics point it made sense for them to do [the pilot] squished together. But I think it would have been a lot better to drag it out and get that the original one, the ten weeks.”* (Sectoral Stakeholder)

*“I don’t think that we advertised it as broadly and I’m hoping that we do in the future. I’m hoping to see that we have night time classes, daytime classes...”* (Sectoral Stakeholder)

For a successful program it is necessary to employ a Project Officer with the necessary skills including lived experience of mental health challenges to undertake the comprehensive project co-ordination

functions and to guarantee project success. A key element of this is to support facilitators during the program delivery. Thus, facilitators can then focus on the delivery of the training:

*“...you need a Project Officer, I think, to be an essential point of coordination for these programs, with hopefully a lot of the logistical work and understanding to support facilitators in that delivery. So that our facilitators can focus on their area of expertise, which will be facilitating from the basis of their lived experience.”*

Building a supportive peer network is another focal point in the further development of the *My Recovery* program as well as developing referral pathways and allowing time for the program to grow:

*“...we don’t necessarily need a trainer in every organisation, we need a pool of trainers, well trained and well supported, to then be farmed out... it’s around what does this look like after everything’s gone. It’s not about having their own trainer in-house, it’s about having a pool that support each other and work with each other...” (Sectoral Stakeholder)*

*“It definitely would need more lead-time to build up those referral pathways and so starting to see that now, getting cold calls from - I mean yesterday the psychogeriatric service, a couple of weeks ago a private psychologist. So that information has started to trickle out, filter outside of even where we’re promoting it.” (Sectoral Stakeholder)*

If the *My Recovery* program was to be developed further, it would be necessary to maintain the voice of people with lived experience on the Steering or Advisory Group; and to evaluate the program to further strengthen the evidence base:

*“Just reiterate that the voice of lived experience, when you're designing programs, I think, is critical. And having them evaluated is also critical.” (Sectoral Stakeholder)*

Over the longer term, a vision to develop a peer support vocational pathway would be beneficial:

*“The vision is, for some other organisation to pick this up and keep running it...we don’t want this to be something at a Cert IV, you might as well pitch it at a PhD, okay. It has to start in at Cert II, Cert III, even if it’s in the electives, so people can start getting a bit of a feel what this looks like, how does this work, yeah, this is...They want a stand-alone recognised course that says, this is peer support workforce...” (Sectoral Stakeholder)*

*“the best thing we can do is have a really open dialogue and just remind everyone what we’re - this is not about just your organisation and your organisational needs. It’s actually about a population of people and pathways for them.” (Sectoral Stakeholder)*

*“There’s no transparency about where to go for help it’s that hard to find out who’s doing what. And I just think that that’s ridiculous, because that’s just a problem that can be solved with someone spending a bit of money to map it and keep it updated. Like it’s a no brainer. You know, people die because they don’t know where to go.” (Sectoral Stakeholder)*

Besides offering recommendations and considerations for the future of the *My Recovery* program, stakeholders described some **opportunities** for the facilitators and participants such as:

- A sense of accomplishment through program completion;
- Building trust and new relationships,
- Gender balance in the co-facilitation,
- Facilitation of peer bonding;
- Active engagement in a discussion about recovery journeys;
- A willingness to reflect and learn;
- Less revision on the previous day content and going deeper into the knowledge.

Gender balance within the co-facilitation processes supported participants' needs while the 6-day program competition, was especially welcomed amongst participants from AOD Rehab environment:

*"...it is always a co-facilitated program but having a male and a female facilitator has been useful as well. So, if people want to catch up with one of us and they have a strong preference, it could be around personality, it could be around gender, could be around culture, those – we have a better chance of meeting those needs appropriately. So that's worked well for us." (Sectoral Stakeholder)*

*"So, some of the opportunities around that, I think it's actually enabled a lot of people to complete the program, particularly where we've got participants who are in a residential rehabilitation program. If this had been over 10 or 12 weeks, that may actually have interrupted their ability to complete. I think it's allowed us to form - given that we don't work in the community here and we're not with a service provider here, this has meant that we've been able to forge relationships very quickly with people. That's probably the main thing." (Sectoral Stakeholder)*

The 6-day *My Recovery* program had an intensive schedule which affected group dynamics, engagement, the building of trust and relationships as well as keeping the program content fresh and supporting participants in gaining a greater understanding, and better life skills:

*"...the bonding has happened really quickly over a very short timeframe. People have been really well engaged with the process. They've come with a genuine open desire to actually engage with it and make the most out of it. That's been key as well..... So, people have come with a – they've come with a willingness to learn and share and really participate in the process." (Sectoral Stakeholder)*

*"...the condensed timeframe, the trust is built very quickly. That group dynamic has moved very quickly into performing... There's also less revision, less time lost through revising what we did last week which you would ordinarily have because last week was this morning.... So, the information largely is still fresh, so that's been quite useful as well, which has allowed us to drive a bit deeper. There's less refreshing so people are ready to go – go in deeper from the start each day. So that's been useful as well." (Sectoral Stakeholder)*

## Perspective of Sectoral Stakeholders' roles and responsibilities

This chapter describes Sectoral Stakeholders' perspectives about the Steering Group members' **roles and responsibilities** around:

- invitation and engagement with the pilot project;
- experience and expertise;
- terms of reference;
- the functioning of the Steering Group;
- project management; and
- future contribution.

### *Invitation and engagement with the pilot project*

The Coalition invited stakeholders to be part of the Steering Group in order to support the governance and deliverables of the pilot project. The concept of inviting stakeholders was to have a local cross-sectional organisational representation on the group:

*"So, it was the [Lead Agency] that invited people, there's letters here to say, we'd like you to be on this, this is what the project is, this is what we're doing, we don't, sort of, added the amount.... So, we invited stakeholders to be on a steering committee to see how they would support this beyond the project, right, the pilot project. Because that's what this has needed, it needs drivers now. So, we've driven it so far, and they need to keep driving it." (Sectoral Stakeholder)*

*"....in terms of the Steering Group... we need to just get the right people and I think it would be important to have the right people from a cross-section of the local organisations, not just the ones that are actually doing it well." (Sectoral Stakeholder)*

Sectoral Stakeholders were asked about their motivations to be a Steering Group member on the PLEP project. The **motivations** were:

- relevant background to the pilot project,
- interest in peer-led education or peer-led workforce area,
- to support the development of a local peer workforce,
- to contribute to improving the mental health of the local community in a safe environment,
- to help roll out the nationally recognised program in the NT.

The need for peer focus in service delivery was discussed in many ways:

*"... in the territory in general, we need to have a more peer focus. I think the territory lacks a bit of that, so I was keen to be involved.... I'm aware that it's something that other states do really well; I've been to a number of conferences like national conferences, where there's been peer speakers or peer led frameworks discussed. People presenting on generally peer led education or peer led workforce, and how successful and beneficial that is for people with mental illness to have someone working with them. ... We don't have enough peer led workforce, or framework, organisations...capacity and how to do it properly. So that's why I was quite keen to be involved." (Sectoral Stakeholder)*

*"Why I wanted to participate was to help to develop program to assist people in recovering from mental illness or wanting to work on their mental health and well-being...I just think the voice of lived experience is not often heard when programs are being designed. So, I did think it was important to take up the opportunity, yeah, so that someone - at least a couple of people could contribute from that point of view." (Sectoral Stakeholder)*

Steering Group members described the pilot project as very inclusive and engaging:

*"I feel very engaged. It's very inclusive. We receive regular emails about what's happening and in the actual group itself, we were all able to work together to get what we needed done, doing." (Sectoral Stakeholder)*

*"I felt that we were pretty engaged... I think we got to speak - we got to have our opinion..." (Sectoral Stakeholder)*

Some of the Sectoral Stakeholders wanted to be more actively engaged in activities and to have been consulted on the pilot project and its structure:

*"...I would have liked to have been involved initially before decisions were made about what they were going to do.... you are best to talk to them about your options of future opportunities to develop the peer workforce...it would have been much better just to be more consultative." (Sectoral Stakeholder)*

*"I did feel engaged, I felt a little bit as though maybe there was a bit of lack of structure in terms of how our input was to be given...and it's fine like I think it was an informal, we're kind of all in a room, we presented with information, what the pilot project was, documentation, [Program Facilitators and Trainers] came in. Then I think there wasn't much structure for input from us, I think, I mean there were a few emails that flew around and that kind of thing" (Sectoral Stakeholder)*

While some members attended the meetings regularly, some service provider representatives were unable to attend as regularly due to competing tasks. However, lived experience representatives felt privileged that they were heard and contribute to the program. Some of their feedback was highly regarded and deemed useful in developing the resources for the *My Recovery* program. Most helpful was the application of the visual plans:

*"I felt like we... contributed significantly, especially to the content of the program. And I think that was valuable. The feedback that we got at the end from [Program Facilitators and Trainers] was that some of the things that we told them to do, they're going to introduce nationally because it was so successful." (Sectoral Stakeholder)*

*"And they were especially pleased with the visual on the plan, your personal plan, recovery plan, because we used images instead of words. People said that they would be using that to hang on their fridge or their wall or wherever. But as the ... facilitator said, she'd never heard that before and never would think that a person would put a written plan up on the wall. But the visual one made such a big difference..." (Sectoral Stakeholder)*

The idea of self-nomination by participants during the recruitment stage was highly regarded, as it helped to recruit participants into the program:

*“one person commented that the people that attend their program are too unwell to participate in this program, which is - that’s not a good attitude to have. You should offer the program and let the person decide regardless.... and what service providers don’t realise is that people only share parts of their lives with them. And even the part that they do share is restricted down to their level of interest... Like you might know that that person has specific illness, but they might not share even symptoms when they’re feeling them or things like that, because of past experience or their experience of you, and they feel that you can’t assist them so there’s no point in sharing. So, I don’t think that they realise that. And obviously, this person, to make that judgment, obviously, is a barrier for people attending in itself.” (Sectoral Stakeholder)*

The Coalition was the secretariat for the Steering Group and provided information to the members to support the pilot project through their expertise and networks which supported the program in Darwin:

*“...the motivation for people to keep coming in is that they need to feel that they’re getting something out of it...we want people to be there to see a vision for this, but we also need them to be very realistic about any conflicts they may find, or any prejudices they bring around to that...in my mind I want the Steering Group to have the most useful information possible because what I’m really looking from them is to leverage their knowledge, connections and understanding of the service system... So, I really wanted them to be engaged, to feel ownership over the project and to reach into the different parts of their brain about what might be possible because I guess we’re looking to push things that haven’t existed before...” (Sectoral Stakeholder)*

While the participation and support from the lived experience representatives and the AOD sector were valued, the contribution from the mental health sector added to the contextualisation of the My Recovery program presented difficulties in the direct promotion of the program to clients:

*“I think there is definitely a two-way learning here, like they can learn from what we’re doing here that’s different to what they do, and we can learn from, particularly those who have got some really strong peer initiatives within their organisation. ...” (Sectoral Stakeholder)*

*“We’ve seen some excellent support from the alcohol and other drugs peak body which was unexpected but fantastic and I think has opened a lot of people’s eyes to possibilities and I guess evidence that we haven’t collected before about the need of that group of people with co-morbid mental illness and AOD.” (Sectoral Stakeholder)*

The Steering Group members included representatives from registered training providers and their representatives and at times were unable to attend the meetings due to other commitments, minutes were taken and distributed to the Steering Group after each meeting.

A representative from the VET sector was also invited onto the Steering Group. The education sector was also invited to be part of the Steering Group but they were unable to participate:

*"It's been difficult to get representation from registered training organisations, but I noticed that we have, where the scheduling hasn't conflicted with one of the VET trainers who has got a really strong interest in this area." (Sectoral Stakeholder)*

*"... the education side... it's to come along and listen, and see whether they see a vision for this, and that's what it's about, and that's what we've been trying to promote to the steering committee...." (Sectoral Stakeholder)*

### *Experience and expertise*

Although Sectoral Stakeholders did not have a definitive understanding of what the roles and responsibility of a Steering Group, found the experience and expertise of the Steering Group reasonably good:

*"it is a reasonable good mix. I am not quite sure what else we might need to be honest but yeah, I think it is a reasonable mix." (Sectoral Stakeholder)*

*"So, having a committee, and whether this is the right steering committee, I don't know..." (Sectoral Stakeholder)*

Some of the Sectoral Stakeholders said that it could have been a better mix, with one representative from each service provider had been invited to participate as well as having a representative from clinical and inpatient settings:

*"If you could have one representative from mental health, one from AOD, one from housing or accommodation services, something like that, that would have been a better mix of people. But it's difficult to get everybody involved and engaged in those things..." (Sectoral Stakeholder)*

*"...I don't know maybe clinical or something like that...I don't know that it's - I think it sort of feels as though the clinical settings, inpatient units and things like that don't regard it too well, don't do it too well, so I think it would have been good for them to be part of it, yeah" (Sectoral Stakeholder)*

Varying opinions were offered about the involvement of supporting service providers to participate in the pilot project. While some stressed the importance of having more service delivery represented, others advocated for less inclusion of service providers in the Steering Group, in order to create a more strategic group:

*"Maybe more service delivery, I feel like maybe I was the only person from service delivery there, like mental illness, like people that actually deliver supports for people with mental illness... [and] maybe in different settings..." (Sectoral Stakeholder)*

*"... if I had a reflective look back, I wouldn't have as many service providers on the steering committee.... Well it could be more a strategic steering committee, rather than opening up to lots of people..." (Sectoral Stakeholder)*

The involvement of people with lived experience, the external evaluators, and local peak bodies was valued. However, irregular participation from Steering Group members was a concern raised by Sectoral Stakeholders:



*"I like that there was two people with lived experience on the Steering Group. I feel like that's really important. To have us as the peak there, that was really good. And then of course [the External Evaluators] being there to update on the evaluation process was good. I think the NT government participation was a little sporadic, but I think if you could get more people there from a broader background it would have been better, but I think meetings up here you never know..." (Sectoral Stakeholder)*

*"I really like that we have got someone to evaluate what's happened. Because so often, programs are developed and implemented without any evaluation. Yeah, it happens all the time...." (Sectoral Stakeholder)*

One of the stakeholders raised concerns about the recruitment process, especially for the carer consumer cohort:

*"I do get concerned about the carer consumer reps constantly being the same people in every group. My understanding is that wasn't an open process where people go to apply and there were concerns developed for the carer consumer roles.... we have carer consumers... and we recruit them to that role and make sure they have got the right skill set." (Sectoral Stakeholder)*

Some of the Sectoral Stakeholders would have liked to see more lived experience representation in the Steering Group because they felt that their contribution was more significant during the consultations and contextualisation phase, though they were aware that financial constraints could work as barriers to invite more lived experience representatives:

*"In my opinion there should've been more lived experience on the - especially male - you know, just representation from different cultures, all sorts of things. Because what we found is that the experts didn't actually contribute that much." (Sectoral Stakeholder)*

*"And I know that money is always a barrier for allowing people with lived experience to attend and participate in these sorts of things, but yeah, if they can overcome that, then I think it's a good idea to have more people with lived experience." (Sectoral Stakeholder)*

The composition of the Steering Group showed some flexibility and openness. It is not a closed process; new involvements were accepted later in order to make the most of the pilot project:

*"I'm very happy to get a nomination from someone that says, I'd like to be on it because I'm the local RTO, and I'd like to see where this goes. So, the Steering Group isn't locked in and done, it's quite fluid. We do understand organisations will come and go. The [Project Officer] is very good at keeping minutes, so they can actually keep up with what's going on through minutes, so they're not lost." (Sectoral Stakeholder)*

### **Terms of Reference (ToR)**

Sectoral Stakeholders were asked whether the ToR was fulfilled. Although they felt that ToR were appropriate, opportunities to draw more comprehensively on people's expertise and background during the early stages of project would have been beneficial. Such engagement could have shaped the pilot project differently:

*"... I just think it could have been more engaging if there was a bit more structure around providing input perhaps, when you were there on the day... I think that's right, and I think it would have been good to maybe - and this isn't a criticism, it's just an observation, that to be aware of what the different expertise, or what in the room of what angle everyone was coming from, and maybe just draw on that a little bit more.... But was it fulfilled? I think reasonably yes, but again I think that we could have drawn more on people's expertise and background..." (Sectoral Stakeholder)*

*"I probably just need to - maybe with the terms of reference get people to hammer out what are the best available times..." (Sectoral Stakeholder)*

In general, people appeared to be satisfied with its structure and the purpose:

*"I think it was fulfilled, everything's been laid out and there's been really good communication around everything. I'm happy with how it was fulfilled..." (Sectoral Stakeholder)*

*"Look, we put a lot of effort and time into that reference, and it's about how people come together, how people work together, and I think it's meeting that goal, people pretty much understand what their role is through the terms of references on the steering committee. And I think that's all they are, they can change. ... Yeah, absolutely. So, a terms of reference is just that, it's just a guide really, to how the committee comes together and their purpose, and I think it's meeting that." (Sectoral Stakeholder)*

### **Functioning of the Steering Group**

Sectoral Stakeholders were asked about what worked well and what did not work well, in the Steering Group.

#### **Areas of excellence (What worked well)**

They reported that the diverse background of the Steering Group members worked well, especially during the contextualisation phase of the pilot project. It created a cross-sectoral representation in the group, which helped with different perspectives and fulfilled the objectives of the group:

*"I think having the various people... from different backgrounds... I think that was good... So, I think it was a good mix of people.... I think that worked well..." (Sectoral Stakeholder)*

*"Everybody that was able to turn up on the days because given that everyone is in – thinking everyone's in full-time roles and in such diverse roles in mental health that everybody just got in and did what they needed to do to get the program up and running...." (Sectoral Stakeholder)*

Regular Steering Group meetings in a relaxed and respectful environment, stimulating discussions, and a strategic approach to the pilot project planning, were described as an enabler of Steering Group function:

*"I like that it was quite laid back. We all just kind of sat around and had a chat about things and it wasn't to a really set schedule where you come in and say, "Do you agree on this?" "Yes." Move on. It was a lot more discussion involved, so that was really nice... I think the*

*Steering Group went well. Everybody was respected and that was really good..." (Sectoral Stakeholder)*

*"Now the ongoing meeting is about, do we call a meeting because we've got something to share, or do we call a meeting for the sake of everybody sitting around meeting. So, we've been more strategic around making sure that the committee is, well there's emails backwards and forwards. I don't necessarily think it's the timing and the schedule, it's about how relevant that meeting will be to you as the steering committee to come..." (Sectoral Stakeholder)*

The flexibility and openness of the Steering Group worked well in terms of inviting new members to support the implementation of stage 2:

*"There's a couple of people particularly before going to stage 2 that we made, we went out of our way to initiate conversations to bring them on-board and then roll them into the group..." (Sectoral Stakeholder)*

The Project Officer was also considered an important driver of the pilot project, by many stakeholders:

*"... I think [the Project Officer] did a great job of driving it and also facilitating the documentation and getting that around and seeking feedback from everybody. I think it was you know, I think it was quite organised, I think it was quite thoroughly researched in terms of having [the Program Facilitators and Trainers] come..." (Sectoral Stakeholder)*

#### **Area for improvements (What did not work well)**

Some Sectoral Stakeholders wanted to see more possibility for active engagement of the Steering Group with providing direction and more reliable meeting schedule:

*"...there should in my view have been more engagement around what the project should look like...it was sort of we have already made all the decisions, now be part of steering committee.... putting forward options for them to make the decision if they are truly a steering committee." (Sectoral Stakeholder)*

*"I think everything was scheduled well until there were dates scheduled for a whole day.... I just couldn't give a whole day of my time. And then the whole afternoon that was scheduled, that only ran for about two hours or an hour and a half, but I scheduled four hours for it...Then the whole-day workshop, that to me was just a bit too much for a Steering Group member...." (Sectoral Stakeholder)*

Some Sectoral Stakeholders confirmed their attendance for the Steering Group meetings; however, they were unable to attend, which was a challenge for the Project Officer as their contribution was needed:

*"I think the meetings have been roughly monthly. What was really important to us is that we try and pick a time that suits most people, but that priority was people with lived experience because they're kind of central. Some of them are working. (Sectoral Stakeholder)*

### *Project management*

In general, Sectoral Stakeholders were satisfied with the **project management**. In their opinion, the factors that supported the pilot project were:

- the proactively shared information and details,
- high-quality work within the project timeframes,
- the role played by the Project Officer in the project,
- the involvement of an External Evaluator in the pilot project,
- the local networks and knowledge,
- previous relationships and involvement, and
- program preparation.

The Project Officer had a significant role in the pilot project, and this was welcomed and appreciated by the Steering Group members:

*“I think the [Lead Agency] have done really well. They certainly shared a lot of information with stakeholders proactively. (Sectoral Stakeholder)*

*“I think [the Project Officer] was really [good] – she had her head around the whole project and how it would look and how it’s supposed to look.... I think they did a good job of trying to work in a timeframe and do it as much quality as possible within that program” (Sectoral Stakeholder)*

*“[The Project Officer] has been absolutely fantastic in making sure that it all rolls on really smoothly... She lives and breathes mental health, so it’s perfect...” (Sectoral Stakeholder)*

*“I’m happy with it, I think the Steering Group are very pleased with how it’s being project managed, I haven’t had any complaints, or there’s been nothing come through...” (Sectoral Stakeholder)*

Stakeholders also suggested **areas for improvement**:

- More engagement and commitment from the Steering Group,
- The pilot project to be delivered over a longer period and additional funding to deliver a 10-week program
- Develop future partnerships that support the program with
- A clear understanding of the deliverables including roles and responsibilities.

*“How could they have done it better? More planned out meeting or commitment from the group, sort of more engagement that way. I sort of felt a bit rushed sometimes, that’s all....” (Sectoral Stakeholder)*

*“I think they did well in terms of what they were given, just the budget and the timing, that was really tough.... I think if the PHN gave them a much longer time and a better budget then they could have done the program over ten weeks like it’s delivered everywhere else, and then delivered it again. It will take a long time to do the program but to do the program itself it should be done like it is everywhere else, because then you can*

*compare and contrast and see what's working. I think that's the only thing really "(Sectoral Stakeholder)*

### **Future contribution**

Sectoral Stakeholders expressed their interest in the continued contribution of the *My Recovery* program more broadly across the NT. The key reason was to help meet mental health needs in the NT, that is, building a local peer support workforce:

*"Yeah absolutely, I'd be really happy to. Because, well I think it's such a valuable thing that the NT needs, the people who need support and I think would really benefit from having a better peer workforce and peer accessible to them... So, we would like to actually attach ourselves or become involved with these people, who come out as peer facilitators to work with our participants." (Sectoral Stakeholder)*

*"Yeah, definitely, because I really want to see people to be able to have access to this program. The program is fundamental skills of how to live well and it's about being accountable for your own actions in life. It's not rocket science. It's fundamental stuff that people should be learning in school so if we could tailor it to meet different language groups, communities throughout the whole of the Territory..." (Sectoral Stakeholder)*

However, time commitment could be a potential barrier of Sectoral Stakeholders continued contribution of The *My Recovery* program because of their competing tasks:

*"I would keep contributing... just to support it, but I wouldn't be able to give a lot of time to it... I don't know if I could do more than an hour every three weeks or something like that, just to give feedback and see how it's going. But I would stay on." (Sectoral Stakeholder)*

Above expressing their interest regarding the *My Recovery* program broader implementation, , they mentioned that further involvement of peers from regional areas would be essential:

*"I would participate if I was invited, but yeah, I'd hope that they would have peers from that region, particular region that they were looking at running..." (Sectoral Stakeholder)*

*"we have to have the peers from that region so that we could also give our input about what we went through, and you know maybe what barriers. I mean I would like to think that they would be open with us and maybe talk about some of the barriers like we just spoke about before. And yeah, I think that that would be a bonus, that having our input, so yes, I would..." (Sectoral Stakeholder)*

Implementing the program broader across the NT may need a different Steering Group of members, additional funding, and a different focus:

*"...but if we were looking at regions across the NT, there'd have to be more funding; there would also be different Steering Group members, okay...So there's a very different way of working in a remote community around mental health...and it's about reducing stigma; it's around education; it's around well managed clients, as best you can in a remote*

*community; it's about having a relationship with your local clinics..." (Sectoral Stakeholder)*

A stakeholder described the changes the pilot project generated in participants' mental health and wellbeing and an extension of the program as a way of providing employment pathway to upskilled local facilitators:

*"...this is a passion project for me, so I've been definitely putting extra time and effort into trying to secure the funding and yeah, so we are really keen to not have an interruption to the flow of funds into this program because we recognise that with all that momentum we generated... So I would love to continue the momentum and empower these people through a part time capacity and potentially we could get them involved in other areas of what we're doing or advocacy or whatever..."(Sectoral Stakeholder)*

## **Phase 2: Train the Facilitator program (delivery of the My Recovery program)**

### **Perspectives of Program Participants of the Train the Facilitator program**

#### *Positive learning environments and creating safe spaces in recovery-oriented frameworks*

As an introduction to new participants, they were asked about their own mental health journey and what their experiences were with recovery-orientated frameworks. These exploratory questions were useful for understanding their mental health challenges:

*"I actually changed my career about seven-and-a-half years ago when I lost my son. I was an accountant and I'm now studying to become a counsellor. I'm actually doing my master's in counselling. I've lived with mental illness of quite severe depression, where I need to take medication for it, and I have complex PTSD as well...I've had that most of my life, but it wasn't diagnosed until about four years ago." (PP 28)*

*"I have two kids. I come from a background of trauma. I have a massive passion for wanting to help people who are vulnerable, and that's my drive. I've been through my own recovery and I feel that I want to lead people on their journey to recovery as well." (PP 27)*

*"Well because it was a first time, I had the opportunity to explore my lived experience and the first time I had the opportunity to share and connect. That was really powerful because I know that that's what the program is for, so understanding really clearly what the objectives were with the Train the Facilitator." (PP 12)*

*"You need to take that next step and say to yourself, for example, I would say, at the moment, that I'm out of recovery from mental health, because I've stabilised. And the same with alcohol and other drugs - I've been through the withdrawals and have stabilised to a point where they're still an issue, but I can think clearly whether or not to do something." (PP 4)*

As above, the range of participants experiences and engagements included complex Post-Traumatic Stress Disorder (PTSD), trauma, severe depression, and emphasized the importance of support opportunities to share and connect in a safe environment:

Participants generally understood the need to have a safe, non-judgemental, shared space that provides positive learning experiences for people to share their stories in a therapeutic way and share with others who may be on their own recovery journey. Many participants throughout the interviews expressed a high recognition for the Train the Facilitator program and the *My Recovery* program, particularly as a way to support people to understand their own self-discovery and a place to connect:

*"I knew that it would be really hands-on and exploratory and experiential, as in I knew we'd be learning by doing because that's how My Recovery was delivered. So, I was very positive about that. I was looking forward to it because I knew it would be a positive experience, not a anxious vulnerable experience." (PP 12)*

*"The facilitators were really good. The way that they created a space where we felt comfortable to share our thoughts, which to me is very unique that it created a space for us to be able to feel comfortable and actually open up and talk...only people that have lived experience were allowed to do it. So, we had that connection by knowing everyone in this room has an understanding of what we've been through. That built a connection, and then we were able to open up and share on really deep levels about how we feel and what we've been experiencing and everything like that." (PP 31)*

*"I think the My Recovery program will absolutely help a lot of people in their journey with their mental health. I think it would help them self-discover and create this feeling of belonging. Because when you're in a room with other people that have gone through the similar journeys, you feel that you're normal...I think people struggle a lot with the label and the stigma that society has. It's going to be a really beautiful experience for them, as well as challenging..." (PP 27)*

Participants made an important point about stigma and the perceptions that exist in relation to mental health:

*So, challenges I think will be building the understanding of the sector, both clinical and non-clinical, to really understand the value of this program. And that is largely because it doesn't have a history here, and there isn't recognition of the value of peer worker in the Northern Territory, which is inhibited by the lack of vocational pathways and just a general lack of knowledge and awareness. And then the other thing I think we will face will be stigma around some people's capacity to deliver the program, based on an organisation's perception of that person's capability...And, I think there will be, on the flipside, other sense of stigma, "How can you deliver that program because you're not sick enough?" (PP 2)*

Promoting a supportive learning environment and recognising the influence of positive group dynamics was important to the delivery of the Train the Facilitator program:

*"I really enjoyed actually co-facilitating somebody in one of the modules. We got a bit of a feeling of what it's actually really like to deliver it. [For example], I really enjoyed group dynamics because I didn't understand how there's so many different aspects of it...I just loved doing the group activities because you get to work with everybody and share your answers. (PP 30)*



*"I liked the way they talked about adult learning and shifted that paradigm in people's mind about what a good learning environment is for adults and how that's different from the traditional view of presenting and imparting knowledge, that for many people it's experiential, it's visual, it can be auditory, it can take all shapes and forms. There is some new information in there that I found really interesting around group dynamics." (PP 2)*

*"That's right. I think there is going to be a very good support between us. As I said, that group dynamic, we all seemed to get on really well. This is something that Darwin really needs and I'm really happy to be a part of it." (PP 28)*

### *Recognition of peer-led knowledge, engagement and skills requirement*

The participants recognised the value of peer-led learning in group settings. In particular, the learning environment was enhanced through the open sharing of lived experiences of mental health concerns:

*"The fact that it's peer-led, I think, was really important. Having presenters that have been through their mental health issues. Much the same as when I was in [AOD rehabilitation], some of the workers there have had drug problems before, and they get a lot more respect from the residents than the ones that haven't. It's not that they're disrespectful of the ones that haven't, but the guys who have been through it, you really listen to what they're saying, because they know what you've been through. That was probably one of the best things about it. [Also], having [co]-facilitators, it was still a shared space and everyone in the group was heavily encouraged to contribute, especially with our own lived experience, which was fantastic." (PP 4)*

*It was really good. I actually learned a lot of different learning techniques. The content covered around just co-facilitation, and the way in which it's delivered was really clear, like how they want it to happen and it's more a facilitation rather...spruiking to somebody, you're actually creating a peer-led group. It was more peer-led learning. Everyone brings their own expertise to the room, so opening up that dialogue through that learning process is really really helpful. (PP 9)*

Many participants spoke about the importance of engagement and discussed strategies on how they would approach group facilitation. Some participants experienced a deeper, more meaningful internal change from the Train the Facilitator program, reporting a profound awareness to be mindful about how to, and what to, say in future challenges:

*"So, the knowledge and skills I learnt during the program are hard to explain because I had like a spiritual, more an internal change. So, the way I feel on the inside has changed. ...how to talk to people, to be very mindful and careful of what you say and how you say things. To have an open mind, a very open mind, all of the time. And, yes, to always be kind." (PP 31)*

*"...for me it was more about - the importance of getting the participants' engagement...that is important with this whole thing, in making sure that everyone does become engaged and feel comfortable about feeling engaged...give that space and create that sort of confidence as well. If they do say something, "That's a really good point."*



*That's the sort of things, or, "That's a really good question." Saying things like that can really inspire more [engagement]" (PP 28)*

*"It gives you the ins and outs. And it's not just a facilitation or how to facilitate, it's how to facilitate and be on [another's] level and in a caring way. So, you kind of have to have the passion to be a facilitator for this, and obviously, have your own journey of mental health with the experiences. But it teaches you in a different way how to kind of be with them, to guide them, instead of just being the leader at the front hosting like a program. They really get you into their world and be as one and it's really cool." (PP 27)*

While some participants felt a sense of nervousness to deliver and practice public speaking - a fundamental skill required to be able to become co-facilitator:

*"So, I think what I suffered with the most is nerves around public speaking. And it spoke to that and I got to practise and learn some different – some tools to help me with that." (PP 10)*

*"I could come face-to-face with any challenge. But the thing that I've learnt is that I have the strength to come face-to-face with those challenges and I'll be okay to get through them." (PP 31)*

The peer-led learning process provided a space for self-reflection and to embrace and understand different worldviews:

*"So my main reason is that I have a really strong world view about the importance of peers leading the recovery of people with mental health challenges. And this is a vehicle to seeing that mode of providing recovery orientated services expand. I need to have done the program to coordinate the delivery of these programs in the future. I want to really grow the other facilitators up, and I need to understand how to facilitate it to do that, to step in if they need extra support...some of the skills I developed was maybe sharing some of my facilitator skills with other people in terms of navigating that session plan and how to flesh it out into delivering a session. I definitely took away from it how to be more cognisant of my own personal bias, and to be inquiring. That was really well demonstrated by [the co-facilitators], to be inquiring of the group to help their learning, but also be inquiring of yourself." (PP 2)*

*"Different ways of learning that people have. Different ways of teaching, or delivering or co-facilitating what the differences are there - how to look into how different people might be feeling and different worldviews that they may have....to really let people have their own worldviews and there's no right or wrong...it's okay not to agree with someone but it's the way that you say that you don't agree. Lots of useful little tools that everyone has in real life but doesn't really implement sometimes and so that was a skill that I've learnt as a facilitator, using certain language to say 'I appreciate that worldview'...using language to help people feel comfortable...some people to disagree as well. It's quite normal." (PP 9)*

### *Considerations of safety and efficacy for future co-facilitators*

Many participants reflected on their future roles as co-facilitators, and the strategies they will adopt to prepare for training delivery:

*"I got positive feedback. Some constructive feedback, which I need to work on certain things like doing more research...to get knowledge on it" (PP 30)*

*"I hope I work as a facilitator. And I think I will. And the challenge, I find the whole thing challenging. It's not an easy thing. It's really not. You really need to put in preparation. And that said, there's an adrenaline kick to it as well, so it's an enjoyable thing...it really can help people. And I hope it does. I hope it rolls out for everyone." (PP 10)*

Some participants expressed a level of excitement and passion for becoming future co-facilitators. At the same time, there were hesitations from some participants around their anxiety which may hinder their ability to be a co-facilitator of a program. However, being able to reinforce the outcome of helping another person, and acknowledging the support with another facilitator, helped them feel safe and confident to progress. The experience helped build resiliency and confidence by providing guidance and support to understand emotionally confronting situations, either directly or indirectly:

*"Yes, I think I will work as a facilitator in the future. It's something I'm very passionate and excited about. As a future facilitator, the changes I think I will face is just things like, am I going to work well with the other facilitator, because obviously everyone's different? Is what I deliver going to be - are people going to understand what I'm going to be delivering?" (PP 30)*

*"Possibly my mental illness, just with the anxiety and stuff like that, but I think that's something I've learnt how to overcome [ my anxiety] ...that's why it's good to be a co-facilitator - you're not there just doing it on your own. You have the help of another person, which is really really helpful for me when it comes to [safety]...it's a better way to take the load, as well. You can share with someone: 'Okay, well I'm not really feeling very good; I'm feeling very nervous.' you can pep each other up and say, 'No, we're going to be awesome. This is going to be really good'. Like that's what happened when we delivered a module...he changed his whole attitude." (PP 9)*

*"As a facilitator, as a lived experience advocate our voices aren't as respected as service providers and that related professional...So this course has just finished and as you saw I came in in tears and overwhelmed with emotion because this profound learning and experience has just happened and it's kind of like well where to now and how do I bring this into my life. But it is a challenge because I'm not experienced at facilitating but of this whole space, we'll need support...I've found this experience quite emotionally confronting. I didn't feel it at the time but now I'm feeling it now that it's over and it's a lot harder than I thought it was going to be. I don't think it's made me vulnerable; it's made me stronger but being mindful, being intentional to keep living a recovery journey that's meaningful to you." (PP 12)*

Another theme was centred around the desire to succeed. Participants were keen to continue their communication techniques in the delivery of the *My Recovery* program and to utilise training practices, and a commitment to opportunities to build their capacity and skillsets. Active participation was described as a way to help transform self-perceptions and empower decision-making:

*"The only challenges would be as far as ensuring participation...it's just about getting it out there. I've certainly had plenty of practice for that with [my organization]. I've had to do a lot of work to let people know what sort of stuff that we actually do. It's about that just continued communication with the different health service providers and that, letting them know that this is another thing that they can do in their road to recovery...we were in active recovery, so getting up and speaking it's not just empowering to speak to each other, it's to transform into something else yet again." (PP 28) "So, yes, I think it was very well delivered in terms of what it was intended to do, which was build capacity and competency to facilitate the *My Recovery* program. But I also feel it developed our skills in the more general peer support space, and just as a recovery, having an attitude to support other people's recovery, and the ways in which that can support our own recovery." (PP 2)*

As above, many participants successfully completed the Train the Facilitator program which built their capacity and competency to facilitate a *My Recovery* program. This was achieved by supporting each other in their ongoing learnings, and support of their journey of recovery. Whilst having the confidence to deliver the *My Recovery* program was another aspect of concern. The strength of the participants with lived-experience would enable the program to be delivered from different perspectives:

*"Maintaining interest for the entire week and staying focused on it and not getting too tired, things like that. And certainly, if I was to do more than one course, I know that I'd find, after the third or fourth one, you can get a little bit flat, because it's the same information that you're delivering. Having said that, because it's peer-led and the group is encouraged to input, I imagine each course will be very different. You deliver the same information but the lived experience that you get from the group would be different, so that would be good." (PP 4)*

One participant acted on the realisation of their own self-awareness, specifically on unequal power relationships. This outcome had a dramatic and positive impact on the participant, by committing the time and gaining the strength to take back control of their decisions:

*"Self-awareness. I wouldn't really call it a goal, but it was certainly an outcome...imbalance in my relationship, this is an example, with my doctors that I've had. I did my presentation on - unequal power relationships, [with others in the group] it was like: 'Wow, that's exactly what I went through, or the relationship I was in with for medical care.' I learnt to take a [my] power back by studying the Acts that I was being held under, and looking into what mental health problems they said I had; looking at the definition of it and being able to say, 'Well doc, I don't think I've got schizoaffective disorder; I think I'm more probably likely bipolar'. I also started recording my sessions with the doctors and when I came in and did that and questioned him on the Act and actually quoted specific sections of the Act, to state to him: 'Yes, I've been walking around talking to myself but I'm not a danger to self or others; I haven't threatened myself or I hadn't threatened anyone else', and just*

*seeing the power relationship change instantly and the doctor's attitude, he started listening. It was amazing." (PP 4)*

Another aspect that was integral to success was safety. The trainers of the Train the Facilitator program were able to highlight to the group their passion in an authentic and genuine manner that bridged connections and confidence:

*"Another really great thing is the importance of the safety that's created in My Recovery spaces. Because in August people talked about that. We recreated that safety in that week long program and that is absolutely integral to the success of the program. I can see that whenever and wherever this goes, in the Northern Territory, that it's always really important and that while this might take forms in different organisations, they must respect what happens within that group and not let the organisational priorities ever supersede what happens in terms of the safety of that group, which is held by the facilitators in the room. And that will be a shift in perspective, I think for organisations, because they're generally not peer run." (PP 2)*

*"The best part was the experience and the expertise of the facilitators and their authenticity with their connection with you and their passion for this program and movement. Also, the way that the facilitator's role modelled how to do it, it was so inclusive. It really honoured us and our experiences. It was safe, so the facilitators and the participants were really able to create this environment where we could feel safe to explore this stuff and to take risks. So, I'm probably more confident than other people in doing stuff like this." (PP 12)*

### *Creating opportunities to co-reflect and build understanding together*

An important element in the Train the Facilitator program was about opportunities for the group to co-reflect at the end of each day. Participants felt this was a restorative process and allowed the group to come together as equals with the Train the Facilitator trainers:

*"Core reflection to me mainly the things that I remember was just [the co-facilitators] let us open up as a group and become one and very equal with each other. And then we took over the co-reflection, and just what happened was, to me, magic, just the way that we all opened up on this deeper level. "Look how much we've evolved." (PP 31)*

*"What I also liked about it was that there was a lot of opportunities for us to reflect on our recovery and connect through a peer sense in that setting. So, it wasn't just about becoming the best My Recovery facilitators. The actual process of doing that also supported our peer connection and our recovery and opportunities for reflection...So having that opportunity to connect and co-reflect is a restorative process, which I think gives us confidence and allows us to ground ourselves in the face of those views, and diplomatically navigate them." (PP 2)*

*"The co-reflection workshop was really good to co-reflect. Unbelievably. Yeah, the co-reflection shop was good. I think most people seemed to be a bit tired but, no, it was a good chance for everyone to say, 'Okay, well this is why it is important to have that co-*

*reflection at the end of each day or at the start of each day, or even after the course is run, to see how people are travelling, what people think of the content that you've delivered'. Again, how they think it can be bettered.” (PP 9)*

Some participants spoke about the sensitive nature of mental health and the importance of being authentic and mindful of the way the program is delivered. They emphasised that the creation of a safe space is fundamental for acknowledging and responding to participant needs at that particular point in time.

*“[the group opportunity to create something is] what is so authentic about this, that it’s not dictated by an organisation what we do. Sure, the content is but it’s allowed to have its own agency here which is really important. Inclusion [and] how to redistribute power and how to practice empowerment. How to encourage participation and people to reflect and connect and engage. Also, personally reflection; mindfulness. It wasn’t taught explicitly but it was part of the process. And especially this concept of intentionality which is about using that reflection and mindfulness to be really deliberate about what you’re doing, why you’re doing it and how to do it so that it is – so there’s no hierarchy of power, so that it’s truly peer-centred, peer outcomes.” (PP 12)*

*“The organisation. I think that the [Lead Agency] got a really important role in socialising this program. And if it does get embedded within organisations, ensuring that they’re aligned with the principles of setting it up safely and how that’s really integral to and imperative for the success of the program. And that will require the organisation to allow those facilitators to hold that room, without trying to superimpose. So, I think their concern will be around risk managing. About risk managing and potentially if someone’s disclosed feelings in the past that they might think that’s creating an urgent risk instead of it just being a safe space for people to share. And that could be the perception of, for example, something could be misconstrued as something that needed to be mandatory reported on the mandatory reporting when in fact, a person is just sharing a reflection maybe of a time that they felt that way and that that’s not a crisis situation. (PP 2)*

### **Expectations and reasoning to participate in PLEP**

Participants were asked about their expectations and reasons to participate and register for the Train the Facilitator program. Some of the participants were curious to see what participating in a recovery-focused program would look like and they were interested to discover new ways of dealing with their mental health issues:

*“My main reasons were to just really see what it was about...I’m always interested in ways to help others with mental health problems. So, it was really just to learn more about what was going on and then if it was a good thing then I would like to continue” (PP 31)*

*“I didn’t really have an expectation. I was kind of just going with the flow and just seeing what comes with it. But it’s actually the best training I’ve ever been to. It’s absolutely amazing. I can’t fault it at all. I’m so glad I came. It was very hard to get here, but I’m so glad I made that commitment...I’ve done lots of facilitation programs, and I’ve also been in the mental health sector. But none have covered even half of the content. And the way*

*the facilitator has done it, it's just wicked. You could see the whole group just got so much out of it." (PP 27)*

*"I'm really passionate about the course, about the politics behind Peer to Peer and the Lived Experience model. I just identify with it so much. Also, because I really enjoy interactions with people [and] I really want to get involved in advocacy for people with lived experience. It's so important and I've been marginalised as a person, particularly within the mental health sector, and this helped me, concretely helped me. It's changed my life and I want other people to have that opportunity." (PP12)*

As discussed above, some participants described the Train the Facilitator program as amazing and reiterated a heightened interest to become more actively involved in advocacy. The participants identified a barrier to their lived experiences of being marginalized by their illness, and this program solidifies further growth and commitment in their lives. Participants also made observations about each other, which appeared they weren't struggling as much, and this was due to the support the participants gave each other:

*"It's hard to find opportunities for those really detailed conversations about your experience of illness in a safe way. I can probably only count less than two hands the number of people who have a similar diagnosis to me, where I can drill into that detail and in having that conversation with them about their experience of illness, actually gives me more insight about my experience of illness. It's something I've looked for in online communities and I haven't been able to get. (PP 2)*

*"the only expectation was to learn as much about it as possible, especially with not having done the My Recovery program. I just found that I was able to pick up quite a bit. The whole thing was actually delivered quite well. I mean, I can't speak for everyone else, but I didn't actually see anyone struggling, so I feel that the team actually all supported each other." (PP 28)*

Participants who completed the 6-day *My Recovery* program reported they had better background information, and a more solid grounding, to undertake the Train the Facilitator program. They suggested this increased their receptiveness to key messages delivered during the training program:

*"I'd actually done the My Recovery course as well, it was really clear on how they would like their program run and why, and why it's beneficial to have it run like this, with a peer. So just creating group discussions through peers (PP9)*

*"...Just knowing what it's like to be on the other side of the table, I think just adds a depth to it that you can't [explain], there's a bit of magic that happens in the My Recovery. And if you didn't see that, I think you'd lose something from the Train the Facilitator. That said, some people came through that didn't do it and I was amazed at how well they grasped it. (PP 10)*

*"I understood it enough. I would have liked to have done the program before so that I could have a better understanding. But I did understand it enough." (PP 31)*

*“There was one other thing: just how important this Train the Facilitator program was for my own personal recovery. It took it to another level. It gave me more hope, strength, community and so therefore the model, which includes being a participant in My Recovery becoming a lived experience peer person in a space...So even if you’re not a facilitator how central that is to the whole model because it allows us to make meaning from our horrible experiences and to make it worthwhile that actually adds value...[it] allows us to reconnect and contribute to society. So, it’s a positive experience of a close loop cycle. So, this is social change in action. And I’m just so grateful” (PP 12)*

### *Viewpoints on training materials, resources and peer-logbook (program-specific)*

In terms of program-specific questions, participants were asked to share their viewpoints about the training material, resources, and peer-logbook they received. Many participants were satisfied and appreciated the way these were user-friendly to teach and applicably significant to their personal lived experiences. There was a variance of supportive statements from participants that enjoyed the way it was designed, structured, and highly relevant. Others recognised the balance of learning and practical time restraints:

*“It’s very user-friendly. And I don’t mean it’s a tick and flick, everyone gets a pass. But they really set you up to succeed. They teach you the stuff you need to know. And I know that because we had to do a delivery and everything that they taught me popped into my head and you know, it just works well.” (PP 10)*

*“[I have taken part] only things like mindfulness, suicide prevention.” (PP 28)*

*“I was mind-blown. I loved what was in there. It was very interesting [to see] that there are other people that think the same way that I do, or similar way that I do, when it comes to mental health. And the different ways that you can get support or recover or get better, it was awesome to see. It wasn’t just one way of looking of it, “Here, take some medication, you’ll be right.” It was, “Have a look at this. These are all these other ways.” (PP 31)*

*“I think it was a good balance. Certainly, I would be happier to sit in and learn more. But can you hold people for more than five days and I think the answer is no. So, you have to do what you can within practical time constraints.” (PP 2)*

*“I found it actually quite easy. I could relate to a lot. This is all from my own work experience and training, from what I’ve been doing with studies and stuff - it was quite easy for me to follow.” (PP 28)*

*“I think that the learning was designed expertly, clearly by people who have done it, who understand this stuff. It meant that we learnt. It wasn’t just stuff that was presented to us. It came from very good sources. It was relevant. The topics and things were perfect. As I said we learnt things that we hadn’t necessarily come across before. It was applied as well to what we were doing. I wouldn’t change it and it included everything we needed.” (PP 12)*

As suggested, participants were able to understand the content of the training material provided and did not necessarily make suggestions to change this. However, there was a need to clearly define what 'recovery' means in a non-clinical context:

*"...the one I'm still struggling with, is what recovery means in a non-clinical sense. And I still think that that word is...something that should be well defined. Because, just to use alcohol and other drugs example, which I think may have also fit people with mental health issues, I've been to AA meetings and NA meetings where people will refer to themselves as being in recovery, but they've been clean for 30 years, and to me it's like: 'No, you really need to have a point where you say, 'I'm no longer in recovery; I'm now a recovered alcoholic.'" (PP 4)*

In addition, there were a number of recommendations that participants were eager to communicate. This included: increased skills, capabilities, and confidence after completing the Train the Facilitator program; greater pride in the work they complete; and, and increased interest in pursuing their day-to-day activities. The gratitude and sense of belonging that the program instilled in participants was explicit and was frequently considered to enhance their quality of life:

*"I'd recommend to anybody experiencing mental health problems. It's an amazing program. Yes. It's awesome." (PP 31)*

*"Very satisfied. One, because I definitely learnt things within it, and I was happy with that. But also, for me, I'd been struggling with mental health up until sometime around this year - still a lot of problems with medication and getting the right - [I] wanted to do a Certificate IV but didn't really have the confidence, but having done this course has given me the confidence to look at that next year." (PP4)*

*"I really want to get into this field...the [way] My Recovery program was delivered, I found was to be really exceptional, and really one of the best ways that I've experienced, that I've dealt with mental illness, so I really wanted to be a part of that and share that with people as well." (PP 9)*

*"...I was so proud at the end of it to see people who came in not confident, somewhat closed in, anxious to see them succeed and to see them realise their own potential. That's what the most amazing thing about it was...the sense of community, connectedness and alliance to say we want to do this, we're going to get this happening, this needs to happen in the NT, we're going to do whatever we can to stay together and make this happen." (PP 12)*

*"What I've seen through some of the participants go through the August program and then come and do the facilitator training, it reflects what I felt 15 years ago when I had the opportunity to move through a same pathway, and it reflects recovery orientated frameworks. So, I think it's really important that [External Evaluators] has been capturing that and that we've got a local context for that model. And that just helps to share in an evidence-based way what I think I felt, and I know...when it's gathered in an evidence-*



*based way, I think that that's critically important and great kudos to the [Lead Agency] for insisting that the evaluation happen." (PP 2)*

### **Personal Journeys of Program Participants**

Among the participants, five were identified as a Personal Journey Participant. This indicated that they were participants in phase 1 (6-day *My Recovery* program) and phase 2 (Train the Facilitator program) of the pilot project, and they also participated in the pre and post-program evaluation of the *My Recovery* program and post-program evaluation of the Train the Facilitator program. Whilst their mental health journey and perspectives about the programs were included in the previous relevant chapters, we summarise and present their perspectives and experiences of the training separately in this chapter to demonstrate the impact of the programs on this special cohort within the pilot project.

***Mental health journey:*** Personal Journey Participants were in different stages of their mental health journey at the start of the *My Recovery* program. Some of the participants were coping better compared to other participants. During the pre-program interviews the participants mentioned the long presence of their illness, different types of mental health issues, alcohol and other drug addictions, and some challenging situations such as being 'boxed' or 'shunned', struggles with school, unemployment, family issues, and the exacerbation of mental health issues within the family unit. The background of their mental health journey was similar to other Program Participants. On completion of the *My Recovery* program, they expressed their deep satisfaction with, and the positive impact of, the training. They conveyed they had developed a better understanding of their mental illness and the signs; developed new skills and tools; and generally felt more energised, motivated, supported, and hopeful throughout their daily lives. Since the program supported their recovery journey, they indicated their genuine interest in the subsequent Train the Facilitator program, and a willingness to deliver this program to other people on their own journeys of recovery. In addition, the previously mentioned positive changes were noticeable with every single participant during the *My Recovery* and Train the Facilitator post-program interviews. There was one participant, whose improvement during the pilot project was particularly visible with regard to their personal appearance, mood, attitude, and behaviour. Another participant also showed incredible changes and expressed determination to continue to advocate for the *My Recovery* program.

***Goals and expectation with the programs:*** The participants' goals regarding the training, included comments on wanting to learn extra skills and tools which they could apply in their own lives; skills to continue dealing with their mental health issues; how to function and stay motivated each day; and how they could make the *My Recovery* model part of their daily lives. The participants also expressed interest in exploring extra training opportunities to gain a deeper understanding of the effectiveness of the program. Most of the participants did not have clear expectations at the start of the *My Recovery* program. This meant they attended with an open mind, willingness to learn, an opportunity to meet with peers, a belief that the training would be professionally delivered, and participants were open to considering further study to become facilitators or the *My Recovery* program.

### **Learning Journeys of two Evaluation Team Members**

The PLEP project was an emotional journey for the researchers, witnessed and experienced through observation and interviews. Participants' stories, emotions, and mental maturations touched the

researchers deeply, triggering empathy and relatability towards them, their predicaments, and healing. Furthermore, the researchers were presented with the opportunities to explore their own strengths and weaknesses with emotional management.

Although both researchers have not had extensive experience with sensitive mental health research specifically, they had been exposed to similar work through the settings they previously were engaged with:

*"The projects that I've worked on have been with vulnerable groups including Indigenous people, younger people that are not so fortunate to be for example, attending schools or have family violence...Prior to my experience...a range of jobs from immigration services as a security and welfare officer, local government criminal/traffic history." (Research Team Member)*

*"We carried out a mixed method research in a refugee and migrant camp where there were refugee people living together with their family and that was a bit emotional to conduct. My second one was this recent PLEP research and that was more challenging than the previous one, especially when the participants were talking about their background, their mental health journey and their family issues in there." (Research Team Member)*

Both researchers considered themselves to be sensitive and intuit to another person's emotion. This consideration of being a sensitive person stems from being an empathetic person, identified by their ability to feel, experience, and relate to other's emotions. Researchers reported becoming emotionally distraught when tragic events were announced, indicative of their empathetic reasoning toward research participants:

*"When you do hear about people's lifestyles, hearing their struggles, their pain-points, or any problems they're processing or they're trying to solve, when you try and mediate that with them, you can understand their level of difficulty. I think in some way, we mirror that, or we relate to our past experiences. So that really just brings it out in me; how you can relate to that person on a mutual level." (Research Team Member)*

In terms of ranking this sensitivity as more or less than others, this question was dismissed, further indicative of their consideration for others. However, one researcher did state that predicaments with a familial context triggered higher emotion within oneself for they were a mother - the maternal instinct:

*"Emotions like love, hope, courage ... I feel myself more emotional when the situation happens ...within a family context, it makes me more emotional than usual." (Research Team Member)*

Either researchers reported their ability to connect with others through similar experiences and mutual understandings while being attentive, relatable and supportive; and considered this both a strength and weakness. Furthermore, their lack of prejudicial judgement, and stigma towards others, which in turn builds and maintains trust and rapport, was considered essential for true emotional connection:

*"Giving quality time and attention to somebody, I think they're my emotional strengths, relating to somebody straight away if needed." (Research Team Member)*

This, however, could divert into a weakness, such as emotional connection into over-involvement, possibly raising expectations which inevitably will not be met, resulting in disappointment. Dedication to others was evident to defer self-care needs amongst the researchers, which impacted their own health and wellbeing; when the healthier, individually focussed approach would offer protection from emotional distress:

*"I think sometimes, you can get too involved. You've got to take care of yourself and be self-full, not selfless" ... "You care too much and that becomes a weakness. It's important to care but too much can leave you overwhelmed and exposed." (Research Team Member)*

However, researchers stated that this was also a strength; for recognition of own weaknesses brings self-awareness and critical reflection, essential for personal growth, insight and developing coping mechanisms:

*"I think I'm emotional, I think that I have good coping skills. ... I was with my family in a very hard and difficult situation, without those coping skills, I wouldn't have survived" ... I still need to practise and develop my skills, I tend to panic and just see the worst scenario ... that's an automatic answer from my mind. It's a cognitive distortion, I have to still work on it to improve it, but otherwise, I think that's my strength, that I can cope well, but still there are some areas I need to improve." (Research Team Member)*

Both researchers described the strategies they had used to cope with the project. Given the field of employment, and sensitive nature of the work that comes with it, both researchers regarded effective coping as vital, and stated that they had been able to separate their professional and personal lives:

*"I usually feel it so intensively that I start to cry ... but on the other hand, I think I can manage it well because I don't take that package with me, I don't bring it home. I can calm down and I can handle it." (Research Team member)*

One researcher reported mental distraction through activities and occupations, such as crafts or household chores, for attention is diverted off their research work to create peace of mind. Their emotions were alleviated through productivity:

*"[When I can] feel it so intensively, I can decide if I need to do action to solve that situation or just to go out from the situation and try to calm down. Activities like washing dishes or doing some craft or something like that." (Research Team Member)*

Furthermore, utilisation of analogies from the researchers' own life experiences assisted in guiding participant conversations of their, sometimes intense, mental health journeys. This provided insight while providing a comparison, and the ability to alter their perceptions from being encapsulated in the issues to be distinguishable and separated, yet remained sensitive:

*"For example, I would say there's a difference between - something that has actually happened in the past, and a story you put in the way and catch yourself repeating over and over; a conflict circle, if you will. Usually what really happened (the event) and the story I tell myself are in conflict and hasn't been properly reconciled. So, if something triggered me and made me reactive, I try and look at that past experience and objectively*

*separate it. I would take responsibility for the role “I” played in creating that story. So, then you can overcome your past and heal inauthentic relationships that may not serve you. Distinguishing this is important because you can get trapped in the story, which can be difficult because it’s like a revolving door of bad habits or thought processes. These are some analogies I like to use to be upfront with myself.” (Research Team Member)*

Additionally, self-care and mindfulness practices such as meditation, yoga, breathwork, and exercise were described as valuable coping strategies. Both researchers foregrounded the necessity to have trustworthy social supports, and debriefing was needed to unpack and resolve emotional distresses. This was either done together, particularly around highly confidential work, or with their partner/relatives at home, if more suitable. Furthermore, self-talk within oneself is conducted throughout as a self-copying strategy, including journaling:

*“Mindfulness works, be it meditation – yoga and journaling is fantastic... Recently, I’ve been doing breath-work to really just help me particularly with my mood when I catch myself either being trapped in the future, being anxious, or living in the past, being depressed. For me breath-work is really important...goal-setting as well, knowing what you’re actually working towards in your future, giving a bit of hope and re-instilling your hopes, your dreams and your ambitions That’s what I use for myself when I catch myself feeling a little bit off and negative...things also to consider would be your support groups, local support networks which is so invaluable, having someone that you can trust wholeheartedly.” (Research Team Member)*

In terms of recognising a participant’s emotions, either researchers considered this ability as mandatory, particularly within sensitive research. Active listening is the skill of truly comprehending and acknowledging what is being conversed/shared and builds rapport and trust between researcher and participant/s. In this project, this skill was a necessity, given the cohort, and the researchers ensured perseverance in this, utilising their trained active listening skills:

*“Active listening. The skill which can develop or create empathy.” I think that can help me to understand the situation better, seeing behind the words or what they are saying (Research Team Member)*

*“I think as a researcher, it’s a skill that I think particularly working in this space with Indigenous and vulnerable groups... I think it’s really needed, almost a mandatory thing given the common history because you can inadvertently cause more harm than what you’re trying to achieve. ... Generally, you’d just be yourself as much as you can... be flexible in your interviews and whatever you’re doing to allow that time to have more grounding in personal conversations. Talk to someone on that human level but read their body language too and actively listen to what they’re saying.” (Research Team Member)*

The PLEP project experience for the researchers overall was heart-warming and positive, and they received a sense of emotional fulfilment through the observation of the participant’s achievements. The researchers stated that the program was crucial for addressing the ever-growing demand for mental health services, through a holistic model of care, which is constantly voiced through academic literature as an imperative:

*"This lived experience, non-clinical approach, without judgement, is something that has been coming up very commonly. So, it's good that these people are almost pioneering something and there's huge potential in that and I can see it'll go longer term if the community awareness is there. I think those key players are really what's taken this project off the ground. That's my experience overall." (Research Team Member)*

*"I had a very positive overall experience with this study. My heart is with this project, I love it. It was really nice to see how the participants grew during the whole process. It was amazing and I could see a good potential in this project with this lived experience, peer support model. So, it was really nice to see them grow and to be with them." (Research Team Member)*

*"I think doing something like this in Darwin is really needed because it seems like most people don't have those interpersonal communication skills and coping mechanisms to deal with important life events that may happen unexpectedly, particularly younger people these days living in a digital world. So, delivering something like this, I think it's really important, such as getting the terminology correct in mental health, re-defining pre-conceived notions, and the stigmas that are out there in society currently, that's a big, big thing that was noticeable working with young people." (Research Team Member)*

The predominant strength of the program for the participants, as observed by the researchers, offered the opportunity for participants to become facilitators of the program. The benefits of being a facilitator enabled a range of holistic health needs, with employment supporting the deterrence of relapse, while finding purpose and a sense of belonging within oneself:

*"There was noticeable impact we were witnessing with participants improving their life dramatically through having the tools and the strategies from My Recovery, and some were given the opportunity to become facilitators, it gave them almost a sense of belonging, a sense of being again, it's like their identity was reformulated ...You can see just how huge these changes were with positive attitudes and direction, aspirations in their life and that's what we're trying to achieve. It's just very meaningful as a researcher to notice that you're doing valuable work that's impacting your community in a positive way." (Research Team Member)*

*"For you to be the person to help other people in that situation because the reward factor is just so strong as well, and that helps you to overcome relapse and any of those forms." (Research Team Member)*

The enhancements to participant's physical appearance with hygiene and dress-sense, indicative of their self-care efforts, and openness in conversation reflected their growing trustfulness and increased wellbeing, was highly rewarding to witness by the researchers:

*"One of them, I can't imagine - I hardly recognised him. His outfit changed a lot. He was well-groomed, he looked younger and glowing...Yeah, and not just his outfit but at the beginning...he didn't give us much answers, he was keeping distance in a way and just answered with short sentences but at the end, he was more open and that was really nice to see." (Research Team Member)*

Suggestions to improve the program incorporated some form of psychosocial support training or guidelines for the researchers to properly provide care and support to participants displaying emotional distress during interviews. Triggered by personal topics, a few participants displayed clear signs of mental anguish or concerning behaviours, which raised concerns among the two primary researchers, with suicidal ideation being a major concern. Follow-up with these participants, including referrals to relevant services and helplines were facilitated. Ultimately there were no adverse outcomes. Yet, this indicated more clearly defined processes for the research team to refer participants for psychosocial management, care, and follow-up, would be advantageous in the future:

The coping strategies of the researchers mentioned above became particularly useful during the project. The researchers supported each other with debriefing post interviews to maintain professionalism. The mix-gender of researchers also was deemed beneficial:

*"I don't freak out in that nature but focus on that individual and really be aware of their body language and the things that they're trying to say." (Research Team Member)*

The heart-wrenching moments triggered reminders of personal hard times, for the relatability created a sense of vulnerability; how easily mental health complexities can arouse for many in society, not just those enduring hardship:

*"I would say that I found myself vulnerable because their stories reminded me that you can easily be in a situation like them and it reminded me that you always have to work on yourself, including your coping skills. Their stories reminded me of some people who are close to me who were in situations like this and that's why I felt close to these stories...It reminded me about some events and happenings in my own social environment." (Research Team Member)*

One researcher stated that their emotions could not be contained during an interview yet expressing these did not bring detriment; instead depicted emotional connection and empathy:

*"I was crying with [the participant]. I could handle it after but, in the situation, it was so intense that I couldn't keep my tears back, but I think it wasn't bad. It was like that person could see that I resonated with them, so it wasn't unpleasant or something like that." (Research Team Member)*

Upon completion, the impact the project had on the researchers was significant, with the personal growth of participants, including relationship formation, connection with others and a boost in confidence to create a whole-hearted and fulfilling experience between them:

*"It was a huge impact, significant, I think. Their confidence increased, their trust. I remember that some of [the participants] refer that they felt themselves isolated, but after the first program they felt much more confident in creating and maintain those relationships as well." (Research Team Member)*

*"Most participants expressed that this training improved their mental health status and it's provided them extra practical knowledge, helpful strategies and important skillsets they can apply moving forward when dealing with mental health challenges." (Research Team Member)*

*“Even though some of it does take time, to them, it was a meaningful experience over that intensive two weeks where they formed close relations with one another...where they, for the first time, connected their vulnerabilities with somebody else and established those common values and mutual respect, collaboratively. It has really boosted their confidence to not be withdrawn in social isolation, but to actually start becoming an active community member that is productive and wilful; detached from a victimhood mentality that can fester into a sense of hopelessness, guilt and shame. So, that hope, that aspiration, that focus, to forward-think was very enlightening.” (Research Team Member)*

### **Perspective of Sectoral Stakeholders on the second phase of the pilot project**

Sectoral Stakeholders provided their **perspectives on the second phase of the pilot** project around the following items:

- accessing the targeted mental health and AOD population,
- implementation of the program,
- training delivery and participants’ engagement,
- experienced challenges and opportunities,
- information and support received from the Steering Group,
- Steering Group members’ engagement,
- perceived program success,
- project management,
- feedback and messages, and
- recommendation, future plans, and considerations.

#### *Accessing the target population and implementation of the program*

Sectoral Stakeholders were asked whether the pilot project reached the intended mental health and AOD population. While they responded in the affirmative, they also indicated that the program timeframes presented limitation for some participants to their participation in the Train the Facilitator program:

*“... I think we did pretty well reaching the intended target population. We had a couple of people, with lived experience, who had to pull out at the last minute, pretty much due to not being able to get released from work. So, I think, maybe if we had of been able to give them a bit more time that, perhaps, we could have overcome that...” (Sectoral Stakeholder)*

One person described the program could be improved with additional funding to go further than Darwin, to reach communities across the NT:

*“...I think that would have been fantastic [if we had been able to involve more people and reach other areas]. If we had more funding and we could have people in Alice Springs, Katherine, Tennent Creek, and Darwin.” (Sectoral Stakeholder)*

They believed that the pilot project was implemented well, with collaborative partners and did the job that was required from their perspective:

*"[Program Facilitators and Trainers] did great on their part. I think we the [Lead Agency] had the venue and the food sorted out in terms of that logistical practical stuff." (Sectoral Stakeholder)*

### *Training delivery and participants' engagement*

When asked whether Sectoral Stakeholders felt confident during training delivery, Train the Facilitator trainers responded positively. They described their **confidence** with training delivery around the:

- solid program structure,
- assessment process,
- facilitation approach,
- Program Participants
- program preparation, and
- expression of interest.

*"I'd felt very confident. [we] have had a chance to really solidify the program that we're running up here. I was really confident with the rigor and the assessment process that we built into it. And very confident in our facilitation approach too...And I'll just add I was also really confident with the people who'd applied too, by and large..." (Sectoral Stakeholder)*

*"... we put a lot of work into the preparation to coming up here, so I certainly felt confident in our delivery and what we were doing and why we were doing it, and what some of the complexities could be..." (Sectoral Stakeholder)*

*"...even with the expression of interest process I think gave us a lot of information. But some people had put in a lot of effort into that, so even just knowing who was going to be in the room and why they wanted to be there was really helpful..." (Sectoral Stakeholder)*

The Trainers were asked to describe the differences in relation to the Train the Facilitator program delivery in Darwin comparing to previous training nationwide. The trainers also indicated the possible reasons for that. The **differences** were described in terms of:

- the group size,
- participants' generous attitude,
- the Coalition support, and
- structure of the program.

*"There was an absolute clarity and understanding about why people were in the room. And we didn't need to encourage connection and sharing at all. People were generous with their time, they were generous with each other from the beginning. It was just a very structured but - it was - yeah, that's what I would say. Nobody - well, no. There was probably one, but essentially everyone absolutely understood what they were here to do, and they were on task.... I think having as many people as we did too was great as well. It was a good number. It was actually a group of learners. It wasn't - yeah, I think the numbers made a difference. And certainly, the work the [Lead Agency] did was really, really helpful around that as well. (Sectoral Stakeholder)*



Some Sectoral Stakeholders identified differences in the recruitment process of the Train the Facilitator program and there was an acknowledgement that lived experience and peer concept created a unique and different environment for the pilot project:

*“... there was certainly a difference in recruiting to training that I’ve experienced previously. A lot of our work at [Program Facilitators and Trainers] is about supporting current service users who have shown various leadership qualities into a training like this. So, I’ll often experience people coming into this space with very little experience in this work and very little experience in concepts of peer education, learning from lived experience. But there’s a hunger and a desire to get involved. So, this has often formed a pathway into employment for people. It’s very different I think to what people I came with here, there was a high level of lived experience, both in terms of work experience or understanding underpinning concepts, et cetera. That was quite different.” (Sectoral Stakeholder)*

*“... and I think it's a different environment that we're doing this work in, so for this training we did meet people with a higher calibre that came to this space with all that knowledge, so we weren't starting from a low knowledge base. So that's been really important to how programs are going to be set up and how My Recovery might be embedded in this particular area, which is quite different, yeah. So that attention had to be paid to how we were going to make it work.” (Sectoral Stakeholder)*

Participants’ engagement in the pilot project was considered exceptional, energetic, and faultless. Participants’ willingness to learn in line with the value of the program were major driven factors:

*“[Participant engagement was] great. Really well, really well. Look, it was just energy, energetic. People just in there wanting to do the work, wanting to learn. But that was driven by the value of the program that is about how do we create spaces where people can explore the life they want to live.” (Sectoral Stakeholder)*

*“[It was] faultless. Yeah, it's exceptional from my perspective. How can they support each other too. It's just lovely, so lovely.” (Sectoral Stakeholder)*

The support that the Program Facilitators and Trainers experienced between Program Participants was described as potentially the first step for the development of a local peer network:

*“... people are going to be out there spruiking this program and taking their learnings from this training, they're going to be supporting each other and taking what's happened here, and the energy, the kind of networks they've created, keeping that going. And that support, yeah.” (Sectoral Stakeholder)*

Given the timeframes of the pilot project, stakeholders described the training and delivery as excellent, and that the program was well-received by Program Participants:

*"I have, I've caught up with three of them and they've all said that it has opened their eyes to things that they hadn't come across before, in themselves, like their own strengths and how they could continue to live well and help someone else..." (Sectoral Stakeholder)*

*"I think they did an excellent program. I think there could have been more that they added to it, but I don't think you could hold people for longer than five days. So, they did a good balance of that..." (Sectoral Stakeholder)*

### *Experienced challenges and opportunities*

When asked about the **challenges** faced during the pilot project, the following ones were reported as the main challenges:

- putting extra work and time in the pilot project,
- making a decision on two participants' competency level and how to communicate it to them and to the group
- keeping the energy up for an extended period,
- deciding who can go directly to the facilitator training during the recruitment process,
- perceived stigma,
- festive season break,
- not having a direct influence on the further development of the pilot project,
- noticing some participants' struggle with training materials and final assessment, and
- location and transport.

*"Probably for me it was recognising that two people were not going to reach competency and making decisions around how to feed that back and how to then - not only to the people themselves but also then to - one other person decided to leave and not come back. So then also how to communicate that to the group and manage things around that. That was probably for me - that and managing the extra time that I've needed to put into this. That's been also challenging. But yeah, I think just trying to work with that" (Sectoral Stakeholder).*

*"I'd certainly go with that. And particularly where that person had a real strong desire and want to do this work. So, it is how you provide that feedback in a way that's useful and supportive of the person as well. So that was certainly challenging..." (Sectoral Stakeholder).*

*"... in terms of really just keeping my energy. Even today I'm done. I'm not feeling tired. So, keeping the energy up for a long period of time has been challenging. And even during the five-day training process, because you've got no option. You have to keep yourself up and moving forward. That can be challenging, I think." (Sectoral Stakeholder)*

*"... [the demand] was massive and making decisions about who was potentially going to be a facilitator and who wasn't I think is probably tricky. And there was challenges because they were wanting to run the program as a bona fide program but also a potential feeder for facilitator opportunities" (Sectoral Stakeholder)*

The intensive workload associated with the preparation of the program, training delivery, assessment, and feedback, was reported as a major challenge within the pilot project:

*“We’re captive for the project at the moment... it’s been pretty relentless for quite a while, even prior to coming up here too, to make sure it was all together and wrapping it up by Friday” (Sectoral Stakeholder)*

*“It’s required a lot of out-of-hours work... there’s been a huge workload for us to not only deliver the training but also to undertake the assessment process, the feedback loop. So, having it in that concentrated period, it doesn’t necessarily indicate how much work sits around that as well. It’s been pretty significant.” (Sectoral Stakeholder)*

*“It’s a lot of work. So, I think when we look at how - this isn’t a five-day program. It might be a five-day program for people attending [not for the facilitators] ... and I didn’t quite finish...” (Sectoral Stakeholder)*

One person described the stigma directed at people with lived experience of mental illness as a challenging part of the pilot project:

*“Personal stigma directed at me, their assumptions about what my background is, and then stigma they directed at other people with lived experience of mental illness, about their ability to do this, this type of peer led program....they’re powerful people saying that to you, that’s really hard to articulate and answer back to....I actually sought out my support networks, which were my other peers, to talk through it, to validate, within myself, what my response was to it. .” (Sectoral Stakeholder)*

During the Christmas break, the pilot project slowed for a period. However, the Project Officer and some Program Participants kept the pilot project rolling during, albeit at a slower speed:

*“The first one that comes to mind, really, is just the time of year; there’s always a general perception that anything around the Christmas period is going to get slowed up. However, I think, given the time of year it was perfect because, apparently, statistically mental illness is really prevalent around Christmas time.” (Sectoral Stakeholder)*

*“Actually, it would have been really nice to not have had Christmas right behind this because that one breaks the momentum of people. I think it’s important for people to actually deliver, or get practise delivering, as soon as possible after you’ve done the training, before your anxiety kicks in and you start to naysay your abilities....But, I think, the other thing about Christmas is it’s just, normally, a stressful time for people who’ve got lived experience in Mental Health or AOD challenges. So, I think, that added a complexity into, certainly, the execution of the practise sessions that we had planned. And again, in hindsight, I wouldn’t have tried to do [the Train the Facilitator program] before Christmas.” (Sectoral Stakeholder)*

*“... we then kept the momentum going by doing some work over the Christmas and New Year break and getting ready for when everyone else was feeling better and back on deck. That’s actually how we got the detailed facilitator, the guide, because we used those windows to go through every module and detail and go, “Gosh, this is confusing. How do we rewrite this so it’s clearer for everyone so they’re not all muddling their way through it?” (Sectoral Stakeholder)*

Whilst recognising this was a pilot project, not having a direct influence over the sustained engagement of the peer-support workforce and the provision of psychosocial support in the NT also presented challenges for a Program Facilitator and Trainer:

*“... one of the challenges actually for me has been really wanting this to succeed and knowing that I have no influence over how it might succeed or not in a direct way, whilst - and that’s hard because we’ve had such a direct influence on supporting people to become a facilitator and be ready to facilitate a program that we have no control over its success post this week. It really needs very dedicated resources. It really needs very dedicated resources that are long-term, that - yeah. And I don’t know about...” (Sectoral Stakeholder)*

The Train the Facilitator program trainers described that some Program Participants potentially faced personal challenges in terms of understanding and internalising the training material and the tasks. There were some participants who were difficult to manage and required addressing:

*“... Personal challenges. We were aware that some people were - there were things going on for these people, and they needed to make decisions around how they were going to manage that. I think they were challenged by the material at times, and the tasks, the fact that they were getting assessed, formally assessed. I think people were challenged by that. There were some personality challenges too in the room that required addressing and managing for people.” (Sectoral Stakeholder)*

Program Participants were assessed against a Wellways competency-based framework at the end of the Train the Facilitator program and they also received feedback throughout the program. Train the Facilitator trainers observed having an assessment resulted in challenges for some Program Participants:

*“We’ve identified everybody’s - I mean, we’ve assessed everybody, and we assessed them using a criteria, the competency-based framework and specific criteria. And we’ve identified people who’ve demonstrated leadership and mentor and have demonstrated competency in a high level, and we also put together suggested learning plans for people to further develop their skills.” (Sectoral Stakeholder)*

*“[the assessment] happened throughout the program too where we identified people who would not receive accreditation, and that occurred in two instances. People were fed that information midway through the program. So, it didn’t come as a sudden surprise in the end. We were very clear that people had a choice of whether they wanted to continue based on that, or whether they wanted to leave.” (Sectoral Stakeholder)*

Location of the training venue and transport imposed further challenges for some participants, as part of the expression of interest process the application asked about barriers to attending the program. The Project Officer in the Coalition was able to provide support:

*“From feedback it was [a challenge] for some people to be able to get to and from was their biggest question in the beginning... Location and just transport, but the [Lead Agency] just came straight up to the doorstep on that one and was taking people to and from.... Without the funding they wouldn't have been able to do that...” (Sectoral Stakeholder)*

The unique learning environment that the peer education space brings could be challenging though it was all a learning process:

*“I don't know whether it's a challenge experienced by people. I think that initial grasping of this notion of creating that intentional peer education space, where it may have been a new concept for people. There are particular skills and ways that we do that... So really getting into that head space and changing the way we think about group work and how we might deliver the facilitator role. Not that I - it wasn't a challenge. I think there was a learning process.” (Sectoral Stakeholder)*

The pilot project also presented benefits and opportunities for experiencing the value of the Train the Facilitator 5-day training program through working together for a common goal:

*“I think there was [some challenge] for me, just in terms of a five-day training. Historically [Program Facilitators and Trainers] we have delivered a five-day My Recovery training, and we've sort of - we've altered those processes just recently and changed the way that we train facilitators within [Program Facilitators and Trainers]. And this was a real opportunity, and I think that experience for me around the value of having a five-day training rather than what we've moved to now - although it's quite similar, there were some strong differences there that I'm not sure I've landed with it, but I think yeah, it was beneficial to have the five-day block, yeah. But what has worked with that, I think, because we've been up here and we've been staying at the same hotel, we've had opportunity to catch up or stay back here if we wanted to, or continue working together... It has been actually a hell of a lot of work. ...” (Sectoral Stakeholder)*

*“... just the fact that we've been up here, just that sort of geographical that we've been able to do that work outside of hours easily that I don't think would really be possible had we been doing this in Melbourne.” (Sectoral Stakeholder)*

### *Provided information and support*

Sectoral Stakeholders were asked about the Coalition performance throughout the pilot project. Steering Group members' and Program Facilitators and Trainers' answer was overwhelmingly positive. One stakeholder felt that while there was less support compared with the first phase, they were still happy with the kind of support they received during the second phase:

*"... Limited, actually, in terms of the Steering Group...I don't know how much influence the Steering Group really had when it came to the train-the-facilitator. I could see their role from - it was more evidence of their role in the initial My Recovery rollout. This was more a keeping them informed rather than seeking support... They do provide a level of accountability, checks and balances, which is important. There just wasn't as much tangible support from my perspective this time around." (Sectoral Stakeholder)*

Others expressed their satisfaction with the Steering Group contribution. Their presented collective local knowledge supported the pilot project effectively:

*"... when people were actually there, or dialling in, and I think the dialling in helped make it more achievable for some of the members, they all contributed very well. They asked very pertinent questions, they were very open, volunteering knowledge and information about what they could provide. So, at one meeting there, I think, we were looking at what types of professional development could the pilot program access to add additional skills to our pool of facilitators, and people were very free volunteering what they knew, and then when we were looking for venues....So, it was really good to harvest that collective local knowledge and expertise; it worked really well." (Sectoral Stakeholder)*

Another Sectoral Stakeholder who was not involved in the contextualisation of the first phase (6-day My Recovery program) of the pilot project, felt the support was very helpful. He highlighted that a continuous quality improvement approach was advocated by the Steering Group:

*"... my first involvement with the Steering Group was the time we spent together in that meeting a couple weeks before the training. So, I didn't really know who the Steering Group was or what had been discussed or where they were sort of placing things. So, it was helpful for me that they just get a feel for the input that was coming into the program from various organisations. That was really helpful. But also, to know that there's some structure around what we're doing and some guidance around what we're doing, even though there was an explicit - it was clear that that's what the group is for. So in that, I felt supported in that sense, knowing that there are a number of people putting into this program....I remember the word "quality" coming up regularly at that meeting I was in, and it was just that if I'm going to devote my time to coming up here and training the facilitators, it was really nice to hear that insistence for quality moving forward. So, I felt more valued to deliver this training." (Sectoral Stakeholder)*

The conversation with the Sectoral Stakeholders also included discussions around the way the Steering Group provided support. This highlighted the repeated questioning about how the program would be practiced locally, bringing network in, participating in contextualisation, open conversations, risk identification, and mitigation:

*"... I know that some of the people who applied...they were through direct word of mouth by some of the Steering Group members from their networks. So, I think, as you know, that's like, I guess, an added way they contributed to the Train the Facilitator program, and they also came to that session before the Train the Facilitator where the facilitators came*

*up and did an information session for potential applicants to Train the Facilitator. They attended a little update session and contextualisation... so that was quite good. We had diverse questions and answers, I remember from that, and, particularly, we had some of our lived experience candidates were good at, I think, helping to tease out some of the risks associated with the quality of delivery, and that sort of thing. And, having open and robust conversation is important; especially important to identify risks and mitigate against them.” (Sectoral Stakeholder)*

*“I think what I really saw was the continual progression in questioning whether or not, and how, the program was going to be able to be practised in the Northern Territory, like in urban Northern Territory. Yeah, it was constantly pulled apart and questioned as to why we thought it was going to work and how.” (Sectoral Stakeholder)*

The pilot project established a Steering Group and Trainers from Wellways, Victoria, the combination of the two supported the pilot project. The trainer’s ability to travel to Darwin to first contextualise the programs with the Steering Group and then deliver the training, speaks to the flexibility, willingness and support for the Territory and opportunities for future collaborations:

*“They were really flexible with their delivery times, the interview times. They were also really flexible with their own participation in it and coming up from southern states, yeah living up here, basically.” (Sectoral Stakeholder)*

*“I think they did a great job, actually. And, absolutely leading into that with the identification of who would participate based on the EOIs, and [one facilitator] and I were talking a lot about that because we had these two streams of people; people who completed the program in August that we knew quite well, and then another stream of people where we felt they could skip [the My Recovery] program and come in...So, that was really important support that I got, and then, in terms of the way they delivered it, I think they did an amazing job in the delivery.” (Sectoral Stakeholder)*

The timeframes were visible throughout the pilot project. One trainer wished if she could have more time to organise an extra day for planning that could have meant some more support:

*“There’s one thing; I wish I had of added an extra bit of time, on the back of that, to have a the [Lead Agency] day for planning with those people, because it was really hard to get everyone back together, at the same time, again. But, I mean, that’s just lesson learnt, and that’s nothing to do with [Program Facilitators and Trainers], that was something that I thought of in hindsight” (Sectoral Stakeholder)*

Sectoral Stakeholders were also asked for their views about how satisfied they were with the information supplied by the Program Facilitators and Trainers. Although satisfied, they wanted to know more about what would exactly be delivered to the participants and they were not sure whether the information provided was enough for other Steering Group members who was not engaged closely to the work on the pilot project:

*"I would have liked to have received more on the final of what was going to be delivered to the facilitators. Yeah, I feel that it got a bit lost there... I would have liked to have received it.... So, "Okay, this is the final, this is what's going to be delivered to facilitators. There you go. "(Sectoral Stakeholder)*

*"I think the information they provided – well, from my perspective as a coordinator, was good enough. Did we do enough to keep the other people informed? I know they had lots of questions as we went through about the coordination, which is why I thought we should have had that day at the end, where we said, "We're going to nut all this out." So, probably, from their perspective – it was not so much information about the Train the Facilitator but would have happened next; they would have liked more certainty, I reckon." (Sectoral Stakeholder)*

Sectoral Stakeholders considered that the mental health of participants' improved throughout the pilot project. They also emphasised the evidence-based format of the training delivery was highly valued. One of them indicated that there was nothing in the program to improve, while another stakeholder stressed the timeframes as an indicator for any future development of a similar program:

*"What I liked the most is the tried and proven format that it's based on and delivered, and I don't – yeah, there's nothing there that I would say to improve." (Sectoral Stakeholder)*

*"What I liked the most is seeing the progression of the participants. What I liked the least – I don't have enough time. No, look that's just a logistical thing. Yeah, probably the timing close to Christmas, that what I liked the least. The most was definitely watching people grow." (Sectoral Stakeholder)*

### *Steering Group members' engagement*

Compared with the first phase of the pilot project, some Sectoral Stakeholders did not feel as engaged with the second phase. This was because the second phase did not require as much input regarding the contextualisation as the first phase did.

Some Sectoral Stakeholders stressed that the community mental health, business, and vocational sectors have an opportunity to work more collaboratively to strengthen the peer-support mental health sector in the NT:

*"I felt less engaged, however, I didn't feel that I needed to be as engaged as what we were in the first part." (Sectoral Stakeholder)*

*"what we started to see emerge, in the second phase, is we – as the [Lead Agency] started to develop relationships with...people from that sort of business and vocational development sector. ... They really started to get onboard and provide us with the tools we need, in parallel to the project, to stimulate this formal vocational pathway. So, that was really good because that's where we're getting that added, or complimentary, benefit to what we're trying to achieve.... So, we're just doing what we hope to do, which is starting to knit together some of the people needed to, actually, get a formal vocational*



*pathway together. But, I think, otherwise where the Steering Group came along, it was good just to keep them informed about their applications going into training the facilitator and then the graduations, and that sort of thing, coming out, so that was the main thing.”*  
(Sectoral Stakeholder)

### *Perceived program success*

Sectoral Stakeholders were asked to reflect on the effectiveness of the Train the Facilitator program delivery and to highlight what worked well and what did not work well.

They were asked to describe **factors that worked well in the pilot** project as well as the program’s success. The following elements were described:

- increased energy around the pilot project as a result of the local demand,
- preparatory work for the program implementation,
- laying the foundation with the delivery of the *My Recovery* program in August,
- intense model of the program (structure and timing),
- lived experience leadership role in delivering the program,
- accommodating participants needs
- upskilling high quality of trainers.

*“I think in terms of why that worked well, probably a number of things that first of all, there was quite an energy prior to this training happening that had already been created, and there was certainly - we’d had the August program itself, there’d been a whole lot of work in recruiting to that program to training with a very short lag time before this training started. So, it was energy that was here and consideration to who came into this space that I think worked really well.”* (Sectoral Stakeholder)

*“I think the timing, I think the structure of the time. So, instead of having one session over a period – like one session a week and closed it in, I think that having the more intense model was beneficial. I think the hours was enough. I think if you have too many hours in one day talking about the one topic you get blurred.”* (Sectoral Stakeholder)

*“I think what worked really well was that lived experience leadership role in delivering the program. They were very flexible, lots of opportunity when people wanted to enquire and find out more, they were very accommodating on that, but they were also good at bringing us back to our schedule.”* (Sectoral Stakeholder)

As one of the Train the Facilitator program trainer expressed, the program seemed successful since very high-quality local facilitators were upskilled:

*“Oh, we’ve been reflecting today on where we landed at the end of training, and I really feel that we have ended up with a really high quality of trainers that I think has been different from my other experiences of this training”* (Sectoral Stakeholder)

At least *My Recovery* program participants' involvement with the Train the Facilitator program knew what to expect, a lack of finality and celebration with participants at the end of the program and taking a risk in the recruitment process with streaming some people directly to the Train the Facilitator program were discussed as factors that did not work well:

*"the big standout [did not work well], I think we had an expectation from running the August program that we'd have a lot more people from that program in this training and didn't end up with so. So, there are a small number of people in this group who had done the program and others who hadn't. It was a complete disservice to people who hadn't done the program. I think it was just that sort of conceptualising our learnings, I think, from people who had done it and had really maybe a clear understanding of how peer education works."* (Sectoral Stakeholder)

*"Actually, what hasn't worked well for me has been a lack of finality and celebration, actually. So, the five days was completely taken up with the program, the train-the-facilitator program, and we haven't had a chance to actually sit back with the group and acknowledge and celebrate that. And so, now [we] I are leaving, and that celebration will occur without us. And yeah, that's challenging as I would have liked that opportunity.... I think because [Program Facilitators and Trainers] doesn't have a presence in the Northern Territory, when we leave, we leave. So, I think that geographic isolation and service delivery reality, I'm just feeling that level of disconnect quite quickly."* (Sectoral Stakeholder)

*"What didn't work so well and why was as the [Lead Agency] we took a risk to stream some people, who hadn't done the August program, into the Train the Facilitator. Five of those people still got through, but it does put them at a disadvantage in that setting and also after. We've tried to address some of that disadvantage by really detailing out the Facilitator Manual and also, quite clearly, writing in there where a facilitator needs to have actually done one of the exercises in the *My Recovery* before they go in and deliver it. But that risk meant that we had five extra people graduate, so we had to do something like that to get a bit of ongoing momentum going, but now that we've got the ability with broader reach it's not something – I would only want candidates who had done the program before to come through and do the facilitator training."* (Sectoral Stakeholder)

### **Project management**

General project management and the role of secretariat to the Steering Group presented some challenges during the second phase of the pilot project due to an increase in workload and maintaining the pilot project whilst continue to look at ways to expand the program passed the pilot phase. The Coalition coped very well:

*"[The project management] was brilliant. So, [the Project Officer] was able to just pick the ball up and just run with it, which was fantastic. Very strong those two people at the [Lead Agency]"* (Sectoral Stakeholder)

*“ My time was really under pressure there, so I didn’t complete my secretariat skills very well, at all, in that phase [phase 2]...I think we dropped the ball on the secretariat skills, and I don’t like breaking rules and the terms of reference is pretty clear about what I need to do, so I felt very bad about that, but, at the same time, I think it was a bit of a balancing act, in terms of holding now a group of people, seeking to keep them engaged, and other things we were trying to do like we were trying to look ahead in terms of accessing funding, we’re trying to raise awareness through publishing. So, while those things might not be, directly, written into the scope of the program they are actually really important for the bigger picture with the pilot. ”(Sectoral Stakeholder)*

Although the program management worked well, some **questions** raised in relation to the

- recruitment,
- communication and responsibilities
- post-program efforts and
- pending queries and some vagueness.

Sectoral Stakeholders stressed their interest in delivering the Train the Facilitator program to those who participated in the *My Recovery* program, participants were aware that there may be some challenges. As a consequence of the enhanced interest in providing a program for the Darwin community some participants were invited to attend the Train the Facilitator training program, this was through a recruitment process:

*“And I would also question, in terms of the recruitment to training, is there a way that the program in August could have been recruited too differently, which will ensure that the people in this room had all done the program, that we’re all hearing the same sort of knowledge in that sense? It might have been more useful” (Sectoral Stakeholder)*

*“But in terms of recruiting to the August program, I think it was always difficult because the demand was so huge... it was massive. And making decisions about who was potentially going to be a facilitator and who wasn't I think is probably tricky...and I think the [Lead Agency] has a funny role as supporting the program but also gatekeeping. ”(Sectoral Stakeholder)*

There was some discussion around collaborative partners’ responsibilities about the program presented some uncertainty:

*“Yes, it's like who is ultimately responsible for the people in this room? Is it... [Program Facilitators and Trainers]? Or is it the [Lead Agency]? And so, information sharing, and communication loops were not as - sometimes got in the way for me. ”(Sectoral Stakeholder)*

The conversation also indicated the need for further pre-program as well as post-program work to gain a better understanding of the program:

*"I wonder if there could've been more work put into having some certainty post-program, because there's a lot of unanswered questions about where to from here..." (Sectoral Stakeholder)*

*"I think what's been evident is that there's been a lot of - from within the five-day training there's been a lot of things that have come up, questions from people that the [Lead Agency] hasn't been able to answer. And I question what prior work could've been done to support that." (Sectoral Stakeholder)*

*"I wonder if there's a collective clarity around what My Recovery, what the intention of My Recovery is. I do question that at times" (Sectoral Stakeholder)*

### *Feedback and messages*

Sectoral Stakeholders were asked to share the feedback that they received from Program Participants. They were provided with formal as well as informal verbal **feedback**. Among them, the following elements were the most frequent:

- empowerment,
- supportive relationships,
- strength-based approach,
- open discussion about mental illness,
- enhanced confidence,
- effective learning environment,
- need for clarity around the next stage of the pilot project,
- increased interest.

Some stakeholders emphasized the personal development, supportive relationships and strengths-based approach when referring to feedback about the program:

*"You know what, it's been really amazing now having known these people since July and watching some of their journeys. People should not underestimate the empowerment that comes through participating in a program like this, and that is not to say these people will never become unwell again, because that's unrealistic to say. But all their strength and expertise they bring is from those experiences, so they should be momentary issues to deal with and not affect these people's development, in terms of career, or pathway, if this is what they want to do." (Sectoral Stakeholder)*

*"Yeah, so I caught up with three of them, and their feedback was that they've made really, really, good positive supportive connections within the group, and one yesterday was discussing the teams that were going to be co-delivering together, co-facilitating, and the relationships that had been formed there. It's fantastic."*

The space for open conversation about mental health needs and issues was also discussed:

*"Opportunities that have come from the program is that people are talking more about mental illness, mental health, mental wellness" (Sectoral Stakeholder)*

For some participants an increased level of confidence was one of the most important pieces of the feedback about the delivery model:

*“We got formal feedback from people. We asked people to identify their levels of confidence prior to doing the training. We also asked them to complete a similar set of questions after. And we also got verbal feedback throughout the program. And we’ll be using that to fine-tune this particular delivery model to use across the organisation in other settings “(Sectoral Stakeholder)*

Among Program Participants’ the learning environment seemed to be very favourable:

*“I think some of the comments we heard particularly from people who have done, had previous training experience or even teaching experience, there was a strong sense from people that how much they gained from a really short amount of time - we really had two days of content delivery in that sense. But they were quite common comments of, “Oh my god, I don't know why I hadn't learned this before,” or, “This was presented in such a well-structured way that makes sense that I could use.” There were a few people who turned up was from those with teaching backgrounds. They were quite surprised that they haven't gone through this material previously. “(Sectoral Stakeholder)*

*Other feedback about the program? I think for the most part it was a good learning environment. “(Sectoral Stakeholder)*

A need for more information about the next phase of the pilot project was also shared, this was in line with a potential platform for the pilot project to further development:

*The one person who didn't complete, I've caught up with them a few times, and they accept that they didn't read the manual before they came in, so they weren't familiar enough with the content to keep the momentum going.... Yeah, they didn't have enough preparations. Enough familiarity to have been able to keep the pace “(Sectoral Stakeholder)*

*“I think the feedback I got was they were wanting to know how the third stage would work. It was those kinds of questions, and I would use that by, you know, factoring that into get people together for a planning day.” (Sectoral Stakeholder)*

*“...the other thing I want to share is, for me, this program is a launching pad, and as long as people leave at any time feeling developed and skills, they might make other choices about their participation, that's perfect. I just need to have enough numbers, moving through each stage, to allow the momentum to keep going, but all that bit of skill development we do along the way – as long– as long as they don't leave with a bad experience of the program I think we've met our target“ (Sectoral Stakeholder)*

### *Recommendation, future plans and considerations.*

Sectoral Stakeholders were also prompted to make some recommendations and future considerations to promote and continue to make improvements to the pilot project. There was a strong emphasis on further funding to keep the project going and extending to the broader NT community:

*"I just hope that we get more funding, yeah keep throwing the funding at the areas that will change a community. "(Sectoral Stakeholder)*

*"I just really would like to have this program adapted so that it can go out into our Aboriginal and Torres Strait Islander communities. "(Sectoral Stakeholder)*

Throughout the interviews support was repeated and discussed in many ways. Among them, these were the most common:

- dedicated resources,
- professional development,
- intentional time, and
- education.

Peer-led education has indicated an ongoing need in the Northern Territory, to further develop a peer-led workforce with dedicated resources and upskilled local facilitators' and ongoing personal development will be essential for further development:

*"... it is about the dedicated resource. And I think from what I've learnt, that notion of learning from peers and expertise gained through lived experience may be a new concept up here, so in terms of success of the program, I think there is something there about resources dedicated towards supporting organisations that are involved in the project. Even community development work, in terms of what we're creating here in spaces where people learn about their experience and they go back to their local community, that might be stigmatising or challenging to being how do we support those communities to be accepting, open, welcoming. So, it's a whole lot of things that come into play to support - that would support the success of this to happen. "(Sectoral Stakeholder)*

*"...and also, professional development purpose in that sense as well. We've already talked about this is quite a new space. Also, a new profession, a new discipline that people are moving into. And are there external supports, whether it be training or resources, that will support that? Maybe there aren't. So that connection is going to be really important. "(Sectoral Stakeholder)*

*"...because even for the people who have got their accreditation, that's not the end of their development needs at all. Yes, some of them have exceeded the expected competency level in a range of areas, but where's the ongoing support for them to practise that craft, extend and challenge themselves, be supported? Yeah. That's when those things fall over." (Sectoral Stakeholder)*

*"And that's where it's really important to have those dedicated resources. Because unless people get an opportunity to actually facilitate the program, then it's been for naught as well, because you just lose them. Lose the skills, lose the confidence". (Sectoral Stakeholder)*

Spending intentional time together supports facilitators to develop and to build a strong and supportive peer networks:

*And you're right, it has to be an intentional time that is valuable for people. So, it's not just about let's catch up and have a coffee. How is this time valuable, and why do I want to be there? "(Sectoral Stakeholder)*

Developing additional educational pathways around peer facilitation, peer-led education, and the My Recovery program to create a better understanding of mental health was also discussed:

*"...there needs to be almost a significant education piece that needs to be done, because for the people that have been immediately involved in this project, there's been an awakening and a collective growth. But at the end of the day that's 20 people. Or no, I don't know, 25, 26 people. That's not very many people to have an understanding of what My Recovery is, what peer facilitation is, what peer-led education is, what recovery even a non-clinical mental health setting means. So, it feels at times that it's acting in too much isolation to a much wider wheel or mechanism". (Sectoral Stakeholder)*

One Sectoral Stakeholder when she was asked about her recommendation to the local skilled facilitators, stressed the importance of being connected and spending intentional time together:

*"Stay connected with intent and purpose. Be really specific about making time and making it matter. I mean, I know that a lot of them have talked about they want a barbecue, and I think the reason they wanted to do that is because we haven't had that formal celebration. I mean, I think that's part of it. But their getting together has to actually have some purpose to the - program purpose" (Sectoral Stakeholder)*

Another person wanted to see the development of a support group with participants from the programs in the near future in order to maintain their own mental health and support others:

*"Definitely continue into a support group where they can continue to maintain their own mental wealth" (Sectoral Stakeholder)*

Finally, one Sectoral Stakeholder described that everyone has their own journey at different paces, and they should be aware of it without any extra burden having this qualification:

*"I think just for people to know that this is a qualification but it shouldn't add any extra burden, you shouldn't think that now you've got a qualification to deliver this program that, you know, you might not get unwell again, because that's expected and that's not going to reflect badly on you, and we can work around that; everyone is moving at a different pace....But, I suspect, maybe people are feeling a bit of pressure, like they may be in a role*

*model or leadership phase and they feel, maybe, a burden that they should have their shit together. And that's, "Be real, like we have this expertise because we do have certain of these lifelong issues, and that's okay, and we'll just need knit together and work through it together....I think let's just be open about how – I don't know – how we're feeling and share the load, and each person, in their own time, but we'll do as much as we can to enable you to be successful. But we're going to get there at different paces and have little breaks, we need to, and that's to be expected." (Sectoral Stakeholder)*

## Conclusion

This chapter provides a summary of the main findings of this study regarding Program Participants', Sectoral Stakeholders' and researchers' experiences and perspectives

### Main findings

Overall, the findings presented in this report provide an understanding of the *My Recovery* program participants' mental health journey and the training impacts of the Train the Facilitator, Sectoral Stakeholders' perspectives about the pilot project, including the most effective program elements, challenges, areas for improvement, recommendations and future considerations, and participants' and researchers' personal experiences throughout the pilot project.

#### Phase 1: *My Recovery* 6-day program

##### *Participants' mental health journey within the pilot project*

**Pre-program components:** Most of the participants reported long-term mental health issues, and the connections between their mental illness and other problems such as drug addiction, family issues, undesirable life events, homelessness, and incarceration. Social isolation was described as the main risk factor while a supportive environment was mentioned as a protective factor, for mental health. Struggle with school and work was presented as a significant implication of their mental health issues. In many cases, factors that exacerbated participants' mental health conditions included inappropriate treatment, polypharmacy, unnecessary and involuntary multi-institution admissions, and unsuccessful attempts to access appropriate help/care.

**Post-program components:** While participants had varying levels of mental health issues at the beginning of the program, all experienced some improvement by the end of the program. Among the developments, increased coping skills, enhanced level of confidence, optimism, trust, resilience, and self-awareness were mentioned. The program helped participants to understand their illness as well as manage and cope with symptoms. The inclusive environment of the program also helped participants to overcome their loneliness and provided an opportunity to voice their opinions and share their experiences and challenges with other participants. At the end of the 6-day *My Recovery* program, their perspective, and motivation changed a lot while forgiveness and acceptance increased.

##### *Participants' perspectives about My Recovery program:*

**Pre-and Post-program Delivery of My Recovery:** Before completing the *My Recovery* program, participants expressed a strong focus on personal development, improved self-confidence, and a curiosity to connect with new local support networks. While many participants shared similar



expectations and motivations about participating in the *My Recovery* program, prior to attending the program trusted relationships were reportedly absent with most experiencing mental health difficulties for a long time. The non-clinical and non-judgmental shared space that facilitated discussions about psychosocial support was highly regarded as an alternative to medication management of their illness. The training which was underpinned by recovery planning, such as the CHIME model, provided skills and tools in detecting signs of anxiety and reinforced a sense of empowerment and self-control. Recognition of experiential learning through a peer-led delivery approach, with a focus on individual's lived experiences, was a major strength that promoted inclusiveness to participants impacted by mental health. It was evident there were no equivalent psychosocial support programs in the NT before the pilot project implementation. This individually oriented approach allowed participants the opportunity to describe and reflect on past experiences, effectively empowering a sense of self-control, (re)building trust, and personal growth.

### *Perspectives of Sectoral Stakeholders about the first phase, My Recovery program*

**Composition of the Steering Group:** Although Sectoral Stakeholders consisted of participants from diverse backgrounds, their motivation toward membership of this group was similar: relevant background, interest in peer approach, supporting a local peer workforce, improving the mental health of the local community and supporting a locally recognised program in the NT in line with similar national initiatives. The diverse background of the Steering Group achieved the terms of reference especially during the contextualisation phase of the pilot project. The composition of the Group showed professionalism, flexibility, and willingness for the pilot project to succeed, other agencies and service providers were welcomed to join the Group in order to support the pilot project.

**Implementation, recruitment, and project management:** The alignment of the program with national and territory priorities was the pilot project's strengths. The Project Officer was applauded for the extra efforts in making the program a success. In addition, satisfaction with the project management was described as a high-quality and within agreed timeframes and deliverables. The involvement of an External Evaluator, local networks and experience, and the Coalition ability to engage with the Program Facilitators and Trainers were also highlighted as a success. The idea of self-nomination by participants during the recruitment stage was highly regarded, as this process recruited people from specific target groups into the program. Where the Project Officer had the opportunity to deliver information sessions and shared a personal journey from a lived experience perspective, the number of applications was high.

**My Recovery program:** The 6-day *My Recovery* program prior to participants attending the Train the Facilitator program was considered a good experience as the Train the Facilitator program was considered an intensive target program. The *My Recovery* program participants reported positive engagement, openness and willingness to engage with other participants, and the confidence to facilitate group dynamics including positive energy and appetite for the Train the Facilitator program. It was outstanding how Program Participants were impressed by and reacted to the peer recovery model. The feedback on the program delivery included excellent, safe, supportive, and enjoyable and participants were extremely satisfied with the Wellways Trainers. Facilitators expressed confidence in the delivery of the Program through previous facilitation experiences and a local understanding of Darwin. Program delivery in Darwin was different compared to previous groups in other states because

of the pilot project timeframes, group size, composition of the group, and participants' limited knowledge of the recovery peer model.

**Participants of the My Recovery program:** Representation and interest from the AOD sector were higher than expected. The AOD sector showed an immediate appetite for the program. The AOD sector considered the *My Recovery* program as a complementary program to their existing rehabilitation programs. There was less uptake by the community mental health and other sectors, so there were fewer participants.

**Most effective elements of the pilot project:** The voice of lived experience was strong and valued throughout the pilot project, their participation in the programs was observed by the External Evaluators, Steering Group members, agencies, and local peak bodies. Sharing updates and providing feedback on the programs' progress and evaluation, during the Steering Group meetings, facilitated a better understanding of the impact of the pilot project. The collaboration and support from the Coalition, Program Facilitators and Trainers and Steering Group members supported the implementation of the pilot project within the agreed timeframes and deliverables. The Project Officer employed by the Coalition was a motive force of the pilot project's success. The Facilitators' previous experience of working in the NT provided an understanding of the context of Darwin and the NT. Participants of the programs evaluated the *My Recovery* facilitators and Train the Facilitator trainers as fantastic and inspiring. Program Participants' engagement in the evaluation process was highly responsive. Their daily feedback was appreciated and included in the training design of the *My Recovery* program ensuring continuous reflection on participants' needs. The adjusted *intensive My Recovery* program enabled participants to build relationships, bonding and trust within a short timeframe, and the gender-balanced co-facilitation of the program was also respected.

**Challenges of the pilot project:** Although program success was expressed in many ways, some challenges were also highlighted. Among them, the Program Facilitators and Trainers from Wellways which indicated the following: (1) distance (trainers were based in Melbourne) and local characteristics of Darwin; (2) venue; (3) dismissing a participant; (4) project timeframes ; (5) participants' lack of knowledge of the peer-facilitation model; and (6) recruitment process and no contact with participants before the *My Recovery* program commenced this was due to the trainers being based in Melbourne. From a partnership aspect, negotiating an agreement on the pre and post Program delivery presented some challenges. However, discussion and negotiations overcame these challenges.

**Areas for improvement:** Among the suggested areas for improvement, long term sustainable funding was primary. It was emphasised in relation to (1) the contextualisation process where Sectoral Stakeholders felt that they did not have enough time to reflect on the content, (2) building relationships and developing referral pathways with the mental health sector, and (3) inviting more lived experience representatives onto the Steering Group. Some Sectoral Stakeholders also wanted to see more engagement and commitment from Steering Group in providing direction to fulfil a more consultative role. There was no clear agreement about the best composition of the Steering Group, indicating that this needs some more consideration and time. Difficulties in managing peers at workplaces were also described implying the need for a better understanding of the peer support model.

**Recommendations and future considerations:** Sectoral Stakeholders expressed interest and willingness to contribute to the broader implementation of the *My Recovery* program. The key reasons included the development of a mental health peer network and workforce across the Northern Territory. To enhance the delivery and expectations of the *My Recovery* program, information sessions before the commencement of the Program were considered important for participants to gain an understanding of the peer-facilitated recovery models. Concerns were expressed in finding suitably qualified trainers to deliver the Program in the Northern Territory, this concern may present new opportunities for the locally trained facilitators from the pilot project. The pilot project program success in Darwin showed the potential to continue a peer-led program across the Northern Territory. For example, a Steering Group which includes people from rural and remote areas, and representatives from Aboriginal and Torres Strait Islander training organisations and peak bodies and Culturally and Linguistically Diverse (CALD) backgrounds and representative organisations with further contextualisation of the training materials. Any future development of the *My Recovery* program, it was considered essential to allocate resources, provide support and mentoring both during and after the program, and invest sustainable funding to promote and sustain the program into the future. Parallel with the ongoing support, providing continuous opportunities for locally trained facilitators to continue to develop ongoing skills was considered necessary.

## **Phase 2: Train the Facilitator program**

### *Participant perspectives of the Train the Facilitator program*

**Post-Program Perspectives:** Participants who undertook the Train the Facilitator program, their experiences and engagement with the mental health system ranged from complex PTSD, trauma, and severe depression. Overall, the delivery of the Train the Facilitator program was reported by participants as being successful. The safety and professionalism of the trainers were particularly noteworthy. The opportunity to share lived experiences throughout the delivery of the pilot project was important. It provided an opportunity for the participants to engage in discussion with others and to self-reflect on the challenges they had faced relating to mental health. Understanding concepts about group dynamics, worldviews, and advocacy allowed participants to develop skills and enhance their tolerance, build resiliency, and confidence to deliver the *My Recovery* program with another co-facilitator as part of the pilot project.

### *Participant Personal Journey*

**Mental health:** However, at the start of the *My Recovery* program, Personal Journey Participants were described with completely different stages of their mental health journey, the background of their journey was mostly similar including the long presence of their illness, challenging situations, alcohol and drug addictions, and mental health issues. Completion of the *My Recovery* program provided deep satisfaction, a positive impact, a better understanding of their mental illness, and skills, and tools. The positive impact and experience motivated them to enrol the subsequent Train the Facilitator program that allows them to deliver the *My Recovery* program to others.

**Goals and expectation:** Personal Journey Participants attended the programs with an open mind and willingness to learn without clear expectation. Among their goals, gaining new skills and tools to function and cope better with their mental illness, stay motivated each day, and have a better understanding of their illness were the most common.

### *Researcher personal journey:*

**Researchers' background:** Both researchers experienced an emotional journey based on the information shared by participants during the project. This invoked a feeling of empathy towards participants, providing an opportunity to explore their own strengths and weaknesses. They both have experience in conducting research studies with different vulnerable populations, though their experience with people with mental health issues and psychosocial support needs, was limited.

**Strengths and Challenges:** The researchers attempted to adopt a sensitive and relatable approach to interviewing throughout the project. This promoted interpersonal connectivity as both a personal strength (e.g. to establish trust and rapport) and a weakness (e.g. emotive responses clouding objectivity). Self-care, mindfulness, and activities were coping strategies fostered/ utilised for the project, with researchers debriefing amongst themselves. Active listening was imperative across the project and researchers were trained in this skill.

**Program impact:** Through engagement with Program Participants the researchers' noted a substantial improvement in the mental and physical health and wellbeing of Program Participants between interview phases. This was conveyed through an increase in self-confidence when communicating with the researchers; and an expressed and observed sense of self-worth, including their physical appearance and the way they presented themselves throughout the project, alongside a notable increase in the way they engaged in each of the pilot project phases. In summary, participants felt more empowered to embrace coping strategies, speak with others, and to seek support for their mental health challenges.

### *Perspectives of Sectoral Stakeholders about the second phase of the pilot project:*

**Implementation and target population:** Program implementation occurred as per the pilot project deliverables through collaborative partnerships. While, the Train the Facilitator program successfully reached the targeted mental health and AOD population, the intensity of the program delivery (i.e. 5-days) presented challenges for some participants, particularly about developing new skills and knowledge that would have benefited from a longer consolidation period.

**Program delivery:** While Train the Facilitator trainers were qualified and experienced in the delivery of the Train the Facilitator program, the trainers identified barriers in relation to the recruitment process, and an understanding of lived experience and peer concepts which created a unique perspective, within a supportive environment during the pilot project. The Steering Group provided overall governance of the pilot project and contextualisation of the programs. The contextualisation of the *My Recovery* program was a 2-day workshop with the Wellways, this first phase was more intense than the second phase (Train the Facilitator program). Overall, the Program Facilitators and Trainers were happy with the support and engagement of the Coalition and the Steering Group. Input from Steering Group members was welcomed including feedback to the *My Recovery* program and training materials. This fostered a collaborative, supportive working environment; within a strength-based approach. There were open discussions with the Wellways on the programs contents which fostered a positive understanding of the programs and an increase understanding of the pilot project.

**Opportunities and benefits:** The pilot project presented benefits and opportunities for creating an increased understanding of peer-led psychoeducation programs. It was also an opportunity to

experience the delivery of a 5-day Train the Facilitator training program and witness participants' progression. Building the capacity of locally trained facilitators has established a strong foundation for the delivery of the *My Recovery* program in Darwin into the future. However, it has also emphasised the importance of ongoing training of local facilitators to promote the expansion of a suitably trained mental health peer-workforce in the NT over the longer term. The evidence-based format of the programs was described as a benefit, along with the intense model of program delivery, while support to the Program Participants was central to the success of the program. Steering Group members offered advice about how to better contextualise and promote the program to potential *My Recovery* program facilitators. Strategies included, identifying possible risks and risk mitigation strategies, recruitment processes and support for the second phase of the pilot project.

**Challenges:** The interstate trainers indicated that the intensive workload associated with the preparation of the contextualisation of the programs within a short timeframe, the delivery of the training program, alongside the assessment and feedback process, was a major challenge for them. Challenges attached to the deliverable were visible throughout the pilot project. This was expressed through the ability to sustain a secretariat role to the Steering Group, dissemination of information to both the trainers, recruitment of participants for the programs, and associated tasks during the delivery of the programs as well as organising graduation for participants on the complement of the programs. Some Program Participants faced personal challenges regarding the training material, tasks, and assessments. While for others, identified stigma directed at people with lived experience of mental illness was a challenge. The month of December posed some challenges to the pilot project. This required the Project Officer and some participants to make extra efforts to keep the pilot project on-track to meet the deliverables.

**Areas for improvement:** Strategies to enhance engagement with the mental health sector was highlighted as an area of improvement. It was suggested that the Coalition continue to lead advocacy efforts that raise awareness about the role and need of a qualified peer-led workforce within the NT. This needs to be underpinned by the development and implementation of clear vocational pathways to support the increased participation of the peer-led mental health workforce. In addition, the Coalition should continue capacity building and professional development activities that support this workforce to be more firmly embedded within the NT mental health system. This will require ongoing partnership work with key stakeholders from within the mental health and AOD sectors, particularly organisations involved in service provision. As a peak body representing community mental health, it needs to be noted that the Coalition is not a service provider and the pilot project was a way of establishing locally trained facilitators with lived experience of mental ill-health to deliver the *My Recovery* program. The idea that the Coalition develop a more comprehensive recruitment process with ample lead-in time to select participants was discussed by some participants, given this was a pilot project with timeframes and deliverables this was not fully understood by participants. Overall, there was strong support for the Coalition to continue to advocate and promote the delivery of *My Recovery* program throughout the NT, including adaptations of the program for remote and culturally-diverse contexts.

**Recommendation and future considerations:** Having local facilitators is an opportunity to establish a lived experience network. Having a lived experience network would support locally trained facilitators to develop and build a strong and supportive peer network. Peer-led education, in this context, is a

concept that needs to continue to develop for the NT. To sustain a peer-led psycho-education program in the NT, such as *My Recovery* program, with sustainable long term funding, and the development of a comprehensive implementation plan across the NT needs to be prioritised.

## Reference

- Aboriginal Medical Services Alliance of the Northern Territory. (2011). *A model for integrating alcohol and other drugs, community mental health and primary health care in Aboriginal Medical Services in the Northern Territory*. Retrieved from
- AIHW. (2012). *National Hospital Morbidity Database, 2011/12*. .
- Allicock, M., Carr, C., Johnson, L. S., Smith, R., Lawrence, M., Kaye, L., . . . Manning, M. (2014). Implementing a one-on-one peer support program for cancer survivors using a motivational interviewing approach: results and lessons learned. *J Cancer Educ*, 29(1), 91-98. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/24078346>. doi:10.1007/s13187-013-0552-3
- Australian Bureau of Statistics (ABS). (2013). *Estimates of Aboriginal and Torres Strait Islander Australians, June 2011*. ABS cat. no. 3238.0.55.001. Retrieved from Canberra:
- Australian Health Ministers' Advisory Council. (2013). *A national framework for recovery-oriented mental health services: Guide for practitioners and providers*. Retrieved from Canberra, ACT:
- Australian Institute of Health and Welfare. (2018a). *Australia's health 2018: in brief*. Cat. no. AUS 222. Retrieved from Canberra:
- Australian Institute of Health and Welfare. (2018b). *Australian Burden of Disease Study 2015: fatal burden preliminary estimates*. Cat. No. BOD 18. . Retrieved from Canberra:
- Australian Institute of Health and Welfare. (2018c). *Family, domestic and sexual violence in Australia 2018*. Cat. no. FDV 2. Retrieved from Canberra:
- Bell, T., Panther, G., & Pollock, S. (2014). Establishing an effective peer workforce: A literature review. Prepared for the Frankston Mornington Peninsula Mental Health Alliance by the Mind Australia Research, Development and Advocacy Unit, Medicare local Frankston-Mornington Peninsula, Mental Illness Fellowship Victoria, Peninsula Health and Peninsula Support Services.
- Blixen, C., Perzynski, A., Kanuch, S., Dawson, N., Kaiser, D., Lawless, M. E., . . . Sajatovic, M. (2015). Training peer educators to promote self-management skills in people with serious mental illness (SMI) and diabetes (DM) in a primary health care setting. *Primary Health Care and Research Development*, 16(2), 127-137.
- Bouchard, L., Montreuil, M., & Gros, C. (2010). Peer Support among Inpatients in an Adult Mental Health Setting. *Issues in Mental Health Nursing*, 31, 5898-5598.
- Boyatzis, R. (1998). *Transforming qualitative information: thematic analysis and code development*. London (UK): Sage.
- Braun, V., & Clarke, V. (2012). Thematic analysis. In *APA handbook of research methods in psychology, Vol. 2. Research designs: Quantitative, qualitative, neuropsychological, and biological*. Washington, DC, US, : American Psychological Association.
- Castelein, S., Bruggeman, R., Busschbach, J. T., van Gaag, M., Van Der Stant, A. D., & Knegtering, H. (2008). The effectiveness of peer support groups in psychosis: A randomized controlled trial. *Acta Psychiatrica Scandinavica*, 118, 64-72.
- Chamberlin, J. (1997). A working definition of empowerment. *Psychiatric Rehabilitation Journal*, 20(4), 43-46.
- Conner, K. O., McKinnon, S. A., Ward, C. J., Reynolds, C. F., & Brown, C. (2015). Peer education as a strategy for reducing internalized stigma among depressed older adults. *Psychiatric Rehabilitation Journal*, 38(2), 186-193.
- Corbin, J., & Strauss, A. (2014). *Basic of qualitative research: Techniques and procedures for developing grounded theory*. CA: Sage Publication.
- Croft, B., & İsvan, N. (2013). Impact of the 2nd Story Peer Respite Program on Use of Inpatient and Emergency Services. *Psychiatric Services*, 66(6), 632-637.
- Department of Health. (2017). *The Fiiifth National Mmental Health and Suicide Prevention Plan*. Retrieved from Canberra, ATC:


- Department of Health and Families Northern Territory Government. (2009). *Northern Territory Chronic Conditions Prevention and Management Strategy 2010-2020*. Retrieved from Darwin:
- Gardner, F. (2003). Critical Reflection in Community-Based Evaluation. *Qualitative Social Work*, 2(2), 197-212.
- General Practice and Primary Health Care Northern Territory (GPPHCNT) (2007). *Indigenous mental health in the NT. Allied Health work force study. Epidemiology of Aboriginal mental illness in the Northern Territory- Literature review*. Retrieved from
- Greenfield, T., Stoneking, B., Humphreys, K., Sundby, E., & Bond, J. (2008). A randomized trial of a mental health consumermanaged alternative to civil commitment for acute psychiatric crisis. *American Journal of Community Psychology*, 42, 135-144.
- Hayes, L. (2016). *Effective, evidence-based psychosocial interventions suitable for early intervention in the National Disability Insurance Scheme (NDIS): promoting psychosocial functioning and recovery*. Retrieved from Melbourne:
- Health Workforce Australia. (2014). Mental Health Peer Workforce Study. In. Adelaide, SA: Health Workforce Australia.
- Jalleh, G., Anwar-McHenry, J., Donovan, R. J., & Laws, A. (2013). Impact on community organisations that partnered with the Act-Belong-Commit mental health promotion campaign. *Health Promot J Austr*, 24(1), 44-48. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/23575588>. doi:10.1071/HE12909
- Kaine, C. (2018). *Towards Professionalisation. Exploration of best practice models in mental health peer work to inform the establishment of a national professional organisation (Literature Review)*. Retrieved from
- Mancini, M. A., Linhorst, D. M., Menditto, A. A., & Coleman, J. (2013). Statewide implementation of recovery support groups for people with serious mental illness: a multidimensional evaluation. *The Journal of Behavioral Health Services & Research*, 40(4), 391-403.
- Marel, C., Mills, K. L., Kingston, R., Gournay, K., Deady, M., Kay-Lambkin, F., . . . Teesson, M. (2016). *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (2nd edition)*. Retrieved from Sydney, Australia:
- Mead, S. (2014). *Intentional Peer Support: An alternative approach*. Bristol:USA: Intentional Peer Support.
- Measey, M., Li, S., & Parker, R. (2005). *Suicide in the Northern Territory 1981-2002. (2005). Health Gains Planning, Department of Health and Community Services*. Retrieved from
- Miller, P., Cox, E., Costa, B., Mayshak, R., Walker, A., Hyder, S., . . . Da, A. (2016). *Alcohol/Drug-Involved Family Violence in Australia (ADIVA)*. Retrieved from Canberra: Australian Capitol Territory:
- Moore, G. F., Audrey, S., Barker, M., Bond, L., Bonell, C., Hardeman, W., . . . Baird, J. (2015). Process evaluation of complex interventions: Medical Research Council guidance. *BMJ*, 350, 1258. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/25791983>. doi:10.1136/bmj.h1258
- Northern Territory Council of Social Service (NTCOSS). (2019). NTCOSS Submission to the Productivity Commission's inquiry into The Social and Economic Benefits of Improving Mental Health. Retrieved from <https://ntcoss.org.au/ntcoss-submission-to-the-productivity-commissions-inquiry-into-the-social-and-economic-benefits-of-improving-mental-health/>
- Northern Territory Department of Health. (2018). *Northern Territory Suicide Prevention Strategic Framework 2018-2023*. Retrieved from Northern Territory:
- Northern Territory Government. (2019). *Mental Health Strategic Plan 2019-2025*. Retrieved from Northern Territory:
- Northern Territory Government Department of Health. (2016). *Annual Report 2015-2016*. Retrieved from Casuarina: NT:



- Northern Territory Mental Health Coalition. (2017a). *Mental Health & Suicide Prevention Service Review. Final Report*. Retrieved from
- Northern Territory Mental Health Coalition. (2017b). *Mental Health Suicide Prevention Service Review*. Retrieved from Darwin:
- Northern Territory Mental Health Coalition. (2019). *2018 – 2019 Mental Health Peer Support Workforce Needs Assessment. Report to NT Primary Health Network*. Retrieved from NT:
- Northern Territory Primary Health Network. (2016). *The NT PHN Mental Health and Suicide Prevention Needs Assessment*. Retrieved from
- Northern Territory Primary Health Network. (2017). *Updated Activity Work Plan 2016-2019: Primary Mental Health Care Funding*. Retrieved from
- Northern Territory Primary Health Network. (2018). *Program Needs Assessment. Comprehensive Review 2018*. Retrieved from Northern Territory:
- Nunan, C. (2019). *My Recovery: Peer education programs that empower people in their recovery*. Clifton Hill: Victoria.
- Parkinson, S., Eatough, V., Holmes, J., Stapley, E., & Midgley, N. (2016). Framework analysis: a worked example of a study exploring young people's experiences of depression. *Qualitative Research in Psychology*, 13(2), 109-129. doi:doi:10.1080/14780887.2015.1119228
- Porter, C. M. (2012). *Psychosocial Models of Recovery from Mental Illness in a Consumer Delivered Service*. La Trobe University, Victoria, Australia.
- Price Waterhouse Coopers Consulting Australia. (2018). *Economic impact of the Safe Haven Café Melbourne*. Retrieved from
- Ritchie, J., & Lewis, J. (2003). *Qualitative research practice: a guide for social science students and researchers*. London: SAGE Publications.
- Sax Institute. (2015). *Evidence check: The effectiveness of services led or run by consumers in mental health*. Retrieved from
- Segal, S. P., & Silverman, C. (2002). Determinants of client outcomes in self-help agencies. *Psychiatric Services*, 53(3), 304–309.
- Sloane, B. C., & Zimmer, C. G. (1993). The power of peer health education. *Journal of American College Health*, 41(6), 241-245.
- Smith, J., Christie, B., Tari-Keresztes, N., Gupta, H., Stephens, D., Wallace, T., & Caton-Graham, P. (2019). *Final report: Promising practice approaches to improve the social and emotional wellbeing of young Aboriginal & Torres Strait Islander people with severe and complex mental health needs*. Retrieved from Darwin:
- Smith, J., Judd, J., Bainbridge, R., Griffiths, K., D'Antoine, H., Cargo, M., & Ireland, S. (2018). Are we going "co-crazy"? An opportunity to learn from health promotion foundations. *Health Promotion Journal of Australia*, 29(3), 223-224. doi:10.1111/1467-8500.12310
- Smith, J., Whetton, S., & D'Abbs, P. (2019). *The social and economic costs and harms of alcohol consumption in the Northern Territory*. Retrieved from Darwin:
- Smith, J., Whetton, S., & d'Abbs, P. (2019). *The social and economic costs and harms of alcohol consumption in the NT*. Retrieved from Darwin:
- Stephens, D., Clifford, S., Mellor, R., van de Ven, K., Ritter, A., Smith, J., . . . Christie, B. (2019). *Demand Study for Alcohol Treatment Services in the Northern Territory*. Retrieved from Darwin:
- Tracy, K., & Wallace, S. P. (2016). Benefits of peer support groups in the treatment of addiction. *Subst Abuse Rehabil*, 7, 143-154. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/27729825>. doi:10.2147/SAR.S81535
- Wellways. (2019a). Retrieved from <https://www.wellways.org/>
- Wellways. (2019b). *Peer Led Education Pilot Coordinated by NT Mental Health Coalition*.
- Western Australian Association for Mental Health. (2014). *Peer Work Strategic Framework*. Retrieved from Perth, WA:

- Yanos, P. T., Primavera, L. H., & Knight, E. L. (2001). Consumer-run service participation, recovery of social functioning, and the mediating role of psychological factors. *Psychiatric Services*, 52(4), 493-500.
- Zhao, Y., Thomas, S. L., Guthridge, S. L., & Wakerman, J. (2014). Better health outcomes at lower costs: the benefits of primary care utilisation for chronic disease management in remote Indigenous communities in Australia's Northern Territory. *BMC Health Services Research*, 14(4), 463.
- Zhao, Y., You, J., Wright, J., Guthridge, S. L., & Lee, A. H. (2013). Health inequality in the Northern Territory, Australia. *International Journal for Equity in Health*, 12(79).

## Appendix A: Ethics Approval



**menzies**  
school of health research

**Postal:** PO Box 41096, Casuarina NT 0811, Australia  
**Location:** John Mathews Building (Bldg 58),  
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**ABN:** 70 495 542 847

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01 August 2019

Prof James Smith  
Menzies School of Health Research  
PO Box 41096  
Casuarina NT 0811

**Ethics Administration Office**  
**File Reference Number:** HREC-2019-3426  
**Phone:** (08) 8946 8687 or (08) 8946 8692  
**Email:** ethics@menzies.edu.au

Dr Noemi Tari-Keresztes

Dear Prof Smith,

**HREC Reference Number: 2019-3426**  
**Project Title:** *Evaluation of a Peer-Led Education Pilot for people who experience severe and complex mental health illness in Darwin*

Thank you for letter dated 21/07/2019 and taking the time to respond to the issues of concern identified by the Human Research Ethics Committee of the Northern Territory Department of Health and Menzies School of Health Research (HREC) at its meeting held on the 26/06/2019.

This project was considered by the HREC and the Aboriginal Ethics Sub-Committee (AESC), and assessed against guidelines for human research including the NHMRC *National Statement on Ethical Conduct in Human Research 2007*.

I am pleased to advise that **full ethical approval** of this research project has been granted following assessment by representatives of both the AESC and the HREC. Please note that approval applies only to research conducted after the date of this letter and continued approval is dependent on annual reporting.

**Approval Date: 01/08/2019**

Approval is granted for the above research project until the next report due date.

**Annual progress report due: 01/08/2020**


**Approved timeframe (subject to compliance and annual reporting): 01/08/2019 – 01/08/2020**

The nominated sites/s participating in this project that have been approved by this HREC is/are:

- Darwin

The documents listed below are approved:

Document	Version	Date
Study Protocol	1	31/05/2019
Interview guide		31/05/2019
Participant Information sheet - program participants		24/07/2019
Participant Information sheet - steering group members and training providers		24/07/2019
Consent Form - program participants		24/07/2019
Consent form - steering group members and training providers		24/07/2019



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Document	Version	Date
Letter of support – NT Mental Health Coalition	xx	18/07/2019
CV – Prof James Smith		

**APPROVAL IS SUBJECT TO** the following conditions being met:

1. The Coordinating Principal Investigator will **immediately report anything that might warrant review** of ethical approval of the project.
2. The Coordinating Principal Investigator will notify the Human Research Ethics Committee of the Northern Territory Department of Health and Menzies School of Health Research (HREC) of any event that requires a **modification or amendment to the protocol or other project documents** and submit any required amendments in accordance with the instructions provided by the HREC. These instructions can be found on the Menzies' website.
3. The Coordinating Principal Investigator will submit any necessary reports related to the **safety of research participants (e.g. protocol deviations, protocol violations)** in accordance with the HREC's policy and procedures. These guidelines can be found on the Menzies' website.
4. The Coordinating Principal Investigator will **report** to the HREC **annually** and notify the HREC when the project is completed at all sites using the specified forms. Forms and instructions may be found on the Menzies' website.
5. The Coordinating Principal Investigator will notify the HREC if the project is **discontinued at a participating site before the expected completion date**, and provide the reason/s for discontinuance.
6. The Coordinating Principal Investigator will notify the HREC of any plan to **extend the duration of the project past the approval period listed above** and will submit any associated required documentation. The preferred time and method of requesting an extension of ethical approval is during the **annual progress report**. However, an extension may be requested at any time.
7. The Coordinating Principal Investigator will notify the HREC of his or her **inability to continue as Coordinating Principal Investigator**, including the name of and contact information for a replacement.
8. The safe and ethical conduct of this project is entirely the responsibility of the investigators and their institution(s).
9. Researchers should immediately report anything which might affect continuing ethical acceptance of the project, including:
  - Adverse effects of the project on participants and the steps taken to deal with these;
  - Other unforeseen events;
  - New information that may invalidate the ethical integrity of the study; and
  - Proposed changes in the project.
10. Approval for a further twelve months, within the original proposed timeframe, will be granted upon receipt of an annual progress report if the HREC is satisfied that the conduct of the project has been consistent with the approved protocol. Report templates are available on the Menzies ethics webpage.
11. Confidentiality of research participants should be maintained at all times as required by law.



12. The Patient Information Sheet and the Consent Form shall be printed on the relevant site letterhead with full contact details.
13. The Patient Information Sheet must provide a brief outline of the research activity including: risks and benefits, withdrawal options, contact details of the researchers and must also state that the Human Research Ethics Administrators can be contacted (telephone and email) for information concerning policies, rights of participants, concerns or complaints regarding the ethical conduct of the study.
14. You must forward a copy of this letter to all Investigators and to your institution (if applicable).

**This letter constitutes ethical approval only.** This project, including amendments to the research protocol or conduct of the research which may affect the site acceptability of the project, cannot proceed at any site until separate research governance authorisation has been obtained from the CEO or Delegate of the institution under whose auspices the research will be conducted at that site, if not already obtained.

Should you wish to discuss the above research project further, please contact the Ethics Administrators via email: [ethics@menzies.edu.au](mailto:ethics@menzies.edu.au) or telephone: (08) 8946 8687 or (08) 8946 8686.

The Human Research Ethics Committee of the Northern Territory Department of Health and Menzies School of Health Research wishes you every continued success in your research.

Yours sincerely,



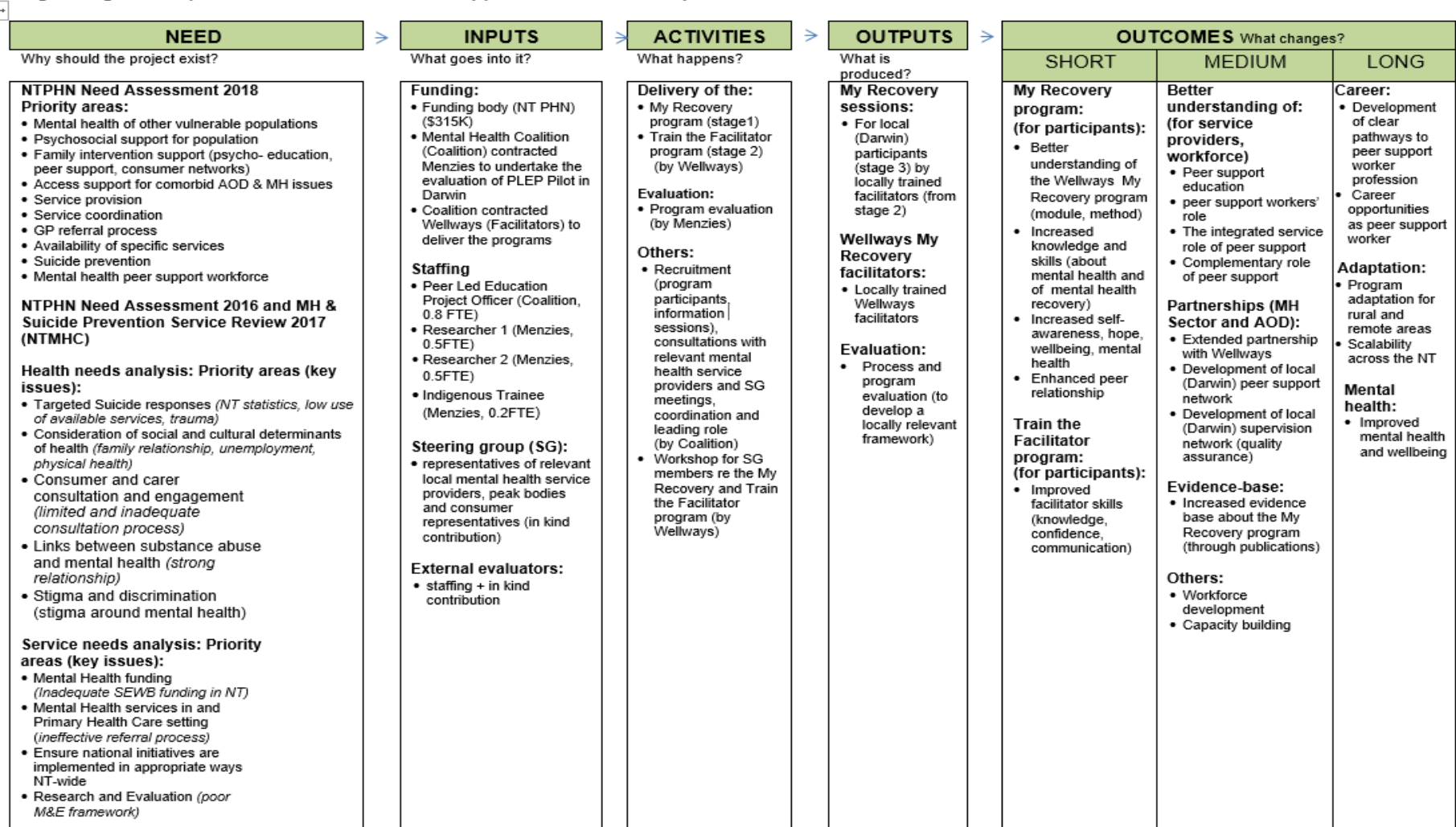
Dr. Lewis Campbell  
**Chair**  
**Human Research Ethics Committee**  
**of the Northern Territory Department of Health**  
**and Menzies School of Health Research**  
<http://www.menzies.edu.au/ethics>

**This HREC is registered with the Australian National Health and Medical Research Council (NHMRC) and operates in accordance with the NHMRC National Statement on Ethical Conduct in Human Research (2007). NHMRC Reg no. EC00153**



## Appendix B: Program Logic

Program Logic – PLEP (Peer-led Education Pilot in Darwin) (Mental Health Coalition)



## Appendix C: Flyer and Expression of Interest

wellways

# My Recovery

"My Recovery has changed my life in how I look at myself and knowing what helps me"

*My Recovery participant*

"For the first time I acknowledged that I am more than my illness. It is only a small part of who I am"

*My Recovery participant*

Wellways My Recovery is a 6-session education and support program for people living with mental health issues. The program is led by peers—trained people who have their own lived experience of mental health issues and recovery.

My Recovery provides a safe and confidential space to explore recovery and build skills:

- learn about mental health and recovery
- explore ways to improve social and emotional wellbeing
- develop communication and advocacy skills
- find ways to challenge stigma and discrimination
- share and learn from others experiences
- develop ongoing support networks

### Workshop location

Charles Darwin University  
Building Yellow, Room 33  
Ellengowan Dr, Casuarina

### Dates

12, 14, 16, 19, 21 & 23 August  
10am – 4pm

[wellways.org](http://wellways.org) | 1300 111 400



Xenia Girdler has over twenty years experience in the mental health and education field and worked extensively across the NT. She brings professional and personal experience of social and emotional wellbeing to her work and will be supporting the Darwin My Recovery program.

Charlie Anderson is pleased to be back on Larrakia land where in 2006 he re-entered study and work after 12 years on a disability pension. He uses his personal and professional experiences with social and emotional wellbeing to support community and organisational change. He has been involved in the My Recovery program for four years.

### For more information contact:

Northern Territory

Mental Health Coalition – 8948 2246

email – [PLEPproject@ntmhc.org.au](mailto:PLEPproject@ntmhc.org.au)



Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### 1. Why do you want to do the My Recovery program? *Tick all that apply*

- |   |  |
|---|--|
| <input type="checkbox"/> To meet new people                     | <input type="checkbox"/> To learn new skills                               |
| <input type="checkbox"/> Explore and try new things             | <input type="checkbox"/> Learn what works for me                           |
| <input type="checkbox"/> Better connect with family and friends | <input type="checkbox"/> Be in a safe place to step out of my comfort zone |
| <input type="checkbox"/> Understand more about mental health    | <input type="checkbox"/> Other _____                                       |

### 2. What recovery skills or strengths would you like to develop? *Tick all that apply*

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Communication | <input type="checkbox"/> How to speak up for myself | <input type="checkbox"/> Discovering my story |
| <input type="checkbox"/> Other _____   |   |   |

### 3. Do you have someone who will support you through this program?

- ☐ Yes ☐ No

Why did you choose them?  
 \_\_\_\_\_

### I acknowledge that I am:

- ☐ Over 18
- ☐ Living with mental health challenges or other related issues (trauma, alcohol and/or other drug issues)
- ☐ On my own journey of recovery
- ☐ Able to access support during the My Recovery program
- ☐ Able and willing to commit to attending all six sessions of the program

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Are there any barriers which will get in the way of you doing My Recovery?

- |                                      |                               |  |
|--------------------------------------|-------------------------------|--|
| <input type="checkbox"/> Transport   | <input type="checkbox"/> Kids | <input type="checkbox"/> Work or other commitments |
| <input type="checkbox"/> Other _____ |                               |  |

Would you like someone to contact you about this and see if we can help you take [part 2](#)?

- ☐ Yes ☐ No

Submit your application to  
[PLEPproject@ntmhc.org.au](mailto:PLEPproject@ntmhc.org.au)



## Appendix D: Interview Guide (Phase 1)

### PHASE 1

#### My Recovery Pre-test questions (participants)

##### **Personal background**

1. Checklist

##### **Mental health status**

2. As you know this is an evaluation of the My Recovery program. It is designed to help you with your mental health recovery journey. Can you please explain a little about your mental health journey and why you have decided to participate in the program? You can share as little or as much as you want.

##### **My Recovery program**

3. What are your main reasons for participating in the My Recovery program? Why?
4. What are your expectations in relation to the program?
5. Where did you hear about the program?
6. Do you have a support person, why did you choose him/her?
7. What are your goals with this program? Why?

#### My Recovery Post-test questions (participants)

##### **Mental health status:**

1. How are you feeling? Do you think the program has helped with your recovery journey? If so, in what ways?
2. Could you please tell me if you have experienced any changes in your mental health status?

##### **My Recovery program:**

3. What were some of the good things about the My Recovery program? Why do you think this?
4. What do you think was most useful in the My Recovery program? Why?
5. Are there any areas for improvement with the My Recovery program? If so, what are they and why?
6. What were your expectations about the My Recovery Program?
7. How satisfied were you with the program? Please explain why.
8. What do you think about the peer logbook you used during the program? Was this useful?
9. What do you think about the additional handouts and resources?
10. What do you think about the exercises?
11. Please give a specific example of how you used one of the skills learned during the training in your life?

12. What knowledge and skills did you learn the program? How will you use this knowledge and skills in your daily life? (probe: private life; work life)
13. What do you think about the topics of the program please? What would you change in it?
14. What do you think about the schedule of the program please? What would you change in it?
15. If you had the opportunity what elements of the program would you change? Why?
16. Would you recommend this course to others?

### **My Recovery program facilitators evaluation questions**

#### **Background**

1. Please introduce yourself in a couple of sentences. You can share as much or as little as you want. You could explain us for example how you became a My Recovery facilitator, how long you have been working as a My Recovery facilitator.

#### **My Recovery program in Darwin**

2. How effective was the program delivery in Darwin? What worked well and why? What didn't work so well and why?
3. How confident did you feel in delivering the program as a Facilitator? Why?
4. Did you get any feedback from participants about the program? What was shared? How will you use this information?
5. Have you experienced any differences in delivering the program in Darwin compared to previous groups? What were the key differences? Why do you think these differences existed?
6. In what ways did the Steering Group support your work? How so?
7. Please explain the challenges and opportunities associated with the timing of the training delivery. (probe: time to prepare; and time of year)
8. How well was the project managed by the NT Mental Health Coalition? (probe: partnership approach)
9. How well did the participants' engage during the program? Why?
10. What did you like the most/the least in delivering the program in Darwin?
11. What was the most challenging situation for you experienced during this pilot project?
12. What would be your recommendation for the further development of this *My Recovery* program in Darwin? And the NT more broadly ('probe: rural)?

### **PLEP Steering Group evaluation questions (process evaluation)**

#### **Background**

1. Please introduce yourself in a couple of sentences. You can share as much or as little as you want. You could explain us for example your background, what is your position, how long you have been working in this position.

#### **Steering Group**

2. Why did you accept the invitation to be a Steering Group member in relation to the PLEP project?

3. How engaged did you feel on the Steering Group? Why?
4. What do you think about the mix of expertise and experience on the Steering Group? Was it a right mix? Were there any skill sets/expertise/experience missing?
5. Do you think that the Terms of Reference of the Steering Group were fulfilled? Why/Why not?
6. What worked well in the Steering Group? Why?
7. What didn't work so well in the Steering Group? Why? (probe: scheduling and timing of meetings)
8. How satisfied were you with the contribution of the Steering Group in providing direction for the project? Why?
9. How well was the project managed by the Coalition? (probe: roles of Executive Officer and Project Officer)
10. If the program was extended with other regions across the NT, would you keep contributing to a Steering Group? Why/Why not?

### **Program**

11. How satisfied were you with the information you received about the program from Wellways Facilitators? Was it enough?
12. How satisfied were you with the information you received about the project from the Coalition?
13. Do you think the program was implemented as originally planned?
14. How well was the program implemented?
15. Do you think the program reached the intended targeted mental health and AOD population? How do you think this could have been improved?
16. How well does the program align with current health priorities at a territory or national level?
17. In your view, how well was the training delivered by Wellways received Program Participants?
18. Have you received any feedback from Program Participants that you wish to share?
19. Overall, do you consider PLEP to have been successful? Why?
20. Do you have any other feedback you would like to share?

## Appendix E: Interview Guide (Phase 2)

### Phase 2

#### Train the Facilitator participant questions

##### **Background**

1. (Checklist)
2. Please introduce yourself in a couple of sentences. You can share as much or as little as you want. You could explain us for example your background, why you have decided to participate in the program.

##### **Train the Facilitator program (general)**

3. Did you take part in the My Recovery program (6-days) before the Train the Facilitator? Did this help you to understand the Train the Facilitator program better?
4. Where did you hear about the Train the Facilitator program?
5. What were your main reasons for participating in the Train the Facilitator program? Why?
6. What were your expectations in relation to the program?
7. What were your goals with this program? Why?

##### **Train the Facilitator program (program specific)**

8. What were some of the good things about the Train the Facilitator program? Why do you think this?
9. What do you think was most useful in the Train the Facilitator program? Why?
10. Are there any areas for improvement with the Train the Facilitator program? If so, what are they and why?
11. How satisfied were you with the program? Please explain why.
12. What do you think about the training materials (e.g. peer logbook, resources)?
13. What do you think about the areas and topics of the program?
14. What do you think about the schedule of the program please?
15. If you had the opportunity what elements of the program would you change? Why?
16. What do you think about the exercises you have done? Did they prepare you to pass the 'exam'? Could you finally pass the exam? (any feedback from Facilitators?)
17. What knowledge and skills did you learn the program? How will you use this knowledge and skills as a Facilitator?
18. Do you think you will work as a Wellways Facilitator in the future? As a future Facilitator what challenges do you think you will face with?
19. Do you have any other feedback you would like to share?

#### Train the Facilitator trainers evaluation questions

##### **Background**

1. Please introduce yourself in a couple of sentences. You can share as much or as little as you want. You could explain us for example your background, how long you have been working with Wellways.
2. **Train the Facilitator program in Darwin**

3. How effective was the Train the Facilitator program delivery in Darwin? What worked well and why? What didn't work so well and why?
4. How confident did you feel in delivering the program as a Trainer/Facilitator? Why?
5. Did you get any feedback from participants about the program? What was shared? How will you use this information?
6. Have you experienced any differences in delivering the Train the Trainer program in Darwin compared to previous groups? What were the key differences? Why do you think these differences existed?
7. In what ways did the Steering Group support your work in relation to the Train the Trainer program? How so?
8. Please explain the challenges and opportunities associated with the timing of the training delivery. (probe: time to prepare; and time of year)
9. How well was the project managed by the NT Mental Health Coalition? (probe: partnership approach, Train the Trainer program)
10. How well did the participants engage during the program? Why?
11. Have you experienced any strengths and difficulties that participants had?
12. What challenges did the participants face with?
13. What did you like the most/the least in delivering this Train the Trainer program in Darwin?
14. What was the most challenging situation for you experienced during it?
15. What would be your recommendation for the further development of this program in Darwin? And the NT more broadly ('probe: rural, Train the Trainer)?
16. How well did you feel being supported by this PLEP project? (probe: why, both projects (My Recovery and Train the Trainer), Coalition, Steering Group)
17. What would be your recommendation for the newly skilled facilitators in Darwin?
18. Do you have any other feedback you would like to share?

### **PLEP Steering Group evaluation questions– after the Train the Trainer course**

#### **Steering Group**

1. How engaged did you feel on the Steering Group in the second phase of the project? Why?
2. How satisfied were you with the contribution of the Steering Group in providing direction for the second phase of the project? Why?
3. How well was the project managed by the Coalition in the second phase? (probe: roles of Executive Officer and Project Officer)
4. In what ways did the Steering Group support the Train the Trainer program? How so?
5. In what ways did the Wellways support the Train the Trainer program? How so?
6. Please explain the challenges and opportunities associated with the timing of the training delivery. (probe: time to prepare; and time of year)
7. What would be your recommendation for the newly skilled facilitators in Darwin?

#### **Program**

8. In your view, how well was the Train the Trainer program delivered by Wellways received Program Participants?

9. How satisfied were you with the information you received about the 'Train the Trainer' program from Wellways Facilitators? Was it enough?
10. How effective was the Train the Facilitator program delivery in Darwin? What worked well and why? What didn't work so well and why?
11. What did you like the most/the least in supporting this Train the Trainer program?
12. Do you think the Train the Trainer program reached the intended targeted mental health and AOD population? How do you think this could have been improved?
13. Did you get any feedback from participants about the program? What was shared? How will you use this information?
14. How well was the Train the Trainer program implemented?
15. What was the most challenging situation you experienced throughout PLEP?
16. Have you received any feedback from Train the Trainer program participants that you wish to share?
17. Do you have any other feedback you would like to share?

### **PLEP Interview questions for researchers**

#### **Background**

1. Please introduce yourself in a couple of sentences. You can share as much or as little as you want. You could explain for example how long you have been working as a researcher or what kind of experience you have in sensitive research.

#### **Emotions and emotion management in general**

2. Do you think that you are a sensitive person in general? Are you more emotional or less emotional than other people? What makes you think so?
3. What makes you feel 'emotional'?
4. What are your emotional strengths/weaknesses?
5. How well can you control and manage your emotions?
6. How do you de-stress after a bad day/challenging situation or stressful event?
7. Can you easily tell how other people are feeling? How useful is this ability?

#### **Experiences during conducting interviews with PLEP participants**

8. What was your overall experience participating in this program as a researcher?
9. What was your best/worst experience?
10. What did you like the most/the least in participating this pilot program as a researcher?
11. What was the most challenging situation?
12. In what ways did you feel yourself vulnerable during participating in the program?
13. How did you feel yourself during the interviews/the coding and the writing process of the study?
14. Did you use any self-care method? Which ones? What worked well/not so well and why?
15. What emotions did you feel participating in this pilot project? What made you feel so?
16. How did you manage your emotions?
17. What was the most heart-rending life story that you heard in this pilot project?
18. How could you handle your emotions during listening to heart-rending life stories?
19. Did you have any situation when you had to handle participants' break down?
20. Did you get any training before the program e.g. on risk/emotion management, how to resolve conflict situations or how to establish your border and protect your privacy?
21. How effective do you think this program was on participants' life?
22. What would be your recommendation for researcher in sensitive research?

## Appendix F: Consent Form

	<b>Postal:</b> PO Box 41096, Casuarina NT 0811 Australia
	<b>Location:</b> John Mathews Building (Bldg 58)
	Royal Darwin Hospital Campus, Rocklands Drv, Casuarina NT 0810
	<b>Ph:</b> (08) 8946 8600 <b>Fax:</b> (08) 8946 8464
	<b>Website:</b> <a href="http://menzies.edu.au">menzies.edu.au</a>
	<b>ABN:</b> 70 413 542 847

### CONSENT FORM – STEERING GROUP MEMBERS and TRAINING PROVIDERS

#### Evaluation of a Peer-led Education Pilot for people who experience severe and complex mental illness in Darwin

*This means you can say NO*

I have talked to \_\_\_\_\_ at \_\_\_\_\_ about this project. I would like to be part of this project.

- I understand what this project is about.
- I understand what is written on the Participant Information Sheet.
- I am happy for my words to be used verbatim in project outputs.
- I am happy for my information to be used in the production of reports, presentations, frameworks, education programs, conferences, journals, or on websites.
- I understand my information will not be used in reports, conferences, journals or on websites in such a way that I could be identified.
- I understand that I can choose not to answer questions, or choose for information not to be recorded.
- I understand that the information I provide may be used in future research projects relating to mental illness or social and emotional well-being
- I am happy for the information that I share in the interview as part of this project to be audio recorded. **YES/NO** (please circle)

Signed: \_\_\_\_\_

Full name: \_\_\_\_\_

Date: \_\_\_\_\_

Name of Witness: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_

If you have any concerns or complaints regarding the ethical conduct of the study, you are invited to contact Ethics Administration, Human Research Ethics Committee of the NT Department of Health and Menzies School of Health Research on (08) 8946 8600 or email [ethics@menzies.edu.au](mailto:ethics@menzies.edu.au)

## Appendix G: Information Sheet



Postal: PO Box 41096, Casuarina NT 0811 Australia  
Location: John Mathews Building (Bldg 58)  
Royal Darwin Hospital Campus, Rocklands Dr, Casuarina NT 0810  
Ph: (08) 8946 8600 Fax: (08) 8946 8464  
Website: [menzies.edu.au](http://menzies.edu.au)  
ABN: 70 413 542 847

### CONSENT FORM –PROGRAM PARTICIPANTS

#### Evaluation of a Peer-led Education Pilot for people who experience severe and complex mental illness in Darwin

*This means you can say NO*

I have talked to \_\_\_\_\_ at \_\_\_\_\_ about this project. I would like to be part of this project.

- I understand what this project is about.
- I understand what is written on the Participant Information Sheet.
- I am happy for my words to be used verbatim in project outputs.
- I am happy for my information to be used in the production of reports, presentations, frameworks, education programs, conferences, journals, or on websites.
- I understand my information will not be used in reports, conferences, journals or on websites in such a way that I could be identified.
- I understand that I can choose not to answer questions, or choose for information not to be recorded.
- I understand that the information I provide may be used in future research projects relating to mental illness or social and emotional well-being
- I am happy for the information that I share in the interview as part of this project to be audio recorded. **YES/NO** (please circle)

Signed: \_\_\_\_\_

Full name: \_\_\_\_\_

Date: \_\_\_\_\_

Name of Witness: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_

If you have any concerns or complaints regarding the ethical conduct of the study, you are invited to contact Ethics Administration, Human Research Ethics Committee of the NT Department of Health and Menzies School of Health Research on (08) 8946 8600 or email [ethics@menzies.edu.au](mailto:ethics@menzies.edu.au)



## Appendix H: PLEP Terms of Reference



*STEERING GROUP  
TERMS OF REFERENCE*

### **Peer-Led Education Pilot Steering Group**

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#### **TERMS OF REFERENCE**

##### **Purpose**

The Steering Group will provide governance to the Peer-Led Education Pilot (PLEP) through engagement with the lead agency, Northern Territory Mental Health Coalition (the Coalition).

Its key duties will include:

1. Work with the Coalition to select and engage with an external training provider to commence adaptation of a psycho-education program.
2. Provide advice to the external training provider through the Coalition on how best to contextualise the My Recovery Program and the Peer-Led Education train the trainer program for the Darwin urban context.
3. Assist in the creation of a pool of potential candidates to undergo training as Peer Facilitators.
4. Ensure there are appropriate mechanisms to support networking and professional supervision of Peer Facilitators engaged in the delivery of the PLEP.
5. Govern engagement with an external provider to develop a monitoring and evaluation framework for the PLEP, particularly with reference to the Northern Territory Primary Health Network's (NT PHN) internal evaluation framework and reporting requirements to the Commonwealth Government.
6. Support the Coalition in ensuring data collection and reporting within the monitoring and evaluation framework is undertaken.
7. Support the development of an activity plan to adapt the PLEP to a rural and remote NT contexts for submission to the NT PHN. (Note: Undertaking the actual adaptation of the PLEP for the rural and remote NT contexts is not within the scope of this project.)
8. Support the Coalition and external evaluator to finalise the monitoring and evaluation of the PLEP.
9. Approve final reports and recommendations to further implementation of the peer-led education for people with severe and complex mental illness in the Northern Territory.

##### **Chairperson**

The primary role of the Chairperson is to ensure that meetings of the Steering Group are conducted in accordance with the agreed Terms of Reference. The Steering Group will be supported by the lead

agency administration officer. The lead agency has employed a Project Officer who will be the primary contact for information flow between the lead agency and the Steering Group.

The nominated Chairperson is the Project Officer.

### **Responsibility**

The Steering Group and the lead agency have a mutual responsibility to each other, to ensure the effectiveness and sustainability of the PLEP.

### **Authority**

The Steering Group will make recommendations to the lead agency. Final approval rests with the lead agency and the NT PHN.

### **Time Commitments**

The Steering Group will convene no more than twice a month, preferably either Thursdays or Fridays by teleconference or face to face. Steering Group meetings be no longer than 2 hours when teleconferencing is used.

Additional ad hoc teleconference meetings may be necessary for discussion of important issues. Remuneration will be provided to Carers and Consumers on the PLEP Steering Group outside of any professional role they may hold.

The end date for the project is the 31<sup>st</sup> of December 2019.

### **Composition**

The Steering Group will consist of representatives from stakeholder organisations that reflect the goals of the PLEP:

NT Mental Health Coalition (lead agency)  
NT Primary Health Network (funding body)  
Department of Health Policy and Planning, Mental Health, Alcohol and Other Drugs Branch  
2 x Consumer and/or Carer representatives  
Charles Darwin University  
Industry Skills Advisory Council Northern Territory  
NT Department of Business |

National Disability Service  
TeamHEALTH  
Hespath - / Anglicare NT  
Mental Illness Fellowship NT  
Mission Australia  
Association of Alcohol and Other Drug Agencies NT  
AMSANT  
Batchelor Institute

As the external evaluator, Menzies will attend meetings as an ex officio member.

The Chairperson will convene regular meetings and make invitations to attend additional ad hoc meetings where appropriate.

If a steering committee member does not attend or respond after 3 meetings, they will be removed from the steering committee composition.

Administrative support will be provided by lead agency, NT Mental Health Coalition.

A quorum of 4 members will be required for a meeting to proceed. Where a quorum is not met, discussion and consensus may be achieved via email, out of session.

### **Meeting process**

The agenda follows a standard format in keeping with the agreed purposes of the Steering Group.

The standard format includes the following headings:

1. Acknowledgement of Country
2. Welcome and Apologies
3. Minutes of the previous meeting - actions completed and outstanding
4. Reports – via Chair and Project Officer
5. Steering Group discussion – progress to date from lead agency
6. Other business
7. Next meeting
8. Close

All documentation (agenda, minutes, actions) relevant to the Steering Group will be administered by the lead agency.

A draft agenda for each meeting will be provided to the Steering Group at least one week before each meeting. Reports and any required additional reading for the Steering Group will be submitted to the Project Officer at least 2 weeks prior to the meeting for distribution with the agenda.

The minutes will be circulated within one week of a meeting having taken place.

**Approval/Review Date:**

The Terms of Reference were reviewed by the Steering Group on Thursday the 18<sup>th</sup> of July and any changes or adjustments have been made accordingly by the lead agency.

Approved: .....  
Steering Group Chairperson Date