



THE UNIVERSITY OF
MELBOURNE

Examining the role of mental health peer support in emergency departments

Peer Support Programs for Emergency Departments

June 2020



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Acknowledgements

We would like to acknowledge Anthony Stratford's outstanding contribution to this project. Anthony was instrumental to the development of the ideas behind this work and was a source of wisdom throughout. Anthony has recently retired from his role at Mind Australia and this project contributes to Anthony's legacy which has tirelessly sought to improve the care of individuals who experience mental ill health and promote the role of peer support workers.

We would also like to acknowledge the support of all members of the expert advisory group who have provided feedback and guidance regarding this project.

We also thank the Melbourne Social Equity Institute for funding this project and providing invaluable support throughout, particularly Charlene Edwards.

Finally, our thanks are extended to all the consumers, family members, friends, supporters, peer workers and other staff who participated in our research activities, thus contributing their expertise and lived experience to this project's findings.

PhD candidate

This project included a PhD scholarship from the University of Melbourne funded by the Melbourne Social Equity Institute to enhance the project and promote on-going development of the potential for peers in emergency departments beyond this first phase. The scholarship was awarded to Helena Roennfeldt who completed her Confirmation of Candidature in 2019.

Suggested citation

Minshall, C., Roennfeldt, H., Hamilton, B., Martel, A., Hill, N., Stratford, A., Buchanan-Hagen, S., Byrne, L., Castle, D.J., Cocks, N., Davidson, L. and Brophy, L. (2020). Examining the role of mental health peer support in emergency departments. Melbourne: Melbourne Social Equity Institute, University of Melbourne.

Executive summary

The provision of peer support work in Emergency Departments (EDs) is on the frontiers of mental health practice. Hospital EDs are often under-resourced and overwhelmed and individuals presenting with mental distress typically experience long wait times – sometimes much longer than those presenting for physical complaints; potentially exacerbating their distress. Peer support¹ is increasingly utilised in the Australian mental health system and may play an important role in addressing the unmet needs for consumers and enhance the responsiveness of the ED service.

This research project sought to develop a better understanding of how peer support work could be offered to people who attend the ED due to mental distress. We consulted with the projects Expert Panel, conducted a literature review and then undertook a site visit and consultations with people with lived experience, families, friends and other supporters, and ED staff. After integrating our early findings, we held a workshop for peer support workers. Collectively, these consultations informed the findings, leading to general recommendations and cautions. We also propose recommendations and cautions for key people and places involved including peer workers, friends, family and support persons, ED staff, the ED environment, organisations, the health and welfare system and the community.

This research makes an excellent contribution to the evidence-base, offering some of the first rigorous research into this topic. The findings highlight an exceptional level of engagement with lived experience experts and stakeholders. Overall, stakeholders expressed concern about the limited opportunity for flexibility in the ED culture and its environment. Despite this, it was clear that peer support workers were valued by consumers and their friends, family and other support persons and ED staff. The optimal role and location of a peer support program for people who attend the ED is yet to be fully defined. We concluded that this was beyond the scope of this study and should be the topic of future research.

Based on this project's preliminary findings, we make the following key recommendations regarding peer support in EDs:

- Continuity of care should be maintained for consumers experiencing mental distress from when they arrive in the ED and after they leave by peer support workers and the ED team
- Relationships between peer support workers and ED staff should be supported
- Peer support workers should experience workplace conditions to support optimal performance, mentoring, and retention of staff (e.g. parity of pay/conditions, career mobility, peer supervision)
- Peer support workers should be supported to maintain role integrity and practice in line with peer values
- Education and training about mental health and peer support should be increased to ED staff; this should be developed and delivered by peer workers
- Several peer support workers (rather than one or two) should be engaged at one time into an ED program, to ensure the above recommendations.

The findings of this program of research should be interpreted within the following limitations. Firstly, we are deliberately positioning the product of this project as preliminary research in the

¹ In the context of this report 'peer support workers' refers specifically to mental health peer support workers.

development of an approach. It includes both a conceptual component and practical suggestions sourced from relevant literature, expert advice, observation, interviews and a workshop. It constitutes rigorous and foundational work in the future development of a practice model, but it remains a relatively small first step. Secondly, the next phase of this work needs to include a broader review of the literature, drawing lessons from the body of research on peer employment. Thirdly, outstanding questions need to be considered, including whether situating peers within the actual ED environment is the best option (or if directing people to alternate, peer-staffed spaces is more appropriate). Lastly, some piloting and careful evaluation of both proposed and current efforts of including peer support work in the ED is required.

In conclusion, although our initial goal was to develop a standalone approach, our findings indicate that further research is needed to refine the elements required to implement peer support within the ED and develop a credible approach of peer support in the ED. The preliminary considerations presented here highlight the importance of both practical and philosophical elements to future approaches to this topic. Further evidence must be sought to better understand the key elements we identified, especially those addressing peer workforce issues such as peer supervision and role clarity. Therefore, we now recommend, in the context of the complexity of the issues we identified, further reviews of evidence, community consultations and the development of collaborative partnerships in an ongoing process. Despite this need for further examination, we are pleased to offer this foundation, based on the integration of findings from multiple data sources and a wide range of expertise.

Project team

In total, around 50 people participated directly in this project. The research team was comprised of 12 investigators, of which half identified as having lived experience. The Expert Panel was comprised of the research team members and investigators plus additional experts.

Table I. Research Team/Investigators

RESEARCH TEAM/INVESTIGATORS	
Other Experts	Experts through Lived Experience
Lisa Brophy [Social Work and Social Policy at La Trobe University and Honorary Principal Research Fellow, University of Melbourne – Centre for Mental Health]	Anthony Stratford [Mind Australia and University of Melbourne - Department of Psychiatry]
Bridget Hamilton [University of Melbourne - Centre for Psychiatric Nursing]	Sally Buchanan-Hagen [Deakin University - Nursing]
Andrew Martel [University of Melbourne - Faculty of Architecture]	Louise Byrne [RMIT - Fulbright Fellow]
Nicole Hill [University of Melbourne - Social Work Health Sciences]	Nadine Cocks [Peer Researcher Mind Australia and Architecture graduate]
David Castle [St Vincent's Hospital -Chair of Psychiatry - University of Melbourne - Department of Psychiatry and St Vincent's Hospital]	Catherine Minshall [Consumer academic, Centre for Mental Health - University of Melbourne]
Larry Davidson [Yale University]	Helena Roennfeldt [University of Melbourne – PhD candidate]

Table II. Expert Panel members

EXPERT PANEL	
Other Experts	Experts through Lived Experience
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Bridget Hamilton [University of Melbourne - Centre for Psychiatric Nursing]	Sally Buchanan-Hagen [Deakin University - Nursing]
Andrew Martel [University of Melbourne - Faculty of Architecture]	Louise Byrne [RMIT - Fulbright Fellow]
Nicole Hill [University of Melbourne - Social Work, School of Health Sciences, Faculty of Medicine Dentistry and Health Sciences]	Nadine Cocks [Peer Researcher - Mind Australia and Architecture graduate]
David Castle [St Vincent's Hospital - Chair of Psychiatry]	Fiona Nguyen [Consumer Advocate]
Emma Cadogan [DHHS Workforce]	Marie Piu [CEO - Tandem]
Rebecca McLaughlin [University of Newcastle - Biomedical Sciences and Pharmacy Faculty of Health and Medicine]	Liam Buckley [Peer worker - St Vincent's Hospital]
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Melissa Petrakis [St Vincent's Hospital]	Helena Roennfeldt [University of Melbourne – PhD candidate]
Larry Davidson [Yale University]	Catherine Minshall [Consumer academic, Centre for Mental Health - University of Melbourne]

Table III. Peers in EDs project participants

RESEARCH PARTICIPANTS	
Project activity	Participants
Site visit to St Vincent's Hospital ED	1 St Vincent's mental health peer support worker (Safe Haven program) led 3 project staff (LB, AM, CM see Table I)
Consumer focus group	7 consumer participants, held at the University of Melbourne
Friends/family/support persons focus group	5 friends/family/support persons, held at Mind Australia
ED staff focus group	7 ED staff of which 6 were ED nurses and 1 mental health clinician, held at St Vincent's Hospital
Workshop for mental health peer support workers	11 peer workers, held at the University of Melbourne

Project scope

This research project sought to develop a better understanding of how peer support work could be offered to people who attend the ED due to mental distress. This project was undertaken between January 2019 to March 2020 by a multidisciplinary team from the University of Melbourne, La Trobe University, Deakin University, RMIT, Yale University, St Vincent's Hospital and Mind Australia. The project was based on co-design principals and included individuals with lived experience in key decision-making roles. The project was also supported by an Expert Panel, of which half had lived experience. This program of research was funded by the Melbourne Social Equity Institute, the University of Melbourne in 2018.

This project was approved by St Vincent's Hospital (Fitzroy) Human Research Ethics Committee (HREC-A 031/12).

Considerations regarding this preliminary proposal for the development of a model

Thought was given to the nature of a proposed model, as defined in the original project plan. Considerations included how the term "model" may denote different forms, purposes and theoretical underpinnings. For example, models may vary from those used in grounded theory, to conceptual models, best practice models as well as models of moderators and mediators. Therefore, having considered the complex nature of the ED setting and the potential challenges of implementing a peer support program in this setting, the Research Team proposes that our work enables a preliminary proposal for how peer support work in the ED should be further developed. This could be used to guide service development and implementation of a "Peers in ED" styled service. Further co-design work and consultations with key stakeholders, local adaptations and piloting would be required by any service planning to be informed by this work, as per the recommendations (Chapter Seven). Further investigation is necessary to ensure that the promising possibilities of peer support work in EDs gives full consideration to the complexity of this role and the challenge of bringing the values and principles of Intentional Peer Support (see 1.5) to the ED.

Structure of the report

This report details a program of research which aimed to work toward the future development of an approach to peer support that could be implemented within an ED. This project comprised of a literature review, site visits, focus groups (consumers, families/friends/support persons, and staff) and a half day workshop for health peer support workers. Each of these research activities are described in separate chapters. The report finishes by discussing the preliminary proposal, including limitations and recommendations.

Terminology

Consumer

A person who is currently using, or has previously used, a mental health service.¹

Emergency department (ED)

The ED is a dedicated part of a hospital where an individual can present in person to receive emergency care for physical health problems and mental distress. Patients are triaged and may receive treatment within the hospital, including in an inpatient unit, or may be discharged home.²

Mental distress

A broad term that refers to the range of distressing or uncomfortable thoughts, feelings or behaviours an individual may experience including feelings of frustration, insecurity, loneliness, intimidation and fear; this may arise, although not exclusively, during period of poor mental health. It may occur as a part of mental health challenges or may arise independently.³

Peer support worker

In mental health services peer support work is a form of direct practice support that is conducted by individuals who identify as having lived experience of mental health issues, trauma, psychiatric illness or severe and persistent distress.⁴

Peer work

Professional work that is undertaken by individuals who utilize their own lived experience, in addition to professional competencies, for the purpose of supporting other people. It includes a range of roles such as peer support work, education and training, advocacy, consulting and advisory roles.⁴

Recovery

A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness or distress. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the profound impact of mental distress.⁵

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1. Chapter One - Background

1.1. Introduction

This chapter introduces the research problem and provides a brief overview of some key concepts (e.g. mental distress, the ED and peer support work).

1.2. Mental distress

Mental distress is an important human experience that may at times require support from services, such as the ED. The term 'mental distress' is used in this report in preference to previous conceptions (e.g. mental illness) that have been criticized for pathologising individuals and their experience.⁶

Individuals experiencing mental distress remain subject to stigma and discrimination within our health system. For example, national data shows that individuals presenting with mental distress often endure exceptionally long wait times and are frequently triaged as less urgent than those with physical conditions.⁷ Be it the function of limited resources within the ED or misconceptions regarding the need for urgent care by staff members, the ED is a space where trauma informed care is yet to be appropriately implemented.⁸

1.3. Emergency Departments

Hospital Emergency Departments (ED) in Australia are often poorly equipped to respond to individuals who present with mental distress.^{2, 7} Individuals experiencing mental distress may attend a hospital ED for emergency treatment and/or to access service pathways.^{2, 9} Consumers and families/friends/support persons may experience further distress in response to social, environmental or service factors, including stigma while attending an ED.¹⁰ Notably under-resourced in terms of time, capacity and training, ED staff are currently limited in their ability to respond to individuals who are experiencing mental distress; this is impacted, in part, by the high number of individuals waiting for beds, those experiencing access blocks⁷ and the impact of substance use.¹¹ Therefore, it is essential that innovative approaches towards support are introduced to support consumers and families/friends/support persons to navigate responses to mental distress. Peer support work could be an effective and recovery-orientated approach to mental health support in the ED.¹²

Public EDs are an essential part of the Australian health care system and an important gateway to the mental health system.^{2, 7} Emergency departments provide medical care for physical and mental health conditions 24 hours of the day, 365 days of the year, most often at no cost to the attendee.¹³ In 2017-18 the Australian public health system had 286 EDs which saw 8 million presentations.¹³ The Mental Health Triage tool¹⁴ is used to assess and prioritise each presentation. Of the 286,985 nationally reported mental/behavioural health presentations to public EDs 2,887¹³ were triaged as emergency (to be seen within 10 minutes), and 17,030 as urgent (to be seen within 30 minutes).¹³ Despite the often urgent nature of ED presentations that feature mental distress, these individuals often face long wait times.² For example, it has been reported that between July and September in 2018 that 53% of individuals presenting with mental distress waited more than 8 hours in the ED before being admitted to a mental health bed.¹⁵ In contrast, 72% of all ED presentations are seen within four hours.¹³ Considering that there has been a 9% rise in overall ED presentations between

2015 to 2016, it is likely that this problem will increase although recent innovations such as Living EDge and other programs aim to alleviate this pressure.^{15, 16}

Generally speaking, consumers and families/friends/supporters that attend the ED are required to endure this often frightening and chaotic experience on their own; frequently encountering power differences between themselves and staff, as well as systemic issues. The ED setting (e.g., the physical environment, specifically; 24/7 lighting, noise, chaos, lack of privacy)¹⁷ may intensify mental distress and contribute to the poor experience of consumers and families/friends/supporters.² Consumers and families/friends/support persons often manage this experience with little or no therapeutic support. Overall, consumers attending EDs have reported feeling intimidated, insecure, afraid and uncomfortable.¹⁸ Additionally, consumers have expressed feeling shame and guilt for presenting, compounded by the triage process which can be experienced as judgmental.^{18, 19} There is good evidence that peer support workers may improve people's experience of mental health services, by using their personal experiences of distress and recovery to support others.²⁰⁻²⁴

1.4. The history of peer support

The provision of mental health peer support dates back to the 18th century in France and re-emerged more recently in Western countries such as America and England.²⁵ In the 1970's, the emergence of self-help groups facilitated the growth of peer support, based on the premise that people who share similar experiences can offer greater empathy, validation and hope.²⁵ Peer support in mental health services is rooted in the process of giving and receiving support based on principles of relationship, respect, learning, mutuality, hope and shared power.²⁶ Chinman and colleagues expand on these principles by defining peer support as "developing coping and problem-solving strategies for illness self-management; drawing on lived experiences and empathy to promote hope, insights, skills; help engage in treatment, access community supports and to establish a satisfying life" p. 430.²⁴

Therefore the literature identifies a clear distinction between peer work roles and traditional practitioner roles in mental health, with peer work roles defined as the ability to draw from lived experience and experiential knowledge.^{27, 28} Hence, peer workers represent a unique workforce that are employed to use their personal experiences of diagnosis, service use and healing to support others. Peer roles also exemplify the possibility of personal recovery for people experiencing mental health challenges.²⁹ Personal recovery for people experiencing mental health challenges focuses on a holistic approach emphasizing hope, autonomy, informed choice, connection and the existing strengths of the person receiving services.^{5, 30}

Internationally, there has been a substantial growth in the peer workforce within mental health services since the 1990s, with peer workers viewed as an integral part of mental health care systems.^{31, 32} In Australia and internationally, peer workers are increasingly employed both outside and within mainstream service delivery. These include a range of settings including consumer run services, prisons, hospitals, community mental health services and non-government services. The employment of peer roles within services has been driven by mental health reforms and evidence of the benefits of peer work.¹⁴

As an emerging workforce, evidence suggests that lived experience workers are at least as effective as traditional mental health workers,³³ with several studies providing evidence of the effectiveness of peer work including reduced hospitalisations.^{34, 36} Further, peer support has demonstrated unique benefits in supporting engagement, promoting hope, activating self-management, combating stigma and facilitating wellbeing.^{24, 37}

The benefits, however, extend beyond people accessing services and include benefits for traditional workers and the organisation including more hopeful and less prejudicial attitudes towards people experiencing mental distress.^{29, 38, 39} Given the need for peer workers to maintain their unique perspective, there are additional concerns for co-option of these roles as peer workers are increasingly being employed within mainstream settings. The potential for co-option arises through tensions between lived experience perspectives and the medical model as lived experience workers are impacted by dominant ideologies within mainstream settings.⁴⁰ Research has uncovered factors that contribute to the effectiveness of peer work within traditional mental health service delivery e.g. adequate training and appropriate supervision; role clarity⁴¹ and supportive workplace culture.⁴²

1.5. Mental health peer support in Australia

In 2019 the Victorian Royal Commission into Mental Health stated that the peer workforce will be an essential part of the mental health system moving forward; also emphasizing the importance of organisational readiness.^{43, 44} The Victorian mental health system introduced lived experience roles/peer support in 1996.⁴⁵ The rise of peer support programs in Victoria is often spoken about in relation to the de-institutionalization and decommissioning of the asylums.⁴ However, it is also a part of a larger movement which seeks to re-orientate ideas around health and healing in a way that embraces the whole person as they are.⁴⁶

In Australia, the National Standards for Mental Health Services (2010) and Fifth National Mental Health and Suicide Prevention Plan states that consumers are integral to the development, planning, delivery and evaluation of services. Although individuals with lived experience may be employed in a number of roles (e.g. advocacy, consultancy, research, education/training, etc), peer support roles are distinct as they utilize direct practice skills in order to support another person who has experienced mental distress. It is now possible to undertake the Certificate IV in Peer Support Work, however this training can be expensive and difficult to access.⁴⁸ Training in Intentional Peer Support training (IPS) is highly valued and very common in Victoria.

Victoria,⁴⁹ Queensland⁵⁰ and Western Australia⁵¹ have recently published peer support workforce guidelines/frameworks; national peer work force guidelines are expected to be released by 2021.⁵² Literature from lived experience academics also highlight occupational challenges such as role clarity, unfair conditions/pay, feeling isolated/being a lone wolf, lack of supervision, lack of training/accreditation and minimal opportunities for employment mobility.⁵⁰

Of note, peer support has long been utilized within the AOD community, including 12 step programs and peer run services such as Self Help Addiction Resource Centre (SHARC).⁵³

1.6. Innovations in service provision – supporting the ED

The ED is a pivotal part of the mental health system, both in its own right and because it acts as a gateway to other service pathways.^{2, 54} The draft report on mental health from the Productivity Commission states that alternatives to EDs for individuals experiencing mental crisis is a top priority.⁵⁵ At this time, a number of new programs/initiatives have been developed in Victoria to reduce the pressure on EDs and improve mental health care,¹¹ as described in Table 1.

Table 1. Local programs supporting mental distress in the ED

PEER SUPPORT – AUSTRALIA			
ED Peer support program ⁵⁶	St Vincent's Hospital (Fitzroy)	PSW x 1	Provides peer support for individuals attending the ED
Acute in-patient/ED liaison ⁹	St Vincent's Hospital (Fitzroy)	PSW and nurse	Provides peer support to individuals being admitted from the ED into inpatient ward
Safe Haven Cafe ⁵⁷	St Vincent's Hospital (Fitzroy)	PSW, social workers, volunteers	After hours drop in, non-acute ED alternative
Hospital Outreach Post-suicidal Engagement (HOPE) ⁵⁸	Bendigo Health (outreach to Mildura) Hospital; Ballarat Health Service (outreach to Horsham); Latrobe Regional Hospital; Mercy Health; Monash Health; Melbourne Health	Various	Support for individuals at risk of suicide and/or self-harm
In-patient peer support	VIC -Multiple locations	PSW	Peer support for individuals admitted to the psychiatric inpatient unit
Post-discharge support ⁵⁹	VIC - Multiple locations	PSW	Peer support for individuals after discharge from the psychiatric inpatient unit
AOD ED peer support	Peninsula	PSW	AOD support in the ED
Living EDge ⁶⁰	QLD - Redland	PSW	PSW supported ED alternative
Pre Admission Liaison ⁹	St Vincent's Hospital (Fitzroy)	PSW	PSW pre-admission support
CLINICAL/NON-PEER PROGRAMS			
Crisis Hubs	Royal Melbourne Hospital, Barwon Health, Monash Medical Centre, St Vincent's, Sunshine and Frankston hospitals	Psychiatrists, mental health nurses and social workers	Urgent/crisis care for mental health/AOD, plus separate 24-hour, short-stay units in ED

* AOD - alcohol and other drugs, ED – emergency department, PSW – peer support worker

These programs highlight how a multifaceted approach should be developed to address this complex problem.

1.7. Conclusion

Understanding the ideal responses to people who are experiencing acute mental distress and attending the ED is an important issue which requires further investigation. This research problem may be addressed through the introduction of peer support programs in the ED although further evidence will be required.

2. Chapter Two - Project aims and methodology

2.1. Introduction

Emergency departments are often poorly equipped to respond appropriately to people who present with mental distress. This is in relation both to the physical environment and knowledge and personnel. There is good evidence that peer workers improve people's experience of mental health services by using their personal experiences of distress and recovery to support others. Our project aimed to identify the optimal role for health peer support workers in an emergency context. Our plan was to co-produce a research project that works towards the development of an innovative proposal for how peer support work in the ED could be further developed, drawing on research evidence in mental health and the built environment, stakeholder perspectives, and expertise from lived experience. This preliminary proposal will complement current innovations in peer roles and emergency settings. Our approach to the methodology and design of this project has been innovative because our project and Expert Panel have been based on, and guided by, principles of co-production. This includes power differences being acknowledged and explored, consumers (or people with lived experience) being partners in the project from the outset, and using the project as an opportunity to grow consumer leadership and skills. Also innovative is the explicit inclusion of the built environment's role in supporting consumer capacity building and leadership.

The findings of this program of research should be interpreted within the following limitations. Firstly, we are deliberately positioning the product of this project as preliminary research in the development of an approach. It includes both a conceptual component and practical suggestions sourced from relevant literature, expert advice, observation, interviews and workshop, and constitutes rigorous and foundational work in the further development of future approaches, but it remains a relatively small first step. Secondly, the next phase of this work needs to include a broader review of the literature, drawing lessons from the body of research on peer employment. Thirdly, outstanding questions need to be considered, including whether situating peers within the actual ED environment is the best option (or if directing people to alternate, peer-staffed spaces is more appropriate). Lastly, some piloting and careful evaluation of both proposed and current efforts of including peer support work in the ED is required.

Developing this program of research directly draws on the unique contributions of peer workers and will complement and enhance current understandings of appropriate ways to support people in mental distress. This includes how to recognise issues in the physical environment and respond appropriately. For example, how to support people to achieve more privacy, reduce noise and unnecessary interruptions while also utilising the resources that are available and ensuring the safety of all, including ED staff. This is timely in an era of increased focus on ED initiatives and alternatives including the development of the ED crisis hubs in some Victorian hospitals and the introduction of post discharge peer support workers.

2.2. Project aim

The aim of the research program was to co-produce findings that contribute towards the development of preliminary recommendations regarding peer support in emergency departments for people presenting with mental distress that could then be further investigated, piloted and evaluated.

2.3. Research phases

The project was comprised of four phases:

- **Assemble Research Team and Expert Panel**
The Expert Panel brought a broad range of experience and expertise including from direct experience of EDs as consumers, consumer academics and being peer workers. At least half of the members have lived experience of mental ill health and recovery. Other members included academics and service providers with expertise in health, psychiatry, nursing, social work and architecture, planning and design. The Expert Panel collaboratively developed a program logic (see Appendix - Supplementary Figure 1.) for the project and the finalised project plan.
- **A literature review**
The Expert Panel supported a consumer academic/researcher to undertake a scoping review of the literature (including the grey literature) regarding peer support in EDs and also investigated non-clinical alternative for support for people coming to EDs in mental distress. The panel assisted to develop the key search terms for the review.
- **A site visit of the ED at St Vincent's Hospital (Fitzroy)**
Team members undertook a site visit at one metropolitan (St Vincent's) ED. We intended to do a site visit at Barwon Health but this was not included due to unforeseeable delays in obtaining ethics approval and then the impact of Covid-19.
- **Consultations with key stakeholders were held including focus groups (consumers; family/friends/support persons; ED staff) and a mental health peer workshop.**
Team members conducted interviews with a range of key informants to gain new perspectives and discuss the findings and implications of the literature review.

Findings have been integrated from the literature review, interviews, site visit, workshop and the Expert Panel to collaboratively develop these preliminary elements that could be further developed into an approach for introducing peer support work in to EDs that could be feasibly piloted as a next phase of this work.

2.3.1. Ethics

This program of research was approved by St Vincent's Hospital (Fitzroy) Human Research Ethics Committee (HREC-A 099/19).

2.3.2. Participants

The participants varied in each of the research phases.

Step One: The Expert Panel consisted of 20 individuals; half of whom identified as having lived experience of mental distress or otherwise experience caring for or supporting people with lived experience of mental distress. Organisations represented included Mind Australia, the University of Melbourne, Yale University, RMIT, Department of Health and Human Services Victoria, St Vincent's Hospital, and Australian College of Emergency Medicine, Tandem and NorthWestern Mental Health. Individuals with lived experience attending in their own time were reimbursed for their time.

Step Two: The scoping review was designed and conducted by a lived experience academic in consultation with the Expert Panel and is reported in Chapter Three. The second reviewer was a PhD candidate with lived experience (University of Melbourne).

Step Three: Three members of the Research Team attended St Vincent's Hospital to complete a site visit of the ED; project staff were led by a peer worker from St Vincent's. The findings from the site visit are reported in Chapter Four.

Step Four: Focus group were held with consumers (n = 7), family/friends/support persons (n = 5) and ED staff (n = 7); this is reported in Chapter Five.

Step Five: A mental health peer workshop was led by two lived experience academics from the project team. Peer support workers (n = 11) attended the workshop; this is reported in Chapter Six.

2.3.3. Consumer focus group participants

Of the 7 consumer participants, 6 chose to complete a brief demographic questionnaire. All participants identified as mental health consumers and reported that they had accessed the ED between 2013 and 2019. One participant reported that they had the ED once, two attended twice, one attended between 3-4 times and two attended five or more times. One participant reported that they were seen by a doctor/other clinician and discharged without treatment, two identified that they were seen by a doctor/other clinician and discharged with treatment, three identified that they were admitted into a mental health inpatient unit.

Participants were aged between 23 to 63 years of age, of which three identified their gender as female, one reported their gender as male and two did not specify. All participants identified their cultural background as Australian and the language spoken at home as English.

Five out of six participants reported having a support person during their last visit to ED. Reported support persons included partners, parents – including step-parents – and extended family (e.g. sister-in-law).

2.3.4. Friends/family/support person focus group participants

Of the five friend/family/support person participants, each person completed a brief demographic questionnaire. All participants identified as having supported a mental health consumer to attend the ED between 2011 and 2019. One participant reported that they supported a person who attended the ED once, three participants reported providing support three or four times and one reported providing support five or more times. One participant reported that the person they were supporting left before they were seen by a doctor/other clinician, two reported that the person they were supporting was seen by a doctor/other clinician and discharged with treatment, two identified that the person they were supporting was admitted in to a mental health inpatient unit.

Participants were aged between 45 to 64 years of age; all identified their gender as female. Three participants reported their cultural background; one identified as Australian, one identified as Greek and one identified as Spanish. All respondents reported that English is spoken at home; one respondent reported that both English and Spanish are spoken at home.

All five participants identified that the person they were supporting was a family member. Of which, two identified that they were supporting their child, one identified supporting their spouse, one supported their brother and one supported one of their parents.

2.3.5. ED staff focus group participants

Of the 7 ED staff participants each person completed a brief demographic questionnaire. All of the participants identified as currently working in a public hospital in Victoria in a role connected to ED. Two participants also reported experience in private hospitals; one reported experience in a rural hospital.

Six participants identified as a nurse, of which one identified as a nurse practitioner. A further participant identified as a social worker from the mental health team. All of the nurses reported that they were involved in triage, assessment/treatment and discharge; one also identified post-ED support as a part of her role. The mental health worker also identified as participating in discharge.

Of the 7 participants, 3 reported their role as full-time, two as part-time and two as both full-time and part-time which may indicate a combination of one or more part-time roles which constitute full-time hours.

Six of the seven participants reported their age. These participants were aged between 25 to 40 years of age and reported their cultural background as Australian/Caucasian and that English is spoken at home. Six participants identified their gender as female, one participant identified as male.

2.3.6. Workshop for mental health participants

Of the eleven peer worker participants, ten completed a brief demographic questionnaire. All participants identified as current peer workers in metropolitan services such as hospitals and mental health inpatient units, Continuing Care Units, Prevention and Recovery Centres, post-discharge programs, community mental health and dual diagnosis programs. Of which nine participants identified that they were in peer support worker roles; one identified as working as a consumer consultant in training/education.

Of the participants, four reported working in pre-ED support, three in triage support, four in assessments and treatment, four in discharge and seven in post-ED support. One participant reported ED-based support.

Participants were aged between 27 to 46 years of age, of which five identified their gender as female and five reported their gender as male.

2.4. Conclusion

This Peers in ED project used a six-step research process. Further detail, regarding the method used in each phase is present in the corresponding chapter.

3. Chapter Three – Literature review

3.1. Introduction

This review of peer reviewed and grey literature sought to identify literature germane to the development and implementation of a peer support program for people experiencing mental distress in the ED. This review was conducted in accordance with the Joanna Briggs Institute's methodology for scoping reviews,⁶¹ which acted as a guide for the methodology including the development of the 'Participant, Concept and Context' and the 'Search Strategy'.⁶¹ The process and findings are reported according to the PRISMA's guidelines.⁶²

3.2. Review method

This review included peer-reviewed and grey literature that could inform the development and implementation of a peer program to reduce mental distress in individuals attending EDs; the experience of consumers, family/friends/support persons and staff are considered.

Inclusion

Participants: peer workers and individuals attending an ED or family/friends/support persons; 18 years or older

Concept: mental distress

Context: hospital ED; alternatives to hospital EDs

Exclusion

Not written in English; no translation available.

3.2.1. Search strategy

Databases searched include MEDLINE, CINAHL, PsycINFO, SocINDEX, Cochrane Library and Web of Science databases and grey literature. Searches were conducted in March 2019. No year restriction was applied. Relevant unpublished data were requested from authors.

3.2.2. Search terms

Broad search terms reflecting the Participants, Concept and Context were used to capture as many interventions as possible that contained information regarding the development and implementation of peer-support programs to reduce mental distress in individuals attending the ED.

"peer work*" or "peer model*" or "peer workforce" or "peer support*" or peer-staffed or "peer orientat*" or peer-run or "lived experience" or "lived workforce" or "life experience*" or "expert by experience" or "psychiatric survivor*" or "service user*" or consumer* or in-patient* or carer* or caregive* or "informal support" AND "mental distress" or "mental illness" or "mental health" or "behavio* disturbance*" or "restraint or seclusion" or SMI or "serious mental illness" or psychosis or "personality disorder*" or "emotional trauma" or "psychological trauma" or "emotional distress" or "psychological distress" or "psychiatric crisis" or "behavio* distress" or "suicidal ideation" or "suicide attempt" or self-harm or "psychiatric distress" or "mental disturbance*" or "code grey" or AoD or "alcohol and other drug*" or "substance use" or "substance abuse" or "dual diagnosis" AND "Emergency department*" or "emergency room" or ER or "accident and emergency" or "emergency ward*" or "respite or emergency nurse*" or "emergency staff" or "emergency clinician*" or "psychiatric patient*" or ambulance or "built environment" or "therapeutic environment"

3.2.3. Study selection

Results were uploaded and screened for duplication. Two reviewers screened studies via title, abstract and full text (CM, HR) and assessed them for inclusion independently. Authors were contacted if it was unclear if the intervention met the inclusion criteria; publications in which the authors that did not respond could not be assessed for inclusion. Disagreements were resolved through discussion or consultation with a third reviewer (LB).

3.2.4. Data extraction

The author, date of publication, country of authorship, methodology, and findings (etc) were extracted on to a custom spread sheet. Due to the emerging nature of this discourse additional literature regarding the physical environment of the ED was sought.

3.3. Results of the review

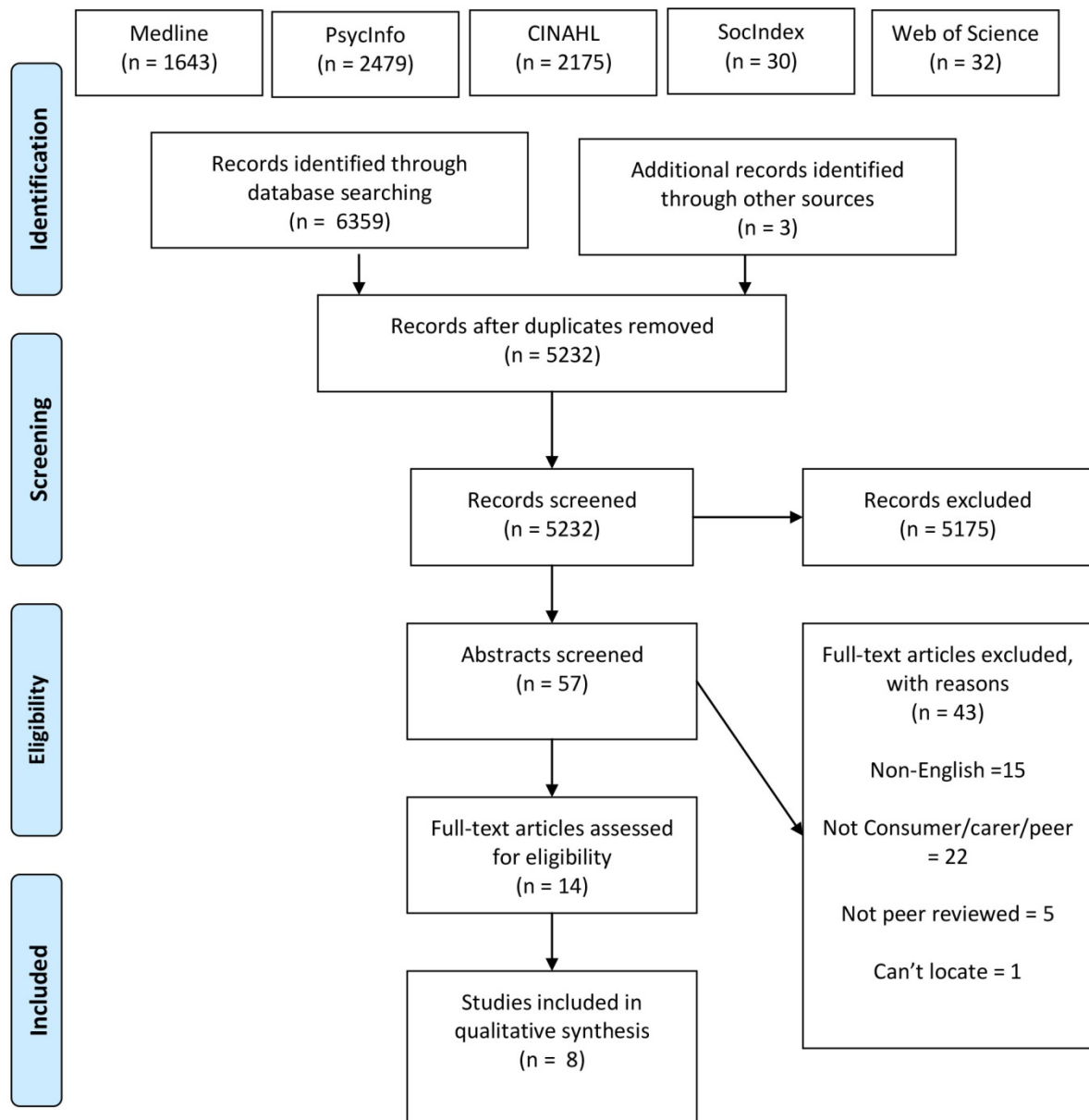
Overall, six peer reviewed publications were identified;^{3, 63-67} of which only one was set in the ED.⁶⁶ A further two publications were identified from the grey literature.^{9, 16} The remaining study's addressed services that an individual could access instead of an ED for mental distress (see Tables 2, 3 and 4).

Important themes arising from this work included the role/impact of time, culture and the overall health and systemic issues. Further, considerations effecting service-level delivery, the service environment, the service user and the peer support worker were reported.

Study selection

The PRISMA flow diagram is shown in Figure 1.

Figure 1. PRISMA chart



From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). *Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement*. PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097

For more information, visit www.prisma-statement.org.

Table 2. Summary of included peer reviewed publications

AUTHOR	COUNTRY	SETTING	PARADIGM	METHODOLOGY	CONSUMERS	OUTCOMES / MEASUREMENT TOOL	RESULTS
Canady et al., 2018 ⁶³	US	Crisis respite	Quantitative/ research update	Anecdotal	Not reported	Medicaid use	Cost-effective, reduced hospitalizations
Fletcher et al., 2019 ⁶⁷	US	Crisis respite	Qualitative	Ethnographic	(N =12)	None stated	Included MH and AOD service users. Emergent themes i) Systemic pressures on public MH services; ii) Peer confusion about programs covert goals; iii) Interpersonal tensions in dominant and emergent governance.
Johnson et al., 2018 ⁶⁴	US	ED divisional	Research update	None	Not reported	None stated	Explains the 'Living Room' model and relevant background.
Lawn et al., 2008 ⁶⁵	Australia	Hospital avoidance/ early discharge	Mixed method	Pilot evaluation	Service users (n = 49)	Bed days saved, crisis service contact, ED presentations and readmission rates. Plus feedback (consumers, carers, mental health staff, GPs, peer workers)	Reduced bed days, cost, re-admission. Emergent themes i) Importance of someone who understands; ii) Discharge experience improved; iii) Improved continuum of care; iv) Peers as a positive role model; v) Walking with the person.
Migdole et al., 2011 ⁶⁶	US	Psychiatric EDS	Qualitative/ research update	Observational/ anecdotal	MH and AOD service users	None stated	Sustained peer employment; flexibility of work conditions; continued training and development of peers; consumers felt respected and understood.
Shattell et al., 2014 ³	US	ED divisional	Qualitative	Phenomenology	N = 18; 9 service users; 5 peer counsellors; 4 clinical staff	None stated	i) A safe harbour; ii) At home with uncomfortable feelings; iii) It's a helping, not judging zone

Table 3. Summary of included grey literature

AUTHOR	COUNTRY	SETTING	DOCUMENT TYPE	CONSUMERS	AIM/OBJECTIVES	RESULTS
Chavulak et al., 2018 ⁹	Australia	ED	Research report	Consumers presenting to the ED	To describe the impact of a Pre-Admission Liaison (PAL) Team/ acute inpatient ward	The PAL intervention was rated as “Excellent” by almost half of the 15 respondents. 7 respondents scored the peer component as “Very helpful”, a further 2 scored it as “Extremely helpful.”
Glover, 2019 ¹⁶	Australia	Peer-hosted ED alternative and community support	Service framework for Living EDge Room and Living EDge Community	Individuals experiencing suicidal distress	Establish a peer led and run service to increase support to individuals experiencing suicidal distress using peer support	Launch of one peer supported programs to support individuals presenting to ED and in the community.

Table 4. Key skills, knowledge and values identified in the reviewed publications

	SKILLS	KNOWLEDGE	VALUES
Peer Workers	Recovery-orientated practice ^{3, 9, 16, 65-67} Lived experience (mental illness/recovery/caring) ^{3, 9, 16, 65, 66} Empathy and compassion ^{9, 16, 65} Relational skills ^{9, 65}	Wisdom ⁶⁵ Leadership/role model ^{9, 65} Support from other peers ^{3, 16, 66, 67}	Recovery values, e.g.: Hope ^{3, 9, 16, 65, 66} Choice ^{3, 9, 16, 65, 66} Autonomy ^{3, 9, 66} Self-empowerment ^{3, 9, 16}
“Peer specialist positions promote a renewed sense of hope for the possibility of recovery, while also offering unique and valuable competitive employment options for mental health consumers.” ⁶⁶			
Service	Remunerated peer role and benefits ⁶⁵⁻⁶⁷ Defined professional peer role ^{65, 66} Line management and peer supervision ^{63, 65, 66} Peer related training and professional development ^{9, 63, 66, 67} Supports peer workers in their ROP ^{46, 65, 66}	Access to specialist knowledge (e.g. clinicians) ⁶⁴⁻⁶⁶ Multidisciplinary support ^{3, 64-67} Staff training/education ⁶⁶ Opportunities to contribute (e.g. committees, leadership roles) ^{9, 66} Medical model ⁶⁵	Fairness in supporting peer workers ^{9, 65, 66} Supportive work culture ^{3, 65, 66} Supports self-care and sustained wellness ^{65, 66} Peer “champions” ^{3, 66} Culture of peer-empowerment ^{9, 66}

SKILLS		KNOWLEDGE	VALUES
Collaborative ⁴⁶ Provides appropriate resources (e.g. telephones) ^{3, 67}			
“Using peers to provide support to consumers at this stage of their recovery seems highly effective as an adjunct to mainstream mental health services.” ⁶⁵			
Program participant/s	Importance of carer support ⁶⁵ Passive vs. empowered recipients of care ⁶⁵ Support strategies for relieving distress ^{9, 64} Problem solving ³ Possibility of forced treatment Coping skills ³ Decision-making ⁶³ Navigate complex support needs (e.g. housing, AoD) ⁶⁷ Social engagement skills ⁶⁷	Resource scarcity ⁶⁸ Illness model - ‘What is wrong with me?’ ^{63, 65} Uncertainty – ‘What is happening to me?’ ^{3, 65, 68} Past presentations /admissions ⁶⁵ Frequency of presentations ^{9, 65} Prefers non-medical language ⁶⁵ Long wait times in ED ³ Accessing referral pathways ⁶³	Recovery values ^{9, 64-66} Trauma informed ⁶⁶ Involvement ⁶⁵ Being listened to ^{9, 65} Comfort ^{64, 65} Empowerment ⁶⁵ Inclusion ⁶⁶ Self-determination ⁶⁶ Free from stigma ⁶⁶ Hope ⁶⁶ Rights ⁶⁶ Dignity ⁶⁶ Person-centred ^{3, 9} Access ³
“The peer counselors are really caring, and they have been through things so they understand.” ³			
Environment	Amenities Communication facilities ³ Self-care facilities e.g. tea/coffee/water ³	Amenities Need for privacy ³ Role of soft/natural light ³ Physical Environment Welcoming/comfortable ³	Amenities Reduction of wait times/boarding ³ Physical Environment Home-like/on-clinical ^{3, 63, 68}
“Our analysis also reveals that persons in emotional distress welcome care and support by registered nurses, counselors, and peer counselors in non-clinical, safe, and comfortable settings.” ³			
System	Integrated into broader service system ^{3, 16, 63, 65, 66} Systemic issues ^{16, 68}	Links to community supports ^{16, 65} Cultural & linguistic sensitivity ⁶⁵	Cost-effectiveness ⁶⁵ Reduced service use ⁶⁵
“Participation in this [peer support] program proved quite significant as it reflected a commitment to treating the peers as valued members of the staff and provided them with a more defined view of their role and related responsibilities within the ED.” ⁶⁶			

	SKILLS	KNOWLEDGE	VALUES
Culture	Recovery-orientated practice ^{3, 9, 16, 65-68} Role of teamwork ⁶⁵ Discrimination ⁶⁵ Crisis-orientated service ^{3, 16}	Recovery-orientated services ^{3, 9} Fast paced ED environment vs long wait times for individuals experiencing mental distress ³	Recovery culture vs medical model ³ Cultural attitudes towards physical vs. mental health presentations e.g. “boarding” ³ Security guards instead of support ³ Provision of medical support ⁶⁶ Increased peer participation ^{16, 65} The value of peer support ^{16, 66} Can people with mental distress lead a meaningful life? ⁶⁵ Stigma ^{3, 16}

Micro:

“The peers carried out these critical functions through specific activities that included discussing hospital procedures and patient rights; sharing their own stories of psychiatric recovery as a means of problem solving and inspiring hope; offering emotional support in the form of an attentive ear or a companion to play cards; and providing basic physical comforts such as blankets, towels, meal trays, reading materials, and water.”⁶⁶

Mezzo:

“The project manager also models and mediates between peers and other service staff as needed to ensure respectful communication by staff and to troubleshoot any potential issues as they arise.”⁶⁵

Macro:

“Some critics...question if recovery-oriented practices have merely served as a rhetorical flourish on neoliberal economic policies to further erode social welfare programs through the privatization of formerly public mental health care and the emergence of new expectations regarding an individual’s “ability” to recover from mental crisis.”⁶⁷

3.4. Limitations

The findings of this literature review should be interpreted in the context of the following limitations. Overall, the review found that publications addressing the implementation of peer support within the ED were scarce, were often reported poorly and did not address effectiveness; these are important areas for future research. Overall, it was not possible to ascertain if the elements reported in these publications would be effective. Comprehensive evaluations of future peer support programs in the ED could improve the level of evidence. Research into potential prospective and retrospective data may be of benefit. Therefore, there is currently little local information which specifically addresses this research problem.

3.5. Conclusion

This chapter presented the findings from a literature review that investigated peer support within the ED or ED alternatives. Of particular value were descriptions of the skills, knowledge and values attributed to peer support work in the included publications. Of note, only one publication addressed support within the ED environment while the remaining was set in ED alternatives. Future reviews may investigate ED alternatives using more specific methods. Having conducted this review, it is clear that substantial investigation into this topic requires direct inquiry beyond the literature and needs to extend to other sources including consulting with key stakeholders through activities such as focus groups and site visits. The conceptualisations synthesised from this chapter are presented in the Appendix - Supplementary Figure 2.

4. Chapter Four - Site visits

4.1. Introduction

The site visit to St Vincent's Hospital ED and Safe Haven program was completed on the 31st January, 2020. The site visit was led by a Peer Support worker from Safe Haven with experience in supporting individuals experiencing mental distress in the ED. This site visit was attended by Prof Lisa Brophy, Dr Andrew Martel and Catherine Minshall from the project team.

4.2. Findings

The participants were asked to take notes about the observations and thoughts that they experienced on the site visit. These themes and notes were discussed and the following themes emerged.

4.3. Safe Haven – ED alternative

Safe Haven is a recent mental health initiative that has been implemented at St Vincent's Hospital. Safe Haven is set within the original hospital building and features heritage windows and high ceilings; it is a short walk to the ED. The environment is spacious, home like and well maintained. It operates as a flexible space and is used as an art gallery during the week. As a result, the Safe Haven staff have adapted and rearranged the spaces furniture and they lay out bean bags, games and books; the staff return the space as it was found at the end of the shift. This program has increased the number of options available for those who may attend the ED and increased after hours support. Both peer support workers and clinicians staff Safe Haven although no referral or appointments are required.

4.3.1. Entering the ED

The members of the Research Team noted that individuals seeking to attend the St Vincent's ED would likely encounter a number of challenges and barriers. It was observed that the ED was difficult to find. Challenges in locating the ED could come from the large hospital grounds in which it is located, the positioning of the ED entrance and the lack of signage to support way finding. It is possible that individuals who are entering via the street may find it confronting that they pass the Security booth in order to enter the ED. Additional entrances are located within the ambulance bay and this is where individuals who arrive via ambulance or police escort are may enter directly into the ED.

4.3.2. Waiting in the ED

The ED waiting room provides an interesting contrast to the clinical spaces such as the nurses' station or assessment cubicles. The researchers noted that, in contrast to the rush and urgency of the clinical spaces in the ED, the waiting room felt as though it existed in "slow time" where everyone was seated watching TV and it was difficult place to be where people were in their progression towards being seen by the doctor. Waiting rooms often lack comfort and privacy for attendees and their support persons. They are generally seated in full view and can thus be seen and heard by ED staff as they wait. While this is true, it is also important to acknowledge there are the safety implications, to ensure consumers that are waiting are visible to staff to check their well-being, observe any deterioration.

The milieu of the ED was that of "waiting." The researchers noted a number of challenges that could be experienced while waiting in this space. Firstly, there were limited private spaces and that it would be difficult to have a private conversation face-to-face or by phone. Further, the layout of the space meant that attendees were always visible to other visitors and could be seen by staff behind the triage desk. This

sense of being visible and overheard is contrasted to spaces which enable privacy and self-care practices. Facilities to support an individual's need for food, water and rest were limited to vending machines and toilets. Similarly, the physical construction of the waiting room meant that there was no window view, natural light or fresh air. Aspects of the waiting room could be experienced as very stimulating (TVs on the wall, 24 hour florescent lighting, confined space/small waiting space/crowding, mixed with physical injuries [e.g. wounds, vomiting], security presence) and, at the same time, profoundly boring.

4.3.3. ED clinical spaces

The clinical spaces provided a stark contrast to the waiting room. This part of the ED is mostly comprised of i) ED clinical bays for clinical staff only; and ii) patient cubicles. Staff only spaces include desks/PC access stations, meeting rooms, staff rest areas and property storage facilities. It is unclear, at this stage, where peer support workers "belonged" in this busy environment. In this ED, the peer support worker's desk was located behind triage and beside the allied health desk. Further questions arose about how these spaces reflected the workflow and protocols within which the peer role would work in this environment, including how the peer support worker might gain access to patients. These spaces were marked by a sense of urgent "hustle and bustle", combined with limited physical space. It was noted that the researchers "always seemed to be in the way". The nurse's desk and clinical spaces were very crowded and there was an observable lack of space.

The clinical spaces gave a sense of "authority" and "urgency". Indeed, a security pass is required to enter these spaces; thus who comes in and out is controlled by staff. The presence of forensic officers/police was observed; a researcher noted that this was intimidating to see – especially their firearms. The space projected a sense of being a highly regulated environment, for example, a TV monitor was used to display a 'dashboard' in the ED including service targets and other quantitative measures of the service.

In the clinical spaces there were a number of features that could disempower or create the potential to inadvertently diminish a person's dignity or privacy, including fabric curtains around beds and seclusion facilities. The researchers noted a number of features that could support recovery including a family room, but access was limited. Generally, the design and location of rooms available that might offer privacy was not ideal.

4.4. Conclusion

The site visit builds on the findings from the scoping review. In particular, it highlights concerns regarding difficulties in supporting peer support workers to find their place in this already chaotic, busy and challenging environment. It confirmed that the physical and environmental issues are important to the development of a preliminary approach to implementing peer support in EDs. Chapter Five presents the findings from the focus groups.

5. Chapter Five – Focus groups

5.1. Introduction

This section outlines the results of the focus groups conducted during the Peers in EDs project. Focus groups were held with consumers, family members, friends and support persons, and ED staff between the 10th and 17th of December 2019.

5.2. Methodology

Recruitment

Participants were recruited using snowball recruitment. Partner organisations (e.g. VMIAC, Tandem) were also asked to distribute invitations to participate. Participants contacted the lived experience researcher (CM) to express interest and be screened for eligibility. Consent was collected prior to commencing the focus groups. Carers (friends, family and other supporters) and consumers who were attending in their own time were reimbursed.

5.3. Data collection

At least one lived experience facilitator led each consultation (approx. 1 hour long). The researchers used a semi-structured interview schedule; each group used the same schedule. The focus groups were audio recorded and transcribed by a professional transcription service.

5.4. Analysis

Thematic analysis was conducted on each of the focus group transcripts according to the methods described by Braun, Clarke and colleagues.^{69, 70} Reflexive thematic analysis of the focus group data was conducted. This analysis style is appropriate for research questions addressing the participants “lived experience” and includes six analysis phases i) familiarisation; ii) generating codes; iii) inductive coding (codes and themes); iv) constructing themes; v) revising and defining themes; iv) reporting.^{69, 70}

The coding was completed by a lived experience academic (CM) and was reviewed by members of the Research Team (LB, NH, HR). Revision and refinement of the themes continued until there was consensus.

5.5. Preliminary key findings

There were common and divergent themes across the findings from the three groups of participants. Four foundational themes arose from the analysis of each focus group: i) individual in distress ii) the ED peer support workers; iii) a Peers in ED service; iv) the ED context, as detailed below and summarized in Table 5. Both emergent and inductive themes arose from the analysis. The themes reflect the complex practical and philosophical components of this research topic.

Table 5. Summary of themes from the focus groups

	FOUNDATIONAL THEMES			
	Individual in distress	Peer support workers	Peers in ED service	ED context
Consumer focus group	Support me	Are peer support workers valued?	Processes	ED culture
	Meaningful engagement - walking together	Finding a place to belong	Peer workforce needs	The physical environment of the ED
	Person-centred care	Role boundaries		Time
	Relationships			Carers and allies
	Dignity			Consumers in the driving seat
Friends/family/ support person focus group				Real change
	Caring for the carers	Are peer support workers valued?	Carer peer workers	Support persons
	Breathing room	The human face in the ED	Trauma sensitive practice	Navigating the system
ED staff focus group	Support to navigate the system	The role of consumer peer support workers		
	Not knowing	Relationships	Collaboration with ED staff	ED culture
	Perception of risk	The human face in the ED	Impact	The physical environment of the ED
	De-prioritising mental health crisis	Listening and engagement	Peer support worker skills	Recognition of risk
				Scarcity
				Time pressures
				Barriers and concerns

5.5.1. Consumers

5.5.1.1 Theme One: Individuals in distress

This theme reflects the perspective of individuals who are attended the ED with mental distress. These findings draw attention to the value of engaging authentically and benevolently with individuals in distress, as experienced by them. In particular, the discussion in the consumer focus groups harks back to inequities which have been previously experienced, including social, cultural and personal injustices that could impact on how someone experiences the ED. In light of these factors values around authentic connections, from individuals and services, was emphasised. Values around the type of support required was expressed and was grounded in respectful and meaningful engagement that supported the individual to exercise choice and autonomy.

“The relationships are at the centre, this is about relationships.”

Subthemes: support me, meaningful engagement - walking together; person-centred care; relationships; dignity

5.5.1.2 Theme Two: ED peer support workers

This theme explores the peer support worker perspective including what their role will encompass. Although peer support work in the ED is not routinely conducted, feedback from the participants highlighted the potential benefit of peers in this setting. The participants included current peer support workers who expressed the importance of feeling supported in their role and feeling valued by their workplace.

"I think that it can be, especially if you're presenting the first time, is what you can expect to occur, I think sometimes the issues can be that you can talk yourself inadvertently into being hospitalised, and I think that knowing what your rights are is really important, and whether you're able to you know fully comprehend that. But I think that you know somebody giving you a bit of an idea of what might occur, or what your options are is probably really important."

Subthemes: *are peer support workers valued?; finding a place to belong; role boundaries*

5.5.1.3 Theme Three: Peers in ED service

This theme explores components and considerations regarding how a Peers in EDs service would run. This research has considered these findings and has identified that organisational and service components such as organisational readiness, staff education and service processes (e.g. referral, documentation, and supervision) are required to implement a peer support work service in the ED.

"And eligibility is interesting, if people are presenting with medical and mental distress which is it their primary presentation that you're going by, and who determines if their primary presentation is mental distress, like there's people who are experiencing physical health and experiencing mental distress, or if they've got a previous diagnosis is that taken into account."

Subthemes: *processes; peer support workforce needs; caring for the carers*

5.5.1.4 Theme Four: ED context

This theme explores the context surrounding the ED, of which the physical environment and culture of the ED provide a formidable challenge. The physical design of the ED was noted by the group to impede recovery and compound distress. Overall, the group suggested that a greater use of low stimuli environments should be tried, however, this may pose a large operational challenge for many services where they are already nearing capacity. Similarly, ED culture was acknowledged as difficult to change, especially with regard to the impact of time pressures on nursing and medical staff. These time pressures are a stark contrast to the extended wait times experienced by people in the ED waiting room. This theme included an emphasis on continuity of care which included considerations regarding the need for person centred care within the ED and how peer support workers may be able to meet this. Overall, the group felt that peer support work was very aligned with person centred care. In particular, the group expressed that relationships were of vital importance. It was also acknowledged that as peer support workers relationships can be challenging to build at times. Although it was expressed that not everyone presenting to ED with mental distress will want to engage with peer support workers it was still important to have that as a choice.

"Someone to be with you and like when say other people haven't got time and there's a long gap, just to explain what's going on, or sit with you and be present with you."

Subthemes: *ED culture; the physical environment of the ED; time; carers and allies; consumers in the driving seat; real change; relationships*

5.5.2. Family, friends and support persons

5.5.2.1 Theme One: Individual in distress

This focus group highlighted that the impact of distress extends beyond the consumer who is presenting, or is considering presenting at an ED. Members of this group spoke about the stress and worry associated with getting access to mental health services and the pressure they feel during a period of extreme distress or crisis. Although the ED journey may last upwards of 8 hours, this discussion draws attention to the role of carers in the period leading up to the ED presentation and a sense of potential anxiety and exhaustion regarding discharge.

“My most perfect way would be to have a separate room that carers could go in and out of, because sometimes it's just too much, we're talking about someone in their most acute sort of distressing moment, so you want to be there but sometimes it can be just too much, but you don't want to leave, so to have a little room where you can just de-stress, have a cuppa and then come back.”

Subthemes: *Caring for the carers, breathing room, support to navigate the system*

5.5.2.2 Theme Two: ED peer support workers

Carers were very passionate in their response to incorporating consumer peer support workers in the ED environment. The conversation often focused on the unmet needs of consumers in this setting although carers identified that they wanted more help navigating the ED/mental health system. Overall, carers saw peer support workers as the human face of support, in contrast to clinical services which may be linked to experiences of trauma and frustration. This focus group expressed that it was essential to provide support to carers, many of whom attend the ED with a loved one who is experiencing mental distress. It was noted that although it was possible for a consumer peer support worker to provide some support to a carer, it may be preferable to also implement carer peer support workers. The group expressed positive views regarding the importance and value of peer support work and expressed concern that consumer peer support workers were not being fully valued by services.

“My experience of not knowing where my son was when I went to ED, I couldn't find him, I thought the police had maybe injured him on the way. Nobody took responsibility for letting me know that he arrived safely.”

Subthemes: *Are peer support workers valued?; the human face of the ED; the role of consumer peer support workers*

5.5.2.3 Theme Three: Peers in ED service

This theme identified that both consumer and carer peer support workers could play an important role in supporting individuals in mental distress and their support persons in the ED. The focus group included family/carer peer support persons who detailed how this role was being utilised in mental health services. Although not in the original scope of this research project, this need was highlighted by this group. Individuals in this group expressed appreciation for consumer peer support workers being the human face of health services, noting the importance of the knowledge derived from lived experience.

“I just think that some information that comes from a lived experience knowledge comes across in a different way than a clinician would.”

Subthemes: *Carer peer support workers too; trauma sensitive practice*

5.5.2.4 Theme Four: ED context

Friends, family and support persons identified a number of contextual elements that impacted on how they conceived of a peer support program in the ED. Of particular importance was continuity of care, both within the ED and in connecting ED pathways to other services. Continuity of care within the ED was discussed in terms of who can be referred and to where, including the pathways for both compulsory and voluntary consumers, inpatient admissions and other services.

"I would love the peer worker or workforce to be able to, with the clinician, say okay well we need an admission here and I'll support you know that process, and talk with the family around what happens there."

Subthemes: *Continuity of care; ED culture; ED environment; system change*

5.5.3. ED staff members

5.5.3.1 Theme One: Individuals in distress

The focus group provides insight into the way that ED nurses perceive individuals in mental distress and the response options they feel are available to them. Many nurses expressed that they would like to better understand individuals who experience mental distress but describe confounders such as the environment and the relentless and urgent demands of their role; indeed these are formidable challenges. Nurses in this focus group expressed a desire to better understand individuals with mental distress although they also expressed some intrepidation about the risks to themselves and the peer support workers in working in this complex environment. In fact, the nurses described times when individuals experiencing mental distress or psychiatric crisis were delayed in receiving urgent care. Overall, the nurses expressed great concern for individuals presenting with mental distress but also expressed a sense of "not knowing". It is possible that this "not knowing" may be linked to de-prioritisation of support which they also described.

"I mean we work up a chest pain patient and we're just trying to smash out the basics to you know, tick our boxes, because then the next ambulance is coming in, so it's not exclusive to psych, but I feel like that they're the people that need our attention more, and we kind of put them on the back burner because they're kind of, they're medically stable so you can move onto your patients that you need to do things for clinically."

Subthemes: *"Not knowing"; presumption of risk; de-prioritising mental health crisis*

5.5.3.2 Theme Two: ED peer support workers

ED staff members were very interested in exploring how a peer support worker could help improve outcomes and support their own roles. The ED staff were quick to identify and discuss practical considerations regarding how a peer support person could be incorporated into the ED setting. The group identified challenges around desk space, supervision/debriefing, support and line management responsibilities. ED staff said that it was important to them that they had the peer support workers' rosters so they knew when they would be available. Participants stated that they valued peer support workers for their skills around listening and understanding individuals in distress; with special regard to their ability to de-escalate potentially volatile situations and restore calm.

"Sometimes he can be an absolute godsend like the patients you can see they're starting to escalate and you just don't have time to go in there and sort of calm them down, because your patients are coming in and out, or you've got a really sick patient and often you'll just find him sort of in there and you can sort of let that patient go for a little bit and not have to worry about them."

Subthemes: *Relationships; human face in the ED; listening and engagement; de-escalation*

5.5.3.3 Theme Three: Peers in ED service

The participants were able to identify a number of benefits to having a peer support worker in the ED and could identify a number of factors at a service level. For example, nurses were concerned with protecting peer support workers who were a part of their ED team. This often entailed a relationship with other parts of the hospital such as security; especially with regard to on the ground de-escalation processes completed by the peer support worker. In contrast, it was also noted that peer support workers capacity for listening and understanding other people who are in distress contributes to an overall improvement in the level of safety in the ward.

“And he works really well within the department, like chats to people; he seems to calm people down.”

Subthemes: Collaboration with ED staff; impact; skills

5.5.3.4 Theme Four: ED context

From the perspective of ED staff it was evident that they work in a complex, high pressure environment in which life and death decisions are made. This environment was described as a crowded one in which important resources (e.g. time, desk space, computers) was scarce. The impact of the physical environment was noted to impact on privacy and it was described as high stimuli. Although ED staff were able to identify these confounders they expressed that they felt stuck and unable to improve them.

“I reckon one of the problems with our department is like the issue of resources, and I’m talking about that practical stuff. Like I think if we had somebody in there full time doing that role in the emergency department, we would actually need to have a space for them, I don’t think, so they’re actually considered a member of our staff. And we don’t have enough computers for nurses and doctors, and we don’t have enough desk space, and I actually think that it could be kind of very alienating for somebody that’s coming in as a peer worker and they just kind of turn up and they haven’t got their spot.”

Subthemes: ED culture; physical environment of ED; safety/risk; scarcity; time pressures; barriers and concerns

5.6. Similarities and differences between the focus group themes and subthemes

This synthesis of findings was organised according to the four foundational themes (the individual in distress, ED peer support worker, Peers in EDs service and ED context) which speak to the practical and contextual elements of the research question. Within these foundational themes a number of emergent and inductive themes arose and constituted the sub-themes, reflecting the practical and philosophical challenges of potentially conducting peer support in the ED. Of note, a number of sub-themes emerged across focus groups. For example, the sub-theme of ‘relationships’ arose in the consumer focus group under ‘individual in distress’ as well as in the ED staff group under ‘ED peer worker’. Likewise, themes regarding ‘ED culture’ and the ‘ED environment’ was identified across all of the focus groups, consumer, friends/family/support persons, and ED staff. Differences were also noted between the focus groups themes. For example, ED staff did not identify relationships as central to their practice but discussed its importance in relation to peer support work.

5.7. Limitations

Future studies should build on these results using robust methods. In particular, it is important that methodologies consider the use of purposive recruitment strategies as this research used convenience sampling. As a result, only one mental health team member and no psychiatrists or other doctors were included in the focus groups. Future research should include other important informants such as medical staff, psychiatric liaison staff, and allied health staff.

5.8. Conclusion

This section has reported the findings from the consumers, friend/family/support person and ED staff focus groups. New contributions to the project include a deeper understanding of these key stakeholder perspectives. Of importance we recognise that support person and ED staff perspectives were thinly addressed in the literature review, making these focus groups of particular value. The conceptualisations synthesised from the focus groups described in this chapter are presented in the Appendix - Supplementary Figure 3. The next section presents the findings from the workshop for peer support workers.

6. Chapter Six – Workshop for mental health peer support workers

6.1. Introduction

A workshop for mental health peer support workers to reflect on and further develop the preliminary elements that could inform peers in ED was held at the University of Melbourne in the Department of Architecture. This half-day workshop sought to further refine the project's findings by engaging current mental health peer workers and seeking their input. All 11 participants had experience working as a mental health peer worker from a consumer perspective.

6.2. Recruitment

Participants were recruited using snowball recruitment and through partner organisations (e.g. VMIAC, Tandem). Participants self-selected and registered for participation by contacting the lived experience researcher (CM). The Participant Information and Consent form was discussed and the consent form was signed prior to commencing the workshop.

6.3. Data collection

Two lived experience facilitators (CM, HR) led the workshop.

A group activity was completed; the participants were divided into three groups and given a topic to explore (see 5.4) and record on poster paper. In an iterative process, further notes were added during the panel presentation and reviewed at the end of the day.

Members of the Expert Panel (S B-H, NC, AM) participated in the panel and group discussion and Professor Lisa Brophy closed the workshop.

6.4. Results

6.4.1 Notes from the group activity – presented verbatim

6.4.1.1 Group 1 – What skills, knowledge and values do mental health peer support workers bring to the ED?

- Listening
- Sit with discomfort
 - Connection
 - Empathy
- Sharing with intent
- Ability to “negotiate”
- Provide confidence and advocacy
- Real world knowledge
- Lived Experience
- Empowerment
- Comfort
- “De-mystify”- Explain the situation
- De-stigmatize

- Confidence in values
 - World view
 - Mutuality
 - Moving towards
 - Culture

6.4.1.2 Group 2 – What is the optimal role for mental health peer support workers in the ED?

- Trauma informed care/approach (and training)
- Having consumer and family/carer peers
- Be present
- Learn skills to sit with distress
- 1:1 work with people in the ED
- Post-discharge support
- Flexible working arrangements and reasonable adjustments
- Active part of the multi-disciplinary teams
- Education (training in psychological de-escalation to support people in distress)
- Working alongside people brought in to the ED by emergency service personnel and supporting them through this journey for them
- Support people to understand the ED processes, navigate the mental health system and understand their journey
- Education and training in AOD
- Lived experience leadership
- Education for other ED staff about peer role
 - Role clarity
 - Reduce stigma and discrimination
- Education and training in homeless supports
- Continuity of care
- Having enough physical space and infrastructure for peers in the EDs – E.g. office space and space to talk with others who need support

6.4.1.3 Group 3 – What do mental health peer support workers working in the ED need from the organisation?

- Program
- Support
- Discipline specific supervision
 - Clear practice framework
 - Peer support framework
 - Training for all peers in EDs, as well as clinicians and doctors in IPS
- List of things to do and don't do
- Space for us – actual desk space
- Clear role definition – career progression appointments
- Decent wages
- Clear roster
- Work adjustment
- Opportunities for on-going training
- Access to extra support for peers

- Anti-discrimination built into the role description
- Language educating staff
- Peer champions
- Debriefing
- Collaborative approach
- Team building
- Coming to the table with disciplines
- Ultimately looking for PW to be valued and respected on-par with other disciplines
- Support for PW who are on their own during the shift!

6.5 Conclusion

This section adds the perspectives of current peer workers. This is an important addition to the findings because the perspectives of peer workers themselves was not comprehensively addressed in the literature review and was not explicitly addressed in the focus groups presented in Section 4. This triangulates previous findings regarding the importance of integrating peer workers, the service and the organisation in the development of a future integrated approach to peers in ED. The workshop also clarifies previous findings regarding the important role and workplace requirements.

7 Chapter Seven – An integration of preliminary research focused on the development of ‘Peers in EDs’

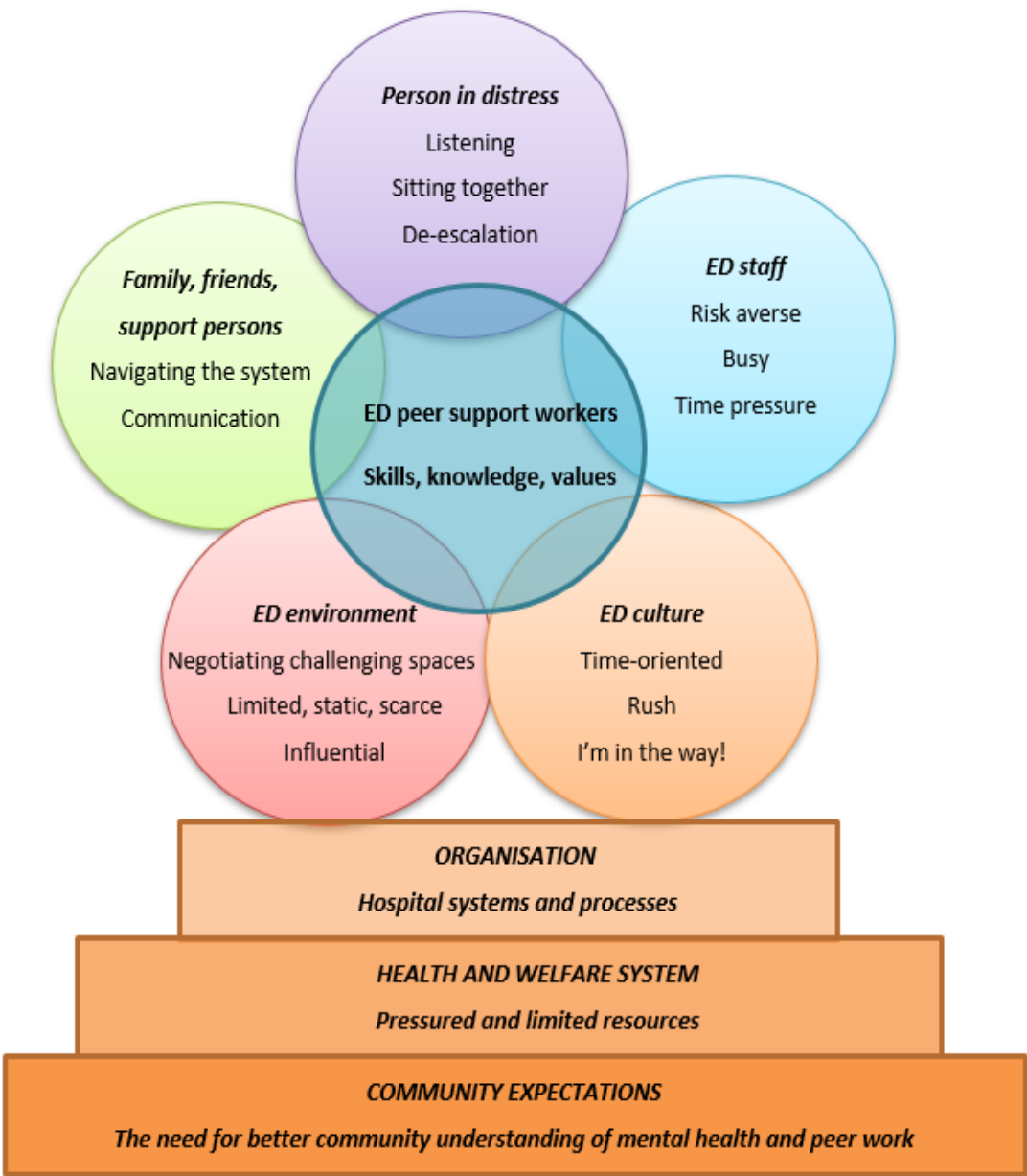
7.1 Introduction

Having considered all the elements in this program of research we present this integrated summary of our findings thus far. This summary highlights foundational elements that would be essential to developing an approach. It includes both a conceptual elements and practical suggestions sourced from relevant literature, expert advice, observation, interviews and a workshop but it remains a relatively small first step. This research sheds light on the potential for peer support workers to participate in multifaceted ways to support individuals in mental distress and their family, friends and support persons. This role may include supporting people in the ED through advocacy, using de-escalation strategies and supporting individuals who are experiencing mental distress and their family, friends and support persons to navigate the ED and foster continuity of care.

The next phase of this work needs to include a broader review of the literature, including the wide body of research on peer employment. Outstanding questions need to be considered, including whether situating peers within the actual ED environment is the best option (or if directing people to alternate, peer staffed spaces is more appropriate). Considerations regarding the setting should take into account factors such as the number of individuals that will be diverted from ED to the peer-staffed space, support requirements for the peer staff (e.g. need to be able to access support from clinical staff), capacity to support complex factors (e.g. AOD, self-harm presentations, medical co-morbidity, security concerns) and how to partner with the ED to ensure that the individual does not risk delaying or foregoing assessment or treatment in the ED. Further, some piloting and careful evaluation of both proposed and current efforts of including peer support work in the ED is required, keeping in mind that each hospital will need suggestions in keeping with their organisational requirements.

This project was developed according to co-design principles,⁷¹ utilising lived experience experts and substantial stakeholder consultations. The project staff would like to acknowledge the importance of these contributions. In light of little literature specifically addressing this topic, this was an essential source of knowledge. Thus, this research constitutes a significant and original contribution to this important topic. Figure 2 highlights the various considerations and key elements considered in this project.

Figure 2. Integrated elements that need to be addressed when considering Peers in the ED



7.2 Components of an integrated approach to peer support in the ED

This research highlighted how the ED is currently the gateway to many important health services. We found that many consumers experience challenges in accessing and receiving support via this gateway and this research responds to this unmet need. A number of positive aspects were noted regarding the potential impact of future implementation of peer support workers in the ED, including:

- 1) Better care for individuals presenting with mental distress in the ED; with an emphasis on non-clinical, recovery-oriented care
- 2) Improved support for carers
- 3) Increased support for ED staff
- 4) Development of the peer workforce; including the development of service and organisational processes.

Further, some concerns were noted, including:

- 1) The ED environment is often poorly designed to support individuals with mental distress, peer support workers may experience limitations regarding how this is addressed and the way it impacts on their work
- 2) Peer support workers may not be sufficiently supported in their role, including lack of peer supervision, role clarity, parity of pay and entitlements and tolerance of peer 'drift'
- 3) Existing ED processes and culture may conflict with peer worker values and duties
- 4) Carers expressed that they would like support from a family/carer peer workers; this is outside the scope of this project.

7.2.1 Consumers

The findings from this research attest to the challenges experienced by individuals attending the ED due to mental distress including lack of support, clinical and impersonal responses to distress, long wait times, lack of amenities, difficulties navigating the process as well as organisational and systemic issues. These findings suggests that an integrated approach is required to this topic, encompassing the individuals, their loved ones, peer workers, ED/organisational staff and the implications for the broader community, and this should be explored in any future research. Figure 2 highlights that clinical care is only one component of a holistic approach to mental distress. For example a consumer from our focus group reported:

"People – anyway, people are here because of treatment or people are here because of a combination of treatment and relationships, and how much importance is the relationship in the treatment."

Our findings suggest that the addition of a peer support worker may ameliorate unmet needs (e.g. having someone sit with you through difficult experiences, navigating the system and encouraging hope).

7.2.2 ED peer support workers

The importance of peer support workers was articulated throughout many aspects of this research project including the literature review and consultations with key stakeholders. They also contextualised this practice with the complex and highly clinical culture of the ED in which there is a clearly defined hierarchy which is discipline and role-based. Considering that peer support workers often report issues such as having difficulty maintaining role clarity and co-opting it could be a challenge to stay true to the peer role and not be become subject to "peer-drift". This environment could also create a conflict between ED culture, which is highly risk-orientated, and peer principles such as dignity of risk and choice. Our findings emphasise the importance of:

- Valuing and supporting peer support work and peer support workers (e.g. unique contribution of lived experience, recovery-orientated, holistic, value-based)
- Supporting peers to stay in their role, prevent attrition and burn out, and develop leadership roles
- Developing organisational and service mechanisms to ensure challenges are responded to and complex issues are considered, so those peer support roles are feasible and sustainable.
- Role-based requirements (e.g. role definition, role clarity, autonomy, EFT, leave and holidays, career progression)
- Service-based requirements (e.g. service processes – referrals, care pathways, communication pathways, and peer supervision)
- Organisation requirements (e.g. belonging to a discipline/team, representation on organisational charts, career advancement pathways)
- The challenge of offering peer support in an environment which is highly clinical, risk adverse and hierarchical.

Of note, this research found that both carers and ED staff stated that they valued the distinct and unique contribution of peer support workers; carers expressed concern that peer support workers may not be supported in their roles. It was noted that ED staff may value peer support workers for their ability and helpfulness (e.g. de-escalation) but may need more opportunities to understand peer support work in greater depth; this is impacted by service and organisation factors (e.g. opportunities and time for training). The review found that “peer specialist positions promote a renewed sense of hope for the possibility of recovery, while also offering unique and valuable competitive employment options for mental health consumers.”⁶⁶ The importance of peer workers as an embodiment of hope, compassion and possibility was recognised in the key stakeholder consultations and in the literature.

7.2.3 Friends/family/support persons

Many individuals who are experiencing mental distress are accompanied to the ED by a person that they know (friend, family member or support person) or may be supported by phone/online communication. This preliminary research takes into consideration the perspective of individuals who identified as carers, friends, family, friends or support persons who expressed their preference to be included (to the extent the consumer is comfortable with) as a part of the broader support team. One focus group participant stated *“So I certainly support consumer peer support workers, but I do see such benefit in a carer being able to, you know, be so significant as part of the team that support.”* The friends/family/support persons focus group found that many of the participants would like peer support from a consumer peer support worker (and carer peer support worker, if possible). In addition to supporting the individual who is experiencing distress it may often be appropriate to offer some support to the carer by helping them understand and navigate the ED system, take a break or use the amenities. To be noted, carer support should be in alignment with the wishes of the consumer and privacy guidelines.

7.2.4 ED staff

These findings reflect the importance of engaging ED staff as partners and equals. The focus group reflected the challenging and complex nature of working in these service environments, identifying barriers including its highly medicalised culture, time pressure and its atmosphere of risk and urgency. These findings have implications regarding the organisations capacity to improve staff education about mental health and peer support amongst this cohort; this is further discussed in 6.2.6. The focus groups identified that nurses lacked opportunities to interact with peer support worker and often did not know when they

were available. ED staff in the focus groups also identified solutions to barriers such as sharing rosters. The findings highlight the need for educating emergency nurses about several key aspects of mental health care and working with peer workers.

It is suggested that the service and organisation will be required to support ED staff to undertake organisational readiness, as well as providing a chance to develop a relationship with peer workers as colleagues (e.g. attending handover/staff meetings, writing notes) and a person (e.g. time together at tea breaks in the staff room). In order to do this the peer support worker will also require appropriate line and peer supervision and mentoring. Mentoring by an ED staff member or a mental health team member may also help, as raised in the staff focus group “So at present if he has a particularly challenging case he will come over to the clinician and a debrief happens.”

7.2.5 ED environment

These findings acknowledge that the physical environment of the ED can be as source of formidable challenges to consumers, peer support workers, friends/family/support persons and ED staff. These findings recognise that short of radical re-developments, it is likely that insufficiencies in the design of ED will constitute an on-going challenge. Peers should be encouraged to advocate for better environmental conditions, when possible. Co-design principles should be employed to include peer support workers and consumers in the development of future modifications or development of the ED.

7.2.6 The individual, the team, the organisation, the community

This element expresses the importance of coming together as individuals, services/teams and organisations to provide holistic person-centred care throughout the continuum of care.

7.3 Conclusion

The findings from this program of research provide important information regarding the elements that should be addressed when developing an approach to peer support work in the ED. It is important to remember that these initial findings will require further investigation in order to work towards a feasible approach that can be confidently implemented and evaluated. It is clear that there is still much that is not known about this topic. Therefore, these findings are of particular importance.

8 Chapter Eight - Discussion and conclusions

8.1 Introduction

The findings of this program of research echo themes identified in the literature review and the broader discourse. This research confirms that the ED is a challenging space to practice peer support work in. In part this is due to its physical environment and the deeply clinical culture; both of these elements appear very rigid and difficult to change. This research is an excellent contribution to the evidence-base, constituting some of the first rigorous research into this topic. None-the-less, it is important that research continues to be developed as so much remains unknown and there is so much at stake.

Based on this project's preliminary findings, we make the following key recommendations regarding peer support in EDs:

- Continuity of care should be maintained for consumers experiencing mental distress from when they arrive in the ED and after they leave by peer support workers and the ED team
- Relationships between peer support workers and ED staff should be supported
- Peer support workers should experience workplace conditions to support optimal performance, mentoring, and retention of staff (e.g. parity of pay/conditions, career mobility, peer supervision)
- Peer support workers should be supported to maintain role integrity and practice in line with peer values
- Education and training about mental health and peer support should be increased to ED staff; this should be peer-developed and delivered by peer workers
- Several peer support workers (rather than one or two) should be engaged at one time into an ED program, to ensure the above recommendations.

In this chapter we build on these recommendations and consider both recommendations and cautions for future research, for peer workers, for family/friends/supporters, ED staff, the environment and organisations.

8.2 Recommendations and cautions

General recommendations and cautions relate to the limited examples of the use of peer support workers in ED, tension in peer values and practice within the highly medical and time pressured environment of ED, and the constraints of the physical environment. Further research into peer support within the ED should be conducted in order to develop a robust understanding of the best approach given these constraints; thus our findings are best considered preliminary. This is in part due to the need to still apply the key concepts we identified to practice and test their effectiveness. Further, the limited literature available did not address the effectiveness of peer support in the ED and has not been evaluated for quality. However, existing examples of the incorporation of peers within ED at St Vincent's Hospital and alternate/adjunct approaches to responding to distress at Safe Haven and Living EDge show that the inclusion of peer-based models of responding to high levels of distress are possible. Yet, the complexities evident from the consultations and untested application of this research defies an easy or one-size fits all application.

8.2.1 Recommendations and cautions for peer workers

The peer workforce is currently undergoing substantial expansion in Australia.⁴ Despite this peer support workers are rarely utilised in the ED; this is reflected in the dearth of research and evidence identified via

the literature review.^{3, 63-67} Indeed, the ED may prove to be one of the most complex environments in which to deliver peer support due to the highly medicalised nature of the setting and its complexities. Considering the intensity of the ED, peer support work practice runs counter to this fast-paced medical focus. The uniqueness of peer support work (rooted in principles of relationship, mutuality, shared power and equality) is at risk of being watered down and undervalued within this setting. The tension of peer work in this setting and the conflict for peer support work in holding a different model of practice could pose a risk for co-option given the pressures to conform to typical practice and desire to be included within the ED team.⁷³ Our research identified barriers to providing peer support in the ED setting, such as the ED workplace culture, the medicalised or predominately clinical approach to care, time pressure, risk orientation, and lack of knowledge regarding mental health and personal recovery. Our findings echo other known barriers experienced by the peer workforce including difficulty accessing training and education,⁷⁴ peer management/leadership roles⁷³ and peer supervision.⁷⁴ Enablers of good peer support include greater exposure to peer work practice, peer workers being embedded within multidisciplinary teams, mutual respect for peer and traditional staff, and understanding of the peer role. This is particularly important in an ED where individuals work shifts and key personnel, such as registrars, are routinely rotated. Therefore, we recommend that:

- It is important to consider pathways to maintain relationships with ED staff and increase their knowledge of peer support and mental distress
- Peer support workers should be supported to practice according to peer values
- Peer support roles will be supported to ensure job security/sustainability including full-time roles
- Peer support training is made more accessible (e.g. Certificate IV in Peer Support Work; Individual Peer Support); employers should play an active part in supporting this
- Workplace conditions and role duties should be reviewed to improve role retention
- Peer supervision, plus support and mentoring from other peer support workers, is readily available and provided
- It is critical that more than one peer worker is employed within a multi-disciplinary team and that strategies are in place for peer support workers to network with other peer workers and peer support workers within the hospital or external agencies and do not work in isolation but are a part of a peer team and supported to connect with external peer networks.

8.2.2 Recommendations and cautions for friends/family/support persons

Friends/family/support persons frequently attend the ED to support individuals in distress;⁷² but this project focused on peer support from a consumer perspective and as such does not directly address the needs and requirements of family/support persons as this was out of scope. However, the need for carer peer support workers was identified by both the consumer and carer focus groups and highlighted the need for friends/ family/support persons to be supported in this environment, identifying the potential positive outcomes for both the consumer and their family or other support persons. Therefore, we recommend that:

- Research be undertaken into the role and feasibility of carer peer support workers within ED
- Peer support workers should be supported to have clear role boundaries regarding the support they can offer friends/family/support persons
- The implementation of carer peer support workers in the ED should be explored.

8.2.3 Recommendations and cautions for ED staff

It was noted that emergency nurses, and other ED staff, have limited or no opportunity to formally build upon their mental health knowledge.⁷⁵ It is important that ED staff receive appropriate training and are attitudinally ready to co-operate with peer support workers. This can be particularly challenging as it may involve acknowledging insufficiencies in one's current knowledge and requires a "letting go" which trusts in the peer support workers ability. It is recommended that emergency nurses receive education about current and contemporary mental health principles such as recovery oriented mental health practice, trauma informed practice, supported decision making, the various roles of consumer workers and working with peer support workers.⁷⁶ The education of ED staff, including ED nurses, is a complex undertaking due to the number of staff and the impact of shift work. This recommendation comes with several thoughts. First, it is known in the literature that emergency nurses have a tendency to stigmatise and discriminate against mental illness/distress.^{18, 77} Employing a peer support worker into a potentially volatile environment and culture where mental distress is stigmatised and misunderstood has been a concern of the research team and addressing this concern is important in creating a safe environment where the peer support worker is seen as 'part of the team'. A lack of education about mental distress has been identified as a factor resulting in emergency nurses stigmatising this group of people.^{78, 79} Thus, the recommendation aims at addressing this potential barrier to peer support work in the ED. Second, it is thought that if emergency nurses are provided with education around mental health, their care and assessment of a person presenting with mental distress will be improved, therefore potentially leading to improved co-ordination and collaboration with peer support workers.

We recommend this education to be developed and delivered by peer workers as contact with peer workers is known to increase empathy for people who experience mental distress.⁷⁴ Education by peer workers and people who have lived experience of mental distress has demonstrated reductions in stigmatising attitudes.⁸⁰ Also, there was the general sense in the ED staff focus groups that staff were curious about peer workers and increasing their mental health knowledge, but may be hesitant to ask questions or engage in conversation. The researchers with lived experience of mental distress and also experience of education have experienced this before where people are interested, but do not want to say the wrong thing for risk of being insensitive. The researchers wondered if this was happening with the ED staff focus group and posit that education from peer support workers may create an environment where ED staff are comfortable to ask questions and have unconscious biases challenged.

Another recommendation to address the potential challenge of a stigmatising workplace culture is identifying a champion among ED staff to instil culture change and to have clear avenues and processes for the peer support worker to raise concerns within the organisational structure. Considering that our research noted that ED staff particularly valued peer support workers ability to "de-escalate" consumers, it is important that they develop a broader understanding of peer practice so that peer support workers are not pigeon-holed. Therefore, we recommend that:

- Education and training about mental health and peer support should be increased to ED staff
- Education and training should be peer-led and peer-delivered
- Peer support workers are formally introduced to ED staff and supported to build relationships
- Peer support workers have access to support persons and mentors, including senior peer support staff and that this be adequately resourced
- Champions of peer support are identified and supported within the ED staff.

8.2.4 Recommendations and cautions for the environment

The ED environment poses a number of challenges for individuals delivering peer support in this setting. Because of the demands of the roles they play in the health system, EDs can be very rigid and difficult to change. Thus introducing a new role that has a commitment to a particular value base and way of working is challenging. Future research should explore the configurations of a Peers in EDs styled program to include not only programs set in the ED but other arrangements. For example, housing (or locating) the program a short walk from the ED could support peer support workers and consumers by providing respite from the ED. Enabling the peer support worker to have a separate but close space may reduce the potential to feel co-opted by a challenging environment. On-the-other hand, locating the service out of the ED may be a barrier to relationship building with ED staff who may perceive the peer support worker as someone “who comes and goes”; this could impact the sense that peer support workers belong in the ED. Thus, there are tensions between being located in the ED and being potentially co-opted or being located outside of ED and being perceived as “separate”. The location of a Peers in EDs styled program may also be impacted by the capacity of the hospital and its overall layout; this could cause tension if peer support workers experienced inequities in their environment, felt as though they were being “squeezed in” or were not located amongst people who support their perspective and values. Also, the ED is often not an ideal space to conduct peer support due to a lack of privacy, chaotic environment and public nature of interactions.

Therefore, we recommend:

- Utilising a co-design approach to the development of the ED space, including consultation with peer support workers
- The relationship between peer support workers and ED staff should be supported, including increased access to training
- EDs should be assessed for their capacity to enable and facilitate peer support work (e.g. is this space adequately private? Is the space quiet enough to hold a conversation? Is this where the consumer would prefer this support to occur? Does this space support the practice of peer values?)
- Alternate space that can be used for peer support work within and outside of the ED should be identified and explored
- Future research should explore the configurations of a Peers in EDs styled program to include not only programs set in the ED but other arrangements. For example, by housing the program a short walk from the ED and thus supporting peer support workers and consumers by providing respite from the ED
- Occupational and physical boundaries are pivotal to retaining the integrity of the peer role and the optimal arrangement needs to be investigated.

8.2.5 Recommendations and cautions for organisations, the health and welfare system and the community

- Service leaders must be realistic at the outset about the opportunity and extent of the challenge that this initiative/concept poses to the current ED service model
- ED peer support workers should be supported by the organisation on a workforce level through a critical mass of people and positions, equitable pay, working conditions, leave entitlements and being able to enjoy career mobility.
- Peer roles require a sound structure for peer supervision, support and mentoring from other peer support workers

- Owing to the unique and its emerging nature of peer support work within hospital systems it is essential to define and maintain peer support worker role clarity.
- Peer support persons should not work in isolation but be a part of a peer team and be supported to connect with external peer networks.

Further, it is essential to establish clearly defined professional roles, position descriptions, representation on organisational charts, department support and a sense of belonging within the program, department and organisation. It is important that peer support work is valued by managers and leaders within the organisation who are willing to invest in the development of the peer support workers and respond to attitudes and behaviours that are stigmatising. Attendance at the ED is impacted by wider system changes and structures. For example, changes to the Victorian mental health system saw many crisis support programs retracted; programs which support people to maintain their mental health and respond to crisis in the community, which could reduce the number of individuals who attend ED. Therefore, we recommend that:

- There is concerted effort by the organisation to establish a workplace culture where peers feel welcomed and valued and respected
- Organisations establish workplace conditions which support peer support workers and demonstrate that they are valued
- Peer support workers are represented in team/line charts/organisational structures
- Role descriptions are developed to support role clarity
- Peer support workers are given support regarding how best to work within the built environment, and advocating for better design/redesign for space that supports relational work
- Peer support workers are supported as these roles develop to ensure the extra pressure of being in a role that is still forming is considered and that positive adaptations, rather than maladaptive responses, can flourish
- Lines of accountability are established that enable reporting and reflecting on events pertinent to their role
- Continuity of care should be maintained – which has the potential to challenge some of the boundary restrictions on care provision that are the current norm in the ED.

8.3 Future research initiatives

Research is required to:

- Further explore how peer support can make a sustainable and valuable contribution
- Explore future iterations of this preliminary proposal which could include consideration for the development of a similar approach to carer peer support workers for family/friends/support persons
- Consider the potential contribution of the Certificate IV in Peer Support Work,
- Examine the link to ED Hub development, which poses an opportunity for growing peer support worker roles.

We recommend that:

- Future research should evaluate the quality of the design and reporting of literature addressing this topic

- Future research should be rigorously designed and reported
- Future research should investigate the effectiveness and acceptability of peer support workers in the ED
- Future research should investigate the impact of delivering peer support in the ED from the perspective of the peer support workers and ED staff.

8.4 Further cautions

- The fundamental assumption that peer support situated in the ED is a sustainable initiative could be challenged
- Cultural work is needed in the ED, to set the scene for shared understanding about, for example, the value of experts by experience and the social model of disability. Further development needs to establish baseline attitudes towards mental health crises and risk, both in relation to the person and their family. This would aim to redress the historical ambivalence among ED workforce about whether mental health presentations are fitting for ED intervention, and occurring by default rather than being skillful work to be embraced.

8.5 Conclusion

Finally, we are grateful to all the contributors to this preliminary research that has enabled rigorous and foundational work to be undertaken as a first step towards the further development of a practice. The next phase will be an opportunity to further explore the exciting opportunities and challenges associated with peer support work in the environment of the ED. What is particularly clear from our work is how highly valued peer support work is in supporting people experiencing mental distress and its great potential to making a contribution to improving the experience of consumer and their families, friends and other supporters when accessing services in a time of crisis or acute distress.

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Appendix

Supplementary Figure 1

Program logic

Questions to answer:

What is the optional role, and environment, for peer workers in emergency departments (ED)?

What space will work well?

For whom? According to whom? (peer worker view, consumer view, staff view).

Situation:

EDs are often poorly equipped, in relation to the physical environment, knowledge and personnel, to respond appropriately to people who present with mental distress. There is evidence that peer workers improve people's experience of mental health services by using their personal experience of distress and recovery to support others.

INPUTS	OUTPUTS	OUTCOMES
<ul style="list-style-type: none"> • Culture change and buy in → Range of 'Champions' perhaps from executive/senior organisational and front-line practice positions to ensure exposure to peer worker model and acceptance for what this role offers; acceptance for change to the status quo • Research / investigate existing models in operation (Nadine has been reading in this space). • Determine scope of our model/project. <ul style="list-style-type: none"> - "Where is the ED?" i.e. is the waiting room included in this or just the department itself? What about separate interview rooms/adjoining space that can be utilised by ED patients/staff? - Mental health-specific presentations only in the scope of this model or physical health presentation with associated mental health symptom conditions? - Is consumer/family/carer peer support also included in our model? • Model must be explicit for preparing for peer workforce 	<ul style="list-style-type: none"> • Workplace culture and staff preparation <ul style="list-style-type: none"> - Attitudinal staff change → readiness and willingness to be part of this and work with peer workers* • Role clarity – clear role and purpose, clear scoping of the role, including what's not part of the role • Increased availability of nicotine replacement • Engaging security to be involved and onboard • Peer supervision for peer workers <ul style="list-style-type: none"> - Identified as being very important for the success and wellbeing of peers themselves - May assist with achieving role clarity - Particularly if we're piloting with two peer workers, risk for these workers to be overwhelmed in the environment - Providing regular and available supervision will likely help these workers to 	<ul style="list-style-type: none"> • Organisational and staff attitudinal change - Readiness and willingness of staff and organisation to meaningful engage and implement this model • Role clarity for all (peer workers and other staff) of what to expect from peer role • Mental health literacy of all staff • Decreased stigma and discrimination • No marginalisation / silos • Change to existing therapeutic space <ul style="list-style-type: none"> - Modifications to furniture, accessibility to natural light/windows, green space with plants or outdoor area/garden - Creation of a specialised space conducive to treatment and wellbeing

INPUTS	OUTPUTS	OUTCOMES
<ul style="list-style-type: none"> - Consider whether we plan to partner with organisations with existing peer workforce or start 'from scratch'? - Idea of 'peer navigators' 	<ul style="list-style-type: none"> • 'stay afloat' and achieve credibility in big organisation • Network of peers, for support and safety and development • Links to peer-rich organisations and embedding with existing peer workforces • Embedding peer workers as included and valued team members that are included in team decisions 	

* Discussed that some of these things we are interested in and things we want to see eventuate from our model could be flagged as potential research ideas/research questions that our research assistant might want to engage and explore further – e.g. *What do we know about these things already? What is readiness and how can we effectively assess and measure staff readiness?*

Indicators:

How will we know if this has been successful?

For peer support workers themselves	For consumers	For carers	For staff
<----- REDUCED COERCION ----->			
<----- REDUCED AGGRESSION ----->			
Reduced aggression from patients towards family members and staff, staff towards patients, reduced use of restraints/codes requiring security etc. Also reduced aggression toward emergency responders (Police, ambulance paramedics)			
Offering patients ready access to nicotine replacement may also assist this.			

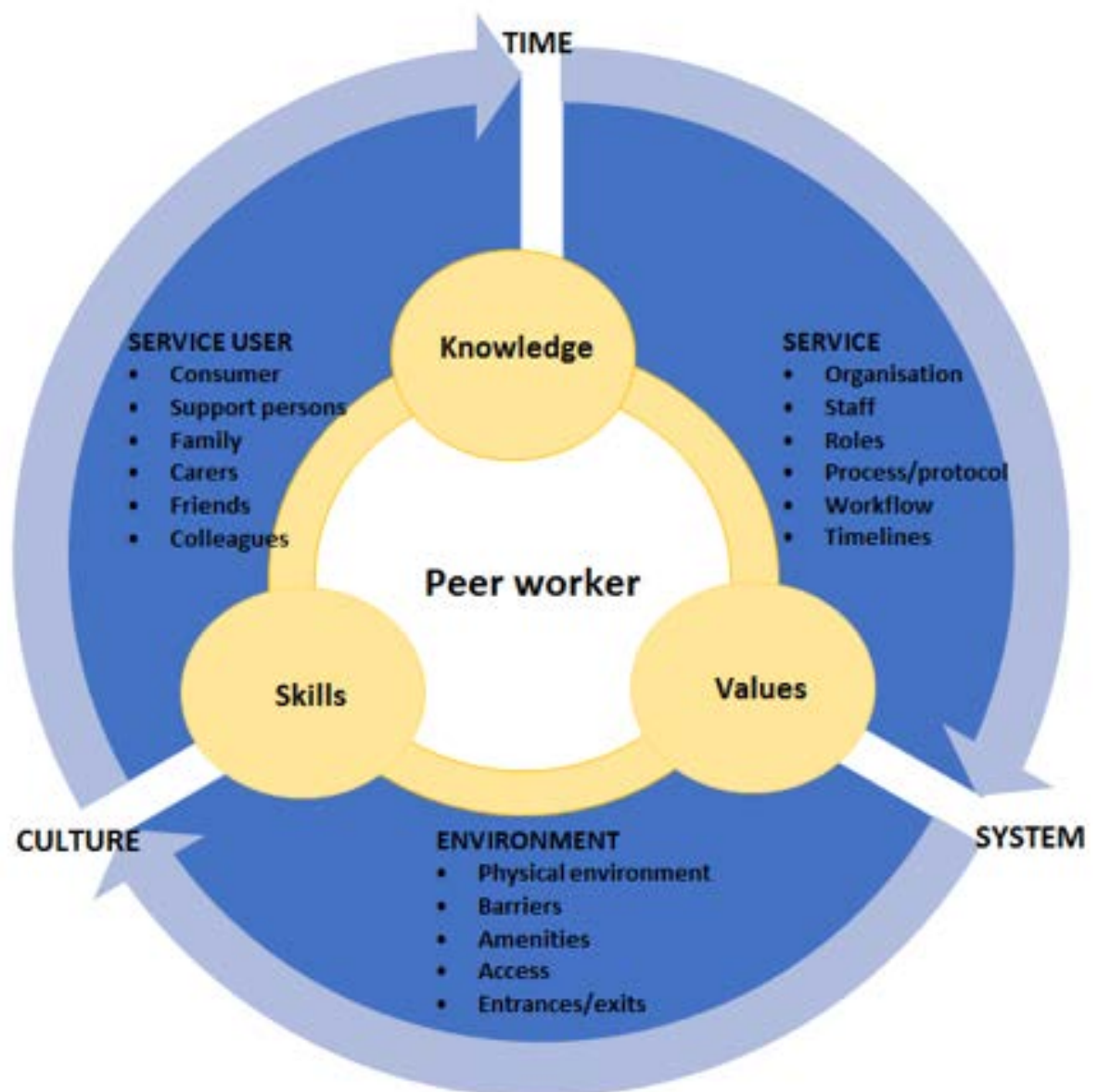
<----- CONFIDENCE in ED process ----->			
To work with and support people in distress	In seeking ED assistance to “ <i>get the help I need...</i> ”	In ED process, treatment and care received	Acceptable and feasible way of providing care to people in distress
<----- HOPE related to recovery of self and others ----->			
<----- REDUCED LENGTH OF STAY in the ED ----->			
Beneficial to all stakeholders, for different reasons.			
<----- CHANGES TO ED UTILISATION ----->			
Some people might present less to ED, find alternatives to ED to receive professional intervention; ALTERNATIVELY, others who previously might have had a negative experience might now feel encouraged to attend ED to receive physical and mental health care.			

Final focus on our Peer workers – what might indicate the success of this peer role in ED?

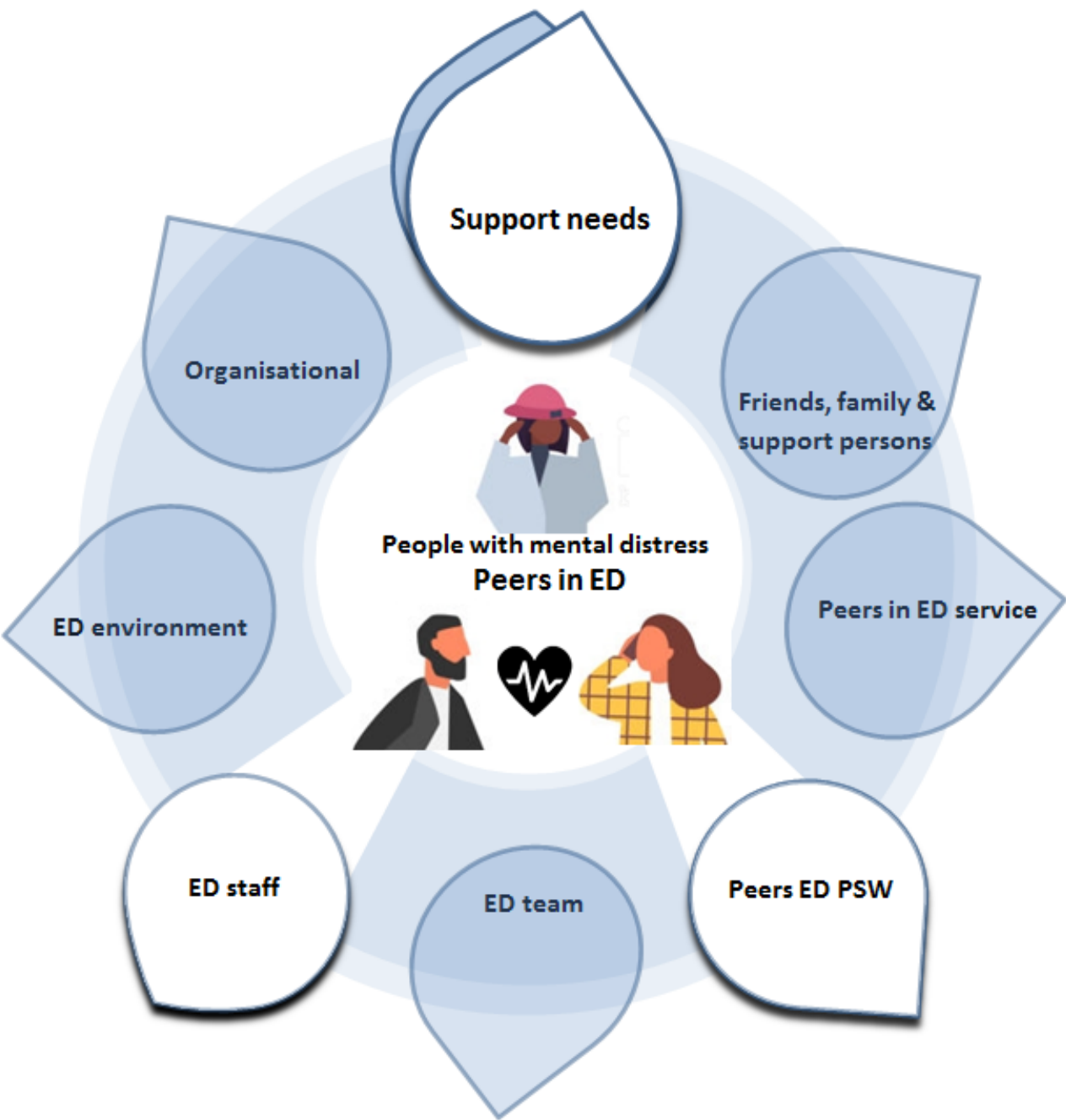
- Job satisfaction with this role
- Supervision – their perspectives on an effective peer supervision framework
- Issues of retention and career advancement – speaks to workforce issues of sustainability and growth of these roles – ongoing funding of these roles as opposed to sporadic/time limited project funding
- Peer support workers included in team and decision-making process.

Supplementary Figure 2

Synthesis of literature findings

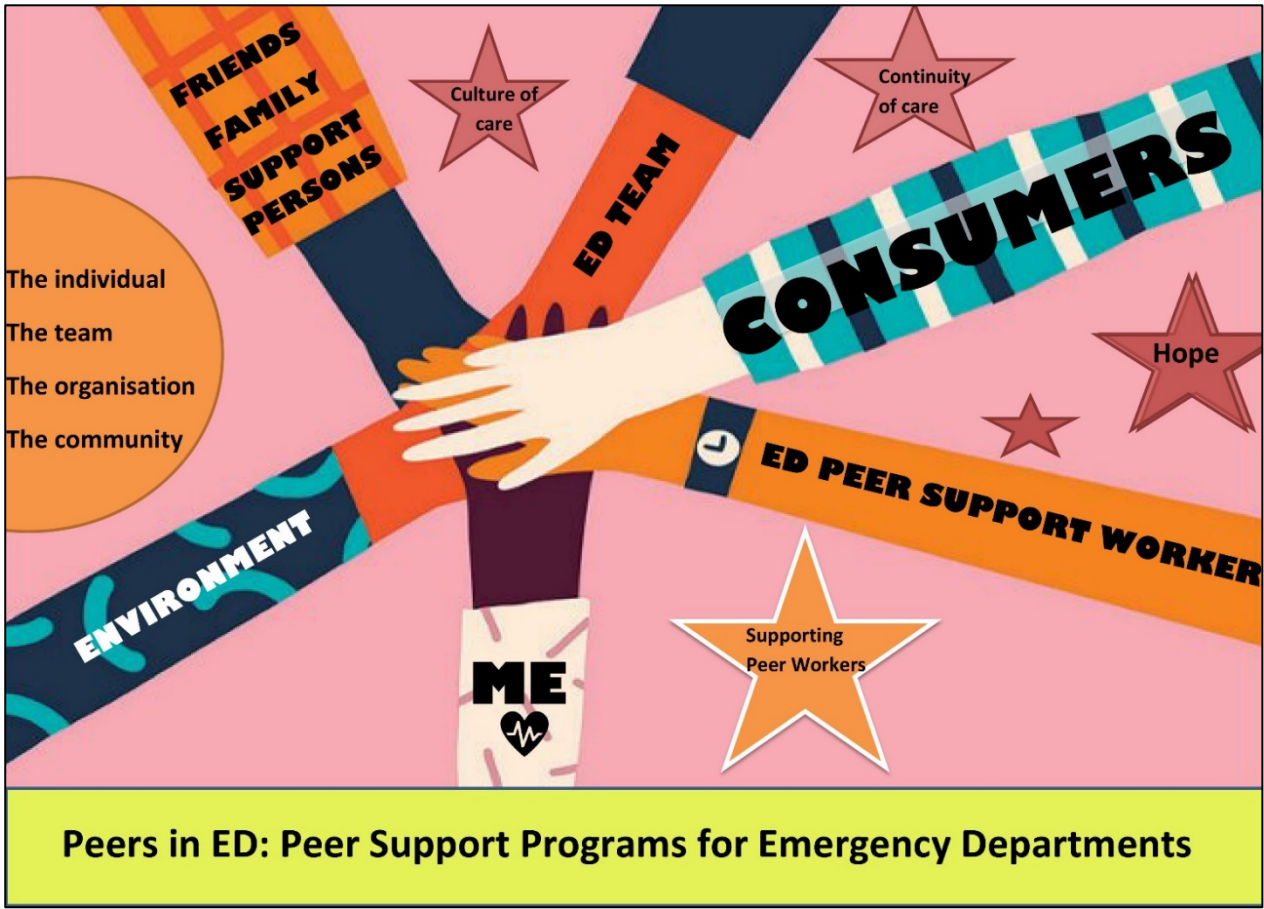


Synthesis of important elements in relation to the individual in distress



Supplementary Figure 4

Illustration of important elements in relation to Peers in EDs





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