

## Peer support work for people experiencing mental distress attending the Emergency

### Department: exploring the potential

\*Catherine Brasier<sup>1</sup>  
Helena Roennfeldt<sup>2</sup>  
Bridget Hamilton<sup>2</sup>  
Andrew Martel<sup>3</sup>  
Nicole Hill<sup>4</sup>  
Anthony Stratford<sup>5</sup>  
Sally Buchanan-Hagen<sup>6</sup>  
Louise Byrne<sup>7, 8</sup>  
David Castle<sup>9, 10</sup>  
Nadine Cocks<sup>5</sup>  
Larry Davidson<sup>8</sup>  
Lisa Brophy<sup>11, 1</sup>

<sup>1</sup> Social Work and Social Policy, School of Allied Health, Human Services and Sport, La Trobe University

<sup>2</sup> Centre for Mental Health Nursing, The University of Melbourne

<sup>3</sup> Faculty of Architecture, Building and Planning, The University of Melbourne

<sup>4</sup> Department of Social Work, Melbourne School of Health Sciences, The University of Melbourne

<sup>5</sup> Mind Australia Limited

<sup>6</sup> School of Nursing and Midwifery, Deakin University

<sup>7</sup> School of Management, College of Business and Law RMIT University

<sup>8</sup> School of Medicine, Yale University

<sup>9</sup> Centre for Complex Interventions. Centre for Addictions and Mental Health

<sup>10</sup> Department of Psychiatry, University of Toronto

<sup>11</sup> The Centre for Mental Health, Melbourne School of Population and Global Health, The University of Melbourne

\* Corresponding Author

Running Head: Peers in EDs

Keywords: Mental health; Peer support; Emergency Department; Lived Experience

### Tables and Figures

**Table 1.** Key findings from the site visit

**Table 2.** Summary of the focus groups key themes

**Table 3.** Key findings from the peer learning workshop

**Sources of Funding:** Melbourne Social Equity Institute, The University of Melbourne

**Competing interests:** The authors declare that they have no conflicting interests

This is the author manuscript accepted for publication and has undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the Version of Record. Please cite this article as doi: [10.1111/1742-6723.13848](https://doi.org/10.1111/1742-6723.13848)

**Word count:** 2,991 (excluding tables and references)

Word count: 2,991

## **Abstract**

**Objective.** This study explored the benefits and limitations of employing peer support workers, who utilise their own lived experience of mental distress and recovery, to support people experiencing mental distress who are attending the Emergency Department.

**Methods.** This co-produced qualitative study utilised four phases: i) Assemble a collaborative multi-disciplinary research team and Expert Panel, of which at least half identified as having lived experience; ii) A site visit to an Emergency Department; iii) Focus groups with consumers, support persons and Emergency Department staff; iv) A learning workshop for peer support workers.

**Results.** Focus groups were run for consumers (n = 7), support persons (n = 5) and Emergency Department staff (n = 7). Eleven consumer peer support workers participated in the learning workshop. Four themes were identified and triangulated: The individual in distress, peer support work, a “Peers in EDs” service and the Emergency Department context. Overall, findings suggest that peer support workers contribute important skills including listening, de-escalation, relationship-building and empathy.

**Conclusions.** This study identified that peer support workers would bring important skills to an Emergency Department (e.g. empathetic support, de-escalation). However, significant workforce and organisational support would be required.

## Introduction

Individuals who present to the Emergency Department (ED) due to mental health crises often face extended wait times and prolonged exposure to conditions which may worsen distress and trauma.<sup>1</sup> Barriers include environmental conditions (bright lighting, noise, frenetic pace, lack of privacy) which often exacerbate this challenging experience.<sup>2</sup> Most EDs lack the fundamental design features (e.g. places to rest, access to showers, phone chargers) to support a person during extended wait times.<sup>3</sup> The implementation of recovery-orientated principles such as CHIME (connectedness; hope and optimism; identity; meaning; empowerment) are yet to be fully realised in the ED.<sup>4</sup>

In Victoria, Australia, many crisis and mental health support services have been reduced or discontinued over the past 10 years.<sup>5</sup> This has left consumers and their support persons (friends, family, other support persons) with little choice about where to seek help. Meanwhile EDs are always open, typically at no cost. In 2018, around 53% of individuals presenting with mental distress waited more than eight hours in the ED before being admitted to a mental health bed.<sup>3</sup>

Peer support workers (PSWs) are individuals who employ their lived experience of mental distress and recovery alongside professional skills and training to provide direct support to others. The implementation of PSWs in mental health services can lead to significant improvements in hope,<sup>6</sup> personal recovery,<sup>7</sup> empowerment,<sup>7</sup> quality of life,<sup>8</sup> reduced hospital admissions<sup>9</sup> and increased satisfaction with support.<sup>10</sup>

PSWs may benefit ED workers and the organisation by promoting personal recovery and challenging prejudice.<sup>11</sup> Enablers of peer work include an accepting organisational culture,<sup>12</sup> role clarity<sup>13</sup> and resources.<sup>13</sup> PSWs face barriers such as co-opting,<sup>14</sup> recovery denial,<sup>14</sup> attitudinal barriers<sup>15</sup> and deeply clinical environments (i.e. the ED).<sup>16</sup>

There is minimal literature addressing the implementation of PSWs in the ED.<sup>17, 18</sup> A US study by Migdole and colleagues (2011) described a recovery-oriented ED program which identified the importance of allies and support strategies. Chavulak and colleagues (2018) explored the impact of an Australian Pre-Admission Liaison (PAL) program to support individuals in the ED who were waiting for an inpatient admission. PAL workers provided: i) system navigation; ii) orientation to the inpatient unit/key staff; and iii) sensory modulation. Participants drew attention to the importance of being informed, connecting with others

who have lived experience and having the PSW provide a connection to the ward. Pioneering projects like the Safe Haven Café, which is established at the study site and opened in April 2018, provide therapeutic alternatives to the ED using clinicians, peer support workers and volunteers.<sup>19</sup>

Therefore, the primary aim of this study was to explore the potential of implementing PSWs in the ED, using co-production to explore consumer, support person, peer worker and ED staff perspectives. Our secondary aims was to explore and identify elements of the physical design and architecture of the ED and how it would impact on a PSWs in EDs service.

### **Methods**

The project was approved by St Vincent's Hospital (Fitzroy) Human Research Ethics Committee (HREC 099/19). Data was collected from participants across multiple services, not just from the study site.

#### *Study methodology*

The qualitative exploratory study was comprised of four key phases:

1. Assemble a collaborative multi-disciplinary research team and Expert Panel, of which at least half identified as having lived experience of mental distress or of being a support person, to investigate the potential employment of PSWs in the ED using a co-production method. The research team included a PhD candidate and a lived experience researcher. Lived experience team members held key decision-making roles and participated in the project's conception and design, conducting core research activities including data collection and analysis, plus the reporting and publication of the findings. This phase aimed to embed co-production and key stakeholder perspectives into the heart of the study.
2. Complete a site visit with members of the research team to a local metropolitan public hospital ED to better understand the experience of attending or working in the ED, with an emphasis on the impact of the ED's physical design and architecture. This phase aimed to ground the study in the ED environment and how it may be experienced.
3. Conduct focus groups with consumers, support persons and ED staff exploring the potential role of PSWs in the ED. This phase aimed to elicit perspectives from key stakeholders to inform the study.

4. Conduct a lived experience-led peer learning workshop to explore the potential role of PSWs in the ED. This phase aimed to elicit peer workers perspectives about the findings; this served as a method for checking the key points and themes to increase trustworthiness.<sup>20</sup>

#### *Recruitment, information and consent*

All participants were recruited using snowball recruitment which allows individuals to pass on the recruitment information to those they think might be interested. Partner organisations were asked to share the study information, using a brochure and email, with interested parties. Potential participants contacted the lived experience researcher (CB) to express interest and be screened for eligibility; study information was supplied in writing and was explained prior to participation. Participants received a Participant Information and Consent Form. Written informed consent was obtained from all participants. A brief demographics survey was offered to all participants which included the participants' age, gender, language spoken at home and last contact with ED.

#### *The site visit*

A site visit to an ED in a metropolitan hospital which has 880 beds and employs around 5,000 staff, including a small peer workforce, was conducted by members of the research team including an investigator with architecture and design expertise (AM).<sup>24</sup> The visit was led by a PSW from the hospital who belonged to a small service which provides ED support and ED alternative. The researchers had ethical approval to take notes about what they observed during/after the site visit; this was shared with the study investigators/Expert Panel. This enabled the research team members who attended the visit (LB, AM, CB) to cross check their observations and develop themes that were meaningful to all involved.

#### *Focus groups*

Considering the exploratory nature of the study it was projected that focus groups of a sample size of between six to 15 would be sufficient.<sup>21</sup>

#### *Focus group methodology*

Three focus groups (approx. 1 hour) were conducted to explore the potential role of PSWs in supporting people who experience mental distress and attend the ED; this was estimated to enable collection of sufficient data for saturation of ideas and themes to be reached in this exploratory research.<sup>21</sup> These were led by a lived experience researcher from the

research team (CB), plus a second member of the research team (AM, NH, HR). A semi-structured interview schedule was used (see Appendix 2). Recordings were professionally transcribed and de-identified. Analysis was conducted using NVivo (version-12).

#### *Focus groups criteria*

*Inclusion:* people who identify as a consumer, support person or ED staff member, aged 18 years or over, comfortable conversing in English, who consent to be audio recorded for data collection.

#### *Focus group data analysis*

Reflexive thematic analysis was conducted on each of the focus group transcripts according to the methods described by Braun and Clarke.<sup>22</sup>

Thematic coding was completed by a lived experience researcher (CB) and reviewed by the research team (LB, NH, HR). The lived experience coding team (CB, HR) added a lens through which the themes were constructed, by reflecting on their own experiences and expertise to encourage a safe and engaging research process, as well as in the data analysis and interpretation. This lens was combined with the broader multidisciplinary lens of the team providing a multifaceted interpretation of the findings.

#### *Peer learning workshop*

A half-day workshop for consumer mental health PSWs was held to reflect on the project findings. The purpose was to uncover new reflections based upon three core questions (see below). The workshop included a panel presentation during which members of the research team/other experts led a discussion. The peer learning workshop was led by two lived experience researchers (CB, HR) from the research team.

Participants were divided into three groups and given a topic to explore and record on poster paper:

1. What skills, knowledge and values do mental health PSWs bring to the ED?
2. What is the optimal role for mental health PSWs in the ED?
3. What do mental health PSWs working in the ED need from the organisation?

In an iterative process, further notes were added during a panel presentation and reviewed at the end of the workshop.

### *Peer learning workshop criteria*

*Inclusion:* consumer mental health peer workers, aged 18 years or older.

### *Peer learning workshop data analysis*

The comments and themes detailed on the poster-paper were transcribed and summarised.

## **Results**

These results report on the site visit, focus groups and peer learning workshop. Additional demographic information is detailed in Appendix 1.

### *The site visit*

A site visit to a metropolitan hospital with an existing PSW program in the ED was completed on the 31<sup>st</sup> January 2020. This hospital has approximately 25 people working in lived experience roles making up a total of 13 EFT. Most work part time and are employed in many areas of the service including the acute inpatient unit, discharge planning, community clinics and specialist teams; they are yet to be included in the Crisis and Assessment Team. It was attended by three members of the research team (LB, CB, AM) and was led by a PSW who had worked in the ED. The focus of the visit was to see the ED in action and understand more about the environment in order to have a more in-depth appreciation of the challenges and possibilities for PSWs. Limited enablers were identified from the site visit e.g. PSW desk being located in the ED and family room. Challenges included lack of privacy, unhelpful stimuli (including noise) and crowding, see Table 1.

### **Table 1. Key findings from the site visit**

[Table 1 here]

### *Focus groups*

#### *Participants*

The consumer focus group included seven participants, aged between 23 to 63 years who had attended an ED for mental distress, between 2013 and 2019. The support person focus group included five participants, aged 45 to 64 years who had supported a person experiencing distress in the ED, between 2011 and 2019. The ED staff focus group included

seven participants, aged 25 to 40 years who currently work in the ED; including six nurses and one mental health staff member.

#### *Summary of the focus groups finding*

Common themes were identified across all three focus groups. Four overarching themes (see Table 2) were identified: the individual in distress; peer support work; a “Peers in EDs” service; and the ED context. The following discusses those themes and compares and contrasts findings from the participant groups.

#### **Table 2. Summary of the focus groups key themes**

[Table 2 here]

##### *Theme One: Individuals in distress*

Consumers recognised the importance of their extended network (family, friends, allies). Support persons also emphasised the need for trauma-informed care, support to navigate the system and the lack of support alternatives. The ED staff reported they would like to increase their mental health capabilities since training was limited due to a lack of resources and time pressures (see Table 2); this may have contributed to nurses often perceiving mental health crisis as less critical than physical emergencies.

##### *Theme Two: Peer support work*

Consumers identified the value of recovery-orientated principles, including the importance of relationships. These contributions emphasised the importance of seeing the whole person instead of defining a person by their diagnosis or symptoms. Support persons concurred stating that PSWs could play a critical role in supporting consumers and help them to access and navigate the ED. Both consumers and support persons advocated for both consumer and carer PSWs.

##### *Theme Three: A “Peers in EDs” service*

Consumers highlighted the incongruity between what they feel that they need (e.g. connection, person-centred support, personal journey) and their experience of the ED (e.g. feeling rushed/confused). Consumers discussed the potential for PSWs to provide information, navigate the ED environment, alleviate frustration and boredom. Support persons stated that the hospital should value PSWs and expressed concerns that PSWs were

not sufficiently supported. The ED staff expressed gratitude for the PSWs that they had worked with, identifying PSW skills around de-escalation and relationship-building, noting that their fast-paced role often impeded their ability to do this themselves.

#### *Theme Four: ED context*

Consumers highlighted how the physical features of the ED impact upon consumers and potentially on PSWs; carer participants also expressed the need for more private spaces they could use for respite. Elements of the ED space (e.g. nowhere to rest, no privacy) compound the time consumers spend in the ED. Consumers also advocated for ‘real change’ including alternatives to the ED, recognising that the ED environment and processes contributed to their distress.

#### *Summary of the peer learning workshop findings*

*“The individual, the team, the organisation.” – Workshop participants*

The peer learning workshop included 11 peer workers, aged 27 to 46 years of age.

Key themes from the peer learning workshop are reported in Table 3:

#### **Table 3. Key findings from the peer learning workshop**

*[Table 3 here]*

#### **Discussion**

This research provides preliminary considerations about the role of PSWs in the ED and highlights the important role that PSWs could play. PSWs are uniquely positioned to respond to the challenges posed by the ED environment, ED culture and limitations in resources. These considerations may apply differently between services and settings (i.e. metropolitan, regional, rural). ED support is often defined in terms of clinical mental health support and triage;<sup>23</sup> however, the consumers who participated in the focus groups defined support in terms of holistic, relationship-based and recovery-oriented practice reflecting PSW capabilities (e.g. mutuality, crisis as an opportunity, listening with intention).<sup>24</sup> The provision of holistic support may improve consumer experience and outcomes. Our findings concur with previous literature<sup>11</sup> which found that the ED can impede recovery-oriented practice due to its fast paced, highly medicalised culture; which may in turn, contribute to consumers feeling “misunderstood”.<sup>25</sup> It may also impede trauma-informed practice as impersonal services and stark environments can create and re-trigger trauma. Our

participants suggested that PSWs are an important solution as they could mitigate this through equitable relationships built on respect and hope, as noted in the literature.<sup>26</sup>

The Australian Fifth National Mental Health and Suicide Plan<sup>27</sup> recognises the essential role of support persons and acknowledges the frustration they experience while trying to negotiate service thresholds such as the ED. Our findings indicate that support persons want more assistance, for themselves and the consumer, to navigate the ED which could be provided, in part, by a PSW. Findings from the peer learning workshop emphasised the importance of the relationships throughout the continuity of care.

This research found that nurses often faced a conundrum; they wanted to be better able to respond to the mental distress but were impacted by severe time pressures. Some expressed relief that PSWs could offer the time and support they could not. Our research suggests that PSWs may improve staff knowledge about mental health. Improving staff understanding may reduce the de-prioritisation of mental distress. Considering this, it is not surprising that individuals who present with mental distress are twice as likely to leave the ED before their treatment is complete, compared to other attendees.<sup>1</sup>

A number of barriers and concerns were identified through the four main themes which spanned across the participant groups. For example, participants confirmed previous findings that many PSWs face inequitable conditions including parity of pay, discrimination and prejudice.<sup>28</sup> Workforce support strategies including peer supervision, access to peer training, professional peer networks and career progression will be important to the long term success of a PSW workforce.<sup>12</sup> Our findings also draw attention to the complexity of conducting peer support within the ED. As observed by consumers and ED staff, many EDs would require substantial capital works while issues pertaining to organisational readiness and ED culture may also be difficult to change. Perhaps this is why there has been considerably less implementation of PSWs in the ED compared to other parts of the mental health system. It is unclear if situating PSWs in the ED or if offering an alternative peer-staffed space would be better. Indeed, further research identifying how the ED environment could impact on PSW is an important topic of future research.

Piloting and careful evaluation of both proposed and current efforts of including PSWs in the ED is required. This research should be peer-led to enable that the strengths of lived experience wisdom is integrated fully into the development, implementation and evaluation

of the program. As observed by the National Productivity Report on Mental Health, it is likely that in addition to PSWs in EDs other alternatives may also be required.<sup>29</sup> It was noted across the participant groups that many people were unsure of how the PSW role would be comprised and this may depend on the setting (e.g. ED or ED alternative), the service and the location (e.g. metropolitan, regional or rural); this is an important topic for further research. It is possible that clarifying the “Peers in EDs” role and clearly describing it as a formalised part of mental health pathways could help PSWs in ED become accepted as a professional asset.

This research should be interpreted within the following limitations. This study employed convenience sampling and snowball techniques. The ED staff focus group only included one staff member from mental health.<sup>30</sup> Future research should include medical staff, psychiatric liaison and allied health staff.

### **Conclusion**

Peer support is increasingly utilised in Australian mental health practice, yet it is rarely employed in EDs where there is urgent need for increased support for individuals who are experiencing mental distress. This research identified some important benefits of employing PSWs, including empathetic support and de-escalation. However, it also draws to light significant barriers such as the clinical nature of the ED environment. Significant investment in changing workplace culture and workforce support is required. Further, PSWs must be recognised as full and expert members of the ED team, a development that will require significant attention to workplace culture, as well as long-term financial and philosophical support from the organisation.

## References

1. Australasian College for Emergency Medicine. The long wait: An analysis of mental health presentations in Australia. ACEM: Melbourne 2018.
2. Connellan K, Gaardboe M, Riggs D *et al.* Stressed spaces: Mental health and architecture. *HERD*. 2013; 6: 127-168.
3. Victorian Auditor-General's Office. Access to mental health services - Independent assurance report to Parliament. Victorian Auditor-General's Office: Melbourne 2019.
4. Leamy M, Bird V, Boutillier CL, Williams J, Slade M. Conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. *Br J Psychiat*. 2011; 199: 445-452.
5. Royal Commission into Victoria's Mental Health System. Royal Commission into Victoria's Mental Health System - Interim report. Victorian Government Printer: Melbourne 2019.
6. Farkas M, Boevink W. Peer delivered services in mental health care in 2018: Infancy or adolescence? *World Psychiat*. 2018; 17: 222-224.
7. Lloyd-Evans B, Mayo-Wilson E, Harrison B *et al.* A systematic review and meta-analysis of randomised controlled trials of peer support for people with severe mental illness. *BMC Psychiat*. 2014; 14: 39.
8. Cook JA, Copeland ME, Jonikas JA *et al.* Results of a Randomized Controlled Trial of mental illness self-management using Wellness Recovery Action Planning. *Schizophr. Bull*. 2012; 38: 881-891.
9. Sledge WH, Lawless M, Sells D *et al.* Effectiveness of peer support in reducing readmissions of persons with multiple psychiatric hospitalizations. *Psychiatr. Serv*. 2011; 62: 541-544.
10. Shalaby RA, Agyapong VI. Peer support in mental health: General review of the literature. *JMIR Ment. Health*. 2020; 7: e15572.
11. Marynowski-Traczyk D, Moxham L, Broadbent M. A critical discussion of the concept of recovery for mental health consumers in the Emergency Department. *Australas. Emerg. Nurs. J*. 2013; 16: 96-102.
12. Byrne L, Roennfeldt H, Wang Y, O' Shea P. 'You don't know what you don't know': The essential role of management exposure, understanding and commitment in peer workforce development. *Int J Ment. Health Nurs*. 2019; 28: 572-581.
13. Ibrahim N, Thompson D, Nixdorf R *et al.* A systematic review of influences on implementation of peer support work for adults with mental health problems. *Soc Psychiatry Psychiatr Epidemiol*. 2019; 55: 285-293.
14. Byrne L, Happell B, Reid-Searl K. Recovery as a Lived Experience discipline: A grounded theory study. *Issues Ment Health Nurs*. 2015; 36: 935-943.
15. Byrne L, Roper C, Happell B, Reid-Searl K. The stigma of identifying as having a lived experience runs before me: Challenges for lived experience roles. *J. Ment. Health*. 2019; 28: 260-266.
16. Byrne L, Roennfeldt H, O'shea P, Macdonald F. Taking a gamble for high rewards? Management perspectives on the value of mental health peer workers. *Int. J Environ. Res. Public Health*. 2018; 15: 746.

17. Migdole S, Tondora J, Silva MA *et al.* Exploring new frontiers: Recovery-oriented peer support programming in a psychiatric ED. *Am. J Psychiatr. Rehabil.* 2011; 14: 1-12.
18. Chavulak J, Buckley L, Petrakis M. Recovery co-design and peer workforce development in the acute inpatient setting. *New Paradigm.* 2018; Summer 2018/18: 34-39.
19. Safe Care Victoria. Safe Haven Cafe.  
<https://www.bettersafecare.vic.gov.au/improvement/projects/mh/safe-haven-cafe> (accessed 20/05/21).
20. Nowell LS, Norris JM, White DE, Moules NJ. Thematic analysis: Striving to meet the trustworthiness criteria. *Int. J. Qual. Methods.* 2017; 16: 160940691773384.
21. Vasileiou K, Barnett J, Thorpe S, Young T. Characterising and justifying sample size sufficiency in interview-based studies: Systematic analysis of qualitative health research over a 15-year period. *BMC Med Res Methodol.* 2018; 18: 148-148.
22. Braun V, Clarke V. Using thematic analysis in psychology. *Qualit. Res. Psychol.* 2006; 3: 77-101.
23. State Government of Victoria. Emergency departments - Mental health service delivery guidelines. <https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/service-quality/emergency-departments-and-mental-health-care/emergency-departments-mental-health-service-delivery-guidelines> (accessed 08/04/2020).
24. Van Weeghel J, Van Zelst C, Boertien D, Hasson-Ohayon I. Conceptualizations, assessments, and implications of personal recovery in mental illness: A scoping review of systematic reviews and meta-analyses. *Psychiatr. Rehabil. J.* 2019; 42: 169-181.
25. Stratford AC, Halpin M, Phillips K *et al.* The growth of peer support: An international charter. *J. Ment. Health.* 2019; 28: 627-632.
26. Davidson L, Amy CB, Guy K, Er RM. Peer support among persons with severe mental illnesses: A review of evidence and experience. *World Psychiat.* 2012; 11: 123-128.
27. Department of Health. *The Fifth National Mental Health and Suicide Prevention Plan*; Commonwealth of Australia: Canberra 2017.
28. State Government of Victoria. Lived experience workforce positions in Victorian public mental health services. State of Victoria, Department of Health and Human Services: Melbourne 2017.
29. Productivity Commission. *Mental Health, Inquiry Report.* Commonwealth of Australia: Canberra 2020.
30. Minshall C, Roennfeldt H, Hamilton B. Examining the role of mental health peer support in emergency departments. Melbourne Social Equity Institute, University of Melbourne: Melbourne 2020.

## Tables

**Table 1.** Key findings from the site visit

<b><i>Entrances and wayfinding</i></b>	<ul style="list-style-type: none"><li>• The ED entrance is not visible from the street</li><li>• Little signage to support wayfinding</li><li>• Those arriving by ambulance or police escort enter through the ambulance bay</li></ul>
<b><i>Waiting room</i></b>	<ul style="list-style-type: none"><li>• Limited private spaces</li><li>• Private conversation (face-to-face or by phone) would be difficult to conduct, point 2</li><li>• Attendees are visible to other visitors and staff at the triage desk</li><li>• Access to basic necessities is limited (i.e. nowhere to rest, vending machines, public toilets)</li><li>• Unhelpfully stimulating environment (TVs on the wall, 24-hour fluorescent lighting)</li></ul>
<b><i>Clinical spaces</i></b>	<ul style="list-style-type: none"><li>• The clinical spaces comprised of ED clinical bays for clinical staff only and patient cubicles</li><li>• Staff-only spaces included desks/PC access stations, meeting rooms, staff rest areas and property storage facilities</li></ul>

	<ul style="list-style-type: none"><li>• PSWs desk is located behind triage and beside the allied health desk</li><li>• The nurse’s desk and clinical spaces are very crowded</li><li>• The presence of armed forensic officers/police was observed</li><li>• Some features could support recovery, such as the family room, but access was limited</li></ul>
--	--

ED = Emergency department; PC – personal computer; PSW – Peer support worker

**Table 2.** Summary of the focus groups key themes

OVERARCHING THEMES ACROSS THE FOCUS GROUPS				
	Individuals in distress	Peer support work	A “Peers in EDs” service	ED context
<b>Consumer focus group subthemes</b>	Support me	Are PSWs 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			Support person and allies
	Dignity			Consumers in the driving seat
				Real change
<b><i>“The relationships are at the centre, this is about relationships.” – Consumer (p.31)<sup>30</sup></i></b>				
<b>Support person focus group subthemes</b>	Caring for support persons	Are PSWs valued by the organisation?	Carer peer workers	Support persons
	Breathing room	The human face in the ED	Trauma sensitive practice	Navigating the system
	Support to navigate the system	The role of consumer PSWs		

***“I just think that some information that comes from a lived experience knowledge comes across in a different way than a clinician would.” – Support person (p.33)<sup>30</sup>***

**OVERARCHING THEMES ACROSS THE FOCUS GROUPS**

	<b>Individuals in distress</b>	<b>Peer support work</b>	<b>A “Peers in EDs” service</b>	<b>ED context</b>
<b>ED staff focus group subthemes</b>	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	

*“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.” – ED staff (p.34)<sup>30</sup>*

ED = Emergency department; PSW – Peer support worker

**Table 3.** Key findings from the peer learning workshop

<p><b>What skills, knowledge and values do mental health PSWs bring to the ED?</b></p>	<ul style="list-style-type: none"> <li>• Supporting and developing relationships and interpersonal communications between themselves and people who are experiencing distress</li> <li>• PSW skills: empathetic listening, connection-building, intentional sharing</li> <li>• Benefits included increased physical/emotional comfort, feeling empowered and decreased stigma by de-mystifying the situation</li> <li>• Peer values appeared to contribute to a common world view grounded in ones lived experience, real world knowledge, mutuality, leaning into discomfort and embracing peer culture</li> </ul>
<p><b>What is the optimal role for mental health PSWs in the ED?</b></p>	<ul style="list-style-type: none"> <li>• Contributing to training/education, conducting one-on-one support, multi-disciplinary teams, supporting people to navigate the system and leadership</li> <li>• Unique perspectives on trauma informed care, being present and sitting with distress</li> <li>• Working directly with consumers and support persons during the ED presentation, post-discharge and throughout the continuity of care</li> <li>• PSWs required flexible working arrangements, adequate physical space, infrastructure and resources (e.g. computers, desk space)</li> <li>• Importance of employing both consumer and carer PSWs as they have distinct contributions to make</li> </ul>
<p><b>What do mental health PSWs working</b></p>	<ul style="list-style-type: none"> <li>• Peer supervision and a clear peer support employment/workforce development and role clarity</li> </ul>

<b>in the ED need from the organisation?</b>	<ul style="list-style-type: none"><li>• Workforce issues such as sufficient resources (e.g. computers, desk space), role definition, opportunities for career progression, regular networking with other peer workers, parity of pay, a clear roster, reasonable adjustments of employment conditions (e.g. flexible work roster) and access to training</li></ul>
--	--

ED = Emergency department; PSW – Peer support worker

## **Appendix 1 - Supplementary Demographic information**

### *Consumer focus group participants*

Of the seven consumer participants, six 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 attended the ED once, two attended twice, one attended between 3-4 times and two attended five or time 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 reported having a support person present during their last visit to ED. Support persons included partners, parents – including step-parents – and extended family (e.g. sister-in-law).

### *Support person focus group participants*

Of the five support persons participants each person completed a brief demographic questionnaire. All participants identified as having supported as mental health consumers and attend the ED between 2011 and 2019. One participant reported that they supported a person who attending 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, 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 into 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.

#### *ED staff focus group participants*

Of the seven 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 seven participants, three 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.

#### *Peer learning workshop participants*

Of the 11 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.

## Appendix 2 – Interview schedule

The interview schedule is:

1. What is your overall impression of the model?
2. What do you think would help make this model work? How do you think we can best make those things happen?
3. What do you think the barriers related to this model would be? How could we reduce barriers?
4. What do you think some of the benefits of this model could be?
5. What improvements to this model would you suggest?
6. Were there any adjustments to the model or the language the model uses to better support the language, cultural and other needs of people?

Is there anything else you would like to say about this model?

# Peer support work for people experiencing mental distress attending the Emergency

Department: exploring the potential

\*Catherine Brasier<sup>1</sup>  
Helena Roennfeldt<sup>2</sup>  
Bridget Hamilton<sup>2</sup>  
Andrew Martel<sup>3</sup>  
Nicole Hill<sup>4</sup>  
Anthony Stratford<sup>5</sup>  
Sally Buchanan-Hagen<sup>6</sup>  
Louise Byrne<sup>7, 8</sup>  
David Castle<sup>9, 10</sup>  
Nadine Cocks<sup>5</sup>  
Larry Davidson<sup>8</sup>  
Lisa Brophy<sup>11, 1</sup>

<sup>1</sup> Social Work and Social Policy, School of Allied Health, Human Services and Sport, La Trobe University

<sup>2</sup> Centre for Mental Health Nursing, The University of Melbourne

<sup>3</sup> Faculty of Architecture, Building and Planning, The University of Melbourne

<sup>4</sup> Department of Social Work, Melbourne School of Health Sciences, The University of Melbourne

<sup>5</sup> Mind Australia Limited

<sup>6</sup> School of Nursing and Midwifery, Deakin University

<sup>7</sup> School of Management, College of Business and Law RMIT University

<sup>8</sup> School of Medicine, Yale University

<sup>9</sup> Centre for Complex Interventions. Centre for Addictions and Mental Health

<sup>10</sup> Department of Psychiatry, University of Toronto

<sup>11</sup> The Centre for Mental Health, Melbourne School of Population and Global Health, The University of Melbourne

\* Corresponding Author

Running Head: Peers in EDs

Keywords: Mental health; Peer support; Emergency Department; Lived Experience

## Tables and Figures

**Table 1.** Key findings from the site visit

**Table 2.** Summary of the focus groups key themes

**Table 3.** Key findings from the peer learning workshop

**Sources of Funding:** Melbourne Social Equity Institute, The University of Melbourne

**Competing interests:** The authors declare that they have no conflicting interests

**Word count:** 2,991 (excluding tables and references)

Author Manuscript