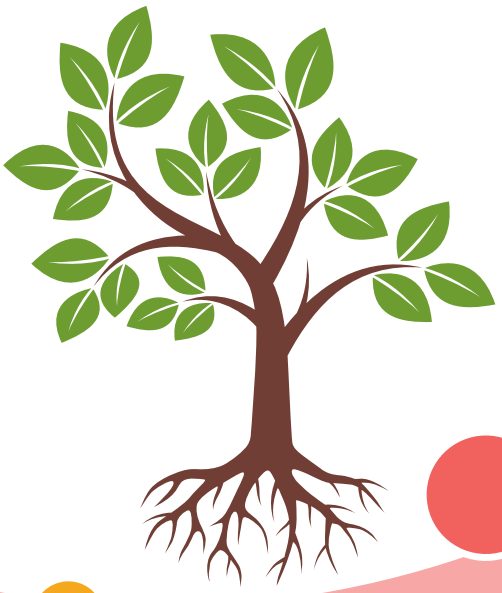
Peer Support Distance Working

Guidance on a Model of Peer Support Working during the Covid-19 Pandemic



Office of Mental Health Engagement & Recovery

June 2020

HSE Mental Health Services

Seirbhís Sláinte Níos Fearr á Forbairt | Building a Better Health Service

Peer Support Distance Working

Guidance on a Model of Peer Support Working during the Covid-19 Pandemic

Office of Mental Health Engagement & Recovery

June 2020

HSE Mental Health Services

Seirbhís Sláinte Níos Fearr á Forbairt | Building a Better Health Service

Contents

Executive Summary

Peer support is not a new concept. It is said to have originated from the civil rights movement of the 1960s/70s. However, there are reports suggesting that the phenomenon had been conceptualised much earlier within the mental health/addiction services. The earliest recorded peer support initiative dated back to the 1920s during the era of revolutionaries in mental health such as Harry Stack Sullivan, who identified the value of such services within a mental health setting. Since its conceptualisation peer support has grown substantially, now with an ever-evolving evidence base which supported the concept to become globally recognised as the future of recovery orientated services within a mental health context.

In 2017, Ireland joined many countries, including the United Kingdom, the United States and others, in recruiting persons with lived experience into the statutory healthcare workforce. The aim of which was double folded: to utilise their lived experience [experiential knowledge] to support service users on their road to recovery, but also to support the services themselves in their transition from biomedical approaches to one that is more recovery focussed. This approach is timely within Irish mental health services as it is compliant with national policies and frameworks: *Sharing the Vision: A Mental Health Policy for Everyone* and the *National Framework for Recovery in Mental Health 2018-2020*.

In 2020, Ireland, among many other jurisdictions globally were impacted by the ever-growing and powerful Covid-19 pandemic. This led to a number of restrictions which limited the access to services otherwise available in “normal” day-to-day life. These restrictions also impacted on many who use the mental health services. Specifically, those utilising community-based interventions, which originally formed as a result of *A Vision for Change: Report on the Expert Group on Mental Health Policy* in 2006. Home visits were cancelled with only essential appointments being undertaken. As peer support was observed as secondary to essential services, this amenity was amongst one of the hardest hit by government restrictions.

The aim of this document is to provide information on the current state of affairs for Peer Support Workers along with guidance on how such peers can continue their work through online platforms. This guidance also recognises that services will eventually return to face-to-face working and as such additional guidance has been provided specifically on how to engage with face-to-face working once restrictions ease.

Introduction & Context

Currently, Ireland is striving to create a recovery orientated service in line with international best practice. This move from traditional care has gained momentum since the publication of *A Vision for Change* in 2006. *A Vision for Change* aspired for services to be delivered within community settings, calling for the closure of the traditional asylums of the time (Department of Health 2006). Part of this service transformation was the move from biomedical parameters of mental illness towards a more holistic, person-centred recovery model.

In 2020 we still have some ways to go to achieve this. Hence, an updated Vision for Change document [*Sharing the Vision*] has been developed to acknowledge what we, as a service have done so far and what we have yet to do. However, we have made some real progress towards these aspirations since the release of the original policy document. Services have now moved from institutional care within asylums to community-based services. The original make-up of service delivery has changed, with community teams developed that are multidisciplinary in nature, allowing for a more holistic approach towards mental ill health and treatment. Along with this, services have started to work in a recovery-orientated manner which views recovery from mental ill health as a journey with many bumps along the way (McKenna *et al.* 2014).

The recovery philosophy internationally began with the rise of the civil rights movement of the 1960/70s (Beeble and Salem 2009). However, there has been no universally accepted definition of recovery until 1993 when one was developed by William Anthony, who states that recovery is a process of living a hopeful and contributing life of ones' choosing even with the limitations imposed on the individual through mental ill health (Anthony 1993). This concept is developing within the literature with Norton and Swords *(in press)* identifying a new social element to recovery which states how recovery can be achieved through the redevelopment of a persona that is socially acceptable i.e: educated, employed etc. For the purposes of this report, Anthony (1993) definition will be used herein.

In Ireland, the recovery concept began to be implemented through the work of the Advancing Recovery in Ireland [ARI] initiative. ARI initially followed the ImROC [Implementing Recovery through Organisational Change] methodology, developed in Nottingham, United Kingdom. This methodology identifies ten areas necessary to gain a recovery orientated service. This new initiative was so impressive in its initial test site that within a short period, ARI was upgraded from a local to a national initiative. The aim of which was to make recovery everyone's' business, not just the service user. From ARI, services began to work in co-production with lived experience stakeholders and now their input are not seen as an optional resource but rather one of necessity. Within such co-produced relationships, learned/professional knowledge is fused with experiential/lived knowledge to inform the design, delivery and evaluation of services (Norton 2019). The move towards more co-productive decision making is now seen as gold standard within Irish mental health services with regulatory organisations such as the Mental Health Commission promoting co-production in service provision through individualised care planning etc (Mental Health Commission 2012). The Office of Mental Health Engagement and Recovery have also endorsed co-production in all aspects of service provision

[from education to service management and evaluation] through co-producing national policy and guidance documentation and modelling co-production in everything the office does.

Within their service plan for 2017, the Health Service Executive [HSE] publicised it's intention to follow other international statutory mental health services in the employment of those with lived experience to support all stakeholders to become more recovery orientated (Health Service Executive 2017). These lived experience professionals are Peer Support Workers. Since the release of this plan, 21 Peer Support Workers have been employed nationally with plans for a further 10 whole time equivalent by the end of 2020.

An impact study conducted by Hunt and Byrne (2019) aimed to examine the effect of employing Peer Support Workers in mental health services. This included collecting data that adequately demonstrated the impact of the role on service users and service providers. Within this report, Hunt and Byrne identified that Peer Support Workers have had an overwhelming impact on service users' own recovery. Such positive impacts come from the Peer Support Workers' use of roles that utilise experiential knowledge therapeutically, thus creating an informal relationship (Norton *et al. In Press*).

However. Since March 2020, this essential work has been stalled due to the coronavirus [Covid-19] pandemic. As of the 04th June 2020, Covid-19 has infected 25,111 people with 1,659 deaths accountable to the disease in Ireland alone (Health Protection Surveillance Centre 2020). Now, Peer Support Workers need to find new and innovative ways of working with their client group which allows service users the full benefits of peer support whilst protecting themselves from the spread of disease.

The aim of this brief report is to identify the mechanisms by which Peer Support Workers within HSE mental health services provide support to service users in a range of settings during the Covid-19 pandemic. The purpose of which is to analyse what is being done currently to provide information and guidance into a model of peer support distance working. This guidance and model will support Peer Support Workers, their supervisors/line managers and the multidisciplinary teams they are situated in to progress with peer support working remotely throughout the pandemic and to support the implementation of such measures in the future as required.

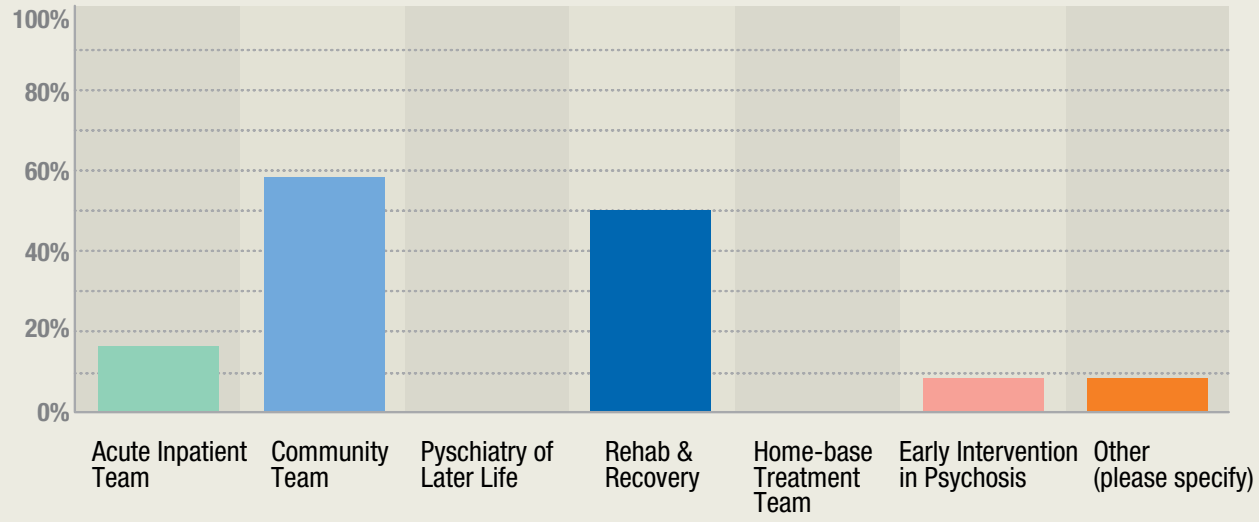
Brief Methodology

In order to achieve the above aims, a mixed method survey was created that allowed for the collection of both statistical and qualitative data. These surveys were sent to the existing Peer Support Worker cohort who were given a timeline of two weeks to complete and return same if they so wished. Data collected was then used to gain a deeper understanding on how Peer Support Workers are currently operating given the present climate and restrictions imposed on service delivery due to Covid-19. The results of which were further analysed to create guidance for a model on how Peer Support Workers could work remotely so that the therapeutic value of the role is not lost.

Current Status of Peer Support Work

There are currently 21 Peer Support Workers employed by HSE mental health services. They are spread across five Community Healthcare Organisation [CHOs]. However, only 12 responded to the survey. These Peer Support Workers are employed in a range of settings including: acute inpatient units [n=1 – 8.33% of respondents] to Rehab and Recovery [n=3 - 25% of respondents] and Adult Community Mental Health Teams [n=3 - 25% of respondents]. From the 12 Peer Support workers who responded to the survey, five are working in more than one area concurring with the type of team they have been placed in. From the sample surveyed, five Peer Support Workers identified working in more than one area. These included the combination of Adult Community Mental Health Teams and Rehab and Recovery services [n=3 – 25% of those surveyed], acute inpatient and Early Intervention in Psychosis services [n=1 – 8.33% of those surveyed] and finally one Peer Support Worker [8.33% of respondents] works in an Adult Community Mental Health Service that also functions as an Open Dialogue team [Figure 1].

Figure 1: PrSW Multidisciplinary Team Breakdown.



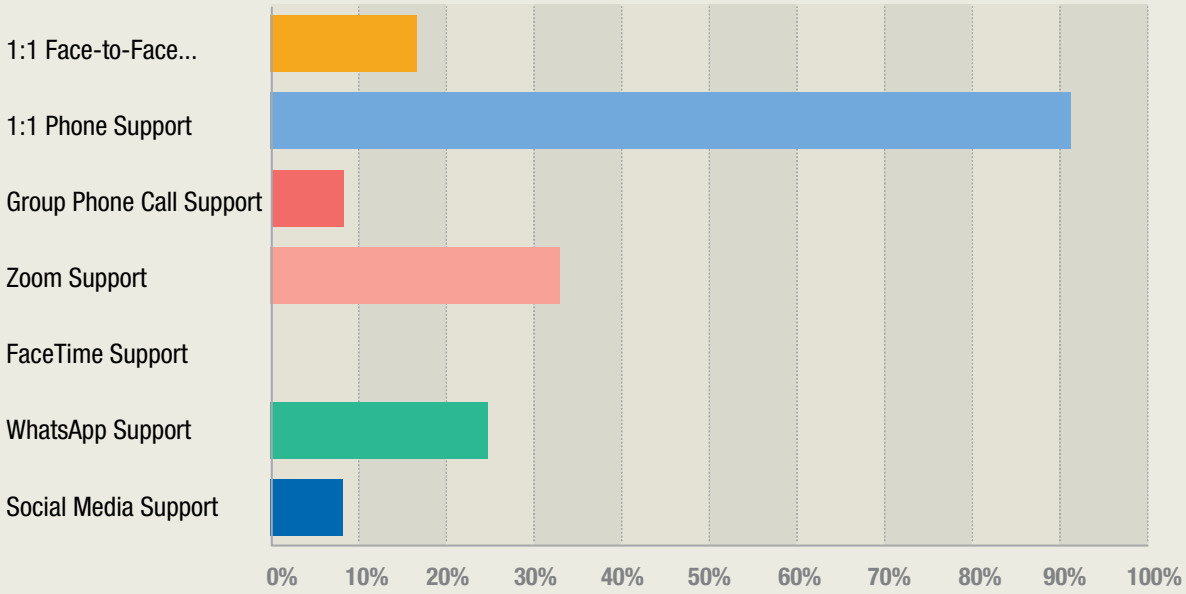
Currently Peer Support Workers are working on average 25.67 hours per week [range: 19.5 to 39 hour]. Of this average of 25.67 hours, Peer Support Workers who responded stated that this allotted period was split between one-to-one peer support work and group activities. The numbers of service users seen by Peer Support Workers within their working week ranged from 0 [reported by two Peer Support Workers] and 12 [Also reported by two respondents]. Out of the two respondents that revealed no one-to-one contact with service users, one highlighted that they engaged with service users primarily through group activities. The other Peer Support Worker is working within an acute inpatient setting but are currently working from home due to the current restrictions.

Some Peer Support Workers [n=5] described doing a combination of both one-to-one and group work. Such groups ranged from mutual support groups to open dialogue sessions to co-delivery of recovery educational workshops. Each group served a maximum number of eight participants.

Methods of Peer Support Service Delivery

Due to the current restrictions imposed on the entire country since March 2020, many ways in which services delivered care and support to service users, family members and carers have changed. During this difficult time, many non-essential services, not relating to immediate care to service users, e.g advocacy, befriending etc, or to the Covid-19 response were stalled. One of the many recovery orientated services that changed its activities during this time was that of peer support. The onset of this crisis left

Figure 2: Methods of Providing Peer Support during Covid-19



many of those employed in such roles disorientated on how they could support the service users they currently have in their client list. Due to such constraints Peer Support Workers had to become inventive in the way they provided peer support service to those in need. These are highlighted in Figure 2.

As highlighted in Figure 2 above, most peer support interactions occurred through the medium of phone support with one Peer Support Worker currently undertaking group phone support. This method of peer support delivery has been identified extensively within the literature as an option that can provide positive results for those receiving support through this medium (Dale *et al.* 2009; Sembi 2018; Chyzzy *et al.* 2020). However, many Peer Support Workers were using this platform along with others to provide support to service users. Some used a combination of phone and other online mediums [WhatsApp, Zoom, Social Media] to support service users.

Some Peer Support Workers also identified other ways of providing support to service users during the pandemic. These included practical supports such as doing errands and dropping messages at residential settings without entering the premises. Interestingly a minority of Peer Support Workers [n=3] continued to engage in face-to-face peer support regardless of restrictions imposed.

When asked, how such face-to-face work is being conducted, clear protection measures were being implemented. These included: having all sessions outdoors [when possible] and at a safe social distance. Interestingly, these Peer Support Workers also mentioned preparatory steps to be taken before each appointment. Firstly, service users are phoned prior to the appointment to assess ones' Covid-19 status. If inside sessions are necessary, the waiting and consultation rooms should be re-organised so that one can implement the Covid-19 social distancing guidelines. This includes having both waiting and consultation areas placed in large rooms where it is possible to follow such guidelines. [For further guidance for Peer Support Workers please see **Guidance on the Peer Support Distance Working Model Part 2: Face-to-Face Working** below].

However, overall a popular theme emerged from the survey results regarding the lack of clear guidance on what online resources to use. This seems to vary depending on the CHO, and in some cases the setting in which the Peer Support Worker provided support in. In some areas, peers have been declined access to online resources, such as Zoom, FaceTime and WhatsApp, due to encryption and confidentiality issues. In other areas, Zoom is seen as acceptable, but the preference is on using Microsoft Teams due to the above encryption and confidentiality issues. As such, many Peer Support Workers have asked within their responses for clarity on what online media platforms to use for them to conduct their business.

Service User Engagement in Peer Support Distance Working Measures

From the Peer Support Workers' perspective, most service users found this new way of working to be positive [n=9] with the remaining three peers finding that service users are responding neither positively or negatively to this. This result may be due to the overall acceptance by service users of the restrictions and pressure put on the system due to the current global pandemic. When asked to provide further information on their positive/neutral response, most Peer Support Workers highlighted that service users were happy to use such platforms, but some were more comfortable than others. Peers identified that for some, the use of such technology and the lack of face-to-face contact caused service users to slip back into unhealthy behaviour, e.g. physical inactivity, isolation. Despite this, Peer Support Workers mostly reported that the service users they are working with appreciated the extra-ordinary measures exhibited by Peer Support Workers to provide continuous support during the pandemic. Overall, Peer Support Workers in general found that service users proved to be more resilient than they previously thought they would be before Covid-19.

Length of Peer Support Session via Peer Support Distance Working

Another interesting aspect in relation to comparison between pre-Covid and today is the length of the peer support session. Pre-Covid durations ranged from one to three hours and could potentially last even longer based on the particular service users 'needs. However, todays' figures show a substantial decrease in the length of peer support sessions. These sessions generally lasted from between five minutes and one hour. The main reasoning for this change in the length of the peer support session has been cited as largely due to the lack of face-to-face contact due to the current restrictions. However, when looking at data from those Peer Support Workers who still engage in face-to-face sessions, these tend to also be shortened somewhat with the maximum recorded length of a face-to-face session today also peaking at the one-hour interval. This is in contrast with pre-Covid levels of sessions peaking at two-hour intervals. However, when looking at the data, one can also identify that peer support sessions that are carried out remotely tend to be more frequent with at least one session

along with several check-ins per working week. The increased frequency could be explained due to inability to progress physical supports due to Covid-19. In this way, the peer support sessions occurring at present could be argued to just maintain a persons' mental wellbeing during such circumstances until physical contact can be made again.

Advantages of Peer Support Distance Working Measures

When asked regarding the benefits to peer support distance working, Peer Support Workers overwhelmingly cited benefits relating to phone support. Here, they described the phone as a vital tool for their work during these uncertain times as they found that they were providing phone support to individuals more frequently. However, the length of these conversations was shorter than pre-Covid face-to-face support. Peer Support Workers also cited the use of WhatsApp and how this was also useful, especially to share web links to appropriate resources online that may have been discussed during the peer support session. Regardless of the platform of support, Peer Support Workers concurred that these methods of communication for certain populations was easier, especially if these service users found it difficult to attend face-to-face appointments due to transport or anxiety issues. However, despite these advantages, little is known regarding service users' perspectives of remote working, thus requiring further exploration.

Areas of Engagement that Requires Improvement

Peer Support Workers highlighted multiple challenges relating to this type of engagement. Once again, some of the challenges relating to remote working related to the lack of clarity regarding what online platform is suitable to use for such engagement. At present Microsoft Teams is the recommended platform identified by the HSE to conduct meetings and other affairs. However, this might not seem the most appropriate for one-to-one peer support work as most service users will not have this software installed on their smart devices plus the fact that this software is not the most user friendly. However, going forward the exact software to be used must be made explicitly clear to alleviate concerns and the lack of clarity by those working on the frontline, including Peer Support Workers. This is necessary as Peer Support Workers have highlighted the applicability of video calls for their practice i.e. in the development of recovery plans.

Such use of technology also brings about issues of confidentiality, not only from hackers and other malwares from computer software but also within the peer support session being conducted. As highlighted earlier, approximately 50% of Peer Support Workers surveyed work in one way or another on a Rehab and Recovery Team. According to Finnerty (2019), the majority of those using the HSE Rehab and Recovery services are in long-term residential accommodation that are supervised by nursing staff either on a 24 hour basis or part of the 24 hour period depending on the residents needs. Most of these service users do not have direct access to their own IT devices and as such many online peer support sessions must therefore occur using staff computers in the nursing station of residential settings. This may hamper the authenticity of the session as service users may be reluctant to fully participate due to the presence of other staff during these sessions.

The fact that these sessions must happen online in the service users own home makes it difficult for both the service user and the Peer Support Worker concerned. For Peer Support Workers, the platform takes away from the human effect of peer support work but also prevents the peer from being able to

read the body language of those they are supporting. This may cause Peer Support Workers to miss vital clues that may suggest a period of distress etc. For the service user, the use of such platforms while been cocooned in ones' own home may prove triggering for the person as they cannot leave the space where such difficulties or trauma have been discussed within the peer support session.

Another contentious area that would allow for improvements in engagement would be the accessibility of IT equipment for service users. This includes IT devices, software, and suitable broadband. The Peer Support Workers who responded to this survey highlighted in general the paucity of basic IT services nationally, especially in terms of broadband. In terms of other aspects of IT equipment/services, those who provide support to service users within the Rehab and Recovery setting also identified the added lack of basic IT devices and skills among residents in these care settings which adds another layer of difficulty in engagement in this model of remote peer working. With regards to access to IT equipment, only one Peer Support Worker identified that all their client base had full access to IT and have full understanding on how to appropriately use same.

This sense of paucity of IT equipment was ironically also evident within the Peer Support Worker population with many using their own laptops [n=4] rather than HSE issued computers for them to do their work. One Peer Support Worker also highlighted that they were sharing a work laptop with another HSE employee. The remaining two Peer Support Workers that had laptops were issued their own laptop from the HSE. The remaining participants had desktops located in their office with yet again one Peer Support Worker was also found to be sharing this appliance with another HSE employee.

Addressing the Challenge of IT Access

Peer Support Workers brought up several ways in which the lack of IT literacy could be addressed within the service user population. Firstly, it was unanimously agreed that some sort of introductory session should be done with all service users on basic IT skills e.g learning how to use the internet, download applications on the phone such as Zoom, WhatsApp and how to use same. This should be further extended in residential settings by having a designated laptop present in such settings for service users to use as well as in-house WiFi access specifically for residents. However, there has been logistical issues in providing such introductory training as face-to-face tutorials would have to be done, especially for those who have never used such IT devices and applications before. Therefore, staff who are not proficient in the use of IT should be trained up in same so that they can pass these skills to their clients. Also, it is important to note that some service users may not want to become familiar with technology for a wide array of reasons and for this population of service users, further engagement measures would need to be introduced.

Potential Risks of Digital Working

Peer Support Workers highlighted several risks associated with using digital platforms. These were categorised into issues surrounding privacy/confidentiality and potential psychological distress. In terms of issues surrounding privacy and confidentiality, Peer Support Workers mentioned the risk of being victims of hacking, especially on platforms that are not properly encrypted. This sense of maintaining confidentiality is also transferable to other members of the peer support group itself as Peer Support Workers also identifying possible dangers as a result of service users sharing personal identifiable information with others utilising the same supports (Smith-Merry *et al.* 2019).

During one-to-one or group peer support through digital platforms, Peer Support Workers also highlighted the possible implications of over-sharing details of mental ill health and recovery within such settings. This may result in embarrassment or other more serious implications towards their psychological health. As a result, peers stressed the importance of video call etiquette during such support sessions [Please see ***Guidance on the Peer Support Distance Working Model Part 1: Digital Working*** below for further details].

However, such negative psychological effect can also make individuals feel more isolated or left out. Unfortunately, this could cause potential issues in using digital platforms during the peer relationship as due to this, Peer Support Workers may be unable to read a persons' non-verbal cues which may have alerted them to the possibility of over-sharing earlier. The lack of physical presence could also cause issues as Peer Support Workers cannot properly/effectively gain insight into the effects of over-sharing and therefore cannot properly support them if they so needed.

Resulting from the above, the use of platforms for peer support activity may overtly limit the effectiveness of the therapeutic relationship for the service user.

The Effect of Digital Working on ones' Recovery Journey

Peer Support Workers also highlighted from survey responses how digital working effects not only the service users' own recovery journey but also that of the Peer Support Worker themselves. Peer Support Workers highlighted several positive and negative aspects these platforms have on ones' recovery. When focussing on the positive aspects of digital working, Peer Support Workers highlighted that such platforms can be liberating for the service user for a number of reasons. These include opening a new world of information and support, a way of escapism from ones' own problems, a method of combatting loneliness whilst also allowing for a space to learn new skills and finally the unrestricted access to support beyond usual business hours allotted by many face-to-face supports. These finding are also represented in the literature by O'Leary *et al.* (2017).

Despite all these positive associations between digital working and recovery, Peer Support Workers also highlighted several challenges to this. Firstly, the impact of digital working on Peer Support Workers themselves can be debilitating with one peer suggesting that this method of carrying out daily business has further alienated them from the remaining multi-disciplinary team. As such, this Peer Support Worker has identified the importance of face-to-face contact for their own wellbeing. In this way, this particular peer could empathise with what other service users are feeling during these uncertain times.

Other negative associations between digital working and recovery for the service user includes: the fear of being recorded; the stress associated with trying to operate digital platforms especially if one is not tech savvy; the potential for this approach to revert progress for an individuals' recovery and finally the inability to be socially present with someone in their distress.

Overall, the responses to this question in the survey suggests that despite the possible positive and negative effects associated with digital working, It was a good substitute for face-to-face physical contact with the service users these peers served in the short-term.

Impact on Peer Support Worker Practice

From the results of the online survey, new guidelines are now being proposed to support Peer Support Workers in the continuous support of service users. These guidelines will focus on providing peer support via digital and face-to-face working. The face-to-face working guidance was added to this model due to the upcoming easing of restrictions. However, even when these restrictions are eased, the ever-present threat of Covid-19 will remain and as such guidance on how to work in a new way, whilst face-to-face working, are addressed below.

GUIDANCE ON THE PEER SUPPORT DISTANCE WORKING MODEL PART 1- DIGITAL WORKING	
Peer Support Worker Responsibilities	○ Complete HSELanD training in relation to Digital Screen Equipment and General Data Protection Regulations [GDPR]. ○ Contact your line manager and organise/complete an ergonomic assessment of your workspace so that your work space can be set up to meet your ergonomic needs ○ As a HSE employee, read and abide by local and national policies in relation to GDPR, lone working and the use of technology. ○ Follow lone worker guidance in relation to digital peer support sessions. ○ Contact your local IT department to identify the recommended software in your area to carry out video calls, install and use same. ○ Contact the service user before the video call to ensure that they are happy to use video technology for the purposes of the digital peer support session ○ At the beginning of each video call, discuss and create a support agreement around what to do and what not do during the call [recording etc]. ○ You should always be the host of the meeting to prevent any unauthorised recording of the peer support session.
Shared Responsibilities	○ The sessions should take place in a quiet space where there are no distractions. ○ Both parties should wear headphones to drown out any background noise but also to ensure confidentiality is maintained during the peer support session. ○ Both parties should position their computer camera in such a way that both participants are clearly visible. ○ In order to further protect confidentiality, both parties should put a background to their video screen. ○ To avoid computer fatigue, both parties should minimise the amount of time spent on online peer support sessions.

At present, we **do not recommend** meeting service users face-to-face. However, if this is the only option the following guidelines should be used. As restrictions ease, these guidelines can also be used to support you in returning safely to face-to-face peer support working.

GUIDANCE ON THE PEER SUPPORT DISTANCE WORKING MODEL PART 2- FACE-TO-FACE WORKING

Pre-Session Steps	○ A phone call should be made on the morning of the peer support session. During which, questions should be asked regarding their Covid-19 status and whether they have been in contact with anyone who is suspected or has Covid-19. **If the service user answers yes to either of these questions, no face-to-face session can occur.** ○ The Peer Support Worker should inform the service ○ user that the peers use of masks is mandatory during the peer support intervention to protect the peer/service users and to prevent the spread of infection. ○ If sessions cannot occur outside i.e due to clinical appointments, the clinic should be conducted in a location that can facilitate large, ventilated rooms to allow for social distancing measures to be implemented. ○ Before leaving your base, ensure that you have alcohol gel in your possession. ○ Before leaving your base and after leaving the car perform hand hygiene using the WHO hand hygiene method – at base, proper hand washing, - leaving vehicle, alcohol gel should be used
During Session Steps	○ All sessions where possible should be undertaken outside within a safe distance from your base as per the Department of Health guidelines. ○ Face masks should be worn during the peer support session if local CHO guidelines requires this. ○ A safe social distance of 2 metres should be maintained between the Peer Support Worker and service user at all times. ○ If the need arises, follow appropriate respiratory hygiene based on the Department of Health's guidelines followed by appropriate hand hygiene. ○ Reduce the overall length of the session in order to reduce the exposure of both parties to possible Covid-19.
Post-Session Steps	○ If using face masks, dispose of same appropriately after each use ○ Use alcohol gel when the session ends [if outside] to sanitise your hands. Once you return to base, ensure that you wash your hands following the WHO hand hygiene method.

Conclusion

This report provided guidance on the use of the peer support distance working model. The report examines, through survey results, the current make-up of Peer Support Workers in Ireland along with how they are currently working during Covid-19. The method of peer working currently appears to be largely phone based with some mixing phone and digital technologies to conduct their work. It was also highlighted that despite the implementation of restriction by the Department of Health, some Peer Support Workers were still engaging with face-to-face peer support sessions.

The report also examined how service users have engaged with this new way of working, which was found to be largely positive in nature. This was despite the clear preference for peer support to occur face-to-face. Finally, the advantages and potential risks to such remote working were also discussed. Such risks included privacy and confidentiality along with the potential psychological implications that a breach in the former may cause.

This report highlights several areas for future research and training needs. More research is needed to clarify the service users' perspective regarding remote working. The lack of service users' perspectives is a limitation of this report as we only present half the picture in relation to peer support distance working. In terms of educational requirements, this report highlights the need for future training to address how Peer Support Workers can attend to the needs of the individual through remote working. These include being present with the person during distress/silence and the added need for reflection at the end of sessions to further support the service user and the Peer Support Worker as they travel on this unique journey together.

Ultimately, from survey responses, the use of two different approaches to peer support work allowed for the creation of appropriate guidance for both digital and face-to-face working to be made. The latter becoming more significant as we exit the current level of restrictions.

References

Anthony W.A. (1993) **Recovery from mental illness: The guiding vision of the mental health service system in the 1990s.** *Psychosocial Rehabilitation Journal* 16(4), 11-23. DOI: 10.1037/H0095655.

Beeble M.L. & Salem D.A. (2009) **Understanding the phases of recovery from serious mental illness: The roles of referent and expert power in a mutual-help setting.** *Journal of Community Psychology* 37(2), 249-267. DOI: https://doi.org/10.1002/jcop.20291.

Chyzzy B., Nelson LR. E., Stinson J., Vigod S. & Dennis C-L. (2020) **Adolescent mothers' perceptions of a phone-based peer support intervention.** *Canadian Journal of Nursing Research* DOI: 10.1177/0844562120904591.

Dale J., Caramlau I O., Lindenmeyer A. & Williams S,M. (2009) **Peer support telephone calls for improving health.** *Cochrane Database of Systematic Reviews* 2008, Issue 4. Art No: CD006903. DOI: 10.1002/14651858. CD006903.pub2. (Accessed 11th June from The Cochrane Library Database).

Department of Health and Children (2006) **A Vision for Change: Report of the Expert Group on Mental Health Policy.** The Stationary Office, Dublin.

Finnerty S. (2019) **Rehabilitation and Recovery Mental Health Services in Ireland: 2018/2019.** Mental Health Commission, Dublin.

Health Service Executive (2017) **CHO plan 2017: Waterford, Wexford, south Tipperary, Carlow, Kilkenny.** (Internet) Dublin, Health Service Executive, Available at: http://www.hse.ie/eng/services/publications/serviceplans/Service-Plan-2017/Operational-Plans-2017/CHO-5-Operational-Plan-2017.pdf, (Accessed 03rd June 2020).

Health Protection Surveillance Centre (2020) **Covid-19 Cases in Ireland.** (Internet) Available at: https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/casesinireland/, (Accessed 04th June 2020)

Hunt E. & Byrne M. (2019) **Peer Support Workers in Mental Health Services: A Report on the impact of Peer Support Workers in Mental Health Services.** Dublin, Health Service Executive, Available at: https://www.researchgate.net/publication/340716658_The_Impact_of_Peer_Support_Workers_in_Mental_Health_Services, (Accessed 04th June 2020).

McKenna B., Furness T., Dhital D. & Ireland S. (2014) **Recovery-orientated care in older adult acute inpatient mental health settings in Australia: An exploratory study.** *Journal of the American Geriatrics Society* 62(10), 1938-1942. DOI: 10.1111/jgs.13028.

Mental Health Comission (2012) **Guidance Document on Individual Care Planning Mental Health Services** (Internet) Dublin, Mental Health Commission, Available at: https://www.mhcirl.ie/file/GuidanceOn_ICPMHS.pdf, (Accessed 03rd June 2020).

Norton M. (2019) **Implementing co-production in traditional statutory mental health services**. Mental Health Practice DOI: 10.7748/MHP.2019.E1304.

Norton M.J., Bergin M. & Denieffe S. (*In Press*) **Service user views of peer support in mental health: A meta-synthesis.** *Psychiatric Rehabilitation Journal*.

Norton M.J. & Swords C. (*In Press*) **Social recovery: A new interpretation to recovery-orientated services – A critical literature review.** *Journal of Mental Health Training, Education and Practice*.

O' Leary K., Bhattacharya A., Munson S.A., Wobbrock J.O. & Pratt W. (2017) **Design opportunities for mental health peer support technologies.** Paper presented at CSCW'17: 2017 ACM Conference on Computer-Supported Cooperation Work and Social Computing, 25th February – 01st March, Portland, United States of America.

Sembi S. (2018) **Mums4Mums Structured Telephone Peer-Support for Women Experiencing Postnatal Depression: A Pilot RCT to Test its Clinical Effectiveness.** Ph.D Dissertation, Published, University of Warwick, United Kingdom.

Smith-Merry J., Goggin G., CampbellA., McKenzie K., Ridout B. & Baylosis C. (2019) **Social connection and online engagement: Insight from interviews with users of a mental health online forum.** JMIR Mental Health 6(3), e11084. DOI: 10.2196/11084.

Mental Health Engagement and Recovery Office

(Working with People who use Mental Health Services, their Family Members, Carers and Supporters)

HSE, St Loman's Hospital,
Palmerstown, Dublin 20.
D20 HK69

Tel: +353 (0)1 620 7339

Email: mhengage@hse.ie

Web: www.hse.ie/mentalhealthengagement