Follow-up Evaluation of the Peer-Led Education Pilot in Darwin

Report prepared for

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PREFACE:

This report presents evaluation findings from Stage 3 and Extension to Stage 3 (hereafter Stage 3) of the Darwin Peer-Led Education Pilot (PLEP). The PLEP was an innovative project, and its staged delivery supported the cumulative development of knowledge and skill by people with lived experience of mental health and related challenges in the Darwin region. Stage 3 of the PLEP included the delivery of My Recovery programs by upskilled local Facilitators, the codesign of a new peer-led recovery program and the delivery of non-accredited Peer Work Skills Training to former Program Participants. The overarching aims of the Stage 3 evaluation were to (1) describe the appropriateness and effectiveness of the My Recovery program, which was further contextualised throughout the PLEP by upskilled local Facilitators, and (2) build on the existing Stage 1 and 2 evidence-base. The evaluation also assessed the challenges, opportunities, key learnings, and issues experienced by the upskilled local Facilitators. Finally, the evaluation report includes detailed indications that support the transition of the pilot project and is intended to complement the Transition Plan prepared separately by the evaluation team

ACKNOWLEDGEMENTS

The evaluation team would like to thank Program Participants, Facilitators, local key stakeholders supporting the Transition Plan and the Northern Territory Mental Health Coalition (Coalition) for taking the time to participate in the evaluation of Stage 3 of PLEP. They all gave their time generously and provided vital information to enable the evaluation team to undertake this work. Without their contribution, the PLEP Stage 3 evaluation would not have been possible. Moreover, we would like to acknowledge the Coalition PLEP staff ongoing and collaborative support to the Menzies evaluation team in conducting the evaluation and gaining a valuable understanding of the peer recovery approach, peer values and the importance of involving the expertise of those with a living or lived experience of mental health and related challenges into psychosocial support initiatives.

FUNDING

Northern Territory Primary Health Network (NTPHN) commissioned the Northern Territory Mental Health Coalition (Coalition) to deliver the PLEP, and Menzies School of Health Research, Alcohol, Other Drugs and Gambling team (Menzies) to evaluate the pilot project.

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Executive Summary

Background

In May 2020, the Alcohol, Other Drugs and Gambling team at Menzies School of Health Research (Menzies) evaluated Stage 1 and 2 of the Darwin Peer-Led Education Pilot (PLEP). The PLEP was well-received by both Program Participants with lived experience of mental health and related challenges and local mental health and alcohol and other drugs (AOD) service providers. The evaluation revealed a strong support and demand for peer-led approaches to mental health and AOD recovery in the Darwin region.

My Recovery is a peer-led education and recovery program developed by and licensed to Wellways Australia. My Recovery programs were delivered to the Darwin community by upskilled local Facilitators during Stage 3 of the PLEP. Between February and September 2020, four programs were delivered. In 2021, the Northern Territory Primary Health Network (NTPHN) funded the Northern Territory Mental Health Coalition (Coalition) to deliver an extension to Stage 3 of the PLEP, based on evaluation outcomes from Stages 1 and 2. Following the delivery of further My Recovery programs, the NTPHN commissioned Menzies to evaluate Stage 3 of the PLEP and prepare a PLEP Transition Plan to guide the potential ongoing delivery of peer-led programs beyond the pilot phase.

Aim and objectives of the evaluation

The Stage 3 evaluation aimed to explore how the upskilled local Facilitators delivered the My Recovery programs. The evaluation objectives were to assess (1) the effectiveness of the My Recovery program, which local Facilitators had further contextualised for the Drawin context, and (2) identify the challenges, opportunities, and key learnings, and issues that arose during the PLEP, as described by the Facilitators.

Methodology

Individual in-depth, semi-structured qualitative interviews were conducted with My Recovery Program Participants and Facilitators. A Transition Plan workshop was also organised and included key Facilitators, other lead agency representatives, and other identified stakeholders. One service provider located in Alice Springs took part in a separate online interview that included the same questions asked in the workshop. All interviews and the workshop were conducted face-to-face except one interview, which was conducted via Zoom for the service provider based in Alice Springs. With Participants' consent, interviews were audio-recorded (and the Zoom interview was video-recorded). After each interview, Participants were contacted by the evaluation team and given the opportunity to provide feedback on interview transcripts. This was a form of member-checking to ensure the accuracy of the details shared. Each interview was transcribed verbatim by a secure professional transcription service. No identifying information was used in the analyses or presentation of the results to ensure Participants' anonymity.

Results

The PLEP was well-received by the local Darwin community of people with lived experience of mental health and related challenges. The Participants described a positive program impact on their recovery journies. The impact included improved symptom management, enhanced coping skills,

and a greater knowledge about mental health, human rights, and self-advocacy. Participants also reported an increased perceived level of compassion, empathy, self-awareness, and self-care. Participants demonstrated significant improvements in the domains of personal recovery, including quality relationships with peers and others, hope and optimism in their own recovery, regaining a positive sense of identity, finding meaning and purpose in life, having control over their lives and taking personal responsibility in their recovery.

The results of the interviews and the discussions held in the workshop highlighted the importance of (1) establishing a cross-sectoral Advisory Board to support the implementation of peer work in the NT, (2) external and internal supervision for peer workers, (3) a stepped vocational pathway to build the NT peer workforce, (4) a multisectoral consortium to support the PLEP to transition beyond the pilot phase, (5) capacity building for organisations employing peers to provide safe and effective working environments for people with lived experience, and (6) support for a local peer work Community of Practice to provide opportunities for ongoing professional development

Conclusion

The PLEP evaluation found the PLEP to be highly effective in addressing unmet mental health needs for people with lived experience of mental health and related challenges in the Darwin region by creating a significant positive impact on Participants' mental health and wellbeing. The evaluation also identified a demand for ongoing program delivery and implementation of peer-led programs in other regions of the NT. Future programs could be orientated toward supporting other Participant cohorts, including long term unemployed people and family members/friends providing care and support to individuals with mental health and/or AOD related issues. Finally, the findings of the Transition Plan and the complementary evidence presented in the evaluation report provide guidance for the implementation of peer-led programs in the NT beyond the pilot phase.

Recommendations

- Use the Transition Plan and evidence presented throughout the evaluation report to support the ongoing planning and implementation of the locally co-designed peer-led recovery program, presently named 'Recovery Together' (hereafter the Program).
- In alignment with the Transition Plan, establish a cross-sectoral Advisory Board to provide guidance and support for the ongoing development of the NT peer workforce, including peer-led programs and professional development activities for people with lived experience of mental health and related challenges.
- Consider adapting the Program through an explicit co-design process for locations across the NT, including Alice Springs, where it is evident there is an appetite for a program of this nature.
- Continue to raise awareness about peer recovery approaches and peer-led recovery programs since this still signifies a new concept for the local Darwin community.
- Embed the Programs delivery into a stepped vocational pathway to support the growth of the emerging NT peer workforce.
- Support a local peer work Community of Practice and the ongoing development of skills and capacity for the emerging local peer workforce by providing access to professional development opportunities.
- Promote the implementation of external and internal supervision with senior peer supervisors for the local peer workforce. Promote and facilitate broader peer connections and support the establishment of the proposed local Recovery College.
- Consider adapting the Program through further co-design processes for specific cohorts of Participants, including people who have been unemployed long term and want to return to the workforce, and family members/friends providing care and support to individuals experiencing mental health, AOD and/or related challenges.
- Provide persistent advocacy for the Program as necessary to keep the momentum alive that was generated through the pilot for the emerging peer workforce. This should include advocacy provided by key funding bodies, sectoral peak bodies, service providers, agencies supporting the local workforce, education and lived experience leaders involved in the pilot project.

Introduction

Overview of the Peer-Led Education Pilot

The Darwin Peer-Led Education Pilot (PLEP) commenced in May 2019 and ended in October 2021. This included three distinct stages. Stage 1 aimed to generate interest in the peer-led recovery model in the Darwin region and included the delivery of the My Recovery program by Wellways Facilitators. Stage 2 involved training and upskilling a cohort of local people (with lived experience of mental health and related challenges) as My Recovery Facilitators to deliver the program to the local community during Stage 3. Stage 3 also included an extension phase that provided an opportunity for the NT Mental Health Coalition (Coalition) and PLEP Facilitators to co-design a program that was more appropriately contextualised for a local audience.

Evaluation of Stage 1 & 2 of the Peer-Led Education Pilot

The Alcohol, Other Drugs and Gambling team at Menzies School of Health Research (Menzies) evaluated Stage 1 and 2 of the PLEP in May 2020. The interview data showed that PLEP was well-received by both Program Participants with lived experience of mental health and related challenges; and key local mental health and alcohol and other drugs (AOD) service providers. The evaluation showed high support and demand for a peer-led approach to mental health and AOD recovery in the Darwin region. Stage 1 of the PLEP supported Program Participants (n=17) to understand and self-manage their mental health and/or AOD issues. The perceived program impact was manifested in decreased self-reported levels of psychological distress, improved coping skills, developed knowledge of and better utilisation of local social supports, and a deeper understanding of their mental health needs. Stage 2 built the capacity of some of the Program Participants (n=11) to deliver the My Recovery program to the local community during subsequent stages of the project. Overall, Stage 2 was reported to be well received by Participants. The Train the Facilitator program built Participants' understanding of the peer recovery concepts, allowed Participants to develop skills, and created confidence to co-facilitate the My Recovery program in the local community.

The identification of challenges and opportunities experienced in Stage 1 and 2 of PLEP was supported by interviews conducted with Wellways Facilitators and Trainers, Steering Group members, Coalition representatives, and Program Participants.

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 to support the pilot project;
- 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 the mental health sector; and

- the need for 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 (Wellways staff facilitating the Stage 1 My Recovery program and Stage 2 Train the Trainer program were based in Melbourne);
- the recruitment process;
- the pilot project timeframe and budget; and
- the lack of Participants' knowledge of the peer-facilitation model.

Overall, Stages 1 and 2 of the PLEP highlighted the importance of incorporating the perspectives of people with lived experience of mental health and related challenges into the governance, planning and delivery of peer-support models intended to support the mental health and AOD recovery of people in Darwin. It also demonstrated 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 areas in the NT (Tari-Keresztes et al., 2020).

Stage 3 of the Peer-Led Education Pilot

Stage 3 of the PLEP aimed to provide My Recovery programs in the Darwin region, facilitated by upskilled local Facilitators. Early in Stage 3, the Facilitators formed a working group to enhance the My Recovery Facilitator Guide. Program delivery commenced with two programs delivered between February and March 2020. Between April and May 2020, project activities ceased because of COVID-19 restrictions. The project was reactivated between June and September 2020, when two more programs were delivered. In November 2020, based on evaluation results from Stage 1 and 2, NTPHN agreed to provide funding to the Coalition to deliver Stage 3 throughout 2021. This was referred to as the Stage 3 Extension and included the delivery of four more My Recovery groups between February and September 2021. In tandem, NTPHN also engaged Menzies to evaluate Stage 3 of the PLEP and develop a PLEP Transition Plan to guide delivery options post-pilot phase implementation.

Meanwhile, the upskilled local Facilitators became more familiar and confident delivering the My Recovery program content and understanding the needs of Participants. Facilitators participated in peer networking and professional development activities supported by external peer work projects. For example, several Facilitators enrolled in the four specialist peer work units from Certificate IV in Mental Health Peer Work. The completion of these units supported the Facilitators to grow in skill and contextualise the program further. This included making changes to the delivery method.

Composition of the Menzies Evaluation Team

The Menzies evaluation included:

- Dr Noemi Tari-Keresztes, Research Fellow, Menzies
- Professor James Smith, Father Frank Flynn Fellow (Harm Minimisation), Menzies
- Dr Himanshu Gupta, Research Fellow, Menzies

All evaluation team members have undertaken multiple projects relating to mental health, alcohol and other drugs, and social and emotional wellbeing at local and national levels. All team members have also participated in culturally responsive trauma-informed care training.

Ethics Submission

A critical part of conducting research and evaluation with a high level of integrity involves obtaining ethics approval from a certified Human Research Ethics Committee (HREC). Since Stage 1 and 2 of the PLEP received full ethics approval on 1 August 2019 (HREC Ref. No. 2019-3426), the evaluation team prepared an ethics amendment application to extend the ethics approval for Stage 3 and make amendments to the protocol. The HREC agreed to the inclusion of an additional qualitative component of the evaluation with approval obtained on 17 March 2021 (HREC Ref. No. 2019-3426) (Appendix A).

Aims and Objectives

The primary aim of the evaluation of Stage 3 of the PLEP was to describe the delivery of the My Recovery program by upskilled local Facilitators in Darwin. The main evaluation objectives were to address the effectiveness of the program that was further contextualised by Facilitators and to identify the challenges, opportunities, key learnings, and issues experienced by Facilitators during the PLEP program planning and delivery.

The main evaluation questions were the following:

- What are the main characteristics of Program Participants' mental health and or AOD journey?
- What are the main reasons for enrolment?
- What are the most valuable elements and skills in the program? And the areas for improvement?
- What is the program's self-perceived impact on Participants' mental health and wellbeing, including their experiences with the CHIME model?
- What does personal recovery mean for Participants?
- What are the enablers and barriers in the recovery process?
- What experience do Participants have with the peer-to-peer approach?
- What are the Facilitators' challenges, opportunities, and key learnings?
- What are the lessons learnt throughout the PLEP that could support the transition and post-pilot implementation of the program?

The evaluation also involved the development of a Transition Plan to inform and guide the future implementation of the peer-led education and delivery program in the NT (subject to the availability of future funding). The Transition Plan was prepared separately by JS leading the evaluation team and is included as Appendix B.

Thus, the evaluation (1) contributes to building robust evidence-based information of a peer-led education and recovery program to inform mental health policy and practices; and (2) provides recommendations related to future iterations of PLEP beyond the pilot phase.

Evaluation Approach

Recruitment of Program Participants

The PLEP staff employed by the Coalition directly recruited My Recovery Program Participants using a purposive sampling method. Enrolment in My Recovery programs was by self-nomination and referral. This process was supported by collaborative partnerships developed in Stage 1 and 2 with Steering Group members, local mental health and AOD service providers and peak bodies. Coalition PLEP staff promoted the My Recovery program at information sessions organised with the support of collaborative partners and through online campaigns. Word of mouth recommendations by previous My Recovery Participants was also an avenue of self-referrals.

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

- over 18 years;
- having lived experience of mental health, trauma or AOD related issues;
- resident in Darwin and or Palmerston; and
- providing informed consent.

Evaluation Study Design and Data Collection

The evaluation applied a qualitative approach similar to Stage 1 & 2 involving individual interviews with Program Participants and Facilitators from April to October 2021. Facilitators, Lead Agency Representatives and Sectoral Stakeholders were also invited to participate in a Transition Plan workshop in September 2021.

The PLEP Project Officer (also a Facilitator) introduced the evaluation team to Program Participants at the commencement of each interview. An evaluation team member explained the intent of the evaluation to Program Participants, and the Information Sheet (Appendix C) was provided to them. It was also explained that participation in the evaluation was voluntary. A Consent Form (Appendix D) was also provided for those who agreed to be involved. The evaluation interviews with Program Participants were conducted at the Nightcliff Community Centre, Darwin.

Participants provided sociodemographic details at the beginning of their interview. This included age, gender, country of birth, the main language spoken at home, the highest level of education, employment status, housing situation, relationship/marital status, number of children, satisfaction with family and friends, and Indigeneity. Then, Participants were given space to share as little or as much they wanted to about their mental health journey. They were also asked about the perceived program impact on their journey, overall experience with the program, areas of program impact, questions relating to the framework for personal recovery, and COVID-19 impact on their life and recovery journey. They also had space to provide any further feedback about their involvement in the program. The Interview Guide is included as Appendix E.

Facilitators were asked about their background, experience with the delivery of the My Recovery program, peers skills, facilitation skills, future aspirations, domains relating to the framework for

personal recovery, and COVID-19 impact on their life and Facilitator journey (see Appendix F for the interview guide).

In support of the development of the Transition Plan, relevant key stakeholders were invited to participate in a workshop where they were involved in activities around the following topics: (1) preferred team for implementing PLEP on an ongoing basis; (2) required steps, tasks and timeframe; (3) risks associated with the transition and risk mitigation strategies; (4) ideal post-project environment; and (5) necessary transition resources. One service provider Participant in Alice Springs participated in a separate online interview covering the same questions (see Appendix G for the interview guide). The Transition workshop and Facilitator interviews were completed at Menzies, and one individual interview was conducted online via Zoom.

Interviews were audio-recorded with Participants' permission and transcribed verbatim by a professional transcription service. No identifying information was used for the analysis and presentation of the results to ensure anonymity. After each interview, Participants were contacted by the evaluation team and allowed to provide feedback on their interview transcript. This was an important form of member-checking to ensure the accuracy of the details shared.

Evaluation Participants

Program Participants

My Recovery Program Participants (n=14)

PLEP Facilitators delivered four programs in Stage 3 between February and September 2020 and four more in the Extension to Stage 3 between January and September 2021. In total, 55 individuals participated in the My Recovery program through these stages. Out of them, 14 Program Participants agreed to partake in the evaluation. The table below (Table 1) presents the evaluation Participants' identified sources of referrals. It shows that while community mental health and AOD sectors were still popular referral sources (similar to previous stages of the PLEP), in Stage 3, online campaigns and word of mouth referrals were also important for program recruitment.

Table 1 – Referrals of evaluation Participants involved in Stage 3 and Extension to Stage 3 evaluation

Referral Source	Frequency (N)
Online campaign	5
Word of mouth	2
Community Mental Health NGO	4
Homeless & AOD Rehab	3
In total (evaluation Participants)	14

The post-program individual interviews (n=14) were conducted with My Recovery program Participants between April and October 2021. NTK conducted all interviews with the Program Participants. The Coalition provided Participants with a $30 Woolworths Essential voucher as an acknowledgment for their time at the completion of their post-program interview. This could not be used to purchase alcohol, tobacco, or gambling products. Those Program Participants who shared their experiences with the co-design activity and peer skills training (see page 12) received an

additional $40 voucher. During the data analysis processes, Program Participants were denoted as PP and allocated a number to protect their anonymity in presenting evaluation findings. At the start of each interview, Participants filled in a My Recovery consent form used by the Coalition if they had not completed it previously. The following table (Table 2) summarises the evaluation Participants' sociodemographic information (n=14).

Table 2 – Sociodemographic characteristics of evaluation Participants involved in Stage3 and Extension to Stage 3 of PLEP

Sociodemographic variable	Frequency (N)
Age	
20-29	2
30-39	3
40-49	5
50-59	1
60-69	2
70-79	1
Gender	
Male	5
Female	9
Other	-
Country of birth	
Australia	14
Other	-
Main language spoken at home	
English	14[1]
Other	-
Aboriginal and Torres Strait Islander	
No	11
Aboriginal	3
Torres Strait	-
Aboriginal & Torres Strait Islander	-
Unknown	-
Highest level of education	
Less than Year 10 or equivalent	1
Year 10 or equivalent	1
Year 12 or equivalent	1
Vocational Qualification	8
Bachelor's degree	1
Postgraduate degree	2
Other (please specify)	
Current employment status	
Employed	5
Self-Employed	-
Domestic duties	-
Student	-

[1] One person mentioned that they also use Indigenous Tiwi language at home above English

Unemployed	5
Unable to Work	-
Retired	1
Other (please specify)	3
Housing situation	
Owner / Mortgagee	3
Public Rental (affordable housing)	-
Private Rental	5
Unstable housing situation	4
Other (please specify)	2
Relationship/marital status	
Single	9
Relationship	3
Married / De facto	-
Other (please specify)	2
Number of children	
0	8
1	2
2	2
3	-
4	1
More than 4	1
Satisfaction with relationship to family	
1 (not at all)	1
2	3
3	5
4	4
5 (completely satisfied)	1
Satisfaction with relationship to friends	
1 (not at all)	-
2	-
3	6
4	6
5 (completely satisfied)	2

Program Participants in the Influential Stakeholder Team[2]

Recovery Together co-design Program Participant (n=1)

Local Facilitators conducted a co-design process to inform the development of a local recovery program more appropriate for the Darwin context. Former My Recovery Program Participants were invited to partake in the co-design activity series. An average of 12 Participants attended each session. The newly developed and presently named *Recovery Together* program incorporates the PLEP Facilitators' learning and My Recovery Program Participants input. NTK conducted an individual interview with a My Recovery Program Participant (n=1) who was also involved in the co-design activity. This Participant shared their experience with the co-design workshop to support the pilot

[2] Influential Stakeholder Team include the key stakeholders who contributed to the program co-design and transition of the pilot project, such as Facilitators, lead agency representatives, sectoral stakeholder supporting the transition of the pilot project, and Program Participants involved in the codesign and/or peer work skills training.

Transition Plan. In this capacity, this Program Participant was denoted as an Influential Stakeholder Team member.

Peer Work Skills training Program Participants (n=6)

The extension to Stage 3 of PLEP allowed the PLEP Facilitators to deliver a non-accredited Peer Work Skills Training program. This provided a skills-building opportunity for former My Recovery Program Participants. Non-accredited peer work training is an intermediary skill-building opportunity for people with lived experience of mental health and related challenges before enrolling in Certificate IV in Peer Work. Six former My Recovery Program Participants (n=6) attended the Peer Work Skills Training. They shared their involvement in the Peer Work Skills Training during the evaluation interviews that NTK conducted to inform the Transition Plan. These Program Participants in this capacity were also denoted as Influential Stakeholder Team members.

Influential Stakeholder Team

Facilitators (n=2)

In Stage 2 of the PLEP, 11 Participants graduated as My Recovery Facilitators. By the beginning of Stage 3, only nine local Facilitators remained engaged with PLEP, as one Facilitator moved interstate and another wanted to explore other work. By the start of the Extension of Stage 3 of the PLEP, only five Facilitators stayed connected with the project. NTK proposed interviewing each Facilitator to identify the challenges, opportunities and key learning gained in the pilot project. Two of them could not participate for personal reasons. Two Facilitators withdrew before the data analysis process for the following reasons: not satisfied with their own answers and not feeling competent with answering the question because of limited experience as a My Recovery Facilitator. Therefore only two PLEP Facilitators' (n=2) interviews were analysed. The information they shared was used to support the transition plan development. In the data analysis process, they were denoted as Influential Stakeholder Team members to protect their anonymity.

Lead Agency representatives (n=3)

The Coalition PLEP staff, including the Project Officer, the Peer Educator and the Chief Executive Officer, were invited to partake in a three-way group interview supporting the pilot Transition Plan. The Project Officer and Peer Educator were also upskilled, local Facilitators. NTK interviewed the Lead Agency Representatives in a group interview session to gather the key lessons learnt in the pilot and support the transition plan development. In the data analysis process, they were also denoted as Influential Stakeholder Team members to protect their anonymity.

Sectoral Stakeholders supporting the Transition Plan (n=17)

The Menzies evaluation team, including the two project leads and an Aboriginal Project Assistant (n=3), organised a Transition Plan workshop on 20 September 2021 and invited 26 relevant sectoral stakeholders, including mental health service providers (non-government), NT Government representatives, commissioning representatives, relevant peak bodies, Aboriginal and Torres Strait Islander stakeholders, and key Facilitators with lived experience of mental ill-health to support the development of a structured plan about the proposed transition of the PLEP beyond the pilot. Table 3 presents the workshop Participants' affiliated sector. The workshop lasted 2.5 hrs with 15 Participants who participated in group discussions that covered the previously mentioned topics (see page 10). The evaluation team delivered a presentation (Appendix H) about the PLEP program in

collaboration with the Coalition PLEP Facilitators. A Transition Plan (Attachment B) was prepared separately, highlighting the main findings of the workshop discussions and developing recommendations relating to the future of potential peer-led programs beyond the PLEP pilot phase. This evaluation report includes additional information on the Transition Plan obtained through the previously mentioned Influential Stakeholder Team members and a separate individual interview (n=1) with a service provider based in Alice Springs (based on interest in expanding the PLEP model in Alice Springs). NTK and HG conducted this interview.

Table 3 – Transition Workshop Participants' affiliated sector

Affiliated Sector	Invited (N)	Attended (N)
Commissioning body representative	3	2
NT Government representative	2	0
Community Mental Health NGO representative	7	5
Housing program representative	1	1
Education organisation representative	1	1
AOD peak body representative	1	1
AOD Rehabilitation centre representative	1	0
Homeless and AOD Rehabilitation centre representative	1	0
Religious Charity organisation representative	2	0
Aboriginal and Torres Strait Islander stakeholder	1	1
Aboriginal and Torres Strait Islander Rehabilitation centre representatives	1	0
Aboriginal and Torres Strait Islander SEWB service representatives	1	0
Mental Health peak body representative	2	2
PLEP Facilitators	2	2
In total	26	15

Data Analysis

Framework method was chosen for the data analysis because the evaluation team aimed to link the data back to pre-conceived ideas that emerged from the Stage 1 & 2 evaluation (Boyatzis, 1998; Corbin & Strauss, 2014). Framework Analysis typically uses pre-existing theoretical constructs (deductive approach) to code and analyse data. It also allows to include data-driven themes (inductive approach) to inform the development of the analytic framework (Ritchie & Lewis, 2003). NVivo 12 software was used to manage and organise the data. See Appendix I for the coding framework.

Results

My Recovery Program Participants' Perspectives

This chapter presents Participants' perspectives about, and experiences of, participating in the My Recovery program delivered by the upskilled local Facilitators. It includes information about their (1) mental health journey background, (2) experiences with the program, (3) self-perceived program impact, and (4) personal recovery.

Participants' Mental Health Journeys and Backgrounds

My Recovery Program Participants presented diverse mental health journeys and backgrounds, regularly citing mental health, and alcohol and other drugs (AOD), challenges they have faced.

> *"…my journey was 30 years of alcohol abuse disorder, and I have been trying for the last three years to recover. So as I was recovering, I was realising that the alcohol was masking some anxiety and depression issues that I didn't realise." (Program Participant 14)*

> *"I've had mental health probably challenges since I was in my teens because my dad died suddenly when I was 10, and it just changed our family's direction, and mum was very depressed and became a binge drinker, and it created a whole lot of domestic things… was when I did Year 12 I was very anxious… I was a nervous wreck, and I wasn't sleeping, and I was crying… I didn't want to live." (Program Participant 2)*

> *"I struggled with addiction issues for over thirty years, and it was finally when I was in rehab for the first time that I looked at why I'm an addict in the first place, and it didn't take too much to get in to discover that it was due to some unresolved issues, trauma as well as mental health issues impacting on each other as well." (Program Participant 3)*

> *"Mental health is definitely something I've struggled with as long as I can remember. I usually don't talk about my diagnosis. It's something I'm quite scared of and avoid. I live with borderline personality disorder, and there's a lot of stigma, even in the professional realm. I've also had traumatic experiences growing up, starting from childhood to my adult years. I think probably the most recent thing I struggled with, which was probably a coping mechanism for everything that's happened, was drug and alcohol, things like that." (Program Participant 4)*

The prolonged presence of mental illness, often from their childhood or their teenage years, was prominent, as one Participant shared:

> *"I live with a bipolar affective disorder… it later turned into schizoaffective disorder. As a young child, in my mid-teens, I knew there was something wrong, there was something just not right, and I couldn't put my finger on it, and I didn't have the insight to realise what was going on… and it wasn't until sort of my early 20s I started to develop psychotic symptoms, I sort of had a bad relationship, financial problems, smoked a lot of*

dope and had a manic episode and that's when I was first diagnosed with bipolar, and I sort of spent some time in hospital." (Program Participant 6)

Many Participants had already received a mental health diagnosis, having accessed respective clinical supports. Some of these Participants commented that the biomedical models they had encountered did not result in significant improvements to their mental health and wellbeing.

"I have a lot of trauma in my past… I tried everything through the medical model… I just was worse… I was on the hunt for the silver bullet… when I saw My Recovery when I was in a group setting run by peers for peers, I jumped at the chance…" (Program Participant 1)

"My mental health background, I mean I've been diagnosed with just about everything there is to be diagnosed. I've always been given a lot of medications to try and stuff. I don't like taking medication. I don't like how it makes me feel. Probably my main diagnoses are ADHD and PTSD and anxiety and depression." (Program Participant 12)

There were Participants in the program in support person or carer roles. They were not diagnosed with mental health issues, but they had their own lived experiences of trauma, violence, depression, anxiety, and panic attacks. One of them felt socially isolated as well.

"I've never been diagnosed with a mental health issue. But I've suffered depression, bouts of anxiety, panic attacks, things like that… I was isolated… But my [family member] has mental health issues and dual diagnosis and all that sort of stuff." (Program Participant 11)

" I did the My Recovery program to support a friend of mine… and I participated in [their] recovery from alcoholism… to support him… you could say I am in a recovery mode. I've had 45 years of domestic violence, so I've had to recover from that. In a way, even though I haven't struggled with the mental issues per se, I do know what it's like." (Program Participant 13)

One Participant shared that mental health issues were frequent in their family. The mental health challenges they had faced were overlooked because of other family members' more severe cases. Violence and trauma in the family context were other issues frequently mentioned in relation to addressing mental health challenges.

" I grew up in a household with lots of mental health issues, and I found it very interesting what one [person] said was due to the enormity of the mental health issues of the other people in the family, [their] were overlooked. And I think that that might have been where I was at as well." (Program Participant 3)

"I come from a pretty broken, shit childhood. My father was very violent." (Program Participant 5)

"I've always had trouble with emotional regulation. What else? Anxiety, depression, that sort of stuff. And some black and white thinking… I've got a diagnosis of complex PTSD from childhood, violence there, repeated. And, as a teen growing up, I always struggled with anger and that sort of thing." (Program Participant 9)

Participants' Experiences with the My Recovery Program

Reasons for enrollment and expectation

Participants enrolled in the My Recovery program for various reasons. First of all, they wanted to understand themselves and their mental health challenges better and learn new skills to manage their illness effectively and heal. Some had wanted to make changes for a long time and hoped that the program would give them additional skills in that regard. Craving for a sense of community connectedness and improved relationships with peers and/or family members motivated participation in the program.

"To get more tools to help me manage myself, and to see if I can't change my life a bit, to feel better." (Program Participants 1)

"The main reason was for my [family member]… it really helped with the relationship with my [family member]." (Program Participants 11)

" I think the main reason is just knowing that I needed to make changes and work towards something better. I think I've been doing that for a while… So, I think it was that accepting something had to change. And I've never done a group activity, like, program before." (Program Participants 4)

***"…** so basically I wanted to learn new skills, have a little bit of insight about my mental illness and have a chance to heal as well." (Program Participants 6)*
"Just sort of your rights, understanding yourself and finding a sense of community." (Program Participants 9)

While most Participants did not have any clear expectations about the program, some had heard about it through word of mouth and decided to attend. Most Participants ultimately described that the program met and exceeded their previous expectations post-program completion.

"I was kind of more just curious like I wonder what this is going to be like. Yeah, I kind of went into it. I feel like not really knowing. Yeah, I just thought I'd just see what it was like." (Program Participants 10)

"What I had heard about it sort of formed my expectation… So that's what I expected, and that's what was delivered." (Program Participants 14)

"I guess the only real thing I knew about it was that it was a My Recovery program designed to help with things like mental health, substance abuse and lots of areas like that. So, I think initially I was a bit scared because I thought that that would be things we would be talking about explicitly and, especially in a group environment, which I've never

done before. But, that was very quickly gone, because I think on the first day it was – the emphasis was on having the tools to, I guess, navigate the future and finding that strength and empowerment and making sure everyone feels safe and no risk of re-victimisation or re-traumatisation. And I think that was a really nice surprise and my whole attitude changed. I was like, "OK", like, it definitely made me want to come back." (Program Participants 4)

"I didn't have any. Having been unwell for so long, I guess... I have had so many experiences with things, just maybe not – it's not even that they don't work, that they don't seem to help me so much sort of thing, and so I get to come away very amazed and pleased and supportive of the program." (Program Participants 8)

Satisfaction with the program and facilitation

Participants were overwhelmingly positive about the program and the program facilitation. This was the first experience of peer recovery approaches for many Participants. It was something that they embraced and reported to be life-changing. They enjoyed learning new things, forming relationships, and sharing their experiences in a safe, non-judgemental space.

"I was very satisfied because it's like a journey you invest in with the people that are in there as well. And you form relationships, and you learn more things… And I think there's a certain sense of power that – it's like reclaiming your life power, that it gives when – there's an old saying that a problem shared is a problem halved. But now you've got people that you can share with. You know? Learning – we're all learning together." (Program Participants 1)

"Extremely satisfied. It exceeded expectations. I was pretty reserved going into it…I definitely would recommend it... I think that's the big thing, is making people more aware of the program and that it is available. Because it is honestly life-changing – I think, for me, it's been quite life-changing, just reframing a lot of thoughts." (Program Participants 4)

Participants appreciated the effort placed on building a trusting environment and valued the voluntary nature of the program. There were various ways to engage in the program by applying different strategies that accommodated the content for Participants with different literacy levels, backgrounds, learning styles, and interests. For instance, the Facilitators used art, craft, and visual mediums to satisfy every Participant's learning needs.

"They were trying to make it comfortable for anybody's type of learning style, which can sometimes be a little bit frustrating when you're hanging around waiting for other people to finish things and that, but I understood why. And it was good because I could see how other people learn differently in terms to me… what was sometimes frustrating, didn't upset me but a lot of learning for people was done through doing drawings and this type of thing, artistic type of learning, and I'm more of a visual guy. I like watching videos and reading books and things, so that's how I learn. So a lot of that stuff, I

participated in, but then we learnt it the way that I'd expected it, and it was much easier." (Program Participants 14)

" I can't imagine how it could've been done better. There was lots of opportunities for everyone to engage. And, even if someone didn't want to engage, that was also allowed. It really promoted a trusting environment. There was structure when there needed to be and more relaxed conversations, which I think everything benefited from as well. Excellent, honestly. It was really well done." (Program Participants 4)

The Facilitators ran a co-reflection session at the end of each day. This approach 'planted the seeds' for a co-design process; and helped to support further program contextualisation, particularly for people with AOD issues.

" Sometimes when [they]'d run a group [they]'d say, 'I would like to change the way we did this again because of this, this and that' and that's based on some of the feedback [they] got from the [rehablilitation centre] people and others who'd had a different perception and different expectations, perception, experiences all of that." (Program Participants 2)

One Participant wished to re-enrol and repeat the program because of the positive impact it had on their confidence, illness management skills, and relationships.

"I wish I could've re-enrolled and do the program again. It boosted my confidence, it taught me new skills, and I've learnt how to deal with people and had some - as well as having support in the classroom, and amongst our own recovery program facilitators and the participants, the facilitators went out of their way to make sure that our journey was a safe journey for everybody." (Program Participants 6)

The satisfaction with the facilitation was also high. Participants liked how the Facilitators were welcoming, open, friendly, and created solid group ethics, morals and values.

"They're [facilitators] always readily available to go into it. And they were mindful as well about how we felt. It felt very friendly, very open, and welcome." (Program Participants 1)
"… the facilitator has to be recognised as quite a unique teacher. [they were] very sensitive, very aware. Nothing was too regimented or organised. [They were] flexible and fluid, and [they] listened… [They] got everything off to a good start by group ethics and group morals and group values, and by the time that course had finished, from that bedrock of group values, it was a very good, strong, united little group at the end, where we still sort of have contact with each other…" (Program Participants 13)

Participants were pleased with the program. They emphasised the stepped approach that provided an excellent flow by mapping individuals' strengths, setting goals, and improving their knowledge about their rights and self-advocacy.

" I was satisfied with the program with the way that it was depicted and portrayed to the class that I was a part of. It started off very gentle, had a lot of workbooks, pictures….and then it progressed on to different stages, and the good thing about the program was it focused on empowering people to identify strengths, and when you're talking about My Recovery, regardless whether it's drugs, alcohol, chocolate, coffee, whatever, nothing really happens until someone becomes empowered with their own strength. When they feel that empowerment, it's a motivation to change. There was a heavy focus on identifying strengths, and once strengths had been identified, goals can be set, and between the strengths and the goals, there was a lot of other interesting, supportive data… [it was] quite a cohesive, unified course… Anyone that did My Recovery … would certainly be a little bit more empowered as to the management of sometimes a very nebulous and disturbing state of affairs that they can often find themselves in. " (Program Participants 13)

Practical program elements and skill development

The program included various topics and skill development associated with living with a mental illness. Among the practical activities, Participants emphasised the ice-breakers, observing short videos, celebrating accolades, and praising other group members.

"Ice-breakers are good, and - think the videos were very good. Yeah, I liked the videos very much. It's just good when you break it up with the videos…" (Program Participants 1)

"One of the activities which I thought was lovely on that last day we wrote something on a card for everybody. I did that, and then [they] laminated it." (Program Participants 2)

The program delivery applied numerous theories, models and concepts. One of them was the "Spoon Theory" (Miserandino, 2003), popular among people dealing with chronic diseases. It describes the idea of having limited energy, using "spoons" as a unit of energy. My Recovery Participants resonated with the concept quickly.

"… everyone's got five spoons. And with those spoons, everything you need to do is going to cost you a spoon. It's like an analogy. If you needed a box of tissues, you're going to have to go down to the cupboard and back. That'll cost you two spoons. And if you've got three – and income is a four-spoon job, and you've only got three. And if you're not counting what's going on with you – and that's a good analogy, the spoons thing. So it's like, "oh no! You're a five-spooner!" And that was extremely beneficial to me." (Program Participants 1)

Kintsugi, the Japanese art of putting broken pottery pieces back together, was also applied in the program delivery. It is a potent analog for resilience, self-development, healing, and personal recovery.

" [It] was about … Kintsugi... So, it's like putting a value on your experience or your trauma and sort of shaping it into something beautiful or different. So, rewiring your

brain, it's always difficult. To start from scratch as an adult, it's very difficult. But if you can sort of modify, change some bits to make it more healthy and useful – Yeah, that was one really important thing I learned." (Program Participants 9)

"The one that everybody really enjoyed was this one. I think it's called kintsugi. …, it's where things that are broken, when they're looked at in a different light, can assume an entirely different appearance…" (Program Participants 13)

Without any previous experiences engaging with non-clinical peer approaches, Participants' were amazed by the concept of personal recovery, peer values and models, including the CHIME model (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011).

"One of the biggest things too is the idea of recovery.. So it helped me to see that what is recovery and valuing it. When you've got through enough that you can say to other people, give them hope… We talk about we've got to see hope for others sometimes before they can see hope, particularly when you're not very well…" (Program Participants 2)

" I only know clinical and so this has brought a whole different frame of mind which I had no idea about…. So definitely that there's a different type of recovery and to learn that that type of recovery is possible because, for me, I was like until they're gone I'm not recovered" and it's like "well that's not what recovery is". So definitely learning about what recovery is was a big thing." Program Participants 8)

"Another one that everybody enjoyed doing, I think, were these ones on the CHIME method. Between the handouts, between the theory, between the book and this, nobody ever really got totally bored…" (Program Participants 13)

" …mainly it was a learning lesson about me and about my peers and being a peer." (Program Participants 12)

Most Participants enjoyed the arts and crafts activities and visual elements that provided a kinaesthetic learning experience. Also, they explained how the different learning tools catered to diverse learning styles, which accommodated the needs of each course Participant.

"…So you had the kinaesthetic based learning, you had the auditory learning, you had the visual aids and then you also the facilitators doing the education as well. … so it was different styles of learning that, yeah, put it together to run the course was really great." (Program Participants 6)

" …I think doing the art thing, the – your past, and what you want in the future, and you start – it gets you thinking about – or, "what do I want in the future of my life?" and, "what's more important?" and that. And you get to – it's like art therapy." (Program Participants 6)

Learning about the warning signs and triggers and developing recovery strategies were also significant parts of the program. It supported Participants to implement daily routines and strategies to keep themselves mentally well. The program also taught Participants how they could self-reflect, monitor their feelings, and identify potential changes and improvements.

> *" [I have learnt a] lot about my warning signs and a few strategies to help keep it at bay… Pretty much just knowing what all my triggers are and trying to avoid situations like that, I'd say… The other day I got woken up violently from a pretty good sleep, and I don't really sleep that well at the moment, so I was quite angry, but I had a few deep breaths and remembered what I'm working towards and stopped myself from flipping out." (Program Participants 5)*

> *" It's like just learning to become aware of when I'm becoming unwell, which is really important for me because it can be catastrophic if I end up picking up drugs again. So to understand that I could feel unwell before I get unwell… so it basically – I just got a really good understanding of how and why routine's so important, and I've built… I've made sure that I've tried to stick with getting up and doing something every day…" (Program Participants 3)*

> *"Probably reflecting. Because I actually got to see how far I've come. And how far I've grown. And not only me, but in the relationship with my kids as well. And gain more confidence. Yeah. And knowledge… Some friendship… Connection. " (Program Participants 11)*

Stigma was another significant element discussed and challenged throughout the program, along with the knowledge about human rights self-advocacy, communication, and goal setting. As the following Participants explained:

> *"… well stigma was a big part of it and how to navigate around stigmatising people and how to identify and start learning some control techniques over different challenges that I've had." (Program Participants 14)*

> *"Tackling the dragon, which was very important, stigma and discrimination, because it is a dragon in society and it breathes fire and people that are experiencing it, don't know how to use a fire extinguisher to put it out." (Program Participants 13)*

> *" I think just knowledge and awareness of our human rights and how to kind of advocate and stick up for yourself. Communication styles was really important. But, I think for me, personally, what really shone through was when looking at setting goals, it could be quite overwhelming, especially if things haven't worked out in the past… And having it broken down like that, I've never looked at it like that." (Program Participants 4)*

We asked Participants to give examples of how they had applied the knowledge and skills they had gained throughout their daily lives. One of the Participants provided us with an example of

integrating one of the approaches in their professional life. In contrast, others shared cases from their personal life, describing how they successfully applied different communication styles.

> *" … the use of "I" statements when communicating kind of how to balance that passivity and assertiveness and aggression. And that's definitely something I would use nearly every day, I guess. So, it just kind of helps see situations a bit more objectively and not getting so lost in the emotion of it all and being more of an effective communicator." (Program Participants 4)*

> *" I took some of the things from the group and kind of incorporated them into a training I did with my peer workers, like the broken pot analogy." (Program Participants 10)*

> *" I use it with my kids every day… When we talk about things … I give them the opportunity to openly discuss… And also, too, I'm not as – the guilt is not there quite as much when I do something for myself. Because I really understand now that I'm helping the whole family…" (Program Participants 11)*

The Participant below gave a detailed outline of the whole program, highlighting the importance of implementing various concepts through collages, photos, workbooks and graphic timelines. This person found the history of mental health, recovery, relapse and relapse prevention vital. In addition, communication styles and self-advocacy elements of the program were highlighted as key areas where practical knowledge and skills development occurred.

> *"The workbook and the collage style of implementing concepts, that worked really well. Everybody felt less pressurised dealing with the photos and the collages, and I think it allowed them to allay a lot of anxiety… there was a graphic timeline of the perception of mental illness from the dark old ages. It didn't go into frontal lobotomies or skull trepanning or anything like that, but it gave everyone an idea… [like a] a cartoon-like strip. Not confrontational at all… How the wheel rolls, recovery is a wheel. There's various stages, there's advanced, relapse. A good soldier always has a backup plan… And a really important section was dealing with the professionals: presenting your case for what you want. I would say this is the biggest stumbling block to the advancement of anyone trying to struggle with mental health. Oftentimes, they're doing it by themselves, but in this section, it was very definite as to how you deal with these people and hand in hand with that – I forgot to put – would be communication styles and body language. Legal rights and advocacy: how to go about it, a lot of people don't know it's wrong to do this, it's wrong to say that, it's wrong to subject you to that. Where to go for help was a very valuable handout, and I think I've got it here somewhere…" (Program Participants 13)*

Areas for program improvement

While Participants were very pleased with the program, they provided some ideas on how it could be improved further. They recommended including some Mental Health First Aid (MHFA) and Dialectical Behaviour Therapy (DBT) elements.

" I think one thing that I'd mention was that learning Mental Health First Aid, even if it was not in an official capacity, but if the topic was in the content, would be good. And also, just being able to identify – learning how to identify a mental illness within yourself was something that I thought could be in there as well because not everyone knows that – I didn't know that I had anxiety until I stopped drinking. I didn't know. And it took me a year to realise the feelings that I had were anxiety panic. I didn't even understand it; I just thought those feelings mean that I need to drink. They weren't; it was anxiety. So just identifying those things. So identifying mental illness, identifying different feelings and emotions could be something that they could put in there extra." (Program Participants 14)

" I feel like when you have a group of people who have difficulty regulating their emotions, it's a good opportunity to practice some DBT skills. Because that's one thing that may keep a lot of people out of crisis. And you've got the group there and people with similar struggles. Yeah, I think that's something good that should be put in there." (Program Participants 9)

However, most Participants reinforced the importance of the experiential learning elements and hands-on skills; some wanted more homework. This was influenced by program participants' literacy, profession and previous working experience.

"Probably less bookwork and more hands-on sort of stuff and visual stuff. But that's mainly because that's how I learn rather than - I don't learn from books." (Program Participants 5)

" I am the opposite….I like the workbook. I like being able to read and take homework home and do my homework, so things were really – I'm not really a visual, auditory learner because I like to go back to things because I feel like I don't have a very good memory." (Program Participants 8)

"Probably only to include homework… I think it probably would be better if homework was set… Practicing the skills or reflecting and it may be the people training it….we definitely needed to do something for week in…" (Program Participants 7)

One of the Participants explained that it would be great to block more time to practice using alternative communication styles and how to self-advocate within group contexts.

"I think the area of – like, self-advocacy and how – especially in different environments as well. I don't necessarily know how to, but I think a good idea would be – Because a lot of these communication techniques, practice is really important, so I feel like maybe starting that practice in the room. Almost with some sort of role-play. Have a case study with maybe three sentences, being like, "OK, you're in your job. This is what's happened. Go." Or, "You're at the supermarket. This is the situation. Go." And then you can have a situation of how it went horribly and then feedback. And then do it again,

but with – Yeah. Because, I remember that was really good information, but I think if we just did more with it, it would, I think, stick a lot better." (Program Participants 4)

To make this program more accessible to and culturally responsive for Aboriginal and Torres Strait Islander people, it was acknowledged that further adaptation would be required:

"I'm Indigenous, so it wasn't very - culturally aware... And it was a lot of in the book rather than hands-on sort of stuff, a lot of stuff from the book… Hundred per cent the terminology, the language and a lot of indigenous people can't read or write as well." (Program Participants 12)

The following Participant described that if someone misses some of the scheduled sessions or is part of a group of people with formerly established relationships, it can be harder to connect and build rapport with Participants.

"I missed a couple of sessions due to being away…I think it was like the first three or four I missed, which I think those ones are usually really important, like building rapport, setting the tone for the training. So I kind of came into it a bit later, and I think that made me feel a bit disconnected. I think, in addition, I mean I don't know the process of selecting who goes in which group, but I felt very separate to a lot of participants who were older, had a particular lived experience that I didn't have, so they had all attended a similar facility, and I think they were still attending that facility so they'd come there together…" (Program Participants 10)

This experience indicated some ideas about the recruitment process:

"Because I think peer work it's like you're not going to have the same experiences as people ever but in what I do at my work, you still sort of match people a bit based on some of those things or some of their needs. So it could just be having more of an interview or form or something before joining the group... Or the reading might be a struggle for some or the writing, so just more of a screening to know participants." (Program Participants 10)

Participants' key learnings

Participants were asked about the key learnings they gained in the program. Understanding the difference between clinical and non-clinical meanings of recovery was frequently highlighted. Also, learning about various models such as CHIME and peer recovery model were classified in the key lessons.

"Obviously, that recovery can be something other than clinical recovery, so that's a bit more achievable…" (Program Participants 8)

"Probably the CHIME model…. Probably because it showed the biological, the physical, the spiritual, the environment and something else. Yeah…. I think the holistic approach." (Program Participants 1)

"I had not much idea of the peer model at all. So probably just about the peers." (Program Participants 12)

The concept of self-care was a new method for many Participants, but they recognised its importance and interiorized it quickly. They became more compassionate with themselves and realised their own responsibility for their lives.

"It was the self-care stuff, and that I am the captain of this ship, and it's 95% of what's going on in my life, I'm responsible for… it made me really self-reflect a lot more…" (Program Participants 3)

"…[being] compassionate and I think also I've learnt about self-care, about taking care of myself, having the insights, learning the skills, having the education about saying, right, I live with a vulnerable mind, I've got a mental illness, but it's not the end of the world." (Program Participants 6)

"…how to refocus. Like not to be so hard on yourself…" (Program Participants 11)

Communication, especially learning about "I" statements, was a powerful module within the program.

"I think the "I" statements and the goal-setting with the role models and stuff was very powerful. But, also, I think it's very important that we do have that awareness of our human rights and ways to self-advocate…" (Program Participants 4)

"The impact of words and we have to throw in there, body language. I think body language constitutes 65% if I'm correct." (Program Participants 13)

Knowing the triggers of poor mental health is a vital element of recovery and good mental health and wellbeing. Identifying them and learning how to deal with them were also essential parts of the program. Implementing strategies to prevent relapses was also considered a vital topic.

"Pretty much my triggers and stuff like that and learning a lot about for people that have been in this situation but diagnosed for a long time, they've learned strategies and understand what I'm going through." (Program Participants 5)

"But that was another part of the program, was identifying triggers and how to stop it before it gets to a 10—identifying it and preventing it from worsening. All of it was so useful. That's the thing, I guess ." (Program Participants 4)

"What happens if you fall off the wagon? How to hitch a ride on the next wagon because relapse is a fact of life. It's not a smooth path. How do we say what we want? Words are important, and a lot of other things are too." (Program Participants 13)

Participants experienced how peer support works through reciprocal learning and sharing stories.

"I guess that everyone's just at a different part in their journey, different experiences to share and you kind of through talking to other participants learn something, then they learn from you, and it's kind of reciprocate more than usual. That's what it's all about, I guess, that's how your peer work's best done to learn from each other just through sharing your stories instead of being told this is what will make you…" (Program Participants 10)

Interviews conveyed that Participants gleaned multiple takeaway messages from the program. One of them was the importance of self-reflection and how the program created space and time for Participants to practice it. Mapping strengths to increase Participants' self-confidence and empower them was also essential, as well as providing skills for making connections to be part of the society and identifying hopes to dare to dream.

"Basically, it addressed the desert of loneliness and the despair the person was in, and this was a course that reach out to those particular people primarily. It helped that person find themselves and value what they found. Because oftentimes with mental illness, they don't self-reflect…Whereas here, you've got an interesting course, they've got interesting collages, they've got an interesting teacher, good vibes around the room, so it gives them time to reflect… Implementation of observation of what is needed and how to ask for change that's sort of empowerment. Development of courage to initiate and manage that change and development of confidence. Courage and identification of strength and confidence… Tapping into hopes and dreams, they're not often expressed in the mentally ill. They don't know how to identify what a hope in their life would be because sometimes there's nothing, there is none…. guide ropes for a person navigating society and all those social laws. That is so critical with a person because oftentimes people with mental illness, they don't have the techniques and skills to be a part of society because a lot of their illness is in secret. It's in dark. It's not spoken." (Program Participants 13)

Self-Perceived Program Impact and Personal Recovery

When we asked the Participants to express the program impact on their journal with a couple of words, they listed the following: (1) enlightening, (2) fun, (3) determination, (4) empowerment, (5) empathy, (6) compassionate, (7) CBT, (8) holistic, (9) understanding, (10) informative, (11) healing, (12) emerging, (13) re-engaging, (14) learning, (15) steps, (16) redirected, (17) purpose, (18) confidence, (19) calmness, (20) hopeful, (21) empowered, and (22) improvement (Figure 1).

Figure 1: Program impact on Participants' journey


Empowered
Redirected
Hopeful
Healing
Improvement
Responsibility
Purpose
Cbt
Confidence
Equipped
Reengaging
Calmness
Learning
Steps
Emerging
Fun
Holistic
Empathy
Self-determination
Compassionate
Enlightening
Empowerment
Reinforcing
Informative
Understanding

Some of them provided a longer description of the program impact. It gave them a better understanding of themselves and tools to make responsible decisions about their lives.

> *"This isn't a couple of words, but I just want to say it. An area that we covered in the courses where all that was really significant was the psychosocial environmental models. Because, like I said earlier, we can be our harshest critics. So, having a deeper understanding of why we do things, not excusing the behaviours, but I feel like as we develop the understanding, we're more equipped to not make the same decisions again. And, it's like, "Oh, it's not because it's all my fault, it's because this happened. But, now it's my responsibility to do something about that." (Program Participant 4)*

> *"It redirected me. It opened wounds, but that needed to be opened." (Program Participant 2)*

The program created relationships and connections among the Participants and gave an increased purpose and value to their lives.

> *"It made me feel less alone by the end of it." (Program Participant 9)*

> *" … it gave me purpose and made me feel like I was a real person, and I had something valuable to give." (Program Participant 12)*

It also helped them better understand the stigma and its impact and reduce self-stigma. The program created a safe and open environment, encouraging Participants to connect and share without being judged or stigmatised.

> *"I think definitely a reduction in self-stigma because I guess I'm a pretty guarded sort of person." (Program Participant 10)*

> *"There's more openness. More willing to talk about things… And also, too, it gave me a little bit of, "Oh my god, I'm not alone…" (Program Participant 11)*

> *"So the program just really helped me connect with people, a lot of good people, and it's also let me talk openly and freely about my journey of my mental health without being stigmatised." (Program Participant 12)*

The concept of personal recovery

In contrast with the clinical concept of recovery that focuses on symptom reduction, personal recovery implies a meaningful life defined by the person themselves. It is underpinned by the following domains: connection, hope, identity, meaning and empowerment (CHIME) (Leamy et al., 2011). We asked the My Recovery program Participants to describe recovery with their own words.

Many Participants acknowledged that recovery is not a linear and smooth way. It involves ups and downs, and the key is to be prepared.

"Personally, recovery to me is when you can see a light at the end of the tunnel. And when you can be thrown a curveball and not break." (Program Participant 11)
"Recovery means – life is ebb and flow." (Program Participant 1)

"Recovery to me is not using drugs and having a clear head without paranoid thoughts and feelings and just being able to think clearly and going in the right direction, taking steps forward instead of taking steps backwards." (Program Participant 12)

"With recovery, I guess the imagery I use for it is being in the ocean and having waves come. And sometimes the water's calm, and it's easier to swim, and sometimes it's really rough, and you're struggling to catch breaths between waves. But, what I learnt here as well is knowing when you need rest and to recharge. Like, when to just kind of lay on your back and float for a while, instead of exhausting yourself trying to swim against a current. And, for me, I think it's always going to be a lifelong journey. But, I love learning, fortunately. So, I think that's life for everyone anyway; it's very dynamic." (Program Participant 4)

"Everyone experiences some highs and lows, and as such, they probably would balance it out more." (Program Participant 7)

Learning, developing practical skills to manage symptoms and stress, practising self-care, progressing, setting goals, and recognising tiny steps could always assist in moving forward whatever happens.

"So to me, recovery was biological, physical, mental, and spiritual, and it's making progress in all those areas. So I'm one of those type of people that would always consider myself in recovery because I don't think that there's – I don't believe there's any human being that can't benefit from growing in all of those areas right until the day they die. But for somebody who's struggled with mental illness, it's even more important to be aware of that." (Program Participant 14)

"I think reflecting back on the My Recovery program, and what My Recovery, what it meant for me was it was a spiritual journey that took me out of my comfort zone, exposed me for my - maybe not exposed, but it opened up doors and allowed me to learn more about myself and have more skills to be able to manage my own mental illness and my own stresses." (Program Participant 6)

"It means to be healing from being unwell. Like I said, I get a bit mixed up with my AOD recovery as well, but that sort of – this, my mental health recovery was crucial once I got drug free… I mean "all I've done"; it was a monumental thing, but I wasn't progressing personally at all. Yeah, I was just stuck in a hole. So I needed to – I knew I'm healing, so my recovery is me healing, but also learning things along the way to be self-aware for – because I had another little slip-up and went down a little bit, but yeah, I knew what to do; I'd know get out of the house…" (Program Participant 3)

"I don't think I have a definite – like I have now more of a holistic idea of what recovery can include… knowing that exercise is actually helping like it's actually a medicine sort of thing… and the thing we were taught is the first thing when you get up is get up and make your bed because you've already done one successful thing for the day, you're starting your day off on a good keel. So it's like it's doing those small things, but actually, those small things mean a whole lot more than somebody telling you who doesn't even really know you." (Program Participant 8)

"I think recovery is removing barriers to miscommunication. So, basically, adjusting the lens that you view the world into a more accurate and clear picture." (Program Participant 9)

In addition, self-compassion, self-advocacy, and recognising the personal strengths and triggers to tackle mental health challenges were also frequently mentioned as critical parts of personal recovery journeys.

"Recovery is I think, being able to understand yourself better, know what you need, and to be able to get those things like speak out, advocate for yourself and being in a place where you can do those things and get the things you need and want basically." (Program Participant 10)

"I'd say it's a state of feeling comfortable in your own skin. Not necessarily fearful, but knowing what your strengths are, having tools to tackle life on a daily basis." (Program Participant 13)
"It's a journey to knowing more about yourself and being true to your own values, and having resources and skills that when you're starting to think hang on, I could be at risk here, and risk could just be going down or being too negative, to be able to recognise that, that's part of recovery, and to actually do something about it…. knowing what my triggers are or my risks are – other people have them too." (Program Participant 2)

One Participant aptly described personal recovery, highlighting the importance of being independent, responsible, and living life in the most meaningful way.

"Recovery for me would be back living on my own, on my own two feet with my dogs. That would be recovery for me." (Program Participant 5)

Recovery Process

We asked Participants about the factors that contributed and interfered in their personal recovery. Making friendships and connections with like-minded peers and Facilitators was one of the most significant contributing factors in the recovery process, particularly creating a sense of community and connectedness.

"I think the connection with other people. The friendship with the facilitators. I think it's the stories that you hear from either participants. Because as we learn together." (Program Participant 1)

One Participant also described how their pet supported personal recovery.

> *"My dog […] has definitely contributed to my recovery process. Being able to do My Recovery and then go on to do the training in the Cert IV of Mental Health and Peer Work. That has just been mind-blowing. It's given me direction, and it's given me purpose, and I think that's awesome. Definitely massive, big help." (Program Participant 12)*

Above the peer community, the below Participants also recognised the role of some local service providers in their recovery.

> *"… probably being around like-minded people and […] and a couple of other organisations that helped me. That would probably be the good parts." (Program Participant 5)*

Participants emphasised how the combination of clinical and non-clinical approaches contributed to their recovery. They appreciated both, highlighting their complementary roles.

> *"So definitely programs – like this was the major stepping stone for me with the first one was this – was the My Recovery program." (Program Participant 3)*

> *"So, once I found one [mental health professional] that ticked all the boxes – It's amazing, a massive difference. Someone who actually listens, but they also – they're educated, have knowledge, and they actually want you to be better." (Program Participant 9)*

> *"… insight and education and empowerment, determination and just that knowing that the great thing about the My Recovery program was knowing that there was other people out there that were going through the same thing that you were." (Program Participant 6)*

The recognition of having control over their lives and taking responsibility for their own recovery was considered a positive tipping point. As one Participant shared:

> *"I think the biggest thing for me was probably like I guess the turning point was realising the opposite of what every health professionals that ever told me is that I can fix me. Until I realised that I was in charge of it and it was my responsibility and these things would only work, even some of the therapies, the CBT and all that, would only work if I wanted them to work, if I committed to them, if I took that ownership…. a contributor to my recover was me and realising that." (Program Participant 10)*

Participants described external and internal factors that interfered with recovery processes. Personal choices, decisions, fears, addiction, and not being ready for recovery were considered interferences.

"Probably my choices, my personal choices….myself, being a long-term self-sabotager, and a person that's had problems with drugs as well, and alcohol." (Program Participant 1)

"I guess something that makes recovery a bit more challenging would be myself. And maybe not always making the right decisions." (Program Participant 4)

"What's hindered my recovery is probably just drugs." (Program Participant 12)

"I think that things that interfered were I think it's that general fear kind of response. I think so many times I dropped off from the services… I think probably maybe not being ready…" (Program Participant 10)

With respect to external factors influencing recovery processes, Participants mentioned inappropriate help from health professionals, people from the past, and local organisations.

"…not having good clinicians, I guess the way they handled my care or my information. Yeah, it kind of depersonalises it… It was very easy to get me off guard pretty quick." (Program Participant 10)

"Interfered? ignorant people." (Program Participant 11)

"What has interfered is people, places and things from my drug-using… I had a confrontation with someone a couple of weeks ago, and I ended up with a migraine, so I'm still – life is interfering with my recovery…" (Program Participant 3)

"I'm drug-free, but there are still people everywhere that are on drugs, my old people." (Program Participant 12)

" […] company has interfered like they love to do." (Program Participant 5)

" …like medication theories, seeing doctors, dealing with Centrelink and all those other issues. So and I think dealing with that sort of stress…" (Program Participant 6)

"Mental health professionals with too much ego and not enough empathy… They made things quite difficult." (Program Participant 9)

Having lived experience of mental health issues and/or related challenges does not guarantee being a good peer. One Participant shared if a person with lived experience does not follow peer values and respective peer frameworks, this could expose them to danger and interfere with their recovery.

"What hasn't contributed is an unhelpful peer, so even though this person works in mental health, they don't have those things that a peer needs to be a safe peer… even just discounting your experiences or something like that or not empathising with you or something, just a dangerous person and I don't know if it's maybe they've had their

mental health challenges and they haven't learnt what's in the My Recovery program to be able to be a safe person for other people sort of thing…. [having lived experience] doesn't mean you're going to be a good peer, 100%." (Program Participant 8)

Peer-based approach

Peer-to-peer interaction is best led by agreed peer values and peer practice principles. Participants were asked about their experiences with this approach. They all expressed positive experiences with this approach, citing the benefits of a shared understanding, mutuality, support and safety.

"I thought it was fantastic. Because we're all part – we're all on the same team. And you automatically feel a little bit like they understand. Because you go to the doctors, and how many times do you fight with the doctor? Because you're telling him, and they don't understand what you're saying to them. But you're telling them, and they don't understand." (Program Participant 1)

"I think it just made me more comfortable to share would be I guess the biggest one… safe to share." (Program Participant 10)

"It was awesome. I didn't have a doctor telling me what was wrong with me or a psych telling me what was wrong with me and how I should fix it. I had a group of people who had a similar sort of journey to mine saying how could we work together and what can we do to help ourselves…Equal, definitely an equal playing field. Yeah. And I felt more in control of my recovery." (Program Participant 12)

In addition, developing supportive relationships with their peers provided them with a sense of connectedness that was genuinely appreciated. It also encouraged them to open up step-by-step and be part of a broader peer community network.

"People are still connecting. I think probably, it's a way of somebody finding their own tribe and feeling comfortable because it's always good to test out the waters and the shallow end of the swimming pool before you go in the deep end, and this was just the wading pool where people with mental distress in any forms. I don't know what constituted the problems of the people in the group, but it's a baby pool. Getting in, wetting your feet, doing collage, and finding that you're not the only one that has problems, so it's a very supportive, and they're still supporting one another out under the tent out there." (Program Participant 13)

Peer-to-peer communication was considered empowering for everyone engaged in the conversation. It supported forming a small peer community consisting of individuals with empathy and increased understanding of stigma and mental health challenges.

"It was empowering to the person who was talking and to the person who was giving and receiving information. It was empowering, and it was more like it was a community where there wasn't really – it doesn't matter what you did or what your issue was, we're in this together to try and help ourselves." (Program Participant 2)

"…it was such a great program, and it helped me develop skills, learn about myself, learn about others, and it was like it was a supportive support group for people that live with mental illness, that could talk about their own struggles, talk about their own journeys and empower people, lift people, build networks, support each other in the community." (Program Participant 6)

"I think those overall sense of the – like, a stigma, more understanding – More empathetic. I think that's where it just provides a different perspective. And, like I said earlier, it's not like we're going back and digging up past traumas, but understanding that we're all there for a reason..."(Program Participant 4)

The CHIME Model

The CHIME framework for personal recovery is a comprehensive framework consisting of five domains, namely: connectedness, hope and optimism, identity, meaning in life and empowerment (Leamy et al., 2011).

We asked program Participants about their relationships, future and goals, mental health challenges and changes after the program, the adversity they faced, and if they want to use these experiences to help others. We aimed to identify their experiences relating to each domain of CHIME.

Connectedness

Connectedness refers to having good relationships and being connected to other people in positive ways. It is characterised by peer support and support groups, support from others and the community (Leamy et al., 2011).

One of the most visible impacts of the My Recovery program was the emergence of a local peer community. Participants that reported feeling socially isolated stepped into a supportive local peer group with a sense of belonging. It helped them to develop supportive networks and quality friendships.

" I felt like I had a network now, and it was professional and also like a friend, social sort of group as well." (Program Participant 10)

"I've gotten a lot more support and made friends, it's helped a lot really." (Program Participant 5)

"… just feeling a sense of community, sort of – Yeah, it's like an oxytocin experience almost. Just feeling like you aren't alone, and people don't – That other people get it, have similar struggles." (Program Participant 9)

"I've got more quality friendships. My interactions with people are better because I think I choose who I want to speak to, and I can duck and weave the ones I don't." (Program Participant 1)

Participants from situations of absolute social isolation found their own 'little family' among their peers.

> *"I was actually really lonely before I did the My Recovery Program. I didn't have that many people I could talk to or anything. So after doing the My Recovery, I made a good network of people doing – all through the – I've met some really good people like […] is number one. And [they] have been such a great support. The people I've met they just want to support you and help you in any way they can, which is beautiful." (Program Participant 12)*

> *"I was chronically isolating, and I sort of – that was a part of my drug recovery… So I just cut everyone out of my life because I had to. I didn't know anyone in Darwin that was drug-free, or I hadn't used with. So I was really isolated, and then – but I got to a point where I knew it wasn't doing me any good at all, and this program was my first stepping stone into reengaging with the world again…it feels like I've formed my own little family there, so yes, it's helped me heaps." (Program Participant 3)*

The program also assisted Participants to improve their relationship with their family members:

> *"I guess the main person up here as far as family would be my son. And I probably persevered with him probably more than I would have if I hadn't done the program." (Program Participant 6)*

Hope and optimism

This domain refers to having hope and optimism that recovery is possible; and relationships that support this. It is characterised by motivation to change, positive thinking, valuing success, and having dreams and aspirations (Leamy et al., 2011).

Participants envisaged a future for themselves, and they were hopeful about it.

> *"… it helped me to see at that stage that there was a future for me, that I did have people that loved me…. it gave me a reminder that there is a bigger world out there and that maybe my future wasn't so bad after all." (Program Participant 2)*

> *"[I am] More positive about the future. I have spent a long time not knowing that there was one, so – still don't know what it looks like but… have this little idea that I just keep doing my thing and keep mixing with these guys, little things will happen…" (Program Participant 8)*

Setting goals and actions and being motivated to get employment were among the key factors Participants identified in relation to generating feelings of hope and optimism.

> *" I'm looking to get back into work." (Program Participant 3)*

"… being able to kind of recalibrate and be in a position where I can make goals and not – Yeah, just make them more confidently and actually believing that it's not just words on paper, these are things I can actually work towards." (Program Participant 4)

"I think it reaffirmed some ideas of the goals, and it reaffirmed that action needed to be taken. I couldn't just sit around and wait for things to happen. So I think it had a motivating effect." (Program Participant 14)

One Participant expressed their hope and optimism with the emergence of the local peer recovery movement.

"I don't think too much about [my future], to be honest…I think I was more hopeful, not necessarily for myself but for the future of mental health and peer support and services available. Because it was kind of like a movement, so I was more hopeful for other people and more hopeful … this to be leading that change with organisations." (Program Participant 10)

Identity

This element of CHIME points out the importance of regaining a positive sense of self and identity and overcoming stigma (Leamy et al., 2011). Participants described the positive sense of their identity with faith, capability, self-awareness, sensitivity, compassion, empathy, calmness, feeling of being accepted and understood, and self-respect.

"A lot has to do with my faith, and I am probably more faithful than I'm not." (Program Participant 7)

" I'm feeling more capable of working towards goals… I think this group is actually a huge part of that." (Program Participant 4)

"I'm more aware and a little bit more sensitive to people… it's given a bit of direction, a bit of self-respect in that oh, I do have something valuable that someone wants to listen to…" (Program Participant 2)

"…it helped me by being calmer and felt like I was understood and accepted…. So then I was also – so the defences were going down… So they were slowly going down and down and down." (Program Participant 11)

One Participant emphasised how the program supported overcoming stigma, while another Participant stated it helped them to 'be yourself'.

"When you talk about a mental illness, the first thing that comes into people's mind is "Oh, he's mad, he's nuts, he's crazy. He's been in and out of county ward", you know, so but having a support group like My Recovery sort of helps break down the stigma of mental illness in society and these groups help with determination, empowerment, they

teach empathy, compassion, and as a group, we lift each other up in the community." (Program Participant 6)

"I guess the main example I'll use is my relationships within the group, just because I have moved here recently and I'm kind of scared to make friends… And we've really gotten to know each other. And I'm kind of less scared to be myself, I think, whatever that is." (Program Participant 4)

Meaning in life

This element of CHIME means living a meaningful and purposeful life, as defined by the person, not others. It is characterised by meaning in mental 'illness experience', spirituality, meaningful life and social goals. (Leamy et al., 2011). Participants had the following experience relating to this domain:

"Being introduced to the whole idea of peer work and that sort of thing… I feel pretty good…. I'm looking forward to starting something and live within my values." (Program Participant 9)

"It helped me with a lot of strategies to maintain mental health, and it also taught me a lot about stigma and how I can be of help to other people." (Program Participant 13)
"I've found that in this program that it helped me understand my goals and helped me find a – using my goals helped me find a purpose and a meaning as to why I'm doing what I'm doing." (Program Participant 13)

" …my goals would be to do the facilitator training and go as far as I can with that to help others like myself." (Program Participant 12)

Empowerment

Empowerment refers to having control over life, focusing on strengths, and taking personal responsibility (Leamy et al., 2011).

Participants identified their strengths and made plans to build on their experiences and help others in their personal recovery. Their adversity made them empathetic, compassionate, and expert in related challenges.

"Oh my God. I had a lot of difficulties in my life. Growing up from a pretty traumatic background full of drugs... I've certainly learnt a lot…I've got – I look at it as I've got 30 years' experience of what not to do. So I look forward to helping other people who are on a similar to journey to mine as I was. I look forward to helping people get through their journey... Well, I can use what I've gone through. I've got a wealth of knowledge. I've got 36 – 34 years of experience to be able to help people make right decisions and just guide people." (Program Participant 12)

" *Sometimes you can't go through storms with other people unless you've gone through your own storm, so if your life is rosy, you can't sit with someone who's [life is not]…" (Program Participant 8)*

"I think sometimes people that have tougher experiences and face more adversities are sometimes more open and more understanding and willing or have less assumptions of other people and what they're going through…" (Program Participant 10)

Focusing on strengths and learning new strategies supported Participants to be prepared for challenging times.

"I can say that it's getting easier to dust myself off and stand back up when I do fall down, which is refreshing, that I can sit here and observe that from the past. I guess that's an exaggerated of life, nothing is going to go smoothly all the time, and there's going to be challenges. And just feeling that sense of preparedness for if things do go sideways, makes all the different. And this was a huge part of that." (Program Participant 14)

The challenges Participants faced made them empowered, strong and resilient. They were driven by self-improvement, learning and compassion. The following Participant expressed how their recovery journey experience made them confident in pursuing a career in supporting others.

"I think mental illness is about lifelong learning and the more insight you have about your own particular mental illness and it's about your own journey, then that's empowerment within itself, and then education is very powerful, so that's part of everybody's journey, about knowing their illness and knowing and being able to talk openly and about their struggles to empower and lift other people…. looking at the peer support model and the My Recovery model for my recovery and my own journey is that it sort of makes me want to pursue a career as a carer or helper, help in the community break the stigma of mental illness and work with people with mental illness in the community service world." (Program Participant 6)

"Life hasn't been easy for me, certainly. 17 years domestic violence with my parents and my years from 30 to 60 were full of domestic violence, back-to-back… All of this developed very high resilience and acute appreciation of danger, but none of this made me a nasty or bitter person. In fact, what drove me, more than anything, was self-improvement. So, there were all of those little experiences and that time in my life was also abusive. I've come out of it, I think, pretty strong, and it takes a lot to bring me under, to bring me undone, and anybody that's had all those experiences that I've had, you've seen life in its grittiest and nastiest and its roughest. It gives you an enormous sense of compassion for people that you deal with." (Program Participant 13)

Influential Stakeholders' Perspectives: A Complement to the Transition Plan

The Influential Stakeholder Team included My Recovery Facilitators (n=2), Lead Agency Representatives (n=3), My Recovery program Participant involved in the co-design of the local recovery program (n=1), Peer Skills Training students (n=6) and an Alice Springs-based service provider representative (n=1). They participated in individual and group interviews to support the pilot project transition and the development of the local peer workforce alongside the Transition

Plan Workshop. These people represented expertise in the community mental health and AOD sectors in various roles involving living or lived experience of mental health and related challenges representatives.

Emergence of the Peer Workforce: *My Recovery Program Delivery by NT Local Facilitators*

My Recovery Group Characteristics

The My Recovery program was delivered to different groups such as women, men, and mixed groups. Every group was diverse, as the Facilitators below explained:

> *"So the very first program…was with a large group of women only, and that group was incredibly diverse. We had quite a few First Nations participants… We had young people from – and older people and middle-aged people from that cohort. And also a mum with kids who there was support provided for that…. Also had middle-aged and older-aged ladies from an Anglo background who'd been living in the Territory for a long time…attending a drop-in program. "(Influential Stakeholder 13)*

> *"The second program was a mixed group. It was a day program, and it was made up of participants who – low socioeconomic background, people who were long-term unemployed, people who were…. very new in their recovery journeys. We also had First Nations people, older, younger, working professionals, peer students or people interested in pursuing peer work. Aboriginal and Torres Strait Islanders, and people who were in the justice system." (Influential Stakeholder 13)*

The program was delivered in various schedules, including morning, afternoon and evening programs with one or two sessions per week. The morning class was dropped because it did not work well.

> *"We only ever did one morning one and – It's not great in the morning. We just dropped it…. With daytime programs, we have a combination generally of people who are at, say, the [homeless] program, then people who may have seen social media or had a first-person referral. What we tended to see in the evening programs is that they were people who'd seen the social media campaigns and were more likely to be working. Bit of a mix*." *(Influential Stakeholder 12)*

Delivering the program over nine weeks presented challenges, as many things can happen in the Participants' and Facilitators' lives in this timeframe. Thus, condensing it may make it more accessible for some Participants—for example, a six-week program with two sessions per week. A Facilitator also reflected on the lengths of each session and considered the 2-2.5 hours session to be optimal.

> *"…that in a period of nine weeks, and this is just like a personal reflection, that in a period of nine weeks I'm probably going to have two meltdowns or life kind of, maybe not crises, but dramas…Which would mean that there may be time in there where I'm unable to continue with the program, or I'm going to be absent, and so those interruptions do result in absences which impact the group dynamics, and you end up*

behind in the content. So it's a challenge as a facilitator to deal with that."." (Influential Stakeholder 13)

"People can get unwell; stuff comes up in their life. So, maybe all of a sudden they have to move house. So, we did see that a couple of times, but we tended to see those people come back and try and do another program." (Influential Stakeholder 12)

Participants and their referral sources varied in these groups. For instance, the afternoon class showed a good fit with rehabilitation programs, while the evening class attracted more people who worked during the day.

"We found that to fit in particularly with the rehab programs, we would need to do after – So, we tried to set up the time, so it was after lunch, and they could be given a lift to wherever the training was and then be picked up in time for dinner. So, the afternoon slot worked really well." (Influential Stakeholder 12)

In the women-only group, persons with non-English backgrounds faced language barriers that resulted in their non-completion of the program. The history of domestic violence in these groups also presented challenges.

"A lot of these ladies didn't speak English as a first language and so chose to self-exclude part way through the program because they weren't able to access it because of cultural appropriateness, literacy… And all of these women disclosed a history of domestic violence and abuse, and that was really important in the group being the safety of women only, but was also a big challenge because the violence perpetuated, some past, some present and ongoing, really impacted participants' journeys of the program." (Influential Stakeholder 13)

Overall Experiences with the My Recovery Program Delivery

The program was perceived to be transformational for the Participants and the Facilitators. The Facilitators enjoyed witnessing Participants' recovery, opening up, and engagement with the recovery concepts. They also liked the professional journey they went on in the pilot project.

"…people opened to you with trying on and trying out the program, the concepts, and the ways of working. And that's a big thing for people to try things out and think differently. And so I felt like it was definitely this shared journey for participants, and for myself, in engaging with these recovery concepts and with people's lived experience, and the peer learnings that were generated out of the program… it was transformational for people, but also for myself… liked the professional development and the professional growth journey I went on." (Influential Stakeholder 13)

"I think my best experiences are seeing the participants recover in front of my eyes. Especially when I reflect back to my first conversations with them where they might have been incredibly apprehensive about coming to an information session. And then watching them as relatively isolated individuals actually bond as a group and really value

each other's lived experience and wisdom. And then that just changes the paradigm of how they see themselves. So, I think that transformation is absolutely the best experience about doing it. "(Influential Stakeholder 12)

On the other hand, the Facilitators also faced some challenges related to the pioneering nature of peer work in the NT and the lack of senior peer leaders. This draws attention to the importance of Facailitators' supervision to protect their own mental health and wellbeing.

"So the flipside of that is whilst it keeps you well and strong, it's also incredibly taxing, especially if you are very new to the recovery pathway. And for someone such as myself in the Northern Territory not having an existing experience seeing your peer workforce, I went through the whole thing on steroids, and that was utterly emotionally and cognitively overwhelming… I didn't like the fact that I wasn't supported by anybody, not because there weren't willing people to help but because a local knowledge base and lived experience leaders didn't exist here, so we had to do it in a very do-it-yourself fashion." (Influential Stakeholder 13)

The My Recovery program was co-facilitated. This approach was considered compulsory from a work, health and safety perspective, as the below Facilitator stated:

"*The co-facilitation process is absolutely mandatory. You would not put a person in that role without a co-facilitator; it'd be risk to the facilitator and risk to participants. Because of the degree of … 'trauma stewardship'. So because as facilitator, whilst we don't work in trauma, we don't provide therapeutic psychological support; we are custodians of the stories, which are trauma stories, that people bring. "(Influential Stakeholder 13)*

The Facilitators need to trust each other, feel safe, and share their workloads to maintain the program integrity and keep themselves and Participants safe. Without appropriately skilled and trained Facilitators, professional collaboration skills, trusted working relationships, preparation work and mutual support, the co-facilitation could be stressful, risky and unsafe.

"What I think worked really well was facilitators having enough time and mental space together to really prepare in a way that would make a program satisfying, not just for them, but for the participants. So, that preparation beforehand. I did work with some co-facilitators who were really short on time so, that preparation phase was just before a session; it felt stressful. Whereas when I did it the day before with co-facilitator we had fresh minds; we'd get excited, then I'd go away and get the last couple of bits and bobs I needed for the session the next day. And that worked really well. The other thing I think was incredibly and worked really well, is really a must, is that after every session is the reflective practice that the co-facilitators do together." (Influential Stakeholder 12)

"So one of those challenges is if the person doesn't truly partner with you to do the huge amount of preparation work, the professional relationship building you need to do with a co-facilitator to be able to effectively do it, to be able to hold each other's

psychological safety, because there are times where you have to call on the facilitator to either support you, step in, manage somebody in distress, change directions of the program because of the – where the group is at". "(Influential Stakeholder 13)

Preparation work was found vital, including commitment and time to do some reading and research into the content areas, seek information about the existing local services and policies, identify additional resources and tools, learn the content, build the relationship with the co-Facilitator, debrief and be confident.

"Time and commitment is how you prepare." (Influential Stakeholder 12)

"I needed to do a lot of research to search for local information… had to do a lot of research to go and find resources and tools that could be adapted and used in our context because those didn't come as a part of that program… And learning the content. A lot of – and just spending that time building a relationship and a practice with your facilitator, so every week, or prior to a session, spending about three hours working through the content" (Influential Stakeholder 13)

The constant feedback and co-reflection processes provided throughout the program ensured professional learning opportunities were identified and that connectedness between the Facilitators and Participants was built in a cohesive way.

"…the professional learning is one of the best parts about it. So you get that role modelling which enhances your professional development and keeps your professional practice on track, especially when people don't know enough about professional peer practice. The inherent feedback loop about your facilitation skills, and that mutual support which you need because you're still in recovery as a facilitator." (Influential Stakeholder 13)

"… when we could all come together fortnightly as a larger group and have an intentional big group of co-reflection as well as on top of the little ones that the co-facilitators did after every session, that was actually really good for professional development. And also connectedness between the facilitators." (Influential Stakeholder 12)

Using Lived Experience Intentionally – Peer Values

The Facilitators discussed the importance of connectedness, supervision, and peer values as contributing to the success of the training.

"… peer support is recovery, and that as a peer professional, I need to remain connected to my peer community, but most importantly have access to peer supervision." Influential Stakeholder 13)

"How important peer values are and how the vocational pathway into peer support has got to be built around peer values. If there are other reasons motivating a person to

enter the lived experience workforce more generally, then it's going to cause challenges. So, yeah, the peer values, mutuality, empowerment, empathy. They're just really, really important. Non-judgment. Valuing lived experience." (Influential Stakeholder 12)

Experience, hope, empowerment and mutuality are peer values discussed during interviews. The peer Facilitators used their lived experience intentionally, thoughtfully, purposefully, and mindfully to encourage and support the recovery of others.

"It's absolutely thoughtful and intentional. It's not random; it's not – none of it is even about you and your recovery, in your journey, what you're doing. It's for the other person. So, when your lived experience is shared, it's principally to promote recovery in the other person. And that might be about possibilities, that might be about how you found empowerment or overcame the challenging times. And it's also not to highlight how bad your dark times were or to sit in your dark times." (Influential Stakeholder 12)

"…to be judicious like that, to use it really purposefully, intentionally and mindfully, so in a way where it doesn't cause harm to others, where it – the purpose of it is about hope and recovery and empowerment, it's not about you… It's more about the relationship that you cultivate in identifying that, hey, I have lived experience. So the need to actually share it through talking about it, or sharing parts of your story, are actually quite rare." (Influential Stakeholder 13)

Using lived experiences of mental illness with intention poses significant challenges. There is potential to reinforce discriminatory, stigmatising or disempowering behaviours, whether intentional or not. On the other hand, sharing these experiences with peers can also create a positive space to reduce stigma, build confidence, and enhance support.

"I think one of the challenges for peers, or lived experience advocates more generally, is thinking through what you'll share with what audience… I feel quite comfortable being open about most things with peers and participants. I feel very differently in an organisational context or … where … I don't know people in terms of their stigma, or there's an opportunity for them to discriminate against me, or I feel that they're a person who intentionally or not intentionally would seek to disempower me. So, that's the challenge, really. In terms of opportunities, I think in sharing your lived experience, you have the opportunity to just smash the shackles of stigma for people. And that in itself is empowering to you to do that and to see that effect impact." (Influential Stakeholder 12)

The Growth of My Recovery Facilitators' Skills: Learning and Professional Development

Knowledge Development

While the upskilled Facilitators involved in Stage 3 of the PLEP were committed to personal growth and co-reflection activities, some were not ready to perform the Facilitator functions because of their limited understanding of key roles and responsibilities, frameworks that underpin peer work, and a lack of understanding about trauma-informed practices.

"I reflect on were people that didn't necessarily go on to continue facilitating, and I guess that's to do with some of the things that they struggled with. What everybody did really well was to commit to being a peer, to peer support. What they didn't do well, I don't think was necessarily – you couldn't ascribe any blame or lack of effort or will, but not understanding the role, not understanding, not having a deep enough understanding about the practice frameworks they were working in, not having those skills yet, so that readiness." (Influential Stakeholder 13)

Some Facilitators demonstrated a deep commitment to their work. Their skills grew significantly by participating in webinars, joining working groups, familiarising themselves with policies and frameworks, and studying Certificate IV in Peer Work units. The additional learning enabled them to develop their confidence and to use their own tools and practices as they saw fit.

"So I've done an absolute tonne of personal research and learning. I've attended webinars, I've joined working groups, I've attended conferences online and watched presentations and speeches. I've familiarised myself with policy, legislation, practice frameworks, international – what's going on in the international space. I did the components related to peer work in a Cert IV." (Influential Stakeholder 13)

Participating in the peer work units was a turning point throughout PLEP, drawing attention to professional development benefits. Knowing that there are very few senior peer-workers in the NT to help support the mentoring of Facilitators was critical.

"We did the Wellways facilitator training. Then, the MHACA[3] project enabled us to do to Cert 4 units. And that was a critical turning point in the project because we realised the professional development we hadn't had as peer workers. And that was 18 months into the project that we did that, I think. It should have happened at the start, but you don't know what you don't know… Also, just having someone senior in the lived experience workforce to connect with and reflect with would've been vitally incredibly important. I think all of our lessons were valuable to learn, but if we hadn't had – They were painful to learn, in ways" (Influential Stakeholder 12)

Characteristics of a Great Peer Facilitator

The characteristics of a great peer Facilitator were described aptly by one Participant:

"Authenticity, flexible thinking, empathy, commitment to personal growth, commitment to other people's personal growth, role model. Self-aware about when to talk, when not to talk. Someone who tries to empower not just their participants but their co-facilitator… So, they need to have deep understanding of recovery and the enablers for recovery… They got have well developed communication skills and be aware of power relationships, highly self-aware of their potential power in a facilitation role. They need to have an understanding of how to support someone to self-advocate." (Influential Stakeholder 12)

[3] This is the Promoting Peer Work project, delivered by Mental Health Association of Central Australia (MHACA) and funded by an NDIS Information Linkages and Capacity Building grant.

Above that, they also need good mental health literacy, a deep understanding of peer values, and knowledge and skills about suicide prevention and mental health first aid. In this pilot project, the Facilitators had to do some psychosocial education because many Participants did not have adequate information about their own mental health conditions and the available resources or people they could access in the community. Feeling confident as a peer Facilitator is necessary to empower Participants to get the information they need and help them make informed decisions about their own personal recovery.

> *"… they absolutely need good mental health literacy, because our population of participants has not been provided with enough information to themselves have good mental health literacy about their own diagnosis. Our facilitators also need to know what is in role and what is not in role when talking about recovery opportunities or medical interventions. We don't tell anyone any hard definitions for what's right and wrong. What we need to do is empower them to get the information and make the decision for themselves. And I think that was a real challenge, seeing maybe another facilitator have a really firm definition about what recovery means to them and trying to project that onto people. That's not appropriate" (Influential Stakeholder 12)*

Peer Facilitators need to have a particular value set, including the ability to collaborate, to be self-directive and commit to learning. Leadership skills and critical thinking are also required to be a good peer Facilitator.

> *"The only ones that I would emphasise are the ability to collaborate with other people, with other facilitators, the ability to self-direct their own practice, the ability to research, learn, integrate that into their practice, to commit to it. So there's definitely a value set there. Leadership skills, you can't do it if you can't be a leader, so it's not for everybody. It doesn't mean to say that peers can't be great peer workers in all different contexts, but this is very unique and sophisticated. And they really have to be open to critical thinking. Well, not open to. They need to have skills in critical thinking, or at least build them, to do ongoing reflection, to receive feedback, to do critical feedback with themselves." (Influential Stakeholder 13)*

The Facilitator expressed that they wanted to be involved in external supervision and further professional development sessions to improve their peer and facilitation skills. This included intentional peer support programs, structured group co-reflection activities and cultural training.

> *"Professional development skills for me would be – I'd love to do an intentional peer support program. For me, where I am at now… I do find myself in a position as a leader and almost like a senior worker, and so for me learning about leadership skills and supervision skills to support my colleagues and my peers would be really helpful. "(Influential Stakeholder 13)*

> *"I would probably say it's less about hard facilitation skills and more about structure around me, having regular external supervision, having access to more structured group co-reflection with my peers and the time to do that would be helpful… Professional*

development sessions to maintain and improve your skills. I'd just like more cultural training. And a deeper understanding of less Western ways of viewing mental health. Because I feel like it was one of the things that My Recovery was missing for our population" (Influential Stakeholder 12)

One Facilitator also described the importance of adopting the stepped approach in training peer Facilitators and workers:

"My other recommendation is before putting anyone through a peer facilitation skill; you need to put them through an entry-level peer work skills training, a non-accredited. I like the idea of having it really clear in the organisation's mind how that maps to professional skills so that that training can be recognised and not repeated. I think those peer work values, peer work skills, ways of being and doing, they have to be bedded down before you can take a person to the next level of facilitation. And facilitation skills are another skill set, and they've got to go on top of the peer work skills. " (Influential Stakeholder 12)

Emergent Facilitators need knowledge and skills in recovery, not just lived experience as it is described below:

"…[they need] sophisticated knowledge of recovery, not just lived experience, recovery experience, self-awareness and the ability to self-regulate and to self-reflect – so for a person to be able to do things like self-exclude, they need to be aware of what's going on for them and to have the professional capability to know when they can't hold that duty of care appropriately or when they might need some support….. So whilst there's definitely scope for people to identify as peers and contribute to peer spaces and to do peer work, peer facilitation is at the leadership end of the scale." (Influential Stakeholder 4)

Utilising Gained Skills: a Locally Co-designed Resource

Beginning of the Co-Design

PLEP staff acknowledged the importance and impact of the My Recovery program on the emerging local peer workforce. That program has been the focal point of the current peer movement in the NT. However, they also recognised that the program in its existing structure is not accessible for many people in the local community, considering the diversity and uniqueness of the NT.

"…the sector is in a different space to what it is interstate, and that's obviously really important in the learning. And then when you throw in that with the differences in the territory and the need to provide something that doesn't have such a high level of literacy or numeracy…. it also really impacts how small the community is sort of thing… I think part of the learning just is that we are different and why we were different and maybe, in the beginning, not realising what some of those differences were and why it had to change – and I'll also just emphasise, I think, what you […] were saying, probably the only way at the start was with the current licensed products because you don't know what you don't know. And I think that's just really important throughout all of this to,

one, recognise that it was a pilot, and it was new, and it's part of the learnings is." (Influential Stakeholder 3)

Facilitators delivering the program have recognised that they were missing key concepts in the foundation of peer work.

"… we had facilitator training without ever having peer work training. And facilitation skills are their own unique set of skills. And so we really missed a foundational part of our vocational development in hindsight… But even before we made that recognition around that missing vocational development for ourselves, we were delivering the program, and we were going, "This is not really feeling perfect." (Influential Stakeholder 2)

My Recovery Facilitators made amendments to the Facilitator Guide at the beginning of Stage 3 of the PLEP. This was monitored further throughout the delivery of the program. The My Recovery Facilitators recognised that even with the program contextualisation in Stage 2 of the PLEP, the program content was impenetrable for some Participants because of population diversity in the greater Darwin region. As the Facilitators gained confidence with the delivery and participated in professional development, they made changes in the recruitment process and delivery of the program, such as applying more visual elements and incorporating additional content.

"Probably toward the end of Stage 3, where we'd had some confidence to make the delivery of the material more visual and creative, we had better retention and participation of, I would say, more culturally diverse people and Aboriginal and Torres Strait Islander participants. I think that that explorative, visual way of delivering the same content appealed more broadly". (Influential Stakeholder 12)

"… the questions in that original recruitment process, or expression of interest process, were not representative of the skills, attributes and values were really needed. So, by the time we did the second recruitment process, we had done some research on peer workforce, the types of position descriptions, interview questions based on… some really good international documents…Then we also made it optional for people to do an interview-style expression of interest, knowing that what we were looking from them were verbal skills as opposed to written skills. And if we had asked everyone to do a written application, we might've triggered insecurities in them and also, we might not get the best representation of who they are and how they can facilitate. So, there are my reflections on recruitment" (Influential Stakeholder 12)

"Part of that was looking at the participants' faces and how they responded and some of the things they said. And it was also, "What would we like?" But it was only with experience delivering programs and developing confidence that we were able probably to go, "This concept here, let's change the way we deliver it so that the concept and the learning is still there," but we were better meeting the needs of our community." (Influential Stakeholder 2)

They also used complementary materials such as the Social-Emotional Wellbeing (SEWB) Model to discuss mental health and wellbeing concepts, or image cards, concept maps, and short videos to support the understanding of the program content. Also, they used additional PowerPoint slides and handouts, short videos, and an A3 scrapbook to create a visual journey.

> *"… to discuss the Aboriginal and Torres Strait Islander social and emotional wellbeing model as another conceptualisation or model to consider when we're thinking about mental health and wellbeing… And I also prepared things like concept maps to help explain the relationships between things, and in particular, I had to do that for teaching the services maps. Also, things like the rights of people having – accessing care." (Influential Stakeholder 13)*

> *"It was just an evolution, I think, of our facilitator skills and knowledge and – We were very open to feedback from participants, and so some of these things were suggested by people in the previous programs as well… We really noticed that some people were highly visual and engaged with images. So, I created quite a few sets of image cards… Then by the last program, when we got the A3 scrapbook, we didn't just have those pictures laminated; we had copies of them. Then they could take the picture, cut it out, stick it in their book and then write the reasons around why they picked that picture. Instead of having, say, three lines in their logbook where they would write some words. So, they had a real visual journey." (Influential Stakeholder 12)*

My Recovery Facilitators received continuous feedback from Participants that identified the strengths and limitations of the program and their experience. The co-reflection process supported recognising the need to co-design the program to make it more accessible for the local community.

> *"… in every session, we facilitate a checking in and connecting activity, and then a checking out activity where we reflect on the day. Some of that was about the experience, some of that was about the content, some of that was just about whatever people wanted to offer. So that was an ongoing feedback mechanism. Participants also really openly offered their feedback about the strengths and limitations of the program and their experience of it. And so I did a lot of work with my colleagues capturing that and feeding that back, and I actually put together quite a few documents of looking at each module of the program, areas for improvement, what we could do to do better." (Influential Stakeholder 13)*

Former My Recovery program Participants were invited to be part of the co-design activity series to discuss the program elements, what worked well for them and what did not, and how they could make it better to be as good as possible for everyone. As the below Participants expressed, they were glad to provide input in a safe place, be part of the local peer movement, be surrounded by their peers, and be heard and valued.

> *"…I felt valued. I felt heard, and I felt like I had a validated opinion, and I was useful. That was bloody awesome… It was a good process to get all that lived experience in*

the room because there's – the saying goes 'nothing about us without us', and it was great to have that input." (Influential Stakeholder 5)

The co-design was generated organically and was driven by program Participants. They engaged with the peer recovery concept and experienced the peer community's connectedness. In the co-design process, they could reflect on the various elements of the program and how they helped them in their own recovery.

"… the co-design process that emerged – perhaps from the beginning unintentionally – was that as people experienced it for the first time and being connected with the peer community… they were able to reflect on what use the different parts of the program had been in their own lives and their own recovery… And so, as it went along, the codesign elements just became clearer and clearer because people engaged with the concept but wanted to make it a reality here. So that's why codesign was important because it was generated, I guess, organically."(Influential Stakeholder 4)

"They came on the – everyone jumped on the train, and they were coming to us really inside and outside of the codesign – because even some of the peers who weren't part of the codesign would come and go, "I've got a really great idea for how you can run this activity." So they were on the bandwagon about it." (Influential Stakeholder 2)

The co-designed process included different activities and strategies as the following person described:

"And there were different levels of codesign, I suppose, and strategies. Some of them, we realised, had happened retrospectively along the way in an ongoing dialogue. And again, it's inherently in the nature of peer work and the peer role, is that reflection, but then also, moving onto some more formalised activities and engagements with different people in the community to co-design workshop sessions and then following on in the peer work training and facilitation skills components, the codesign continued on with that. And we've been collecting different documents and stuff along the way." (Influential Stakeholder 4)

Upskilling A New Cohort of Facilitators and Peer Workers: Peer Work Skills Training

Background and Reason for Enrollment

Training Participants represented a broad and diverse background, involving working or volunteering in mental health, AOD rehabilitation, education, the justice system, and having lived experience of violence, AOD issues, bipolar and anxiety disorder, depression, and family members of an individual with mental health and/or related challenges.

"… in my case, a huge, violent, powerful man and my mother had an undiagnosed illness. I don't know whether it would've been borderline personality or schizophrenia. I grew up in a very remote timber town... It was a dysfunctional, little, isolated community." (Influential Stakeholder 9)

I've been volunteering at the rehab. I did a rehab course, and then I volunteer there now. I've been there since January. I'd done three months, and then I'd done the rest of the time just volunteering, going in and stuff and running programs. It's been really good." (Influential Stakeholder 8)

"So I've covered […], covered […], I went to […], I've done the Sinclair Method, that also involves some peer work but on social media, some interactions with media, lots of public speaking and sharing my story. I've shared my story in interviews on YouTube, shared my story in public with politicians in the NT and shared my story at GROW meetings, GROW functions and AA meetings…. I've done various volunteering, mainly for GROW, some for AA, and some for – little bits and pieces for suicide prevention. Also looked after my brother as a carer for six years. So that was some experience I've had. But mainly it's lived experience through the alcohol abuse disorder." (Influential Stakeholder 10)

"I have worked in mental health, I've worked in prisons, I've been a probation and parole officer. I've done a lot of teaching." (Influential Stakeholder 9)

Peer Work Skills training students described the reason why they had enrolled for the training. Most of them were invited after they participated in the My Recovery program. The motives were to gain employment, learn new skills, deepen their understanding of certain mental health issues, support a friend, experience being included 'in the community', and obtain a further qualification.

"…I was asked to…I was sent an invite. But I'm glad I did [it] because I've wanted to do something like that…I love – it's food for the brain. Otherwise you just sit there in a bloody frigging ploopy mess… I like to keep the brain going and things like that. And even just with a room full of different people, you're learning new stuff anyway without even the content. And I'm not antisocial, but I'm not one to run out into social gatherings and things like that, but these sort of things I do like to go to… it's a good way to actually be included in the community and feel like you're part of something and things like that, which makes you better in yourself." (Influential Stakeholder 6)

"Because I want to gain employment in the area, so it was a great opportunity that I couldn't say no to." (Influential Stakeholder 8)

"… my mother had nervous breakdowns and, as such, I wanted to understand my mother better." (Influential Stakeholder 7)

The below Participant outlined the stepped vocational pathway in peer support that is considered an optimal way to grow the local peer workforce in the NT.

"… my philosophy in life is the only way you can really get a community or get yourself out of poverty is through education. And so initially, when I enrolled into My Recovery, I wanted to learn about myself, identify my issues and give something back to the community, but then that was step one. Then step two, which was Peer Work and Skills,

and again it was I guess that we learn about our issues, but we start to learn about to gain skills to be able to work with our issues but work with other people. And I think that the next step is to - it leads onto further education, not to forget there's a certificate for peer support…" (Influential Stakeholder 11)

Students also liked that the peer-led education and recovery approach presents a novel way to deal with mental health and related challenges in the NT.

"…it was an area that I wanted to learn more about. And also, I like the fact that it's in its infancy, it's a pioneering area for the Northern Territory, and I like to be involved in things that are new and proven to be working… working with peers in this area in the NT, no one knows about it. I know a little bit about it through what I saw at the rehab. That guy was the one we listened to. So I can see that an industry could be built around well-trained peer support people, and I'd like to be involved in that." (Influential Stakeholder 10)

While some Participants felt disempowered and de-humanised by being pushed through the clinical system, the My Recovery program and the Peer Work Skills training gave them hope, empowerment and encouragement. The non-clinical approach offered a therapeutic journey enabling Participants to support others on their own journey.

"I've been more pushed through a clinical structure, so I've got a diagnosis… and you go through the medical models…and the health sector is very regimented where they point the finger and say, "Right, you can't do this, this, this, this, this and this."… it's almost like being de-humanised, you're actually pushed through a system, you're not treated with their respect or dignity, and you're looked at as a number rather than an individual person with individual issues… it's easily, it's so very easy to get caught in that system… caught in this vicious system and cycle… Whereas a peer support or this Peer Work Skills Training and My Recovery it breeches outside the paternalistic system of the health system, and it offers determination, it offers hope, and it offers encouragement, and it gives people a bit of an insight into some of their own illnesses and how to manage their own illness and be able to work back into the community…it says, "All right, we've got issues, but those issues, we shouldn't be judged for those issues"… I've learned about those issues and be able to use those issues to help other people, and it's a therapeutic journey that takes you outside of that paternalistic system, it puts you - and gives you that and makes you feel more human, and you treat it with respect." (Influential Stakeholder 11)

Reflections on the Training Content

Training Participants engaged in detailed conversations about the training content, schedule, teaching method, skill and knowledge the training covered, and the key learnings. They touched on the facilitation – peer - and communication skills, role modelling, trauma-informed care, building trust, and creating a safe place and mutually empowering relationships, and strategies for addressing stigma.

"In part one in My Recovery, we talked openly in group discussion, but in part two [Peer Work Skills training], there was a little bit more of an expectation that we had to give this about a five-minute speech to a class, and then our own experiences about our life experiences and dealing with trauma, identifying trauma and being able to speak openly in front of an open class about our issues and feeling comfortable about talking in front of an open group. And that was a hard task because it was emotionally confronting to say that we were all exposing ourselves to a whole class of strangers. So we were talking about our innermost personal issues and our secrets and our hurts, and talking about it in front of a group of people which was, it was very scary, but afterwards, it was therapeutic to actually be able to… express how you feel, to have that stress lifted from your shoulders." (Influential Stakeholder 11)

"…you just learnt different techniques of teaching a lot of self-soothing things, check-ins, trauma – like trauma-related. So it was like a sort of a softer version of educating… there was a facilitator skills in there as well. So it was all wrapped up." (Influential Stakeholder 6)

"My Recovery was asking us to learn how to recognise ourselves and personal growth, and this was teaching us how to professional behave when you're working with other people." (Influential Stakeholder 10)

"… we learned a whole lot of new techniques. So we were able to learn about ourselves, and we were able to identify the issues that we had within ourselves, but we looked at the time model, we talked a little bit about CBT's, Cognitive Behavioural Therapy, and we looked at mental health as a timeline… And I think that the skills that we learned we learned about ourselves, we learned about our issues, we learned techniques like counselling for non-counsellors really, and we learned about the peer support work, we learned about lived experience, and we learned about using ourselves as a point of contact to be able to help other people." (Influential Stakeholder 11)

One student considered that the teaching method in the peer work skills training enabled everyone in the group to succeed; how the program was structured also supported a deeper understanding of the content.

"the course doesn't babytalk to people. They're introducing topics here which are really universal level. Salutogenesis and pathogenesis, flourishing versus floundering. Now, I thought that was great in the course. They need to know that. They need to know that there are models that depict why you're having such a damn hard time—social determinants of health. For example, government policies, values." (Influential Stakeholder 9)

"… it's a softer way of educating… it's good because it gives everyone a chance because there are some people that – well, I mean, I remember myself growing up, you'd call it a test. Oh, I'd go to water. Whereas if I didn't realise it was a test, I'd be all right. So there

is a lot of people that don't like the pressure or the things like that. So it's just – it caters for more people probably is a good way to say." (Influential Stakeholder 6)

"It [Peer Work Skills training] was a lot easier to work with this than what it was with My Recovery because My Recovery was unstructured. This, structured." (Influential Stakeholder 9)

One Participant also emphasised that role modelling was helpful in the program, especially how the Facilitator put that into practice.

"Well, there was a part of the situation where they taught about training and role modelling…and there's part of the training that looked at how to put it into practice… I found useful the role modelling, the way particularly [the Facilitator] put it into practice" (Influential Stakeholder 7)

The training taught Participants how to facilitate a group, be trauma-informed, and support someone from an equal relationship that builds on mutual empowerment, trust, shared understanding, and respect.

"Facilitating and how to be trauma-informed and just working beside someone not above somebody, so working with people and you're not the boss, you're not the leader or anything… you're just trying to help them through their journey and push them to be make the best decisions for them… And then facilitating and then how to create a safe space… How to do activities to get the group warmed up and build trust up and stuff." (Influential Stakeholder 8)

The Participant below provided a detailed overview of the program, pointing out the importance of understanding concepts such as adversity, trauma and stigma and their impact on mental health. It was also confirmed that the My Recovery and the Peer Work Skills training are empowering courses, mapping out the strengths and using recovery language.

"And once again, what's appearing here is mapping strengths. They're still doing it in here, they're still carrying it through, and that's the link to this My Recovery is those strengths… the most important part in the course was session four. Now, session four, because if this isn't understood, nothing works. Impacts on mental health: adversity, trauma and stigma. If you don't get a good grip on all of that, what came before it and what you're expected to do after it, it just won't cement…Now, what was really emphasised here in this course was stigma is the most serious obstacle in the field of psychiatry. I read that, and I thought, "Yeah, that marginalises. It mainlines people. It isolates. It destroys confidence. It wrecks the ability to engage and a whole lot more…This was an empowering course, and it focused on recovery language, as opposed to being a helper, instead of being a support. Empathy, respect, personal experiences and mutual support. It was strength-based, which starts with, once again, identifying strengths. What's strong in that person that I am trying to support? As opposed to what are they suffering from or what's wrong, which is often the way of diagnostic

intervention helps. The course promotes vision. It's solution-focused. It's got hope, resilience and a better ability to cope with difficult times." (Influential Stakeholder 9)

One non-Indigenous training Participant acknowledged and valued the Model of Social and Emotional Wellbeing (SEWB)[4] over the CHIME model[5], highlighting that trauma is not just an Aboriginal issue, but it also impacts the non-Indigenous population.

"I personally didn't identify much with the CHIME model in this. I was more with the Aboriginal models…[the SEWB] because of heavy, heavy, heavy trauma in my background, that was more fitting for me than [than the CHIME]." (Influential Stakeholder 9)

Students increased their self-confidence, connectedness and public speaking skills while also learning how to be trauma-informed, engage in a group, and be prepared for a potential peer worker position.

".. [key learnings are:] how to interact and engage in a group. How to apply your personal lived experience in one-on-one setting. How to actively listen. How to just be there for somebody. What to expect in the workplace as well as a support worker, so things – just preparing us about what we might see if we get a job in that field. We might see certain things and preparing us for that." (Influential Stakeholder 10)

"I think it's being able to sit down, talk to people, learning public speaking, learning to feel comfortable within a group, feeling comfortable within a group setting, network with other people… I like that part about public speaking; I like learning about myself, I like hearing stories of other people when it's saying, "I'm not the only one with issues, there's a lot of people with issues, and we're all going through the same journey together." (Influential Stakeholder 11)

They appreciated the potential of the vocational pathway that the training offered. In addition, participating in the My Recovery and Peer Work Skills training empowered them, gave them hope and meaning to see the adversity they had experienced as an experience they can use to support others from a remunerated peer worker capacity.

"I've already run groups and stuff before. And to be on my way to get my certificate is bloody gold." (Influential Stakeholder 8)

[4] This model refers to the broad term of social and emotional wellbeing that is the foundation for physical and mental health for Aboriginal and Torres Strait Islander peoples. It has seven overlapping domains: body, mind and emotions; family and kin; community; culture; country; and spirituality and ancestors. Also, it includes nine guiding principles, such as holistic health, right to self-determination, needs for cultural understanding, the impact of history in trauma and loss, recognition of human rights, impact of racism and stigma and recognition of the centrality of kinship (Australian Government, 2017)

[5] CHIME is one of the most accepted theoretical frameworks to understand personal recovery. It stands for Connectedness, Hope and optimism, Identity, Meaning in life and Empowerment (Leamy et al., 2011)

"… it's like the old saying that you might have academics that spend years and years at university and they might go on to do psychology, but when they finish university they can't get employment because they've got no life skills, but you've got people that have got all the life skills but go no qualifications so why not tap into [it]." (Influential Stakeholder 11)

Training Participants were satisfied with the course and how it was delivered. Those who had an expectation reported that the training exceeded it. They also expressed the demand for non-clinical programs and training and outlined the respective benefits for the broader community by reflecting on people's mental health and wellbeing and promoting employment opportunities for those with mental illness.

"I had a little bit of expectations, but it exceeded my expectations by a lot. Just the amount that I learnt and stuff and the content. It was quite good. And I learnt a hell of a lot during the skills training. It was bloody good." (Influential Stakeholder 8)

"[The Facilitator] did a very good job. She had an excellent person working with her. I don't have anything but the highest regard for them, but the thing that I was very mindful of too, is that it is peer-to-peer. Both our facilitators, which was really nice to see, everybody exercised a duty of care towards them." (Influential Stakeholder 9)

"… why isn't this course being offered to people - why isn't it offered through Charles Darwin University, or why isn't it offered through Batchelor Institute of Indigenous Tertiary Education? It's a good course, there is a need for it, there's a need for this course in society where there are outcomes, whether people want to learn to go on and become a skilled practitioner and be able to have been an experienced worker and get employment out of it, or whether they just want to learn about it themselves and learn about other people and to know that the journey they're going through is not an individual fight, but there's a lot of people that are going through the same thing…why aren't we invested in investing in training like this?… you look at the results that we've experienced just in the small group that we've had; the course offers so much, offers so much academically, spiritually, therapeutically, and I think people should be able to tap into that." (Influential Stakeholder 11)

Areas for Improvement

Some students struggled with the intensity and the content of the course, especially those in the early stages of their own recovery or who have not been studying for too long. However, the Facilitators and some individuals in the group were there to support them to succeed through a process of mutual support.

"A lot probably would've struggled with it; with the amount of paperwork, with the amount of assignments….Some of them, I think you had to have a fair bit of schooling and focus to do it, and I know that there would've been people in the group because I was aware of it, that will need help, with somebody like me or [the Facilitator], sitting down and saying, "Right, which one of these don't you have?" And then I turn to my

section, and I say, "Well, I'm not going to give you the answers, but I'm going to tell you my impressions of it to jog your memory of what you recall." (Influential Stakeholder 9)

"… it was top-heavy. A lot of that was actually university standard… I'd like to see the curricula structured a little bit differently, broken down. That unit, I think it's four. That's a huge, massive unit…" (Influential Stakeholder 9)

"…it may have been a little bit over the heads of some of the people, it doesn't matter, because the takeaway message is if you listen, if you care, if you have empathy, if you know your rights, if you know your boundaries, if you have values, if you have ethics, if you know what that person's expecting, what you can expect out of it, you know it's mutually empowering, it doesn't matter about this because it's friendship support. Without being dangerously overprotective or focusing too much on giving someone solutions. (Influential Stakeholder 9)

Beyond the Pilot: Governance, Structure, Safety, Resources and Risks

Opportunities Raised by PLEP

The PLEP has been the birthplace of the NT peer education and recovery movement. It has responded to the community needs with its bottom-up approach and has provided benefits in recovery, empowerment, and connecting. In addition, it has challenged the current health system and has initiated changes in service delivery for individuals with mental health and related challenges.

"It birthed a workforce, and I think an advocacy movement and a community that didn't exist and role models." (Influential Stakeholder 2)

"[The opportunity that PLEP brought are] Healing, recovery, people's growth, people were in employment…We're talking for people in recovery, for people in employment, people who were socially isolated all of a sudden now have somewhere, someone." (Influential Stakeholder 4)

" I see this huge benefit out of it and further opportunities around the fact that they've done well. There's become this community of people who challenge the system as such…and then that puts this pressure on services to change." (Influential Stakeholder 3)

PLEP has laid down the foundation of a potential career pathway in peer work, empowered Participants, and built their self-advocacy capacity.

"– I always think of little birds taking off on a runway. That's how I see this stuff." (Influential Stakeholder 2)

"Empowerment at all the different levels, at a systems level, at an individual level, but also people in their workplaces wanting to know their rights, who didn't realise they had rights to know about and assert like the existing health care, et cetera, et cetera, et cetera." (Influential Stakeholder 4)

"[the] demand on us supporting participants in the early stages compared to the lack of demand on us at the end when they were supporting each other because they actually built a lot of skills along the way…they were actually stepping out for each other." (Influential Stakeholder 3)

Supporting the PLEP transition

The collaboration and allyship that the PLEP staff developed along the way with different sectors and representatives, including not lived organisations and Steering Group members, support the idea of a small multidisciplinary consortium arrangement for the transition of the PLEP post-pilot implementation.

"…I think, is there have been some really strong allies that are not lived experience…have been on the journey and around the strength and empowerment we've got from their belief in us… So I think something is – in terms of what we've gained is our community peer or lived experienced has developed, strengthening – and allies have developed skills and capacity building and readiness. It's why I actually really like the steering group because we took all these sectorial stakeholders on the journey, and it was really a two-way – very much a two-way learning thing. It taught me a lot about the importance of governance." (Influential Stakeholder 2)

"…people – not with power – doing what they could and to see the evolution of the relationships and the trust and the value – yeah, there's a lot to grow and go to, but from the start of the program to now, it's – just think of all those people coming up and saying – not just as allies, but like, "Hey, let's work together in the […] project." (Influential Stakeholder 4)

PLEP staff have now developed interstate connections through the various phases of the pilot project.

"We started with no connections interstate with advocates or peer communities, and we have, through our own personal investment in our project, sought them out and really fostered them and nurtured them. And they've been generally pretty wonderful back to us where it ." (Influential Stakeholder 2)

The consortium arrangement might also bring various opportunities for securing funding to keep the movement rolling.

"… this job trainer funding that's come through business, that will keep little bubbles happening through the next couple of months at least… the RTO's got different knowledge about pulling money from different parts of government." (Influential Stakeholder 2)

PLEP staff appreciated the support provided by the Steering Group formed in Stage 1 of the PLEP. They also acknowledged the MHACA project impact on the pilot. In addition, they believe that a

broader peer workforce advisory group would be helpful to guide the future planning and implementation of the PLEP.

> *"…So we had a fantastic steering group for this. It was great. And it would have been really great to have kept those stakeholders together and meeting as a broader peer - supporting the peer work sector…..[and] I don't think you could really look at the PLEP without acknowledging the MHACA project." (Influential Stakeholder 2)*

> *"…it would actually be really useful…[to have a] more broad workforce advisory groups and stuff, but one that was just focused on peer support would be really, really useful, just not too frequent, but just the right people at the right table. It's keeping them up to speed." (Influential Stakeholder 2)*

Since recovery and peer support are relational processes and practices rather than programs, they have to be connected to peers and the broader community of practice rather than to an organisation. Otherwise, it will lose its explicit peer focus.

> *"… recovery and peer support are processes and practises. They're not programs. They cannot exist in a program without practises. So what comes with practises are practitioners. So the second part to that is that recovery and [peerness] happen in between people, their relational – a program cannot go and sit somewhere, whether in a booklet or in modules on a computer. It cannot sit there like that because it happens between people. It cannot sit with an organisation because it happens between people and peers. And because there's practise and peers, it must be connected to that broader community of practise because peer work in this country is still emerging, and there's work at the moment being done nationally to develop some sets of an agreed kind of, well, what are the practises and values of peer work? So that dialogue, that emergent co-design part, has to keep happening because as soon as it's in isolation, it's not recovering; it's not peer and it's not connected, and it's not rigorous, professional practise." (Influential Stakeholder 4)*

> *"And also, what's really important – which will happen because our community will make it happen whether it's financially supported or not – is a community of practise, which is cross-organisation because peers in isolation are really vulnerable." (Influential Stakeholder 2)*

The transition of the PLEP could not happen by simply handing over some key documents and evaluation reports. A lot of learnings have happened between people, and it is hard to document those relational things. Thus, key PLEP persons and Program Participants need to be invited to participate in an advisory capacity or in a broader intersecting peer work advisory group.

> *"I don't know how you can pick this up and put it somewhere else without some of the key players and the key knowledge here. You'd be starting again like we did two and a half years ago. Although they'd have our documents." (Influential Stakeholder 2)*

"I would hope they try and get some of us into an advisory group…. it's also about transitioning other people who have been through the program." (Influential Stakeholder 4)

"Like an intersecting peer work advisory group [resourced to do something]." (Influential Stakeholder 2)

"… this project and wherever it lands is a big well of experience and knowledge that can most certainly be shared, and I think that well, with some resourcing and maybe some external consultancy from people of choosing interstate who maybe know some other things could actually build a network or an entity that mutually supports all of the other little things going on. And I know that's a community of practise." (Influential Stakeholder 4)

Ongoing Support

The demand for a local peer support group was visible throughout the pilot project because of the unmet needs in the local community. People want to be connected with the peer community, and they need an ongoing place where they can come back, connect and feel safe to ask for support.

"Through the course of being involved in peer stuff more generally and lived experience, I could not count how many times I've said, "People want peer support… People came to […] projects because they wanted to be part of a peer community. They went to training within their organisation because they wanted to be part of a peer community. Even the Lived Experience Network, I think a lot of that is about people wanting to be connected to a peer community and peer support." (Influential Stakeholder 4)

"… we have seen that people come back and they go, "Oh, this has happened in their new job. What do I do?" And you're like, "Let's have a look at the Fair Work website together. Well, these are what your rights are. Try this. Write to your workplace. If that doesn't happen, get some advice from here," that sort of stuff. And so I think that – and they're just self-empowerment activities. But it's just they've got that rapport relationship they want to – they feel safe. They've just come for a bit of advice, a little bit of incidental stuff. But that sort of ongoing [support]." (Influential Stakeholder 2)

"And whilst there are some fantastic community models of volunteer peer groups, it's not cutting the mustard, which is why people come flocking to us as people and in our roles because their needs aren't getting met elsewhere." (Influential Stakeholder 4)

"… we really needed an ongoing place to hold these former participants so that they could keep tapping into the peer community and empowerment community after they had done the program because it was a cliff really… I think it's an important part of the transition plan… Fundamental." (Influential Stakeholder 2)

This support needs to be ongoing and resourced to keep Participants and peer workers safe and well. Ongoing support implies a connection to the community and recovery.

"When you're doing a nine-session recovery program, you can't keep providing ongoing peer support after that. It's time limited. unless there's resources… I've had to keep – and it's really bloody difficult – I probably haven't expressed that – to keep pushing back and putting down boundaries because I am not resourced to do that. I'm already compromised." (Influential Stakeholder 4)

"By having that model in the community, we would be providing the leadership for them to learn how to do what they're supposed to be doing if we just got resourced for it." (Influential Stakeholder 2)

"Recovery happens in a community. To keep connections with community, there must be an ongoing peer support group that accompanies the recovery program that runs at the same time, ongoing. So that people in recovery can continue to practise those skills… and stay on recovery and stay connected. And if they experience challenges, they can get back up on the horse, recommit." (Influential Stakeholder 4)

The momentum needs to keep moving by asking sectoral stakeholders to advocate for the program whatever time and effort it requires, along with various key players to sustain the momentum. Any demobilisation could be damaging.

" … in terms of the transition, and [….] said something earlier around not sitting within any of *the current silos. I think there's also this danger of I don't think planning for the perfect places are also going to be the right thing because momentum gets lost… to wait for the perfect thing is also, I think, a real danger…. And that's part of the challenge, not losing that momentum. People move on, and we don't want to lose that." (Influential Stakeholder 3)*

"…when momentum gets broken, we've seen it's just so hard." (Influential Stakeholder 2)

" I think wherever it lands; there has to be this responsibility of fighting for it….. keep fighting for this thing, wherever it lands." And it might be in two years' time, you've got to keep fighting, or five years, but you know that the journey is long around that peer or consumer stuff." (Influential Stakeholder 3)

Safety - Structure, Policies, Practices, Mentoring and Supervision

While the PLEP staff felt supported by their peers, allies, local sectoral stakeholders, and lead agency, the pilot nature of the project presented challenges and provided learnings that will help the transition. For instance, it drew attention to the lack of policies, procedures, supervision and mentoring sessions that may increase the risk of Facilitators' safety.

"In some ways, I felt unsupported… felt like we didn't have things that might ordinarily be there like policies and procedures, clarity. But, you know, this is stuff from the pilot." (Influential Stakeholder 12)

"I've always felt really supported by my peer facilitators and by the peers themselves in the program. I think that they've been amazing. And we've had allies, as you know, outside of that as well. And that's kind of grown as that allyship with other organisations has grown as the project went along." (Influential Stakeholder 13)

"..we travelled that journey for the first time, unsupported in terms of local expertise – we experienced quite a few challenges. I don't like the use of the word safety, but for ourselves as leaders and peer practitioners – but also in the rollout of content, program, cultural appropriateness and learning what we didn't know about what we didn't know" (Influential Stakeholder 4)

Most of the PLEP program Participants have never learnt about or experienced peer support, so participating in the program involved education and recovery simultaneously. This is taxing, so a stepped and supported vocational pathway would be ideal in this particular community context.

"… peer participants have never learned about recovery, and they've never experienced peer support on the most part. Some from interstate have. Therefore, when they did our peer education, the foundations and peer work peer-to-peer, they were doing recovery while they were doing an education program. And that's full-on, and hopefully, it doesn't stay like that." (Influential Stakeholder 4)

"That is why I see its real importance as a stepped– it's a gradual – and whatever happens with the future of the project, it is as much about the supported vocational development as it is about the delivery of the peer-led – and they are peer-led in recovery programs." (Influential Stakeholder 2)

Peer workers need supervision for personal and professional wellbeing and sustainability. This should include internal and external supervision. In addition, Program Participants starting their own personal recovery journey should access mentoring opportunities to feel supported.

"…peer supervision stuff is really important and absolutely important in all of this. But I also think that there's sometimes a need for something external to that because sometimes you need to step out of that, and that's not to say that that person that you're then getting supervision or whatever from doesn't need to have an understanding of what you're doing, but I think there's times when it's really important to have somebody external to that. (Influential Stakeholder 2)

"…without a relationship that I formed with a peer…who's doing – we do peer supervision and then external, from another state…[they have] got what I consider to be expertise, as in years of experience, working in frameworks and systems that know this stuff." (Influential Stakeholder 4)

"…the ability for mentoring….to mentor the people starting on their journey. Yeah, where possible, I think that would be really helpful." (Influential Stakeholder 2)

Solid structures, including policies and procedures, play key roles in providing safety for peer workers. They give guidance in certain situations. However, these structures do not exist in the peer workforce, presenting challenges for anyone taking the program. Resources are required to adapt existing procedures into the peer workforce.

> *"I think there has to be – this is where I feel like wherever it ends up, there needs to – some of the structure that needed to be there that there wasn't, in a sense, and some of that was around the supervision or whatever, but some of that is also – in my view – around the fact there's already these certain policies and procedures that– this is what you're abiding by. You don't have to go away and think of it all. They're actually there, and they already exist, and this is what's going to happen. And sometimes it needed that existing structure to say, "Actually, this is what's going to happen now," kind of thing." (Influential Stakeholder 3)*

> *"It's going to be a challenge for who takes it on because we don't have that existing, let's say, structure of policies and procedures in the community at this stage because they also don't know what they don't know, that we know a little bit about." (Influential Stakeholder 4)*

> *"I just think it's resource time, and it needs to be developed and contextualised for the peer workforce." (Influential Stakeholder 2)*

> *"… when I was creating a code of conduct and a position description. Those things should have been [exist from the beginning of the project]. " (Influential Stakeholder 4)*

Professional practice frameworks and tools for peer Facilitators and peer workers could ensure the program's reputation, Facilitators and Participants' wellbeing and prevent causing harm.

> *"And then last point on that is peer facilitators as leaders in the space must have professional practise frameworks and tools to draw on. They may come in with different levels. They don't have to be experts. However, they must be able to draw from people in leadership who can coach and mentor them because ultimately, if a person cannot manage role and professional role and the switching and the holding of personal and professional and that, they cannot do the program because I think – sorry, I'm being very persuasive – I think it's ethical for the wellbeing of participants, the reputation of the program, but also for the personal sustainability and wellbeing. So that practise impacts harm to participants. It also causes harm on one's recovery journey and to your current facilitators. So the richness of this work is the connectedness, but the point of fragility can be the connectedness." (Influential Stakeholder 4)*

Roles and Responsibilities – Facilitators and Peer Workers

It is critical for Facilitators to use peer values, have deep knowledge of recovery, put recovery into practice, role model it, and maintain safety and wellbeing for themselves and others. In addition, this

role also requires maintaining professional boundaries and participating in self-reflection, co-reflection, supervision, and monitoring and responding to people's experiences with the program.

> *"Your main responsibility is to work in a collaborative way, that's intentional and mutual with your co-facilitator, and together you are responsible for the safety of the whole group." (Influential Stakeholder 12)*

> *"So the first one is to have a very strong, mindful, intentional professional practice, really strong identification and use of peer values, deep knowledge of recovery, how to do recovery onto practice, role modelling recovery, active commitment to recovery." (Influential Stakeholder 13)*

Having lived experience of mental health and related challenges is not enough to be a peer worker. It is not the same as working intentionally from the basis of your lived experience to support recovery, which is what a good peer worker does. Peer work roles need to be clearly defined and included in policies and procedures because the term 'peer work' is misused in many settings.

> *" … intentional peer support…. It's not getting people with lived experience to come and wash dishes after lunch. That's very different. But I think we've seen a lot of people use the word peer inappropriately, largely in this sector. It's not volunteering or doing anything. It's actually about using knowledge to support recovery and self-actualisation, and empowerment. So it's practise, knowledge and skills. It's not your lived experience." (Influential Stakeholder 2)*

> *" I want to say about a peer support group in Darwin, is that obviously, the community has been asking for it desperately. But I believe – because of the things I was saying before about it being professional practise – that to have resourcing for facilitators of that space or host to have some kind of nominal funding to support that practise in development – because volunteering your time when you're carrying duty of care and risk is risky business." (Influential Stakeholder 4)*

PLEP on a Broader Scale

The delivery of the peer-led education and recovery program to people with mental health and related challenges supports their personal recovery. Based on the beneficial impact of the program on Participants' mental health and wellbeing, this program has the potential to help unemployed individuals to return to the workforce. This would also provide broader funding opportunities for the PLEP.

> *"… I know it [PLEP] was about developing our peer workforce, but the value of people doing this stuff to then re-enter the workforce in other locations – and when it's about re-entering what they used to do or a new profession, going in for the first time, whatever – I think that value was underestimated and not seen as part of the value. It was all about creating the peer workforce. And yes, to me, that's about actually creating the ability to re-enter the workforce, and during it, they've made these peer connections which were all kind of really important." (Influential Stakeholder 3)*

"Because what we facilitated in that program really was self-actualisation in people who were broken – for lack of a better word –, and you can't re-enter the workforce until you've patched yourself back together." (Influential Stakeholder 2)

"feel like it would devalue the program, and it limits where it gets funding from or whatever if it's only seen as this peer workforce thing. And I know that that's the important intent, but the value is so much bigger than that, so that multiplier effect." (Influential Stakeholder 3)

An AOD rehabilitation service provider expressed the demand for PLEP in Alice Springs. They believed that their residential rehabilitation and transitional aftercare units would benefit from the program. Further, the stepped model providing pathways to peer facilitation and peer work could be a potential vocational conduit for their clients. However, they don't have the funding required to roll out a PLEP in this location. They believed that the whole community in Alice Springs would benefit from a localized version of the PLEP

"…at the residential rehab, we have people move in after the residential rehab to transitional aftercare units. So, that way, if they can get this opportunity, that gives them the skills, and then maybe they can be the facilitators after that…. they have the resources here, they can use the resources around the house itself… [The necessary resource] would be the funding. We can, if we have the funding, even if we can fly our staff, over to Darwin; it all depends on funding, I think. That's the main thing; once we have the funding, once we have that tick, I don't think there would be any other issues. That's the only and main concern for me." (Influential Stakeholder 1)

Impact of COVID-19

COVID-19 did not impact the NT as significantly as other jurisdictions in Australia or worldwide; however, it still impacted people's overall health and wellbeing in the NT. People with psychosocial support needs had diverse health experiences attributable to the worldwide pandemic over the last nearly two years. COVID-related restrictions brought challenges to the PLEP project management and delivery of programs in multiple ways.

"COVID unfortunately really interrupted the growth and development process where after delivering the first one [My Recovery program], doing the huge preparation and development to get to that point, then later on in the piece I kind of had to start all over again..." (Influential Stakeholder 13)

"What we learned from the PLEP was the breaks due to COVID and then the contract delays; it was like revamping from zero every time to raise awareness in the community. And without cultivating that pool of people in recovery, we can't cultivate our next facilitators. " (Influential Stakeholder 12)

COVID-19 also impacted some of the new upskilled Facilitators, and it has been devastating for other peers Facilitators to witness it.

"And watching comrades…. Watching other facilitators get too unwell." (Influential Stakeholder 12)

On the other hand, the COVID-19 situation impeded Wellways from coming to Darwin and delivering the training for the second cohort of Facilitators. This provided the opportunity for co-designing a local program.

"Well, it was unfortunate and fortunate, because it opened up an opportunity when they couldn't travel due to COVID" (Influential Stakeholder 12)

People who participated in PLEP, including lead agency staff, Facilitators and Program Participants, have had diverse personal experiences during this time. While some have not been impacted significantly, others have had negative experiences. Also, some of them were able to highlight some positivities.

Dealing with suicidal ideation, losing daily protective routines, feeling worried, job insecurity, challenges with social isolation and being locked up, coping with relapse, being stranded overseas, and losing control were mentioned among the negative impacts.

" It was shit... Look, I lost all my routine in the COVID shutdown. I think that's part of the reason all those protective factors I'd taken years and decades to set up all got wiped out, and then I haven't been able to re-instigate them. (Influential Stakeholder 12)

" [I was] locked in my house, and it just about broke me. It really tested my ability." (Program Participant 12)

"… my workplace is heavily affected by COVID just because job losses and things like it's not – it's also made me people more stressed. Those people who are stressed are not being very kind to one another." (Program Participant 8)

" and all of that [studies and engagement in community programs] got shot down in one fell swoop, except for one thing didn't shut down, the bottle shops. So it set me back a year. COVID was horrible, and I was binge drinking all through 2020 for about three or four days at a time, and then I'd have three weeks off, and then three or four days, all through the whole year. It was horrible." (Program Participant 14)

"Well, it made my isolating even worse… after a couple of weeks of all my supports being gone, and I wasn't leaving the house at all; I just really slipped downwards. And yeah, just even personal hygiene and stuff was suffering and all that stuff, so just staying in bed." (Program Participant 3)

".. well, I definitely don't think there's any positives… I'm not seeing a positive…. think the loss of control of different parts of people's lives has impacted everyone, the uncertainty. People acting out of fear has had a knock-on effect or rallied the fear in you. So I think

COVID has impacted everything like I think now because it's so long and everywhere, it's affected everyone. " (Program Participant 8)

Some Participants have not been significantly affected, especially those who prefer socialising less.

"I'm someone who doesn't need a lot of social stimulation. I prefer having fewer relationships but deeper connections. And I've got a limited about of energy for social stuff anyway, so it hasn't really impacted me negatively" " (Program Participant 9)

"I'm a loner. I socialise with life on my own terms, so COVID, when everything shut down for three days, I thought it was just great. It had no, no effect on me. I know how to provide for myself. I know how to have a good stocked larder. I know how to be self-sufficient and secure. So, no, it was a piece of cake for me." (Program Participant 13)

A Participant emphasised that they had to be very conscious of avoiding drinking and using other substances during lockdown when time passed slower.

" I was very much twiddling my thumbs. So, slowly rocking back and forth. And, usually I'm fine, I don't necessarily thrive on – I kind of learned to be satisfied with my own company. So, I think that's what it was. Making the conscious effort not to drink and not having access to the other substances. And it felt a lot longer than a week, and it felt a lot more real, having to wear masks and things like that." (Program Participant 4)

Among the potential positivities, Participants described the following: telehealth services, working from home arrangements, feeling Ok to have some breaks, increased income by access to superannuation, and motivation to work more.

"But I think there's been a lot of positive things that have come out of it too, such as Tele[health] – you ring your doctor for a script, and they write it out, and they send it to you. There's a lot of changes which has actually been quite beneficial, I feel." (Program Participant 1)

"I liked working from home; I really enjoyed that. It wasn't so I could slack off or whatever; I actually felt really productive. It was like because I could make it comfortable for me. Offices and schools aren't set up, bright lights, cold air-cons. I found I was actually productive from home… I think it should have been more of what do you feel comfortable doing because nobody knows enough about it, and if people didn't feel comfortable they should have been able to stay home. " (Program Participant 10)

"… the changes meant that I was able to access my super as well, and so I bought myself a car and stuff like this was happening… my mental health's impacted by my poverty as well, and that I was able to keep up with society for a little while… So I guess it's – in effect with that money now almost being gone, it's making me really want to push to find work because money can be the answer to help there as well… So yeah, so it's inspired me to work more. I think that I appreciate things a bit more now… And to be

able to have that time off, like it's okay just to stay home… and it was like now everyone knows it's okay to take a breath, you know?" (Program Participant 3)

One Participant emphasised the importance of educating the community about COVID-19, just like any other disease, instead of threatening people that might cause further harm.

" I think the thing with COVID is that COVID, it's the name of a disease, just like any other disease, and it's made people more susceptible to knowing that there's a pandemic, so it causes social isolation, getting people to stay inside and social distancing… And I just think maybe instead of like the scare tactics of COVID; we should've just been putting education back into the community. Yeah, so the same as mental illness, the same as people with diabetes, the same as heart disease… put education back into the community to empower a community, not scare tactics, you know?" ?" (Program Participant 6)

Main findings

This chapter provides an overarching summary of the program's impact on Participants' mental health and wellbeing by developing a figure based on the findings of the Darwin PLEP study. We collected the most frequent words used by the Participants according to the appropriate domain of the CHIME model and created word clouds (Figure 2) by a method repeating these words. Participants used the following words to describe their experience with each domain:

Connectedness: network, friend, social, group, support, reengaging, included, inclusive, safe, quality, interaction, people, family, relationship, connectedness, community, loved, peers, society, supportive, friendship, connection, bond, rapport, participants, others, facilitators, together, organisation, programs, team, equal, connecting, tribe, world, movement

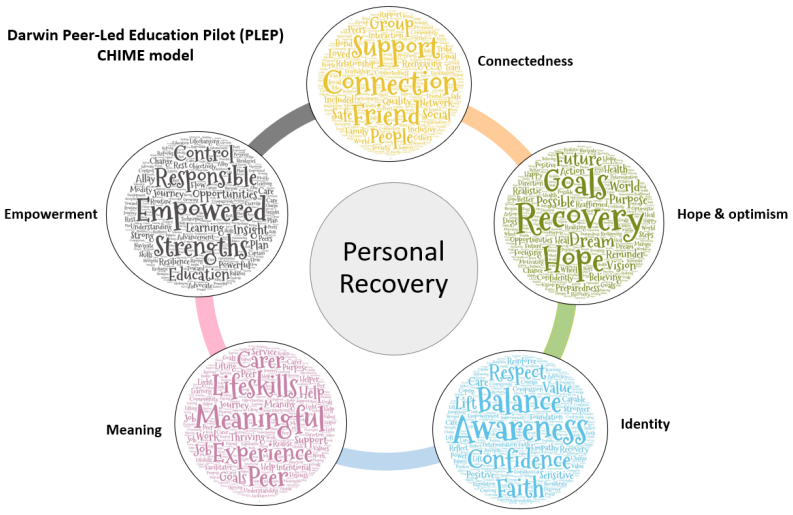
Hope: future, goals, purpose, preparedness, reminder, world, believing, confidently, opportunities, possibilities, vision, realistic, focusing, health, reaffirmed, action, motivating, direction, hope, hopeful, positive, recovery, possible, happy, dream, realising, chance, manage, better, heal, recovery, navigate, reclaiming, wheel, steps, dogs, determination, optimistic

Identity: balance, sensitive, recovery, positive, reinforce, foundation, stronger, determination, empowerment, empathy, compassion, lift, values, faith, faithful, capable, respect, care, recalibrate, regulation, confidence, reflect, awareness, advocacy, confidence, strength, courage, respect, responsibility, improvement, empathetic, compassionate, coping, discover, change, curious, power, reframing, rewiring, value, comfortable

Meaning: meaningful, goals, thriving, help, experience, lifeskills, support, peer, work, helping, journey, intentional, understanding, meaning, purpose, service, community, job, facilitator, lifting, carer, helper, realise, learning, opportunities, discuss, light, direction, values, help

Empowerment: empowered, opportunities, learning, education, responsibility, insight, understanding, journey, powerful, resilience, strong, strengths, lifechanging, strengths, change, modify, allay, plan, advancement, objectively, advocate, navigate, control, techniques, routine, strategies, toward, refocus, captain, responsible, care, compassionate, flow, rest, recharge, balance, progress, growing, skills, exercise, peers, education, control, development,

Figure 2 – CHIME model in the Darwin Peer-Led Education Pilot



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Appendix A: Ethics Approval

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17 March 2021

Prof James Smith
Menzies School of Health Research
James.smith@menzies.edu.au

Ethics Administration Office
File Reference Number: HREC-2019-3426
Phone: (08) 8946 8687 or (08) 8946 8692
Email: ethics@menzies.edu.au

CC: noemi.tari-keresztes@menzies.edu.au
Via Email

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***

The response to conditional approval of amendment to the above project submitted on **16/03/2021** was approved by the Human Research Ethics Committee of the Northern Territory Department of Health and Menzies School of Health Research (HREC). Please note that this approval applies only to research conducted after the date of this letter.

The following amendments are approved:

1. Extend project completion date until 31st January 2022.
2. The addition of Phase 3 evaluation.

Please note: The HREC cannot provide approval for the quantitative survey that was submitted with this amendment request.

Please note that all requirements of the original ethical approval for this project still apply.

Approval is granted for the above research project, until the next report due date.

Annual progress report due: ***01/08/2021***

Approved timeframe (subject to compliance and annual reporting): ***01/08/2019 – 31/01/2022***

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 original protocol.
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 or telephone: (08) 8946 8687 or (08) 8946 8692.
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,

Mary Morris

Dr. Mary Morris
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

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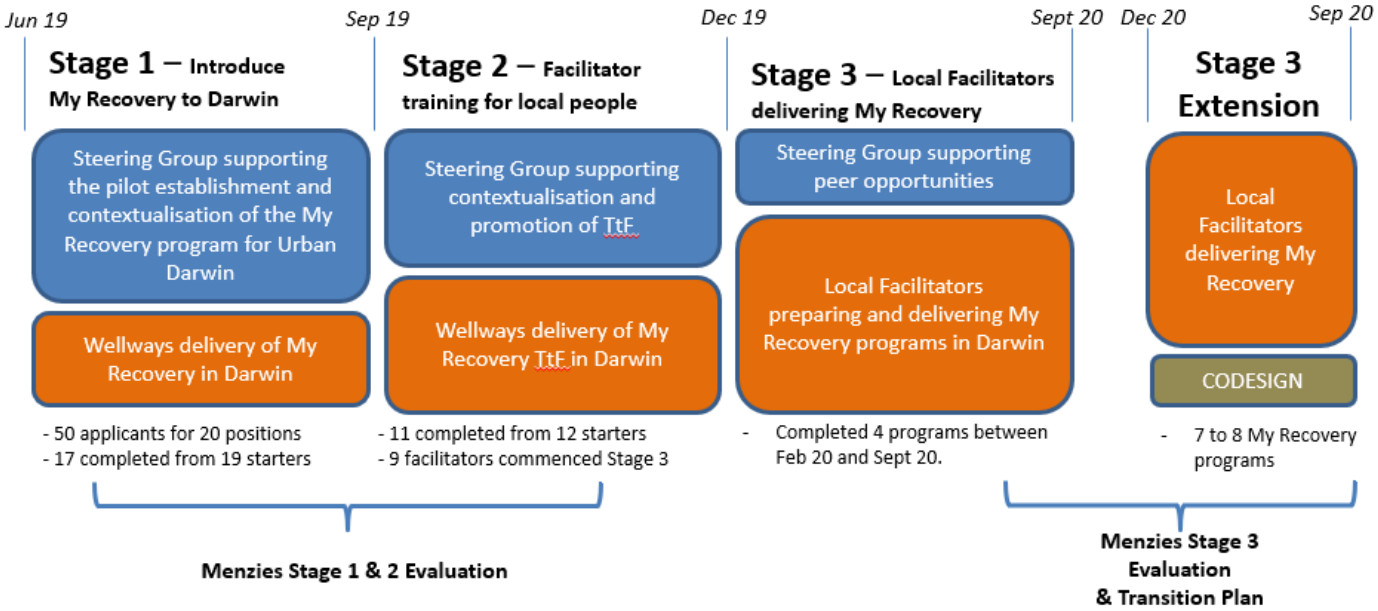
Appendix B: Transition Plan

Prioritising peer-led psychosocial education, support, and workforce development in Darwin

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. Indeed, peer-led education for the self-management of mental illness is now considered to be 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. These concepts are now firmly embedded in numerous territory and national mental health plans, reports and frameworks. For example, the *Fifth Mental Health and Suicide Prevention Plan* has an explicit focus on recovery and emphasises the importance of involving people with lived experience of mental health issues in system responses. This is reinforced through the Productivity Commission's recent inquiry into mental health in Australia, which emphasises that 'peer workers are increasingly important to drive positive system change. Similarly, a guiding action of the *NT Mental Health and Suicide Prevention Foundation Plan 2021-2022* is to 'establish a long-term strategy to support sustainable engagement of people with lived experience, prioritising pathways to employment that will assist to fill workforce gaps and build local capacity.' There is compelling evidence and a clear policy commitment that investment in peer-led and recovery-oriented education, support and workforce development in the NT is needed.

Context

Throughout 2019-2021 the Northern Territory Mental Health Coalition (Coalition) was funded by NT Primary Health Network (NTPHN) to lead the delivery of a Peer-Led Education Pilot (PLEP). This project involved multiple stages, as shown in the Figure below:



- The delivery of a contextualised version of the Wellways *My Recovery* education and support program to people with lived experience of mental illness in the Greater Darwin region (Stage 1)

- The delivery of a Train the Facilitator program was for people with lived experience that were either involved in Phase 1 or were assessed as having sufficient experience working or volunteering in the sector (Stage 2)
- The delivery of PLEP by newly upskilled local Facilitators; and the development of '*Recovery Together'* a new locally co-designed and contextually responsive resource to guide the future delivery of peer-led psychosocial education and recovery activities in the Greater Darwin region (Stage 3 + Stage 3 Extension)

Menzies School of Health Research (Menzies) was engaged by the Coalition to evaluate Stage 1 and 2 of PLEP and commissioned by NTPHN to evaluate Stage 3 of PLEP. The Stage 3 evaluation also included a request to develop a Transition Plan for PLEP (i.e. the delivery of *Recovery Together*).
The requirement for a Transition Plan was considered important for a few reasons. The Coalition Board and its staff recognised it was a peak body and not a direct service provider. Despite the relative success of PLEP, the Coalition was clear to funders and key stakeholders it was not suitably equipped to deliver PLEP on an ongoing basis. Instead, it was thought that existing mental health service providers would be better positioned to take on this role. In that sense, the request from NTPHN for a Transition Plan is not a commitment of funding. Rather it aims to provide a roadmap for what a transition could look like if funding were available.

Stakeholder engagement process
Menzies held a stakeholder workshop on 20th September 2021 to discuss outcomes from PLEP and respective transition planning ideas. The workshop included mental health service providers (non-government), commissioning representatives, relevant peak bodies, Aboriginal and Torres Strait Islander stakeholders, and people with lived experience of mental illness, including consumers and carers. Representatives from NT Government were invited but did not attend. Additional individual and small group interviews were conducted with key stakeholders that were either unable to attend the workshop or that could provide additional contextual information to inform the transition planning process.

What did we hear?
- The majority of stakeholders agreed that the Coalition was not ideally positioned to lead PLEP (or subsequent iterations) on an ongoing basis. Yet, most still considered the Coalition to be a key stakeholder, critical partner, and advocate. All Participants were thankful for the contribution the Coalition had made to the sector through PLEP.
- All stakeholders agreed that the delivery of a peer-led psychosocial education program was important and filled an important service delivery gap. There was unanimous support for the continuation of a contextually and regionally relevant program, designed by local people with lived experience of mental illness, akin to *Recovery Together*. There was interest expressed by one service provider to expand the program to Alice Springs.
- PLEP is considered to be an important avenue of skill development for people with lived experience of mental illness and is a suitable strategy to help grow the mental health peer-workforce in the NT and for supporting their re-entry and employability into paid work more generally.
- It is important to maintain the momentum and build upon the existing achievements of PLEP. This will ensure stakeholder confidence is maintained.

- A program governance structure that prioritises people's views with lived experience in a safe and meaningful way, and engages with multiple stakeholders across health, education, and employment sectors, is essential.
- There was an appetite from some individual service delivery organisations - specifically Top End Mental Health Consumers Organisation and Neami – to deliver the program moving forward. While they are considered key stakeholders, and respected service providers, there was a general reticence for any one individual organisation to deliver the program.
- Most stakeholders indicated a collaborative service delivery model was required involving a combination of mental health service delivery expertise, peak bodies (including the Coalition and Association for Alcohol and Other Drugs Agencies NT), and people with lived experience of mental illness (e.g. NT Lived Experience Network, with potential alignment with the proposed Recovery College).
- The program must be peer-led, and the lead organisation should have substantial experience and expertise in supporting people with lived experience of mental illness to embark on their recovery journey.
- Some organisations offered to provide in-kind support if a collaborative model was adopted (i.e. marketing and promotion of the program to potential clients/Facilitators; and a venue for program delivery or gatherings involving the emerging community of practice).
- There was feedback that future iterations should be culturally responsive and cater to the needs of Aboriginal and Torres Strait Islander and Culturally and Linguistically Diverse communities located in Darwin/NT. This would include a more explicit focus on trauma and healing and a reduced demand for Participants to have confidence reading and writing.
- It was acknowledged that the facilitation of PLEP is resource intensive and can be burdensome for those delivering program. Therefore, practical workforce support, such as debriefing and active external and peer supervision and mentorship, is important to sustain the safety, health, and wellbeing of Facilitators.
- There was a strong commitment for ongoing monitoring, evaluation, and evidence-building in any future iterations of PLEP. It was recognised that past evaluations provided a useful platform to guide future program delivery.
- There was strong support for NTPHN to fund the implementation of *Recovery Together* on an ongoing basis, noting this has already been co-designed with people that have lived experience of mental illness in the Greater Darwin region. However, it was also noted that other commissioning bodies such as the Australian Government and NT Government could co-fund a program of this nature, and that funding sources may extend beyond the mental health, and alcohol and other drugs sectors, particularly if the program is geared towards building the confidence and resilience of Participants to re-enter paid work (e.g. education and training; workforce and employment funding avenues).
- If PLEP (or future iterations) continues to be implemented or is expanded, there are opportunities to develop a Community of Practice with current and emerging Facilitators across the NT.
- Consideration could be given to expanding and further contextualising PLEP for other geographical regions across the NT, subject to adequate funding. This would need to involve an explicit co-design process akin to that adopted during Stage 3 of PLEP.

- Opportunities for PLEP to more explicitly support National Disability Insurance Scheme (NDIS) Participants should be explored further.

Proposed transition arrangements

It is recommended that a small multi-disciplinary consortium arrangement would work best if PLEP is to transition away from the Coalition. The consortium should be guided by evaluation outcomes and feedback from key stakeholders involved in the delivery of Stages 1-3. The *Recovery Together* resource should be used to guide future implementation.

At a minimum, the consortium should include:

- An organisation representing people with lived experience of mental illness
- A peak body focused on mental health and/or AOD in the NT
- At least two mental health service organisations with experience delivering non-clinical and clinical services and programs
- At least one alcohol treatment service organisation
- A training provider or organisation with expertise in training and employment pathways with an interest in peer-workforce development
- An organisation with expertise to undertake an independent evaluation.

There should be collective evidence that the consortium has knowledge of contemporary recovery processes; experience engaging people with lived experience of mental illness in a safe and genuine way (including skilled peer workforce and lived experience governance); expertise in delivering responsive mental health services in the NT, including psychosocial education and support programs; a commitment to integrating mental health and AOD supports; and a commitment to building the peer-workforce in the NT.

A multi-disciplinary Steering Group should be established to support the delivery of PLEP on an ongoing basis. This should include lived experience representation and peer work representatives.

A strategy to keep previous and new peer Facilitators engaged through PLEP is important. The establishment of a Community of Practice could assist in this regard. Connection between PLEP Facilitators and the broader peer workforce is also an important consideration.

This approach aligns with multiple mental health policy actions at territory and national levels.

The active engagement of the commissioning agency/ies will also be important for the ongoing success and sustainability of the program.

Appendix C: Information Sheet

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Website: menzies.edu.au
ABN: 70 413 542 847

PARTICIPANT INFORMATION SHEET – PROGRAM PARTICIPANTS
(Individual interview)

Evaluation of a Peer-led Education Pilot for people with psychosocial support needs in Darwin
(Phase 3)

This is yours to keep

What is the project about?
This project involves the evaluation of the Peer-Led Education Pilot (PLEP) in Darwin. After a successful 1st and 2nd phase of the pilot project, the intention is to evaluate the 3rd phase and develop a structured plan about the proposed transition of the program beyond the pilot. This project has been funded by NT Primary Health Network (NT PHN) and the Lead Agency is NT Mental Health Coalition (the Coalition). We would like to understand how the My Recovery Program influenced program participants' mental health journey.

Who will undertake this evaluation project?
The evaluation will be co-led by Professor James Smith and Dr Tari-Keresztes based in the Wellbeing and Preventable Chronic Diseases Division, Alcohol, Other Drugs and Gambling (AODG) team at Menzies School of Health Research (Menzies). Other investigators include:

- Dr Himanshu Gupta, Menzies
- Ms Tessa Wallace, Menzies

What is the project doing?
In this project, individual interviews with *My Recovery program* Facilitators, participants and key stakeholders; and a consultation workshop with sectoral stakeholders will be conducted. It will also involve observations during Steering Group/Advisory Group meetings. It is envisaged these findings will help to build an evidence-base about the effectiveness of a peer-led education program in Darwin.

What will happen during the project?
This participant information sheet specifically relates to the individual interview component listed above. You have been identified as a program participant. We would therefore like to invite you to participate in an individual interview. It is anticipated these will last between 45-60 minutes.

If you agree to participate, we will ask questions about your mental health journey, experience with the program including the most effective program components, and what worked well and why. We will also ask questions about what could be improved. We will also ask you about how the program has impacted your mental health journey, and the challenges you have faced during the COVID-19 pandemic.

It is important that we properly record the discussions, and the information that people share. We will write down and audio record what is said and done during interviews. The information you share will be used to build an evidence-base about the effectiveness of the peer-led psycho-education program.

Your information will anonymous. This means that the information you share will not be used in reports, conferences, journals or on websites in such a way that you could be identified. Also, you are free to withdraw at any time during your participation in the individual interview without any negative consequences.

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ABN: 70 413 542 847

A final report and presentation will be publicly available upon project completion. You will not be identified at an individual level in the research reporting.

Benefits and Risks
If you choose to participate, you will be assisting to build an evidence-base about a peer-led education program aimed to improve the lives of people with psychosocial support needs in Darwin. There are no specific risks for you to be a part of this project. If you choose not to participate, it's OK.

If you feel concerned or distressed during or after the interview, the following helplines and services can be accessed free of charge (Northern Territory Mental Health Line: 1800 682 288, Beyond Blue: 1300 224 636, Lifeline: 131114, Mental Illness Fellowship of Australia NT: 1800 985 944)

Ethics Committee Clearance
This project has been approved by the Human Research Ethics Committee of the NT Department of Health and Menzies School of Health Research

Who can I contact if I have a question or want more information?
If you have any questions about this form, the project or about the use or exclusion of any particular information you provide, please contact Professor James Smith at Menzies on 0455 088 501 or via email at james.smith@menzies.edu.au

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

Appendix D: Consent Form

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Website: menzies.edu.au
ABN: 70 413 542 847

CONSENT FORM – PROGRAM PARTICIPANTS
(Individual interview)

Evaluation of a Peer-led Education Pilot for people with psychosocial support needs in Darwin
(Phase 3)

This means you can say NO

I have talked to _____ at _____ about this project. I would like to be part of this project.

	Please circle	
I have read and understand what is written on the Participant Information Sheet.	Yes	No
I understand what this project is about including the purpose, procedures, benefits and risks associated with my participation.	Yes	No
I understand who I can contact if I have any questions regarding the project or ethical conduct.	Yes	No
I am happy for my words to be used in project outputs such as reports, presentations, frameworks, education programs, conferences, journals, or on websites.	Yes	No
I understand my information will not be used in reports, conferences, journals or on websites in such a way that I could be identified.	Yes	No
I understand that I can choose not to answer questions.	Yes	No
I understand that I am free to withdraw at any time during my participation in the individual interview without any negative consequences.	Yes	No
I understand that the information I provide may be used in future research projects relating to mental illness or social and emotional well-being	Yes	No
I am happy for the information that I share in the interview as part of this project to be audio recorded.	Yes	No

Signed: _____

Full name: _____

Date: _____

Name of Witness: _____

Siganture 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

If you have any questions about this form, the project or about the use or exclusion of any particular information you provide, please contact Professor James Smith at CDU on 0455 088 501 or via email at james.smith@menzies.edu.au

Appendix E: Interview Guide (Participants)

1. Program Participant individual interview

Overarching goals:

- Explore Participants' background and previous experiences (who they are?)
- Evaluate the effectiveness of the program on participants' mental health and wellbeing
- Assess the areas of program impact (communication, advocacy, recovery planning)
- Identify the strengths and limitations of the program

Mental Health 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 (background).
- Could you please tell me if you have experienced any changes in your mental health journey thanks to your participation in the program? If so, what were they?

Overall experience with the MR program:

- How satisfied you are with the program? And with the facilitation? Please elaborate.
- What were your expectations about the My Recovery Program? Did your expectation meet with the program?
- What do you think was most useful in the My Recovery program? Why? What were some of the other good things about the My Recovery program?
- What are your main reasons for participating in the My Recovery program? Why?
- What knowledge and skills did you learn during the program? How will you use this knowledge and skills in your daily life? (probe: private life; work life)
- Could you give a specific example of how you used (or intend to use) one of the skills learned during the program in your life?
- How satisfied were you with content in the program? Would you change anything in the program? Are there any areas for improvement with the My Recovery program? If so, what are they and why?
- What do you think about the peer logbook, additional handouts and activities?
- Please share your reflection in regard to the program schedule? (frequency, days, date)
- What were the key learnings that you took away from the program?
- Would you recommend this course to others?

Areas of program impact:

- How would you define recovery with your own words? What does recovery mean to you, personally?
- What has contributed in your recovery process? What has interfered in your recovery process?
- How could you summarise the program impact on your mental health/AOD journey in 3-5 words?
- Please share your experiences with the peer-to-peer approach used in this program? How has this approach influenced your journey in the program?

Questions about Connectedness, Hope, Identity, Meaning and Empowerment (CHIME)

- How satisfied are you with your relationship with others now? (family, friends, neighbours, colleagues). How has the My Recovery program influenced your relationship with others?
- How do you feel about your future? Are you hopeful? What goals do you have? Did you experience any change about your concept about hope after completing the My Recovery program?
- How would you describe your mental illness? Do you think others see it in a same way or differently?
  Please explain to me the difficulties and adversity you have faced throughout your life? How have you used these experiences to help yourself and/or support others?

COVID-19:

- 2020 was a tough year for everyone. How COVID-19 has impacted your life? What are some of the challenges you have faced? Any positive changes or impact?

Other:

- Do you have any other feedback you would like to share?

Appendix F: Interview Guide (Facilitators)

2. Facilitator interview

Overarching goals:

- Explore Facilitators' background and previous experiences (who they are?)
- Discover Facilitators' experiences with the My Recovery program delivery (challenges, opportunities, and learnings)
- Identify Facilitators' strengths and difficulties (Facilitation skills)
- Detect Facilitators' plan and future aspiration associated with the MR program

Background:

- Please introduce yourself in a couple of sentences. You can share as much or as little as you want. You could explain to us for example your background, your facilitator journey, how you became a My Recovery (MR) facilitator, what were the main reasons for becoming a facilitator.

Experience with the My Recovery program facilitation:

- Do you have any previous facilitator experience for example delivering other programs?
- How many MR program groups have you facilitated so far?
- Who did you deliver the MR program for? Please give us a short description of the group (e.g. gender, age, participants' background)
- How would you describe your experience with the MR group/s? What did/didn't you like?
- Please describe the challenges and opportunities associated with the MR program facilitation. What worked well? What didn't work well?
- What was the most challenging situation for you?
- How well has the co-facilitation process worked? (difficulties, co-operation, advantages/disadvantages)
- Please share your experiences with the recruitment process and the venue. What difficulties did you experience during recruitment? How satisfied were you with the venue?
- How well have you felt being supported by the Coalition? by Wellways? by Peers?
- How have you prepared yourself for the MR program delivery/facilitation?
- Have you (or other facilitators) done any further contextualisation of the program for example program materials, peer logbook, additional handouts or exercises?
- What did the schedule of the program delivery look like? In the pilot, the program was delivered over 2 weeks. Was this different during your delivery?
- What do you think are the main roles and responsibilities of an MR facilitator?
- What was the greatest learning for yourself during the MR program facilitation?
- Please describe your best experience as an MR Facilitator.

Peer skills

- Do you have any previous experience before becoming a Facilitator using your lived experience in a peer capacity (paid or volunteer position)?
- How would you describe using your lived experience in an intentional way to support the recovery of others?
- Please describe the challenges and opportunities of using your lived experience. What worked well? What didn't work well?
- Think about other peers that you know. What do you notice that they do well? And not so well? Describe in as much detail as you would like
- What training opportunities have you undertaken to support you to use your lived experience as a peer? At what point did you do the training? What was valuable to learn? What was missing?

Facilitation skills:

- How confident did you feel in the Facilitator role during the delivery of the My Recovery program?
- How do you evaluate the effectiveness of your MR program facilitation? Did you get any feedback from participants about the program and/or about the facilitation? What was shared? How will you use this information?
- Describe your strengths and weaknesses as an MR program facilitator?
- What do/don't you like in working as a program facilitator?
- Think about someone whom you think is a great facilitator. What is it that makes that facilitator great? Describe in as much detail as you would like
- Do you think MR facilitators need a good understanding of mental health and wellbeing challenges? What would you say about your knowledge and experience with that?
- In addition to having lived experience of mental illnesses, what skills and knowledge does a good MR facilitator need to have?
- How could you improve your facilitation skills? What support do you need to improve? What Professional Development sessions you would need to maintain your skills and improve?

Future aspirations, plan, feedback

- Please describe your future goals, plan as an MR facilitator. What are your future aspirations?
- What would be your recommendation for any new cohorts of MR facilitators?
- As a Facilitator, please share your thoughts about how the program could be sustained. How could the program be continued beyond the pilot? What organisation do you think is best positioned to deliver the program and provide Facilitator support?

Questions about Connectedness, Hope, Identity, Meaning and Empowerment (CHIME)

- How satisfied are you with your relationship with others now? (family, friends, neighbours, colleagues). How has the opportunity to facilitate the My Recovery program influenced your relationship with others?
- How do you feel about your future? Are you hopeful? What goals do you have? Have you experienced any change about your concept about hope after facilitating the My Recovery program?
- How would you describe your mental illness? Do you think others see it in a same way or differently?
- Please explain to me the difficulties and adversity you have faced throughout your life? How have you used these experiences to help yourself and/or support others?

COVID-19:

- 2020 was a tough year for everyone. How COVID-19 has impacted your life and your facilitator role? What are some of the challenges you have faced? Any positive changes or impact?

Other:

- Do you have any other feedback you would like to share?

Appendix G: Interview Guide (Transition Plan Workshop)

3. Sectoral stakeholder workshop

Overarching goals:

- Provide an overview of the PLEP project to the key sectoral stakeholders (current state)
- Identify the necessary steps and elements to support the successful transition of PLEP from the Coalition to a local mental/AOD organisation engaged in service delivery (define future state)
- Based on the workshop outcomes, identify key stakeholders for a further individual interview

Workshop schedule:

- Introduction of the Peer-Led Education Pilot (PLEP) in Darwin – presentation (30 mins)
- Discussion about the PLEP project – Q&A session (10 mins)
- Purpose of the workshop (5 mins)
- Activities relating to the transition plan (small group discussions, open discussions, pair activities, individual associations and reflections) – (60-90 mins)
- Reflection (15 mins)

Activity details:

The activities will be organised to identify:

- the preferred team/organisation for implementing PLEP on an ongoing basis and could make the program sustainable (including consideration of project transition and governance arrangements)
- the required steps, tasks and timeframes (including checkpoints, milestones and checklists) associated with the transition
- risks associated with the transition and the required risk mitigation strategies
- the ideal post-project environment
- essential elements for effective knowledge transfer
- necessary transition resources

Appendix H: Transition Plan Workshop Presentation

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Project Overview:
Peer-Led Education Pilot (PLEP)

NORTHERN TERRITORY MENTAL HEALTH COALITION

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phn NORTHERN TERRITORY

RURAL Workforce AGENCY NT

wellways

Menzies Evaluation team

Stage 1 & 2
Prof James Smith
Dr Noemi Tari-Keresztes
Mr Benjamin Christie
Dr Himanshu Gupta
Ms Tessa Wallace
Ms Donna Stephens
Ms Paris Caton-Graham

Stage 3 & Stage 3 Extension
Prof James Smith
Dr Noemi Tari-Keresztes
Dr Himanshu Gupta

Transition Plan Workshop - 20/09/2021, Darwin

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Acknowledgement of Country

In the spirit of reconciliation, we would like to begin by acknowledging the Larrakia Nation as the Traditional Custodians of the land on which we are meeting and their connections to land, sea and community.

We pay our respect to their elders, past and present and extend that respect to all Aboriginal and Torres Strait Islander peoples attending today

Acknowledgement of people with Lived Experience

We would like to recognise those with lived experience of issues related to mental health, trauma and alcohol and other drug use.

We acknowledge that system reform can only occur through valuing, respecting and drawing upon the lived experience and expert knowledge of individuals affected by these issues, their families and supporters.

We acknowledge their contribution for the evaluation of the Darwin Peer Led Education Pilot, which would not be possible otherwise.

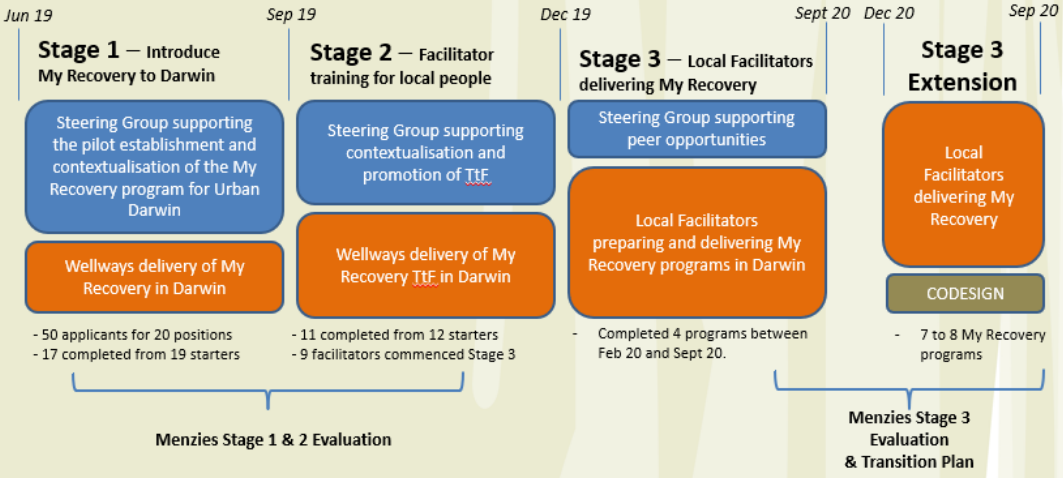
PLEP Project Aims

1. To deliver a peer-led education and recovery program.
2. To provide a supported vocational pathway in peer support.
3. To stimulate greater utilisation of the peer workforce and a local pathway to complete the Cert IV in Peer Work.

PLEP Partnerships

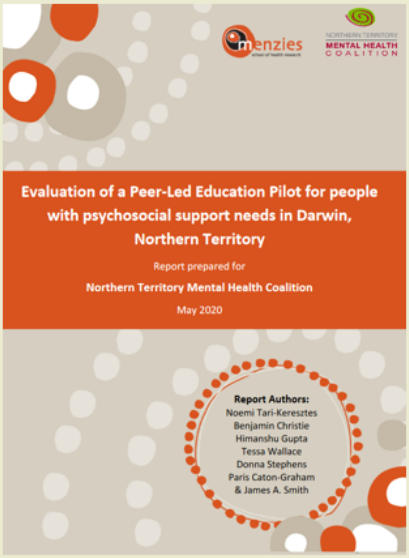
- **Funded by NTPHN**
- **Three-way collaboration:** NTMHC, Wellways & Menzies
- **Steering Group including**
  - Lived Experience Representatives
  - Community Mental Health Organisations
  - AADANT & National Disability Service NT
  - NT Government MHAOD Branch & NT PHN
  - Industry Skills Advisory Council NT
  - DSS Building the Local Care Workforce
  - Charles Darwin University

PLEP Project Stages



Stage 1 & 2 Evaluation report available: https://www.menzies.edu.au/icms_docs/320338_Evaluation_of_a_Peer-Led_Education_Pilot_for_people_with_psychosocial_support_needs_in_Darwin_Northern_Territory.pdf

PLEP: Evaluation Aims

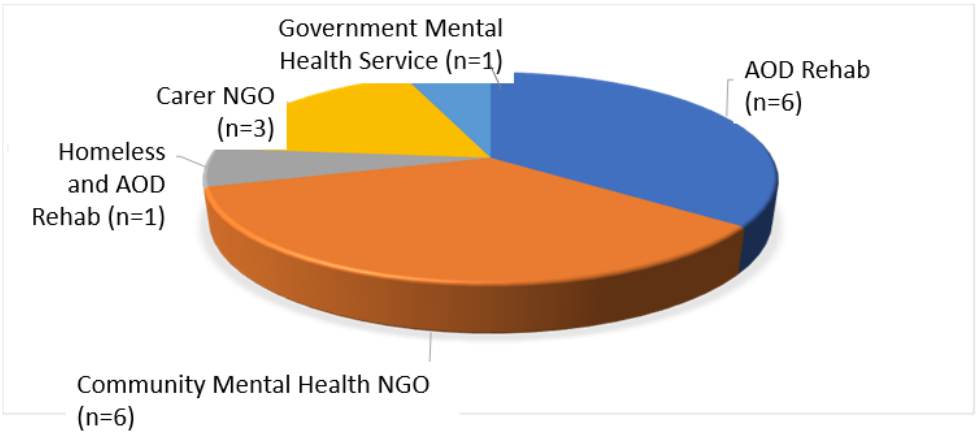


- To describe and evaluate the delivery of the My Recovery and Train the Facilitator programs delivered by Wellways in Darwin
- To assess the effectiveness and appropriateness of these programs, including the identification of current issues, challenges, and opportunities associated with the delivery and by targeting people with psychosocial support needs in Darwin with the support of the mental health and AOD sector.

PLEP: Methodology

- Ethics approval (HREC Ref. No. 2019-3426)
- Qualitative evaluation involved individual pre and post program interviews with My Recovery and Train the Facilitator program participants; and sectoral stakeholders, including Program Facilitators and Trainers, Steering Group members, and NTMHC representatives.
- A thematic analysis of Program Participants' interview data was undertaken.
- 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.

Stage 1: My Recovery Program participants - Referral sources of Participants



Evaluation Results

- PLEP was very well-received by program participants and local stakeholders
- Interview data demonstrated that *My Recovery* program supported program participants (N=17) to understand and self-manage their mental health and/or AOD and develop a deeper understanding of their mental health needs
- We found a high demand and appetite for the peer-led approach to mental health and AOD recovery
- Train the Facilitator program built the capacity of interested Program Participants (n=11) to deliver the *My Recovery* program to other people in the Darwin community

Evaluation Results

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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
- The inclusion of people with lived experience throughout various elements of the pilot;
- The essential role of program contextualisation;
- The significance of the self-nomination in the recruitment process;
- The potential to develop a stronger relationship between AOD and mental health sectors; and
- The need for vocational pathways for people with lived experience of mental illness that incorporate a focus on peer support.

Evaluation Results

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Some challenges included:

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

Discussion

- PLEP highlighted the importance of incorporating the perspectives of those with lived experience of mental illness into peer-support models to aid mental health and AOD recovery journeys for people in Darwin, NT.
- PLEP demonstrated the potential to develop peer support networks and grow a peer workforce across the greater Darwin region, with potential for scalability and expansion across other regions of the NT

Thank you for your attention!

Appendix I: Coding Framework

Coding framework for Facilitators

Themes	Sub-themes
Background	education and work experience experience as a facilitator previous peer experience
My Recovery (MR) group facilitation	MR group characteristics challenges associated with facilitating groups opportunities associated with facilitating groups co-facilitation recruitment schedule venue perceived support preparation work program contextualisation roles and responsibilities (facilitator) key learnings
Peer Skills	using lived experience (LE) intentionally challenges associated with using LE opportunities associated with using LE professional development reflections of other local peers
Facilitation skills	confidence in the facilitation role strengths as a facilitator challenges/weaknesses as a facilitator overall facilitator experience characteristics of a great facilitator understanding of mental health challenges professional development future goals recommendation for the new facilitators
Domains of the CHIME model	connectedness - relationship hope - future identity meaning empowerment
COVID-19 impact	
Other Feedback	

Coding framework for Program participants

Themes	Sub-themes
Mental health journey	background perceived program impact
Experience with the My Recovery program	satisfaction with the program satisfaction with the facilitation expectation reason for enrollment practical program elements and knowledge skills learnt in the program example for using a skill areas for improvement activities, handouts, logbook program schedule venue key learnings recommendation to others
Personal Recovery	definition of personal recovery enablers and barriers in recovery perceived program impact peer-to-per approach
Domains of the CHIME model	connectedness - relationship hope - future identity meaning empowerment
Impact of COVID-19	negatively impacted not significantly impacted positive impact
Other Feedback	

Coding framework for Transition Plan interviews

Themes	Sub-themes
Background	education and work experience understanding of PLEP
Necessary element of the transition	preferred team required steps risks and risk mitigation post-project environment necessary resources
Project-related experience	NT peer workforce co-design safety structure (policy, practices) mentoring ans supervision collaboration, allyship re-entering the workforce a place to host the program momentum and advocacy support the peer workforce opportunities arose
Other feedback	

Coding framework for Co-design workshop participants

Themes	Sub-themes
Experience with participating in the workshop	reason for participation schedule worked well worked not so well challenges key learning
Other feedback	

Coding framework for Peer Work Skills training participants

Themes	Sub-themes
Background	education, work experience
Experience with participating in the training	
	reason for enrollment
	personal goals with the training
	schedule
	modules, skills and activities
	satisfaction
	expectation
	key learnings
	areas for improvement
	challenges
Other feedback	