“It’s definitely been a roller coaster”

An exploration of youth service users’ understandings of personal recovery and experiences of intentional peer support.

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ABSTRACT

Worldwide, young people aged 18-25 experience high rates of mental distress. Youth mental health services are under immense pressure, resulting in ongoing unmet need. Currently, Aotearoa policy supports recovery-oriented practice, however literature is sparse on how youth understand personal recovery. Furthermore, peer support is an established but underutilised recovery-oriented intervention, which may be viable as a complementary or alternative modality to conventional services. However, little is known about the experiences of young people accessing peer support. Additionally, collaboration with young people is paramount if we are to create responsible and responsive youth research. This thesis aimed to explore youth service user understandings of personal recovery in the context of mental distress. It also aimed to explore their experiences of accessing intentional peer support.

The research used co-production with 12 youth service users across the project. A further 26 youth service users were recruited through their involvement in a mental health service (delivered in the Wellington region) and interviewed as research participants. The data were analysed separately for each study aim, using Interpretative Phenomenological Analysis (IPA). The first aim explored how youth understand personal recovery in relation to mental distress. Recovery was understood to be a complicated and multifactorial phenomenon, involving connection with the internal and external worlds. There were three superordinate themes relating to youth understandings of recovery: recovery is paradoxical; recovery is awareness about yourself; and recovery is connecting with others. The second aim explored participant experiences of accessing Intentional Peer Support (IPS). IPS was seen as a novel and personalised intervention, which supported participants if they were able to connect with their peer support workers. Regarding experiences of peer support, three superordinate themes were identified: experiences of business as (un)usual; seeing themselves reflected; and peer support as a tailored practice.

Overall, findings demonstrated how young people held important and meaningful information about their recovery experiences. In turn, this research provided much-needed lived experience perspectives on the utility of IPS as an intervention for youth. Furthermore, this research demonstrated that co-production can and should be utilised by researchers (including those at doctorate level), despite academic constraints. Taken together, these findings emphasise the importance of youth-appropriate recovery-orientated interventions within clinical practice and provides a platform for further research into youth experiences of IPS.

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We all exist in the context of our environments. This thesis was written in the context of an ongoing global pandemic, and an escalating and devastating war between my two motherlands where I spent my childhood: Ukraine and Russia. As this thesis goes to publication, my childhood province and the city where my grandmother recently took her last breaths, continues to be attacked. As these unprecedented events make me reflect on my life and loss, so too I acknowledge all those who have supported me to get to where I am today.

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I dedicate this thesis to my blood family, who have never fully grasped why I have gone into this field but supported me in their own way and as best they could. I also dedicate this thesis to my chosen family, without whom I could not and would not survive in this world.

It is no measure of health to be well adjusted to a profoundly sick society.

- Jiddu Krishnamurti

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CHAPTER ONE: INTRODUCTION

In Aotearoa, one in five New Zealanders live with mental distress and/or addiction (Allan, 2020). Despite this, our mental health system has remained under considerable strain due to understaffing and underfunding. At the end of 2017, after a decade of cuts to mental health funding, a centre-left Government came into power. With this change, the new Government announced an independent inquiry into the mental health and addiction sector, dubbed *the Inquiry*. In November 2018, after more than 5200 submissions and 400 meetings, the He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction was published (Paterson et al., 2018). The Inquiry was an historical moment for the future of mental health in Aotearoa. It included perspectives from previously underserved communities across the country, and represented voices of tāngata whaiora[1], and their whānau[2].

He Ara Oranga revealed irreparable flaws in the current mental health system. The report stated that a paradigm shift was required and that current mental health services needed an overhaul due to extensive unmet needs, delayed and inappropriate interventions, and high suicide rates across the country (Paterson et al., 2018). The report made several recommendations which included expanding access and options to services. Recommendations were also made for strengthening consumer voices across the sector, and incorporating interventions such as peer support into existing services. The report identified populations with poor mental health outcomes that required urgent attention. Young people, and in particular those who were Māori and/or Rainbow, were identified as priority groups, long underserved by existing services.

In response to the recommendations, the Ministry of Health released a tender, seeking proposals to improve the capacity, capability, and equity of access to psychological services for

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[1] Person seeking wellness. See Language and Terminology (p. 6) for more information.

[2] Family and extended family, including friends.

youth aged 18 to 25. This tender was created to address the service provision gap highlighted by He Ara Oranga. The successful proposal came from multiple stakeholders (i.e., primary health organisations, charitable and Government-funded organisations, and the University of Otago) working together, and resulted in a publicly funded primary mental health service pilot called Piki[3].

Piki was a comprehensive and complex pilot, active in the Greater Wellington region between July 2019 and December 2021. It was designed to increase access to mental health support for young people who experienced mild to moderate mental and/or substance misuse-related distress (Piki, 2019). Piki incorporated several conventional interventions commonly seen in existing mental health services. The main intervention it provided was access to individual Cognitive Behavioural Therapy (CBT). Additionally, Piki included other standard and already existing mental wellbeing supports, such as online and phone services.

However, one intervention offered by Piki was innovative and consistent with the paradigm shift described in the He Ara Oranga report. For the first time in publicly funded Aotearoa primary mental health services, Intentional Peer Support (IPS) was included as an alternative intervention for young people. IPS - developed from the principles of peer support where people with similar difficulties help each other through distress - was an established intervention adapted for Piki. I go on to elaborate on peer support and IPS in Chapters Two and Three. Suffice to say, the existence of this intervention created an opportunity for my doctoral thesis topic.

The Research Context

Given that existing services are failing our young people, a paradigm shift within clinical practice and research is long overdue. This thesis draws on interviews with youth service users in Piki to describe how they understand recovery from mental distress. It also captures the lived

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[3] To support or aid, and to climb or ascend.

experience of youth who accessed IPS, with the aim of exploring the viability and success of this intervention as a complementary or alternative modality to current conventional services.

This project was motivated by my desire to contribute to youth clinical research that can lead to real change in service delivery in this under-researched group. Being a young person who experiences mental distress is challenging, and youth voices are rarely heard in mental health service development. As a result, there is often a mismatch between the values of services that provide interventions, and what is genuinely meaningful to young people in their recovery. I wanted to give my participants the opportunity to articulate the areas of personal recovery that matter the most to them.

This research was influenced by my own experience as a youth service user, and later, as a peer supporter. Throughout my life, peer support provided me with an alternative perspective to framing mental distress. Within it, I found an established community that supported my recovery in a variety of ways conventional interventions could not. As an adult, I trained in the principles of IPS and saw first-hand how helpful this alternative approach could be for inpatient service users in a locked mental health ward. Given its usefulness with adult populations, I wanted to explore how youth experience this intervention. Thus, I hoped to contribute to a growing body of research on the transformative power of IPS.

This research was carried out as part of the DClinPsych requirement. Initially, I thought that my lived experience would enhance my clinical training; however, I found navigating the consumer/clinician duality to be consistently precarious. The very act of disclosing lived experience in clinical training has been dubbed “the kiss of death” (Devendorf, 2022; p. 1) by some of my colleagues, so my precariousness is unsurprising. I had a strong sense of my service user academic identity; however, my clinical scientist-practitioner identity was a contradiction to this. Throughout much of my clinical training I was in a state of flux, and felt like a foreigner. I did eventually naturalise into my dual identities; however, this has not been without contention. Now, I may have views that are informed by this diagnosis-based training and that are impossible to fully untangle from my lived experience. In some ways, I am an insider to my research, in that I have the lived experience of being a youth who has accessed mental health services. However, I am inherently privileged in that I am also a doctoral candidate and have gained a certain academic status. My identity, knowledge, and assumptions are all part of this research and, therefore, deeply tied to the outcome of this work. Throughout, I use first-person pronouns to reflect this. As parts of this thesis are co-produced with youth service users, I refer to “we” when describing collaborative perspectives from the group. This occurs predominantly in Chapter Four.

In terms of my career progression, all my choices have been underpinned by my insider knowledge. I am passionate about changing the unfair treatment of service users, who are commonly stereotyped resulting in prejudice, discrimination, and social exclusion. My work seeks to improve approaches used by health professionals with people experiencing mental distress, especially underserved youth and Rainbow communities. I believe that the fabric of clinical psychology as a profession is changing to be more service-user led, and I am excited to be a part of this shift. However, ongoing discrimination towards consumer clinicians remains strong within the profession. As a clinician, I have experienced micro-aggressions because of my disclosures, an experience too commonly shared by my colleagues who occupy both spaces (Victor et al., 2021).

At times, the clinical training required me to shelter parts of myself. I see this thesis as a return to my service user activism, which lay dormant for the duration of my clinical training. This research reflects my passion for youth mental health, alternative modes of care, and my continued refinement of the balance of my dual identities. It would be arrogant of me to presume that I could cover with any certainty the full gamut of service user experiences within one thesis. The youth who gave me a glimpse into their world have experiences far wider than what I can illuminate here. I am learning to leverage my expertise against the power that I now possess. As such, this research reflects a moment of my existing knowledge, frozen in time.

Organisation of the Thesis

This thesis is presented in seven chapters. Following this introduction, Chapter Two sets the scene with a timeline of the service user movement from past to present, explaining the recovery-oriented practice supported by current services, which orients the reader to the co-production approach. Chapter Three provides an international and local review of the current literature on youth mental distress and recovery. It briefly outlines existing youth mental health services and resulting service user experiences, and provides a review of current peer support research, thereby developing my rationale for the present research. The remaining four chapters present the current research and findings. Chapter Four outlines my methodology, researcher positioning, and method. Chapter Five details the findings and discussion of youth understandings of recovery. Chapter Six presents findings and discussion pertaining to service user experiences of IPS. Finally, Chapter Seven provides three overarching conclusions; addresses research strengths and limitations; and provides implications for future research, policy and practice, before concluding with closing reflections.

CHAPTER TWO: SETTING THE SCENE

This chapter provides the context to my research. First, I reflect on the language used within this thesis and how this may at times contradict the language of conventional mental health research. I then provide an overview of the history of the service user movement in Aotearoa, and the resulting service user involvement and recovery-oriented practice within mental health services. I introduce the reader to the co-production framework that underpins this research. This background is essential for putting my literature review, research methodology, and findings in context.

Language and Terminology

There is a diversity of perspectives on the language used in mental health with no universally agreed upon language or terminology for mental distress or recovery, or for the people who have these lived experiences. Commonly used terms such as *ex-patient, survivor, consumer, service user, client, expert by experience,* and *tāngata whaiora*, are purposeful (Morrison, 2000). Individuals with lived experience of mental distress apply language in a way that is most consistent with their expressed identity and historical context (Archibald, 2021; McLaughlin, 2008).

Language has a significant impact on the lives of service users and can be used to validate identities or to stigmatise and exclude them (Mental Health Coordinating Council, 2013). Additionally, clinical language can create power dynamics that reflect ongoing paternalism and coercion (Morrison, 2000; Stickley, 2006; Walker, 2006). Respecting the rights and autonomy of an individual by identifying them by their chosen terminology is an essential component of interpersonal ethics (Jourian, 2015). The language of the service user movement has often been a point of contention within literature globally (Beresford, 2005). Ongoing tensions exist between the language used by service providers and policy makers versus the language used by service users. Service-user terminology is increasingly utilised within Governmental documents. However, clinical research and practice continue to rely mostly on medical jargon (including diagnosis; Kinderman, 2019).

Service users are a heterogeneous group with a variety of perspectives, with polar views that at times contradict each other (Beresford, 2005; Daya et al., 2020). As a result, there is a spectrum of experiences in the service user language. Some service users find that a diagnosis provides relief and hope and, as a result, embrace this aspect of their experience. Still, others experience anger and disillusionment and reject diagnosis as null and void (Chamberlin, 1990; Moeke-Maxwell et al., 2008; Perkins et al., 2018). These experiences are not binary, but rather complex and nuanced, and can shift overtime or co-exist together. Similarly, some service users prefer person-first language (i.e., a person with a disability), while others feel it pertinent to claim identity-first language (i.e., disabled person; Dunn & Andrews, 2015). Some individuals reject clinical terms entirely. Others, such as those who are part of the Mad Pride movement[4], reclaim terms such as *nutter, mad, psycho,* and *mental* (Farber, 2012; Lewis, 2006). Therefore, language is not arbitrary, it is contextual, political, and emotionally charged, which has important implications for one's sense of self. This thesis includes terminology that is in opposition to what is generally used in conventional clinical psychology research. Specific terms require further rationale for including them within this thesis as outlined below.

Disease, Illness, or Distress?

Clinical literature generally conceptualises mental ill-health by categories of disease or illness. These categories are defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association, 2013) or the International Statistical Classification of Diseases (ICD; World Health Organization [WHO], 2016), both of which outline syndromes that

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[4] The Mad Pride movement was formed by people with lived experience as resistance against psychiatry. This movement extended into social, political and cultural domains, and aimed to reclaim and de-pathologise *mad* identities (Farber, 2012; LeFrançois, 2013).

must be of a certain frequency, intensity, and duration to constitute a diagnosis. Service users are divided on clinical terminology that positions experiences as disorders and/or illnesses. Within the international Mad Pride movement, psychiatric terminology is seen as oppressive (Crossley, 2006; Farber, 2012; Stickley, 2006). However, it is important to note that some service users can value diagnosis. In cases where the diagnosis fits the person's experience, it can help to provide validation, context, and empowerment, but only if this makes sense for the service user and fits with their recovery journey (Moeke-Maxwell et al., 2008; Perkins et al., 2018).

Publications such as the DSM and ICD remain controversial, biased, and maintain an ongoing stigma toward people in psychological distress (Kinderman et al., 2017). A move away from the conceptualisation of mental ill-health as a disease or illness represents a recognition of the reductive parameters the sector has created, for something which is part of the complex human condition (Walker, 2006). As a result, clinical psychology has moved away from using pathologising language in favour of *mental distress* (British Psychological Society, 2015). This shift is also supported by some service user activists, who state that the term mental distress can be used to place the power back within the service user community, rather than "big psychiatry" (O'Hagan, 2018, p. 1).

Mental distress serves as an umbrella term for a variety of disturbing or unpleasant experiences. Some may be diagnosable, while others may be subclinical (meaning they do not meet diagnostic criteria) but hinder recovery nonetheless (Flett, 2020). Throughout this thesis, I use the term mental distress to identify and describe the experience of psychological and emotional distress, regardless of whether this meets diagnostic criteria according to the DSM or ICD. I do this for three reasons. Literature is often inconsistent in the way it conceptualises psychological distress. Many articles use language that inevitably discriminates against service users, with terms such as *severe mental disorder* or *serious mental illness* suggesting that mental distress is chronic and incurable. On the contrary, I believe that service users can achieve recovery in a way that is meaningful to them. Secondly, mental distress is a preferred term among many service users as it signifies a move from biomedical model framing to human experience framing, which is consistent with the values of the grassroots service user movement (Beyond Insanity New Zealand [BINZ], 2022; O’Hagan, 2018). Finally, I am of the view that distress accurately articulates the experience of my participants, for whom youth is, by definition, distressing.

Recovery

Recovery is a process and an outcome where a previously unwell person returns to a state of wellness (Gordon, 2013). Within mental health, there are two generally accepted types of recovery: clinical and personal (Gilburt et al., 2013; Roberts, 2013; Slade et al., 2008). Clinical recovery (recovery from) is an individualistic outcome, which primarily concerns the reduction of psychiatric symptoms (Gordon, 2013; O’Hagan, 2004; Slade, 2009b). Clinical recovery is consistent with the biomedical model of understanding distress, which centres around the idea that mental distress is a disease or illness (Anthony, 1993). This definition is narrow, deficit-focused and largely stigmatising (Watts & Higgins, 2017).

Personal recovery (recovery in) is a process and is defined as an entirely subjective experience, focused on living life well in the presence or absence of symptoms (Gordon, 2013; Mental Health Commission, 1998; O’Hagan et al., 2012; Slade, 2012). One of the most widely accepted definitions describes recovery as:

> 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. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness. (Anthony, 1993, p. 12).

This definition outlines the subjective experience of personal recovery, which is qualitatively different from clinical recovery historically used by mental health services. In essence, personal recovery is a set of values that emphasise hope and restoring autonomy and meaning to one's valued life (Jacob, 2015; Perkins & Repper, 2015; Roberts, 2013). Personal recovery is what underpins recovery-oriented approaches that are models of support within mental health services based on personal recovery values (Roberts, 2013). I go on to elaborate on this model in the next chapter.

Service users have many varying definitions of the recovery experience. Some service users may derive meaning from clinical recovery, and others from a combination of clinical and personal recovery (Gordon, 2013; Schrank & Slade, 2018). For some, their lived experience may fit neatly into the developed frameworks above, and others may disagree with this categorisation (Stuart et al., 2017). Furthermore, some service users reject the concept of recovery entirely, in favour of *unrecovery* (Recovery in the Bin Collective, 2016). The position of these service users is intersectional and speaks to the fact that social inequalities and overarching ideologies make recovery difficult, if not impossible for some individuals (McDaid & Kousoulis, 2020). In short, recovery is too complex to define objectively.

My research methodology is underpinned by the definition of personal recovery, which is aligned with the service user movement and recovery-oriented practice. Consistent with service user literature, I view recovery as a nuanced non-linear process; a journey through a deeply personal experience (Deegan, 1988; Gordon, 2013). Within my research, recovery is also the focus of my first research question, and I honour the subjective personal definitions of recovery and allow each participant to define recovery on their own terms.

Umbrella Terms

Although it may not be possible to capture each individual's personal preference, the service user movement at its core has one common objective: to resist and challenge the concepts historically imposed by mental health service providers. It positions and privileges service user voices as central, in an environment that has continuously silenced individuals and their communities (Noorani, 2013; Slay & Stephens, 2013). This movement is the foundation from which I consider my language.

As the focus of this research is to specifically explore the experiences of service users, it is of paramount importance to honour multifaceted, complex constructs of identities. Throughout this thesis, I predominantly alternate between the terms *service user* and *tāngata whaiora*, with occasional use of *consumer*. These terms have been deliberately chosen. The terms service user/consumer are widely accepted within academic literature and clinical training in Aotearoa. It is also the terms with which I identify; thus, this is a personal preference signifying my positioning. The terms service user/consumer refer primarily to those who have lived experience of mental distress and have sought support from services.

Tāngata whaiora is a distinct term that acknowledges the unique context of the Aotearoa landscape. It honours a service user recovery orientation, literally translating to a *person seeking wellness*. Previously, this was a term used to describe specifically Māori service users. However, in recent years, this term has been expanded to refer to people "from all ethnic backgrounds who experience mental health or addiction challenges and who are seeking wellness or recovery of self" (Paterson et al., 2018, p. 22). This term encapsulates people who use mental health services, as well as those who do not, but seek recovery nonetheless. Many young people may not seek professional support, and, therefore, this term is pertinent to youth mental health.

Finally, I refer to *those with lived experience of mental distress* to address the collective. I speak of *movements* and *communities* and acknowledge that these umbrella terms do not reflect the nuance I described above. Throughout my thesis, I also use terms such as *young people*, *youth* and *rangatahi* [5] to describe those going through the developmental stage of adolescence. Furthermore, I use the terms *Pasifika* (indigenous people of the Pacific Islands), *POC* (people of colour), and *Rainbow* or *LGBTQI+* (lesbian, gay, bisexual, transgender, queer, intersex, and other non-heterosexual and non-cisgender identities). I recognise that individuals may disagree with these terms or feel unrepresented by them, either through personal preference, lived experience, or prior exclusion. In cases of research articles using stigmatising or outdated language, their usage is followed to highlight the problematic inconsistencies. With participants in this research, their self-identified language is given preference.

Mental Health Service User Movement in Aotearoa: A Brief History

The Aotearoa ex-patient/survivor/service user/consumer[6] movement was heavily influenced by events occurring across the United Kingdom and the United States of America. Internationally, the foundations of modern service user activism were established in the late 1960s (LeFrançois et al., 2013; Morrison, 2013). Two major movements influenced this development: the rise of anti-psychiatry and mental patients' liberation (also known as the psychiatric survivor movement; Chamberlin, 1990; Crossley, 2002). The anti-psychiatry movement began with a group of scholars and psychiatrists who challenged the notion of diagnosing mental illness and proposed alternative conceptualisations of madness (e.g., as a strategy to cope with adversity, or *saneness* in an insane world; Crossley, 2006; Rissmiller & Rissmiller, 2006). This opposition to the status quo served as a catalyst within psychiatry. However, this "revolt from above" (p.142) largely excluded service users

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[5] Younger generation, youth.

[6] Terminology depends on which country and year the material is referenced.

and was heavily criticised by those with lived experience, otherwise known as those "revolting from below" (Crossley, 2002, p. 142).

The early 1970s was an era of major civil-rights movements, with marginalised groups rallying together to advocate for self-determination, legal recognition, and freedom from oppression (Gong, 2017). It was within this socio-political context that service user groups began to emerge from subjugation (Chamberlin, 1990). Around this time, individuals with lived experience of institutionalisation established grassroots groups to advocate for changes to coercive paternalism within psychiatry (LeFrançois et al., 2013; Morrison, 2013). "Nothing about us without us" was the slogan of discontented service users (Nelson et al., 1998; Phillips, 2006). This development lay the foundation for service user participation in the planning, delivery, and evaluation of mental health services at individual and systemic levels (Mental Health Commission, 2007).

Though critical of each other, the anti-psychiatry and psychiatric survivors' movements at times merged together amidst a backdrop of social change to advocate for service user rights. As a result, there was an international shift in the way service users were treated. Clinicians and researchers in Aotearoa acknowledged and supported this movement. The enactment of the 1969 Mental Health Act led to the early stages of deinstitutionalisation, and a shift towards community-based models of care (O'Brien & Kydd, 2013). Consequently, mental health services began to incorporate the rights of service users and broader ideas around personal and clinical recovery.

In 1974, the Mental Health Foundation was established to reduce stigma and promote service user involvement within mental health services (Gawith & Abrams, 2006). This was followed by the establishment of the New Zealand Schizophrenia Fellowship in 1977. A first of its kind, the organisation offered resources for service users and their whānau affected by mental distress. Tāngata whaiora, influenced by the traction gained overseas, began to share their experiences and found a unified voice in wanting the sector to change. They created groups and established their own "networks of resistance" (p. 143) against psychiatry (Crossley, 2002). This created an opportunity for service user activism and evolved into a service user-led movement in the 1980s (Mental Health Commission, 2007).

Throughout the mid-1980s, several service user-led organisations across Aotearoa were founded. One of the first organisations was Psychiatric Survivors, a consumer-run self-help and advocacy organisation founded by Mary O'Hagan in 1986 in Auckland. This organisation was later expanded with Pauline Hinds and evolved into the Aotearoa Network of Psychiatric Survivors (ANOPS). The development of these organisations led to more independent service user-led organisations being established across the country. However, as with all social movements, there was a great deal of diversity and disagreement within this space, and the groups often worked separately from each other (BINZ, 2022).

Similar to the international movement (Crossley, 2006), in the early days, many Aotearoa peer-led services were siloed by region, without national connections (BINZ, 2022). Unfortunately, there is no formal published history of the service user movement in Aotearoa or the organisations they set up. As a result, much of the information is largely consigned to online groups and private archive collections of those who led the movement. Individuals within BINZ (a closed Facebook group for tāngata whaiora), reported that many of the early service user organisations were short-lived. Some were forced to close due to financial pressure, others were diluted or absorbed into new services (BINZ, 2022). It is a great shame that the history of this movement is so fragmented. However, some current organisations, such as Balance Aotearoa, carry the legacy of these prior services (Balance Aotearoa, 2022).

Although there is diversity between the service user groups and organisations established within Aotearoa past and present, they share two fundamental purposes. The first is to promote hope and peer support where service users can heal, change, and achieve personal recovery to regain personal power (O'Hagan et al., 2012). The second is political - giving voice to service users, promoting leadership and involvement, and changing systems of oppression (Mental Health

Commission, 2004). As a result of this work, service user activism began to be increasingly recognised in policy development and health services.

Progressive Policy Development and Support

In Aotearoa, there was little research on psychiatric care delivery before the 1970s, and the first major review of mental health practices did not occur until 1988 (Gawith & Abrams, 2006). Government agencies began to pay more attention to service users and their work from 1989 onward (Mental Health Commission, 2007). In 1994, mental health was identified as a priority for the Government of the day, resulting in the establishment of the Mental Health Commission in 1997. This organisation was established to monitor progress in the mental health sector, fund anti-discrimination initiatives, and incorporate consumer leadership through funded programmes. One of these initiatives later developed into the Like Minds Like Mine campaign, a five-year project established in response to the Mason Report of 1996 (Gawith & Abrams, 2006; Mason et al., 1996; Mental Health Commission, 2007).

In 1998, the Mental Health Commission published a document entitled *Blueprint for Mental Health Services in New Zealand: How Things Need To Be* (Blueprint; Mental Health Commission, 1998). This document was the first of its kind and outlined a move away from the paternalistic treatment of service users. The Blueprint (1998) stated that, at an individual level, service users should take an “active part in their assessments and in decisions about their treatment” (p. 17). Furthermore, at the collective level, service user participation should exist across “planning and evaluation of services at all levels” (p. 17). The Blueprint (1998) was innovative, as it also defined and articulated a new, recovery-oriented model of practice, establishing a precedent for modern services (and is described in the next section).

Shortly after the release of the Blueprint, two of the first independent peer owned and run consultancies were established. Mind and Body Consultants established in 1998 by Jim Burdett, was an organisation that initially offered consumer advisory services to the Auckland District Health Board. The Consumers as Advisers, Supervisors and Educators (CASE) Consulting was formed in 2000 by Sarah Gordon and Gary Platt. CASE Consulting was the first consumer-led organisation to contract services to the Ministry of Health and "offer a consumer perspective in the development and consultancy of work for the mental health sector" (Kites Trust, n.d., para. 1). Neither consultancy exists in their original form, having evolved and continued their work through other organisations. It is the existence of organisations like these, which led to a proliferation of community-based peer support services in the early 2000s. However, it was not until 2007 that the first peer support-led respite facility (recovery house), Key We Way, was opened and funded by the Capital & Coast District Health Board (Peters, 2009).

In the early 2000s, the Ministry of Health and the Mental Health Commission developed two guiding frameworks that led to developments within the sector today (Gawith & Abrams, 2006). The first was *Te Puawaitanga: Māori Mental Health National Strategic Framework*, which for the first time called for the incorporation of indigenous perspectives within the Government of the day's national health strategy, with a particular focus on Māori mental health (Ministry of Health, 2002). The second, *Service User Participation in Mental Health Services: A Discussion Document*, built on the Blueprint, outlining specific information relating to service user participation (Mental Health Commission, 2002). This document included a detailed section of the degrees of service user participation in decision-making, which went from no participation (neglect and abuse), before limited participation in decision-making (paternalism and tokenism), then joint decision-making (partnership), to the highest degree being autonomous service user decision-making (Mental Health Commission, 2002). Together, these frameworks set the expectations for the development of mental health services.

The Blueprint earned Aotearoa an international reputation for leading the way in mental health care (O'Hagan et al., 2012). However, this momentum soon came to a halt. Mental health funding cuts, which were instigated by a conservative National Government in 2008, left services in an ongoing deficit (O'Hagan et al., 2012). Over the subsequent decade, the situation has continued to worsen. Clinicians have described our mental health services as severely underfunded and understaffed, resulting in a state of crisis (Every-Palmer et al., 2022; McAllen, 2017). In 2018, the centre-left Labour Government conducted an investigation into the mental health and addiction sector, which resulted in the report *He Ara Oranga* (Paterson et al., 2018). The inquiry identified chronic systemic problems within mental health services and made 40 recommendations with an aim to transform the sector. The Government endorsed 38 of these recommendations.

Soon after, the Government developed the *Child and Youth Wellbeing Strategy* that included a commitment to improving mental distress in our young people (Department of the Prime Minister and Cabinet, 2019). The underfunding of mental health services was also acknowledged by the Wellbeing Budget, which saw an injection of NZD$235 million dollars for mental health services (Treasury New Zealand, 2019). Although this implicit acknowledgement of need was gratefully received by the sector, only nine million dollars of this funding had been used by 2021, and this is insufficient to meaningfully address the compounding effects of long-term underfunding (Scotcher, 2021). This is particularly evident within youth mental health services (Every-Palmer et al., 2022).

In response to *He Ara Oranga*, the Ministry of Health released *Kia Manawanui Aotearoa*, which provides a 10-year plan for transforming mental health services (Ministry of Health, 2021). The report used a population-based approach and identified five areas of development. These acknowledged mental distress as holistic; supported ongoing service user involvement; called for power to be put with communities; and proposed expanding and strengthening existing services. This plan also adhered to recovery-oriented practice. More recently, the Mental Health and Wellbeing Commission released *Te Huringa*, the mental health and addiction services monitoring report that highlighted the ongoing need to invest in our services (New Zealand Mental Health and Wellbeing Commission [NZMHWC], 2022). The changes the Commission was wanting to see included: addressing inequity in particular communities (i.e., Māori and Rainbow communities); development of peer and youth services; maximising autonomy and rights of service users by including them in service development; and supporting recovery-oriented practice, with measures of recovery defined by service users.

Recovery-Oriented Practice

The landscape of mental health services in Aotearoa has continued to evolve over the past half a century. Following the publication of the Blueprint, there was a notable and innovative policy shift to recovery models of care (Mental Health Commission, 1998; O'Hagan, 2004). This type of practice facilitates personal recovery and supports "people to build and maintain a (self-defined and self-determined) meaningful and satisfying life and personal identity, regardless of whether or not there are ongoing symptoms of mental illness" (Department of Health, 2011, p. 2). This practice takes the view that mental health recovery is a broad holistic experience, and that services need to be tailored to an individual's needs and quality of life (Gilburt et al., 2013; Slade, 2008, 2009b). Thus, the personal definition of recovery (described in Chapter One) underpins recovery-oriented practice.

Recovery-oriented practices are seen as more client-centred, strength-based and holistic (Jacob, 2015; Slade et al., 2014). While supported in principle, the move towards recovery-oriented practice has remained slow internationally and within Aotearoa due to a lack of clarity and consistency (Le Boutillier et al., 2011; Mancini, 2018). This has resulted in some countries, such as Australia, developing their own public health care frameworks to support recovery-oriented practice (Department of Health, 2011).

Recovery-oriented practice has many benefits. Service users are more involved in their own care, which provides opportunity for self-determination and growth (Farkas et al., 2005). For service users, recovery-oriented practice promotes a culture of hope, which is instrumental to personal recovery (O’Hagan et al., 2012). It allows for individuals to be supported to participate in their communities and wider society, and to have autonomy in goal setting and self-management (Department of Health, 2011; Mead & Copeland, 2000; Ramon, 2018). Services must also adhere to structures that promote these values for service users. Service providers need to show a genuine commitment to this partnership if they are to be effective (Deegan, 1988; Le Boutillier et al., 2011; Slade, 2012). Despite this, many clinicians who attempt to incorporate recovery-orientation still use psychological jargon and practice with values based on the biomedical model (Slade, 2009a; Walker, 2006).

Recovery-oriented practice is consistent with service user movement values - it embeds service user involvement at all stages of service delivery and positions peer support as a valuable intervention (O’Hagan et al., 2012; Slade, 2012; Slade et al., 2014). Once seen as radical, this model resists conventional biomedical practice and conceptualisation of mental distress (Slade, 2012). This recognition has led to increased participation of service users in the delivery and planning of mental health services.

Barriers to Service User Involvement in Mental Health Services

Current Aotearoa legislation highlights participation and leadership of service users at all levels of service (Ministry of Health, 2021; NZMHWC, 2022; Paterson et al., 2018). As a result, there has been an increasing call to incorporate service user involvement in planning, provision, and evaluation of mental health services (Sheldon & Harding, 2010; Thornicroft & Tansella, 2005). Service user involvement in mental health services occurs predominantly through positions known as *consumer advisors*. These roles are now embedded across most District Health Boards (DHBs) and some non-Governmental organisations. Their existence is consistent with the direction of mental health services and the adoption of recovery-oriented approaches (Mental Health Commission, 2004). Tāngata whaiora are employed for their expertise through the subjective knowledge they bring based on their lived experience and accessing services (commonly referred to as *experts by experience*; Noorani, 2013). However, institutional power discourses and ongoing injustices prevail within this mental health field, creating barriers for consumer advisors (Gordon, 2005; Stickley, 2006; Watson & Meddings, 2019).

Many service users appreciated the opportunity to collaborate with DHBs and non-Governmental organisations (BINZ, 2022). However, some have criticised this move, citing legitimate concerns about the commodification of service users by the mental health system (BINZ, 2022). Namely, threats to erode service user leadership, and the creation of ongoing barriers to genuine service user involvement (Faulkner & Kalathil, 2012; Gee et al., 2016; O'Hagan & Beresford, 2021). Within the current mental health system, consumer advisors often work as siloed voices alongside teams of mental health clinicians in environments that systematically disadvantage them (Coney, 2004; Gordon, 2005). As a result, some service users in existing roles feel they are unheard, and that their positions are tokenistic (BINZ, 2022).

Furthermore, despite clear recommendations that service users should be involved in service design, delivery, and evaluation in principle, there remains a gap between policy and practice. Many mental health clinicians are sceptical about consumer involvement (Coney, 2004; Kortteisto et al., 2018; McCann et al., 2008). Support for service user participation ranges greatly across mental health care and strained power dynamics between clinicians and service users prevail (Goodhew et al., 2019; Roennfeldt & Byrne, 2020). Consumer advisors experience stigma and discrimination from clinicians, creating barriers to meaningful participation (Gee et al., 2016; Gordon, 2005; Jones et al., 2019; Scholz et al., 2018). Clinicians may also be protective of their established roles and titles in the clinical environment (which is already hierarchical in nature), meaning service user views get dismissed in favour of *tradition* (McCann et al., 2006).

Although service user perspectives in clinical psychology and mental health more broadly have become increasingly visible within the past half-century, this has not been without challenge (Ibrahim et al., 2020; Kent & Read, 1998; Rebeiro-Gruhl et al., 2016). Mental health professionals are more likely to support participation of service users in a capacity of mental health educators, or when it is related to their own treatment, as opposed to equals involved in service planning and delivery (Kent & Read, 1998; Kortteisto et al., 2018). Similarly, clinical psychologists support the integration of service user perspectives overall; however, implementation of these changes has been gradual (Soffe et al., 2004; Sheldon & Harding, 2010).

There is growing evidence that suggests service user perspectives provide indispensable input within mental health research and service delivery (Coney, 2004; Haskell et al., 2016; Phillips, 2006; Scholz et al., 2017; 2018; Thornicroft & Tansella, 2005). Successful collaboration is dependent on mutual respect, clear integration of roles, and a supportive organisational environment (Ehrlich et al., 2020; Elstad & Eide, 2009; Hillman et al., 2022; Ibrahim et al., 2020; Kent, 2019). To date, collaboration with service users within mental health care has been enacted with varying degrees of success. At present, Aotearoa services lack cohesive consumer input (Coney, 2004; BINZ, 2022). Drastic improvements must be made within mental health research and service delivery to incorporate service user leadership in future initiatives (Scholz et al., 2017; Thornicroft & Tansella, 2005). More opportunities for meaningful consumer leadership are needed. One approach that provides full service user collaboration in principle, but falls short in practice, is co-production.

A Co-production Approach

Co-production (sometimes erroneously called co-design; Health Navigator, 2022; Vargas et al., 2022) is an act of genuine collaboration between service users and mental health professionals where all parties have an equal status and respect each other’s expertise (Roper et al., 2018; Slay & Stephens, 2013). The mental health professionals in this space are sometimes called allies, reflecting their status of actively unlearning and re-evaluating their positioning (Happell & Scholz, 2018; The Anti-Oppression Network, 2022). Co-production is the highest level of service user participation, which conceptually originates from Arnstein’s Ladder of Participation (1969). The

Ladder of Participation is a model that details different levels of citizen participation that can occur - from non-participation, tokenism, to citizen control (Arnstein, 1969). Slay and Stephens (2013) adapt this model to understand the participation of service users in mental health practice and research. In their pictorial model of a ladder, the bottom rungs illustrate *doing to* processes (informing, educating, and coercing). The middle rungs show *doing for* processes (engaging, consulting), and finally the top rungs illustrate *doing with* processes (co-designing, co-producing). Co-production is fundamental to my methodology and underpins the philosophy and approach of this research. Thus, it is important to describe it upfront.

Co-production is a research approach based on a set of values and evolving methodology that, at its simplest, provides a framework that "involves a more equal sharing of power and decision-making between service user and service provider" (Mayer & McKenzie, 2017, p. 1181). In short, the co-production approach is about the transformation of power and control (Carr & Patel, 2016). This approach empowers service users to participate meaningfully in collaborative activities with service providers and researchers. It is in stark contrast to conventional clinical and academic approaches, where paternalistic attitudes have seen service users coerced, silenced, and excluded from service design and research (Carr, 2019; Lambert & Carr, 2018). Co-production prioritises experiential knowledge, creating opportunities for emancipatory research that provides novel insights for the field of mental health (Russo, 2012; Slade & Sweeney, 2020).

Co-production is consistent with the recommendations made for incorporating service user involvement within the mental health sector of Aotearoa (Ministry of Health, 2021; NZMHWC, 2022; Paterson et al., 2018). During the past decade, principles of co-production have begun to be adapted to the field of mental health and used as a model for full and meaningful consumer participation (Gordon & O'Brien, 2018). Co-production is consistent with recovery-oriented practice and service user control of projects (Faulkner, 2011). As outlined in Roper et al. (2018) resource: "co-production identifies, validates and utilises service users' strengths, supports people's participation and fosters engagement between services and service users. Thus, co-production very much fits within a recovery-oriented framework" (p. 3). Co-production can guide service design and delivery, as well as mental health research.

Co-production has been criticised for lacking clarity in terms of differentiating from other similar approaches such as co-design, participatory action research, and wider qualitative research (Vargas et al., 2022). Some have proposed that these approaches are blurred because they are not as distinct as they claim to be (Locock & Boaz, 2019). Scholars have also outlined several challenges with the way co-production is perceived and carried out within mental health services and research (Bracken & Thomas, 2009; Carr & Patel, 2016; Gee et al., 2016; Gordon & O'Brien, 2018; Williams et al., 2020). However, even if these methods are similar in nature, we need to use them more to improve our mental health services and the communities they serve. In the words of Mark and Hagen (2020), "it would seem that scholarship about co-design has not kept pace with wide usage in practice and does not yet reflect the level of activity happening in communities" (p. 19). Co-production possesses tensions and challenges, however it is a hallmark of socially conscious research that can have profound impacts on service user outcomes (Oliver et al., 2019).

As a research methodology, co-production is an advanced form of participatory action research. Mental health researchers and service users collaborate equally on research projects to challenge and disrupt the historical power relationships that exist between these two groups. Co-production is a framework, which positions service users as experts in their lived experience. They are therefore equals alongside researchers in all phases of the research, which is particularly beneficial to youth (Mayer & McKenzie, 2017). Co-production in research allows service users to set the priorities and highlights differing perspectives to clinicians and academics (Roper et al., 2018). It is a space "between the expert knowledge of the professional and the expert experience of the service user" (Rose & Kalathil, 2019, p. 2).

As a method, co-production has four established prerequisites for co-production to occur: co-planning, co-design, co-delivery, and co-evaluation (Roper et al., 2018). There are also established guiding principles for co-production, to ensure that the voices of service users hold equal power. For example, it is important to have a shared understanding, establish ground rules, and manage roles and boundaries that will inevitably be challenged (Carr & Patel, 2016). An additional component is that service users should be in paid positions that adequately reflect the value of their time and expertise. Self-reflection is encouraged for all parties, as is learning and making mistakes (Carr & Patel, 2016). Those who want to co-produce also need to understand different levels of service user participation that exist. They must strive for *doing with*, within their collaborative relationships with service users (Slay & Stephens, 2013).

However, true co-production is difficult to achieve in practice, particularly in spaces such as universities, where white Eurocentric-thinking continues to be prioritised as the primary source of knowledge production (Rose & Kalathil, 2019). Because of this, it is important to acknowledge that attempting to perform co-production within an academic setting is already a futile endeavour. Working towards a doctoral qualification requires work to be produced within a certain time frame, budget, and I must maintain authorship. These factors inherently oppose the principles of co-production. These external pressures are the reality of many service user academics working within research ecosystems (Scholz et al., 2019a; 2019b). With that in mind, I balance the values of carrying out co-production against the constraints placed by university requirements.

As a result, what co-production looks like in practice varies between research as each project is unique and built inductively with service users (Carr & Patel, 2016; Roper et al., 2018). True co-production is laborious and time-consuming with all parties holding equal status. Decision making is an active, symbiotic process. Co-production can be an “unsettling or disruptive experience” (Carr, 2019, p. 10), particularly for clinicians and researchers who are used to conventional and hierarchical environments (Roper et al., 2018). However, there are many benefits to be gained, such as greater validity in research findings and increased learning for both parties (Faulkner, 2011; Happell et al., 2018a; 2018b). When done well, co-production can be transformative (Gordon & O’Brien, 2018).

Chapter Summary

This chapter set the scene for my research. First, I covered language and terminology. I then provided a timeline for the mental health service user movement, and the resulting practice that recommends service user involvement and leadership within the field of mental health. Finally, I outlined the framework of co-production; an approach to service user involvement that I draw on for the present research.

CHAPTER THREE: REVIEW OF THE LITERATURE

In this chapter, I situate my research within the global crisis that has become youth mental distress, paying particular attention to Aotearoa research and specific populations. I provide a brief contextual overview of the current mental health services available and highlight the current unmet need, drawing on the experiences of youth service users. I review research on youth recovery and argue that for existing services to be youth-centric and fit-for-purpose, we need to have a better understanding of how youth service users conceptualise recovery. I introduce peer support, an established but currently underutilised intervention. I provide a rationale for why intentional peer support is an important alternative to existing mental health services. Finally, I outline the aim of this research: to explore how youth understand personal recovery, and how they experienced intentional peer support. These aims contribute to specific academic conversations and service development in these under-researched areas.

Youth Mental Distress

Adolescence (also referred to as youth) is commonly understood to be a formative developmental stage, occurring between 12-24 years of age, where young people transition from childhood to independent adulthood (Carr, 2016). Adolescence is a fluid, culturally bound period for which there are no universally agreed-on definitions (Patel et al., 2007; Uhlhaas & Wood, 2020). It is a time shaped by individual and environmental changes that must be navigated in the context of contemporary life (Gluckman, 2017; World Health Organization, 2021).

A key function of adolescence is to develop an integrated sense of self and arrive at maturation and stability of identity (Branje et al., 2021; Carr, 2016; Ward, 2014). Identity formation is strongly associated with the psychosocial stage of adolescent development proposed by Erikson (1968). Given that young people develop in the context of their world, they are more likely to articulate their identity through shared experiences with their peers (Ragelienė, 2016). An integrated sense of one's identity contributes to resilience and supports wellbeing. This has the function of extending self-confidence, independence, and building lasting relationships (Erikson, 1968). On the other hand, identity confusion contributes to ongoing distress, a fragmented sense of self, and a lack of confidence in self and others (Erikson, 1968). Identity is not formed in isolation; it is shaped by close family and friend relationships (Branje et al., 2021).

As well as identity formation, adolescence encompasses profound developmental changes and maturation in a wide number of physiological, cognitive, and emotional domains (Carr, 2016; Steinberg, 2005). Novel social, cultural, and educational stressors also emerge during this unique period (Patel et al., 2007; Uhlhaas & Wood, 2020). Young people may also experience discrimination and stigma throughout this time, resulting in increased risk of distress (Holman & Williams, 2020; Mental Health Foundation of New Zealand, 2014). Consequently, biological changes in puberty and neurological development are compounded by increased emotions, social pressures, life transitions, and the quest for independence (Uhlhaas & Wood, 2020).

Learning how to navigate life in the modern world also involves managing pervasive anxieties about the precariousness of the future (Gromada et al., 2020). Compared to other countries, life in contemporary Aotearoa presents a number of freedoms and opportunities for young people. This multitude of options can result in a lack of clarity and leave youth with a "growing sense of dislocation" (Gluckman, 2017, p. 2). Additionally, a bleak future around unstable job prospects, unaffordable housing, climate change, the COVID-19 pandemic, and other ongoing world conflicts such as war prevail in the current age (Idele & Banati, 2020; Menzies et al., 2020; Organisation for Economic Co-operation and Development [OECD], 2021; United Nations Children's Fund [UNICEF], 2021). These factors can also cause young people to experience adolescence as a turbulent and distressing time.

Mental distress most often begins in this developmental stage and is the leading cause of health-related disability in youth (Addington et al., 2018; Erskine et al., 2015; Kieling et al., 2011;

Patel et al., 2007). Research has consistently shown that in developed countries, youth mental distress is increasing and the factors for this are multifactorial (Centers for Disease Control and Prevention, 2019; Fleming, 2020; Gromada et al., 2020; Menzies et al., 2020; NZMHWC, 2022; OECD, 2021). Globally, youth mental health has been described as an ongoing crisis (Benton et al., 2021). There has been an international call to action to alleviate youth distress, with researchers increasingly advocating early intervention as the best way forward (Bowman et al., 2017; Colizzi et al., 2020; Idele & Banati, 2020; Richmond-Rakerd et al., 2021; Uhlhaas & Wood, 2020).

In Aotearoa, one in five New Zealanders live with mental distress and/or addiction. For many this distress first emerged during youth (Allan, 2020). In the past decade, there has been a dramatic increase in youth experiencing distress, depressive symptoms, self-injury, and suicidal behaviours (Fleming et al., 2022). The risk of ongoing distress is even higher for young people with underserved identities due to ongoing intersecting oppression they experience (Chiang et al., 2019; Fleming, 2020; Pihama et al., 2020; Roy et al., 2021; Wong & Menkes, 2018). In fact, researchers have coined the term *silent pandemic* when describing trends pertaining to youth mental distress (Menzies et al., 2020). There is an increasingly urgent national call to support our young people and improve access to mental health services (Department of the Prime Minister and Cabinet, 2019; Ministry of Health, 2021; New Zealand Mental Health and Wellbeing Commission [NZMHWC], 2022; Paterson et al., 2018). The true impact and onset of youth mental distress are difficult to determine as “objective and comparable international data […] are not available” (UNICEF, 2017, p. 20). Historically, youth mental distress has not been as widely researched as adult populations (Erskine et al., 2015).

Furthermore, the clinical literature predominantly reports on psychiatric diagnosis, which tends to pathologise some experiences while excluding others. Despite this, around 10%-20% of youth are estimated to experience mental distress globally (Kieling et al., 2011; WHO, 2021), with Aotearoa estimates around 9.4% (Duncanson et al., 2020). More than 13% of those live with a diagnosable condition (OECD, 2021). More specifically, around half of all mental distress begins in adolescence, and by the early twenties, three-quarters of all lifetime mental distress will have emerged (Belfer, 2008; Colizzi et al., 2020; De Girolamo et al., 2012; Kessler et al., 2007). Around one in five youth meet the criteria for diagnosable mental distress (Kieling et al., 2011; Merikangas et al., 2010). Of these, phobias and impulse control disorders emerge in early adolescence, while mood disorders, anxiety, substance use, and psychosis tend to be diagnosed in later adolescence (De Girolamo et al., 2012; Kessler et al., 2007). Using data from Aotearoa, Koenen et al. (2008) found that posttraumatic stress disorder in adulthood was highly correlated with the onset of diagnosable psychiatric disorders in adolescence.

Diagnoses of depression and anxiety are especially common in young people (Benton et al., 2021; Eyre & Thapar, 2014). In a recent report by the OECD (2021), young people were 30-80% more likely to report experiences of depression or anxiety in contrast to adults. This trend has been increasing following the COVID-19 pandemic (Benton et al., 2021; Idele & Banati, 2020; Menzies et al., 2020). In their meta-analysis, Racine et al. (2021) found that rates of clinically significant depression and anxiety in youth have more than doubled compared to a pre-pandemic world, with estimates now being 23.8% for depression and 19% for anxiety. The aforementioned statistics focus on diagnosable disorders and the magnitude of the problem is evident. Furthermore, many young people may have subclinical (but nonetheless significant) distress that may not be captured by the existing literature (Sheppard et al., 2018). In the past two decades, the rates of mental distress in Aotearoa youth have more than doubled. Compared to their peers, 17% of young people report high levels of isolation, leading to a seven-fold greater likelihood of experiencing severe depression (Kvalsvig, 2018; Menzies et al., 2020).

Young people have high rates of non-suicidal self-injury (NSSI) and suicidal behaviours (Carr, 2016; Clark et al., 2013; Gromada et al., 2020; Patel et al., 2007). International prevalence rates for NSSI fall between 17 and 60% (Brown & Plener, 2017), with Aotearoa lifetime estimates around 49% (Garisch & Wilson, 2015). Clark et al. (2013) reported around 38% of adolescents had deliberately harmed themselves in a 12 month period. Although NSSI is clinically distinct from suicide (Nada-Raja et al., 2004), these statistics are concerning. The presence of self-injury can be a risk factor for suicidal behaviours (Klonsky et al., 2013), and youth have higher rates of hospitalisation for this behaviour, compared to adults (Paterson et al., 2018).

Currently, suicide is the second leading cause of death among young people in Europe (UNICEF, 2021). According to 2019 data from the Centers for Disease Control and Prevention, 18.8% of young people have seriously considered suicide, with 8.9% making an attempt (2019). In Aotearoa, adolescent suicide rates are among the highest in the OECD (Duncanson et al., 2020; Menzies et al., 2020; Ministry of Health, 2019b) and the highest among 41 countries according to UNICEF (2017). Recent data from the *Youth2000* survey show that in the past 12 months 6% of participants reported that they have attempted suicide (Fleming, 2020), and 21% seriously thought about attempting suicide (Fleming et al., 2022). Youth suicide is complex and multifactorial (Gluckman, 2017), and when asked, young people recognise this too (Stubbing & Gibson, 2019). Suicidal behaviour during adolescence has been linked to detrimental social and health outcomes in later life (Goldman-Mellor et al., 2013). Existing services may be failing some youth, and there is increased recognition that tailored mental health youth support may help to minimise suicide numbers (Ministry of Health, 2019a).

Left unaddressed, mental distress in young people creates risk factors for future distress in adulthood (Addington et al., 2018; Copeland et al., 2013; Koenen et al., 2008). Youth who experience mental distress may leave school early, creating severe disadvantages, and restricting opportunities in adulthood (Bowman et al., 2017). Mental distress that continues into adulthood can be a risk factor for persistent psychological difficulties in the future (Copeland et al., 2013; Eyre & Thapar, 2014). This can lead to continued use of mental health services and contribute to poor quality of life and premature mortality (Cunningham et al., 2014). Furthermore, the global burden created by a lack of support for young people in distress can also have wider implications, resulting in economic impact and placing further ongoing pressure on mental health services (Colizzi et al., 2020; Goldman-Mellor et al., 2013). Thus, it is imperative that we focus on early intervention and youth recovery to alleviate these long-term pressures (De Girolamo et al., 2012; Uhlhaas & Wood, 2020).

Māori and/or Rainbow Youth

Certain youth populations have growing mental health inequities. For example, rangatahi Māori tend to experience higher rates of distress compared to Pākehā[7] peers (Fleming, 2020). Rainbow youth are also consistently overrepresented in poor mental health outcomes (Fleming, 2020; Lucassen et al., 2011). Māori and Rainbow communities have been highlighted in policy as some of the priority groups in urgent need of further focus (NZMHWC, 2022).

It is well established that Māori continue to experience ongoing mental health inequities (Health Quality & Safety Commission, 2019; NZMHWC, 2022; Paterson et al., 2018). For Māori youth, systemic effects of intergenerational trauma through colonisation can result in a fragmented cultural identity that contributes to ongoing mental distress (Farrelly et al., 2006; Williams et al., 2018). Māori have some of the highest suicide rates, compared to non-Māori (Clark et al., 2018b; Durie, 1999; Fleming, 2020; NZMHWC, 2022; Paterson et al., 2018; Williams et al., 2018). The inequity of Māori health highlights that while adolescents generally engage in higher rates of self-injury and suicidal behaviours compared to other age cohorts, Māori youth are particularly vulnerable, and this risk is increasing (Health Quality & Safety Commission, 2019; Ministry of Health, 2019a). Furthermore, racism, depressive symptoms and limited health care all contribute to ongoing disadvantages for rangatahi Māori (Clark et al., 2022). For rangatahi Māori, in the last seven years depressive symptoms and suicidal attempts have more than doubled, to 28% and 13%,

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[7] New Zealander of European descent

respectively (Fleming, 2020). This is a higher proportion compared to Pākehā youth, 20% of whom had depressive symptoms and 3% attempted suicide (Fleming, 2020). Rangatahi Māori aged 15–24 are the group with the most frequent contact with mental health services in the Wellington region (Duncanson et al., 2020).

Similarly, Rainbow youth are at an increased risk of distress, self-injury, and suicidal behaviours compared to cisgender, heterosexual youth (Batejan et al., 2015; Clark et al., 2014; Fleming, 2020; Jackman et al., 2021; Veale et al., 2019). Depression is common in LGBTQI+ communities (Clark et al., 2014; Lucassen et al., 2017). In the wellbeing and mental distress report, 79% of Rainbow participants reported feeling isolated (Kvalsvig, 2018). Rainbow individuals have higher rates of self-injury and suicide rates, compared to non-Rainbow peers (Batejan et al., 2015; Jackman et al., 2021; Lucassen et al., 2011). Transgender youth are five times more likely to have attempted suicide in the past year than their cisgender peers (Clark et al., 2014). Furthermore, Rainbow youth have been detrimentally impacted by the COVID-19 pandemic through being subject to discrimination while in lockdown (Salerno et al., 2020). Moreover, there is ongoing prejudice against Rainbow individuals in health care, making this group less likely to seek support for fear of being misconstrued (Dolan et al., 2020; Fraser et al., 2022; Veale et al., 2019).

Māori and/or Rainbow individuals remain priority groups, as they are among some of the most underserved by mental health services (Clark et al., 2013; Mental Health Foundation of New Zealand, 2014; NZMHWC, 2022; Paterson et al., 2018). These two identities are distinct, but can intersect, making Rainbow rangatahi Māori (sometimes self-identified as takatāpui) one of the highest risk groups for depressive symptoms and suicidal thoughts (Roy et al., 2021). In the Youth2000 survey, 53% of Rainbow rangatahi Māori participants reported depressive symptoms, and 46% reported serious thoughts of suicide in the past 12 months (Roy et al., 2021). Mental distress among Māori and/or Rainbow youth is often exacerbated by the ongoing effects of institutional discrimination and structural stigma (Dolan et al., 2020; Ellis et al., 2020; Torres

Sanchez et al., 2022; Veale et al., 2019; Williams et al., 2018). These populations are also less likely to access mental health care when they need it (Jackman et al., 2021; Veale et al., 2019; Williams et al., 2018). The presence of intersectional identities can create further disparity through ongoing inequality (Roy et al., 2021). As a result, Māori and/or Rainbow youth who have low socioeconomic status, use substances, or disengage from education, may have some of the poorest mental health outcomes of all youth (Hall et al., 2019; Kvalsvig, 2018; Menzies et al., 2020). There is a need for better tailored youth mental health services for these consistently underserved groups (Kvalsvig, 2018).

Summary

Adolescence is a turbulent time of change, creating many vulnerabilities and risk factors. Within this age group, youth mental distress is the predominant cause of disability, and this has implications for the future of young people (Kieling et al., 2011). There are more young people in mental distress than ever before (Cardwell, 2022; NZMHWC, 2022; OECD, 2021). Rates of self-harm, suicidal behaviours, and suicide completion in youth are alarming. Youth mental distress is a grave concern with far-reaching implications, with specific populations, particularly Māori and Rainbow, even more at-risk. Young people require early intervention and mental health services that are fit-for-purpose and can address the unique needs of this age group to provide support and recovery (Colizzi et al., 2020; De Girolamo et al., 2012; Uhlhaas & Wood, 2020).

Recovery in Mental Distress

As discussed in Chapter Two, Aotearoa national health policy has required mental health services to support recovery-oriented practice since the early 1990s (Mental Health Commission, 2002; Ministry of Health, 2012). This approach supports the personal recovery process as previously conceptualised by service users (Deegan, 2005). However, the construct of personal recovery is difficult to standardise, with some studies conflating clinical and personal recovery

(Drake & Whitley, 2014). To date, research in this area has been limited. A major focus of research to date has been on synthesising lived experience accounts in an effort to identify commonalities and construct recovery frameworks.

Recovery frameworks are useful and can serve as guides for helping mental health services support recovery-oriented practice. However, the way in which service users articulate their experiences does not always fit neatly into these frameworks. Furthermore, much of the research focuses on recovery as it applies to adult populations (Lapsley et al., 2002; Resnick et al., 2005; Ward, 2014). Personal recovery is just as relevant to young people as it is in adults. However, young people may have unique factors that are not encapsulated by adult models (Law et al., 2020; Naughton et al., 2020; Ward, 2014). Given that there is a significant gap in the existing literature on youth recovery and adult models are most prevalent, I address them first.

Researchers have proposed multiple frameworks to capture the essence of adult personal recovery. One well-known framework is based on the work of Slade (2009b), who identifies four key domains of recovery within his Personal Recovery Framework. These are: hope; self-identity (current and future self-image); meaning in life; and (taking) personal responsibility. In line with the Personal Recovery Framework, Slade identifies four key tasks of recovery: developing a positive sense of identity; reframing and redefining and making sense of mental distress; learning to self-manage the mental distress; and developing social roles in accordance with one’s values (Slade, 2009b).

Another commonly used model is the CHIME framework by Leamy et al. (2011). Here, five recovery processes are instrumental: connectedness (to whānau, peers, and community); hope and optimism about the future; identity (a developed sense of self); meaning in life; and empowerment. CHIME has been recommended as one of the ways to measure personal recovery in recovery-oriented practice (Gilburt et al., 2013). This framework has also been found to be applicable in youth recovery, with the exception of particular developmental stage differences (Ballesteros-Urpi et al., 2019; Mental Health Coordinating Council, 2014; Naughton et al., 2020; Ward, 2014). Stuart et al. (2017) proposed an extension of the CHIME model, developing three additional categories to account for the breadth of lived experience and recovery. These include: difficulties in the recovery journey (such as ambivalence or negative experiences as a result of recovery, or relapse); benefits and concerns about therapeutic input into one's recovery journey; and returning to, or have a desire for normality that includes reduction in symptoms and a return to basic functioning (a factor previously more consistent with the biomedical model).

While service users describe recovery as a deeply personal process, Deegan (2005) states: "there are common themes, challenges, and strategies used by most people" (p. 29). One such service user-developed framework is the work of Mead and Copeland (2000), who propose five facets of recovery. These are: having hope; taking individual responsibility for one's wellness; engaging in, and being provided with resources for ongoing education; self-advocacy and information-sharing between service users; self-advocacy with support from whānau and clinicians; and engaging in peer support (Mead & Copeland, 2000). These facets form the foundation of some peer interventions, such as Intentional Peer Support, which I cover later in this chapter. Peer support has also been identified as instrumental in personal recovery by other researchers in this area (Slade et al., 2014).

Taken together, the adult frameworks proposed by Slade (2009b), Leamy et al. (2011); Stuart et al. (2017) and Mead and Copeland (2000) emphasise personal autonomy and connection to self and others. A growing sense of agency and autonomy is central to adult recovery (Drake & Whitley, 2014; Lapsley et al., 2002), as is social recovery (Ramon, 2018; Tew et al., 2011). Research into adult recovery is consistent with service users' points of view, who articulate that hope, self-determination, and a sense of belonging are vital to recovery (Deegan, 1988; O'Hagan et al., 2012; Rose, 2018). Similarly, first person narratives from service users emphasise that recovery is an active, muti-faceted process. This process moves people from despair and denial to hope and acceptance, through reclamation of the self, and in partnership with others (Ridgway, 2001). In short, having accessible and personalised support that allows for autonomy and connection to develop is crucial for adult service users.

Albeit limited, the research into youth recovery shares some commonalities with adult recovery frameworks (Naughton et al., 2018; Rayner et al., 2020; Temesgen et al., 2019). When asked, young people tend to define recovery as a personal process, in line with other service user literature (Perkins & Repper, 2015). Similarly to adults, young people describe their recovery as a non-linear, dynamic, and nuanced process that is personal and holistic (Barnett & Lapsley, 2006; Bergmans et al., 2009; Rayner et al., 2020). However, differences in priorities have also been highlighted in youth recovery research (Law et al., 2020). For example, young people are less independent than adults, and exist within restrictions of their environments. Thus, including family is an important consideration in youth recovery (Hancock et al., 2020; Holman & Williams, 2020; Ward, 2014).

Research examining youth recovery frameworks is limited, and inductive research with young people is even more scarce. The commonly cited, but increasingly outdated Aotearoa research of Barnett and Lapsley (2006) focused on qualitatively exploring recovery in young adults aged 18-29. The participants described recovery as a process that moved from surviving day-to-day, then moving forward, before living well. This articulation of recovery as a journey is similar to adult interpretations. In a more recent UK study, Law et al. (2020) emphasise that recovery goals for young people are dynamic and fluctuating and services must work to identify recovery domains relevant to each young person. In their research, participants aged 14-25 spoke of recovery as complex and paradoxical and the focus was on recovery as inherently unique to each individual (Law et al., 2020). Young people stated that balancing contradictory goals of recovery (e.g., support vs. independence; reduction vs. acceptance of symptoms; and discovering yourself vs. being the best version of self) was part of the recovery journey. Interestingly, young people also questioned the nature of recovery - arguing it was a contentious and unrelatable term (Law et al., 2020). This echoes the stance taken by the adult Recovery in the Bin Collective (2016) who argue that recovery is a misnomer, and instead prefer *unrecovery* as a term that encapsulates intersectional lived experiences.

The work of Rayner et al. (2020) provides the most recent and comprehensive youth recovery framework to date. This qualitative research focused on interviewing participants with "severe mental health conditions" aged 18-23 and aimed to develop a thematic model of youth recovery based on participant narratives. Rayner et al. (2020) identified five key youth recovery processes.

The first process is *self-belief and resilience*. Young people spoke of the need to gain confidence as part of their recovery journey, leading to greater resilience in the face of adversity. The second process, *responsibility and personal agency*, reflected that young people need to have autonomy over their lives to feel personally fulfilled (Rayner et al., 2020). However, other researchers have placed importance on fostering young people's independence in the context of what is developmentally appropriate, meaning that autonomy needs to be matched to the person's ability (Hancock et al., 2020; Naughton et al., 2018). These first two processes described by Rayner et al. (2020) are consistent with findings from Schneidtinger and Haslinger-Baumann (2019), who stated that optimism and (having access to, understanding, and using) resources were important in youth recovery.

Identity, awareness, and acceptance was the third youth recovery process (Rayner et al., 2020). A strong sense of self increased resilience and autonomy in young people, which in turn empowered them to take control of their lives. Similarly, other research has identified identity and sense of self as important to young people's recovery (Ward, 2014). Within other research, youth service users often had to lose and renegotiate their sense of self and their identity throughout their recovery journeys (Simonds et al., 2014). Given that the main goal of adolescence is to come to a strong sense of self, it is unsurprising that identity, awareness, and acceptance were crucial recovery factors.

Process four involved *connection*, in particular with peers (Rayner et al., 2020). Through connection, young people share experiences with their peers and whānau, reducing isolation and loneliness. Being around like-minded people can also help to develop a young person's identity. This is consistent with other research that states relationships and connections within young people's ecological systems are crucial (Kelly & Coughlan, 2019; Ward, 2014). Social connectedness also means that youth service users experience a sense of belonging and support (Schneidtinger & Haslinger-Baumann, 2019), and provides opportunities for social recovery (Simonds et al., 2014). This process is especially important given the current global pandemic, as there has been an increase in social isolation of young people, including the loss of peer interactions and other social supports (Benton et al., 2021). Feeling connected and knowing who you are can serve as a protective factor against self-stigma and contribute to a more optimistic outlook, so social recovery is particularly relevant to young people, whose sense of identity is often shaped by who is around them (Simonds et al., 2014).

The final process in this model was *hope and positive expectations* (Rayner et al., 2020). For young people, believing that things could and would improve led to increased self-efficacy. Other research indicates that many young people experience anxiety about their future, which is wider than their immediate environment (UNICEF, 2021). Thus, being hopeful about wider social and ecological systems plays an important role in youth recovery (Barnett & Lapsley, 2006; Ward, 2014). Having hope also contributes to a stronger sense of meaning in one's life and can foster self-confidence and increase motivation (Schneidtinger & Haslinger-Baumann, 2019; Temesgen et al., 2019).

The work of Rayner et al. (2020) addressed some existing critiques in youth recovery research. For example, some studies in this area do not solely focus on young people's perspectives and include perspectives of adults, such as parents or caregivers (Kelly & Coughlan, 2019; John et al., 2015). Although research of this type can provide ideas for what is helpful, it is not the same as asking young people directly. This also removes autonomy from young people's experiences, who can and should articulate what they need (Claveirole, 2004). Having interviewed youth directly, Rayner et al. (2020) provided the much-needed narratives to support their framework.

While the research of Rayner et al. (2020) was the first of its kind and thus, important, it had two major omissions. First, the authors failed to include co-production in their methodology. This meant they did not collaborate with either youth or adult service users throughout their research. This perpetuates the belief that professionals are at the forefront of knowing what works best for youth service users. Second, the articulation of distress through a clinical lens meant that only participants who had "a psychiatric condition" or "severe mental illness" (p. 334) were included, meaning young people who did not fit into these restrictive parameters were not eligible to participate. Rayner et al. research (2020) perpetuated the critiques existing in other youth recovery research. This topic has been hampered by studies focussing on only specific diagnoses such as psychosis (Temesgen et al., 2019); anxiety and depression (Simonds et al., 2014); or in the case of Rayner et al. (2020) - a diagnosable condition. This view severely limits the understanding of the youth experience and is inconsistent with personal recovery where diagnosis is not considered necessary. Thus, future research ought to explore how youth understand personal recovery in mental distress where they can articulate it from the perspective of their lived experience.

Māori and/or Rainbow recovery

There is a scarcity of research looking specifically at the experiences of recovery in Māori and/or Rainbow youth. These populations experience ongoing effects of stigma and discrimination, which affects recovery outcomes (Fleming, 2020). In line with policy and recovery-oriented practice, Māori and Rainbow communities should be prioritised, rather than overlooked in recovery research (NZMHWC, 2022).

Māori cultural frameworks for understanding distress and recovery such as Te Whare Tapa Whā (Durie, 1994); or the Meihana model (Pitama et al., 2007) are increasingly recognised within mental health spaces. Indigenous Māori interventions pose genuine viable alternatives to current Western practices (Kopua et al., 2020; Taitimu et al., 2018; Verbiest et al., 2018). Research into recovery frameworks is largely euro-centric, which is a critical limitation as it does not adequately address the complexity of the rangatahi tāngata whaiora Māori experience. Thus, it is critical we pay attention to personal meanings and the cultural context within personal recovery for tāngata whaiora Māori (Durie, 1999).

The limited research looking into protective factors against mental distress for rangatahi Māori cites a strong sense of identity and connection to others as critical to recovery and wellbeing (Carlson et al., 2022; Pihama et al., 2020; Williams et al., 2018). This is similar to the overarching themes of existing non-Māori focused recovery frameworks. However, personal recovery in tāngata whaiora Māori is nuanced and culturally embedded, meaning Māori youth may have particular goals or understandings of recovery that may not yet be known due to limited research (O'Hagan et al., 2012; Taitimu et al., 2018). However, tāngata whaiora Māori who have attempted to conceptualise their lived experiences through cultural rationales, have been consistently dismissed and pathologised by mental health services (Taitimu et al., 2018).

Similarly, research into how Rainbow individuals conceptualise recovery is sparse. Indeed, some researchers have cautioned against recovery research with Rainbow people due to participants reporting that recovery is unclear and implausible due to systemic oppression (Das, 2012). Prejudice against Rainbow individuals is well documented and contributes to a high proportion of mental distress in this population (Ellis et al., 2020). Ongoing experiences of stigma and discrimination make recovery much more difficult in Rainbow individuals (Dolan et al., 2020; Mizock et al., 2014). While people in this population often face particular issues related to their identity -which can exacerbate distress and make recovery more difficult - it does not mean that recovery research should not be carried out. On the contrary, the need for more research with these communities becomes more salient due to their increased risk of mental distress.

Protective factors against mental distress for Rainbow individuals have included a strong sense of identity and a feeling of belonging (Scourfield et al., 2008). Similarly, developing a positive sense of self in the face of mental distress has been identified as instrumental in recovery (Mizock et al., 2014). For Rainbow people, having a chosen family can provide support, and community connectedness (Blair & Pukall, 2015; Huynh, 2022). Furthermore, peer and intimate relationships where the person can fully be themselves, without fear of stigma or discrimination, were instrumental to recovery in this population (Kidd et al., 2016; Robertson et al., 2015). As with tāngata whaiora Māori, research reflects similar themes to existing adult frameworks, however there may be other themes that Rainbow individuals need - but fall short because of a lack of focus and attention in the current literature.

Summary

Most recovery research is carried out with adult populations. Research that details perspectives of young people on personal recovery from mental distress is emergent. For young people, mental distress and personal recovery are deeply related to the context of their world. From the limited research available, we can surmise that for young people recovery is a subjective, non-linear, and at times contradictory process of meaning-making and healing. There is a need for better understanding of youth perceptions of recovery in Aotearoa. Empowering youth service users to voice their priorities in further research is imperative (Stubbing & Gibson, 2021; Summerhurst et al., 2017). Concerningly, research to-date has largely failed to address the topic of recovery in priority populations such as Māori and/or Rainbow youth. Research that captures the impact of more culturally competent interventions is needed (Lu et al., 2021). Recovery should be measured by what is most meaningful to tāngata whaiora (NZMHWC, 2022). Future research needs to incorporate young people within research methodology; focus on priority groups; and explore how young people understand recovery from mental distress through their own autonomous perspectives (Claveirole, 2004).

Youth Mental Health Services: Near Collapse

Local and international researchers have long posited that youth mental distress has been neglected by mental health services (Every-Palmer et al., 2022; Kieling et al., 2011; Menzies et al., 2020). In Aotearoa in 2018/19, child and youth mental health services (CAMHS) received only 13% of total DHB funding (Allan, 2020). Furthermore, access to youth mental health services has been widely disrupted by COVID-19 (OECD, 2021). This has resulted in increased referrals to services and enormous pressure on resourcing (Every-Palmer et al., 2022). Youth mental health services are nearing collapse, with staff overworked and waitlists of more than five months (Cardwell, 2022; Elliot & Cloet, 2017; McAllen, 2017; Truebridge, 2021). Long wait times are a considerable barrier to all service users (Elliot & Cloet, 2017), including young people (Edbrooke-Childs & Deighton, 2020). Our mental health system is under considerable strain and young people are one of the most underserved groups (Allan, 2020; Every-Palmer et al., 2022; Menzies et al., 2020; NZMHWC, 2022; Paterson et al., 2018).

Mental health services may also be failing our young people due to not being fit-for-purpose, resulting in inadequacies in responding appropriately to cultural and developmental needs (McGorry et al., 2013; Mental Health Foundation of New Zealand, 2014; Patel et al., 2007). Many publicly funded mental health services are difficult to access and navigate, resulting in ongoing barriers for youth (MacDonald et al., 2018; Summerhurst et al., 2017; SURG, personal communication, 2020; Te Ahi o Ngā rangatahi , 2020). In Australia, there is limited access to mental health services available, with Hall et al. (2019) reporting that around a quarter of young people feel there is a lack of support. Other barriers to services are long waitlists and protracted wait times between intake, assessment and treatment. In these contexts young people have to repeatedly share their experiences with different clinicians, and in the event their experiences are invalidated, poor therapeutic alliances result (Leijdesdorff et al., 2021; Platell et al., 2020). The picture is similar in Aotearoa, with one in five youth unable to access support when they have sought help (Fleming, 2020). Clinicians too have been found to be under huge pressure (Every-Palmer et al., 2022). This ongoing unmet need results in youth feeling like they have to be in a state of crisis to access mental health support (Barnett & Lapsley, 2006).

Furthermore, services have specific threshold criteria that must be met to access support, resulting in a treatment gap (Allan, 2020; Schnyder et al., 2020). When youth do gain access to services, these are often fragmented and lack a continuum of care (Paterson et al., 2018). Most CAMHS services have arbitrary age limits. It means that when a young person turns 18, they age out and are required to transition from youth to adult services, resulting in “terrifying” experiences for rangatahi tāngata whaiora (Cleverley et al., 2020).

Treatment-as-usual is failing our young people, as it seldom includes youth perspectives. Involving young people in their care at the structural level (e.g., in service design) is incredibly important for the development of fit-for-purpose services (Claveirole, 2004; McGorry et al., 2013; Te Ahi o Ngā rangatahi , 2020). Recovery-oriented practice needs to take precedence, alongside systemic change and service cohesion (Mental Health Coordinating Council, 2014). Young people want to feel supported when accessing services, and services need to be sensitive to their unique needs to be seen as relevant and accessible (Gibson, 2021; Summerhurst et al., 2017; Te Ahi o Ngā rangatahi , 2020).

Given that young people miss out on critical support, there is a strong rationale to invest in additional youth mental health interventions across services (Benton et al., 2021). Early intervention has been cited as important for positive youth outcomes in all mental distress (Bowman et al., 2017; Colizzi et al., 2020; Uhlhaas & Wood, 2020). Improving services has been consistently recommended by young people themselves (Holman & Williams, 2020). Those working in mental health have an ethical and moral responsibility to advocate for accessible and appropriate interventions for young people in distress (Bagshaw et al., 2015; Colizzi et al., 2020; Duncanson et al., 2020). In particular, recovery-oriented practice that supports service user wellbeing and personal recovery should be prioritised (NZMHWC, 2022).

Summary

Current services are poorly equipped to work with young people, and existing conventional interventions may not be appropriate or desired. It is imperative that we focus on early intervention to alleviate these long-term service pressures. A key element in improving youth interventions lies in understanding what matters to young people in personal recovery, which can provide rationale for alternative interventions. Utilising alternative interventions that honour the complexities of youth experiences may result in greater support seeking by young people with distress and can also broaden the scope of available services to support personal recovery (Benton et al., 2021; Elliot & Cloet, 2017). Given how established peer support is internationally, and the recommendation to invest in the peer workforce across Aotearoa (NZMHWC, 2022), peer support could be a viable alternative to treatment-as-usual.

Peer Support

In mental health and addiction spaces, peer support is an organised practice where individuals with lived experience of mental distress and recovery support others who face similar difficulties (Mead, 2014; O'Hagan, 2011; Penney, 2018; Repper & Carter, 2011). Peer support involves a bidirectional relationship that is reciprocal and non hierarchical between the peer supporter and their peer. Through a human rights approach of mutual dignity and reciprocity, adult and youth peers grow and learn from their shared lived experiences (Mead et al., 2001; Orygen, 2020). Peer support is not based on diagnostic or clinical framing, but rather on a set of values aimed at achieving a holistic understanding of distress and wellbeing (Mead et al., 2001; Scott et al., 2011; Watson & Meddings, 2019). The guiding values of peer support are underpinned by equity, hope, trust, respect, acceptance and understanding, shared experiences, and shared responsibility (Mead, 2014; Stratford et al., 2019). As this intervention has been largely dismissed by conventional mental health services, providing adequate background is warranted as part of this literature review.

The origins of peer support can be traced back as early as the 18th century; however, contemporary peer support grew largely out of the grassroots service user movement of the 1970s (O'Hagan, 2011; Kemp et al., 2020; Tang, 2013). At the time, peer support (also called self-help or mutual aid) was independent of the mental health system, and tāngata whaiora came together to support each other (Penney, 2018; Shalaby & Agyapong, 2020). The rise of the service user movement was political and signified a social change in mental health activism and peer support became more mainstream thereafter (Mead, 2003; Penney, 2018). Peer support is generally categorised into two types. The first is naturally occurring (informal and unstructured), while the second is intentional. The latter formalised approach involves peer supporters working or volunteering within peer-run or clinical services (Davidson et al., 1999; Mead & MacNeil, 2006; Penney, 2018).

Within formalised peer support, peer support workers (PSWs) are experts by experience who draw on their knowledge and lived expertise to provide support to their peers (Grant et al., 2018; Mead et al., 2001; Scott et al., 2011). Throughout the 1980s, Government-funded peer-run organisations began to emerge, which saw an increase in formalised peer support roles across the mental health sector (Mental Health Commission, 2004; Penney et al., 2021; Walsh et al., 2018). Currently, policy in Aotearoa advocates for peer support services to be integrated into mental health care (Ministry of Health, 2021; NZMHWC, 2022; Scott et al., 2011; Te Pou, 2020). Additionally, peer support is an increasingly important part of the paradigm shift in mental health services toward recovery-oriented practice (Bradstreet, 2006; Paterson et al., 2018; Watts & Higgins, 2017). Peer support is a recovery-informed intervention that frames recovery as a personal process rather than an outcome (Mental Health Commission, 2012; O’Hagan, 2011; Walsh et al., 2018).

Peer support has been formally endorsed by the American Psychological Association as “an essential component of recovery-oriented systems of care” (APA, 2018, p. 1). It is complementary to current mental health services, designed to expand options for service users rather than supersede existing practice (Bradstreet, 2006). PSWs can have mutually beneficial relationships with their clinician colleagues (Dark et al., 2017), and contribute to the uptake and fidelity of recovery-oriented practice in the services they are based in (Chisholm & Petrakis, 2020; Stefancic et al., 2021). However, PSWs continue to be discriminated against within mental health services (Walker & Bryant, 2013). It is important to diffuse these barriers and acknowledge that peer support plays a unique role within services and provides an alternative and a complementary mode of intervention (Watts & Higgins, 2017).

As peer support is values-based and unique to each peer relationship, there are many variations in how it is performed in practice (Faulkner & Kalathil, 2012; Gopalan et al., 2017; O’Hagan, 2011). Peer support can be used in a wide range of situations and communities and can be carried out individually (Gidugu et al., 2015) or run in groups (Worrall et al., 2018). It can exist for specific populations, occur in a range of organisations, and involve many different resources, depending on the needs of a peer (O’Hagan, 2011; Stefancic et al., 2021). Peer support is context dependent, but, through its values, provides a safe space for processing experiences (Watson & Meddings, 2019). Furthermore, it creates hope and social change for the future of individuals, as well as the broader mental health system (Mead et al., 2001). While the specifics of peer support vary, PSWs are encouraged to maintain cultural responsiveness and commitment to peer support values throughout their practice (Stratford et al., 2019).

Service user activists have widely advocated for the inclusion of peer support as a viable mental health intervention (Deegan, 2021; Mead & MacNeil, 2006; O’Hagan, 2011; Stratford et al., 2019). However, some have also questioned the appropriateness of professionalisation of peer support, with concerns that this grassroots practice can be diluted by mental health services (Faulkner & Kalathil, 2012). Furthermore, those with lived experience of mental distress have stressed the importance of services being responsive to allowing peer support to occur:

> To achieve positive impacts from a peer support intervention requires a serious organisational commitment to integrating peer support workers as valued and vital members of the team, which in this case will be achieved through workforce development and role definition. (Davies et al., 2014, p. 119)

Relatedly, peer support roles have been criticised in the mental health sector for lacking professional boundaries and roles not being clearly defined, resulting in clinicians being apprehensive about the presence of PSWs in services (Ibrahim et al., 2020; Jones et al., 2019; Korsbek et al., 2021; Mutschler et al., 2021; Roennfeldt & Byrne, 2020; Scott et al., 2011). An opposing view to this is that services that are resistant to change (and do not utilise peer support) continue practicing via the biomedical model that violates human rights and inadvertently privileges “risk-averse, coercive and controlling treatments” (Kemp et al., 2020, p. 50). Thus, services that do not endorse interventions such as peer support maintain hierarchy and power over service users.

Despite criticisms, many clinicians do support the inclusion of peer support in mental health services (Chapman et al., 2018; Chisholm & Petrakis, 2020; Korsbek et al., 2021; Moore & Zeeman, 2021; Perez & Kidd, 2015; Simmons et al., 2020). However, peer support remains underutilised despite its potential power to transform conventional services (Kemp et al., 2020). An ongoing lack of clarity about peer support and its roles is cited as one of the factors that results in implementation issues (Ehrlich et al., 2020; Hopkins et al., 2020; Ibrahim et al., 2020; Kent, 2019; Mutschler et al., 2021). Greater specificity about the peer support roles is needed if we are to advocate for this promising intervention (Stefancic et al., 2021).

To aid in the development of the Aotearoa peer support workforce and create consistency between roles, several documents have been developed (Scott et al., 2011; Te Pou, 2020). Training and qualifications are offered through organisations such as Mind & Body and PeerZone, with Intentional Peer Support (IPS) training being the most common (PeerZone, 2021; Scott et al., 2011). IPS is a type of formalised peer support that provides a framework to alleviate mental distress and support recovery. It is one of the most internationally recognised peer support models, developed by Mead (2014). IPS is firmly grounded in, and evolved from, the 1970s service user movement origins, and serves to address some of the criticisms put forward by mainstream services (Faulkner & Kalathil, 2012; Penney, 2018; Shalaby & Agyapong, 2020). It does so by being a structured, theoretically-based intervention with specific goals and competencies for peer support workers and their peers (Mead, 2014; Mead et al., 2001; Penney, 2018). It is a structured, trauma-informed approach with a focus on skill building (Mead et al., 2001), which places relationship-based mutual learning as central, and supports purposeful engagement (Penney et al., 2021). Its focus lies in "creating meaning and connection through mutual, transparent and transformative dialogue" (Kemp et al., 2020, p. 54).

IPS is based on three principles and four tasks that support service users to "purposefully communicate in ways that help both people step outside their current story" (Mead, 2019, p. 7). The three principles aim to: reframe helping as learning together; move from individualism to collectivism with focus on relationships; and transform fear to hope and possibility (Intentional Peer Support, 2022). Additionally, there are four overarching IPS tasks that must be addressed in order (Mead, 2014). The first is "connection", which is the basis where peer support can occur. This task is about the relationship and shared engagement between the peer support worker and their peer. "Worldview" is the next task and involves being curious about the knowledge peers have come to possess. Task three, "mutuality", involves collaboration and shared responsibility of power, where both parties engage in co-learning. This is also a step whereby peers reflect on their past and present relationships and their patterns. The final task, “moving towards”, helps peers articulate their values and vision for the future. It is a space where conscious decisions are made about future behaviours and relationships between whānau, and wider communities are strengthened as a result (Mead, 2014). Peers work through these four tasks and gain skills along the way on their recovery journey. IPS provides a framework for peers, supporters, and educators. It allows for consistency in training and delivery of peer support, guided by competencies.

IPS is only one type of peer support, and there are, of course, many others where service users can be supported. For this reason, Te Pou (a national workforce development organisation) established core competencies for all PSWs in Aotearoa, regardless of the type of work they do (Te Pou, 2021). These competencies are developed with adults as PSWs in mind, and excludes youth PSWs (Te Pou, 2021). However, it is a positive step in acknowledging that peer support requires a certain level of competency. As well as knowing how to safely communicate their lived experience of distress and recovery, the competencies highlight other necessary knowledge and behaviours PSWs are required to meet. These include maintaining professionalism, ongoing learning and development, and applying a human rights approach to their work (Te Pou, 2021). The competencies highlight that peer support is increasingly acknowledged as legitimate in the mental health sector and that regulations for these roles are in place to maintain ethical safety.

The Evidence Base of Peer Support

The last decade has witnessed an international increase in research into informal and formalised peer support, with its evidence base reviewed (Davidson et al., 2012; Mutschler et al., 2021; Repper & Carter, 2011; Shalaby & Agyapong, 2020; Watson, 2019; White et al., 2020). Service users continuously and consistently report that peer support is both helpful and valuable (Watson & Meddings, 2019). These lived experiences of recovery achieved through IPS should constitute the evidence base this intervention needs (Cyr et al., 2016; Deegan, 2021; Mead, 2014;

O’Hagan, 2011). However, the scientific community has historically dismissed these lived experience perspectives as anecdotal evidence that lacks rigour (Davidson et al., 1999).

Despite the critiques from the scientific community, a considerable amount of research positions peer support as an empirically validated intervention with a growing evidence base (Bradstreet, 2006; Farkas & Boevink, 2018; Klee et al., 2019; Mental Health America, 2019; Orygen, 2020; Pfeiffer et al., 2011; Slade et al., 2014; Stratford et al., 2019). Numerous studies report that peer support is beneficial to service user recovery (Chinman et al., 2014; Kowalski, 2020; Lee et al., 2019; Mak et al., 2021; Repper & Carter, 2011; Shalaby & Agyapong, 2020). Formalised peer support has been found to be at least equally effective as conventional clinical services (Bellamy et al., 2017; Grant et al., 2018). Peer support can exist in early intervention services, as well as acute crisis care (Substance Abuse and Mental Health Services Administration [SAMHSA], 2022). It improves the quality of life of peers by reducing psychological distress and facilitating recovery (Barker & Maguire, 2017; Cyr et al., 2016; Lyons et al., 2021). Moreover, peer support is cost-effective and reduces the burden on pressured mental health services by reducing service user attendance at emergency departments and hospitalisations (Davidson et al., 2012; Fava et al., 2020; Mental Health Commission, 2012; Pitt et al., 2013; Repper & Carter, 2011).

A consistently articulated outcome of peer support has involved improvements in hope and empowerment, both of which are crucial to self-esteem and recovery (Fava et al., 2020; Lloyd-Evans et al., 2014; Mak et al., 2021; O’Hagan et al., 2012; Orygen, 2020; Repper & Carter, 2011). PSWs also provide role modelling and strategies for life skills that build self-efficacy (Davidson et al., 2012; Farkas & Boevink, 2018; Fuhr et al., 2014; Grant et al., 2018; Mak et al., 2021; Mead & MacNeil, 2006; Watson, 2019). Peer support reduces harm related to addiction (Barker & Maguire, 2017; Barton & Henderson, 2016; Grant et al., 2018; White & Evans, 2014). Peer support provides social connection and improves social functioning (Barker & Maguire, 2017; Drake & Whitley, 2014; Repper & Carter, 2011; White et al., 2020). In people with diagnosable mental distress, peer support provides a sense of belonging, which minimises loneliness and isolation (Davidson et al., 2012). This social inclusion is also important to counteract the ongoing stigma service users experience throughout their lives (Gordon, 2017; Mental Health Foundation of New Zealand, 2014; Repper & Carter, 2011).

There is a dearth of qualitative studies exploring experiences of accessing peer support, with most of the literature focussed on PSWs. To illustrate, in their qualitative metasynthesis, Walker and Bryant (2013) identified only four studies that related to experiences of people accessing peer support services, and 20 relating to experiences of PSWs. The four studies identified by Walker & Bryant (2013) were not related to a structured, manualised approach of IPS. Regardless, these four qualitative studies of service users accessing peer support established benefits around role modelling, increased hope, motivation and better rapport (Walker & Bryant, 2013).

One qualitative study carried out with adult service users identified that peer support is valuable because of its shared experience between peers and PSWs (Gidugu et al., 2015). The researchers also reported that peer support provided peers with practical, emotional, and social support and established a shared connection that was closer to friendships than clinical relationships (Gidugu et al., 2015). Those who accessed peer support found it beneficial due to its social and experiential learning (provided through role modelling and emotional support). They also found lived experiences were normalised and validated as a result of a shared understanding (Gidugu et al., 2015; Walker & Bryant, 2013). Peer support enhanced social networks and reduced isolation (Solomon, 2004; Walker & Bryant, 2013). These factors, which were reported on in individual peer support, have also been found to apply to peer support groups (Worrall et al., 2018). The importance of this shared experience has also been reported on from the perspectives of PSWs (Stefancic et al., 2019). However, one critique is that all of these studies were carried out with adult service users.

Formalised peer support has real value in the youth mental health space. When asked, young people advocate for more support from peers with similar experiences to them (Barnett & Lapsley, 2006; Mental Health Coordinating Council, 2014). Peer support hopes to eliminate power imbalances (which may be unavoidable for clinicians working with youth), builds connections, and fosters a stronger sense of self (Gopalan et al., 2017; Orygen, 2020). This is consistent with the finding that young people feel more involved in their mental health care when they have a peer supporter by their side during the assessment process (Simmons et al., 2017). Youth who engage in peer support show improvements in self-confidence and positive social behaviours, which may lead to a stronger sense of self (Grant et al., 2018; King & Fazel, 2021). The connection peer support provides is particularly protective for young people, who navigate ongoing social changes and pressures during this formative period (Barton & Henderson, 2016; Fava et al., 2020; Mental Health Coordinating Council, 2014).

The area of formalised youth peer support has not been explored in depth. There is a paucity of research on peer support for youth, as research is most commonly focused on adults with long-standing distress (Ansell & Insley, 2013). Research into youth formal peer support has been largely concerned with psychosocial components (Gopalan et al., 2017), and other outcomes are frequently surmised from adult studies on peer support interventions (Orygen, 2020). Furthermore, youth peer support studies commonly address informal peer support, or peer support provided in academic context such as schools or universities (King & Fazel, 2021; Shalaby & Agyapong, 2020), rather than mental distress-specific interventions such as IPS. Studies that address youth experiences of IPS, have primarily focussed on homelessness (Barker & Maguire, 2017; Kidd et al., 2019) and addiction (Ansell & Insley, 2013). Furthermore, research into youth peer support also tends to evaluate the implementation of peer support services or PSWs, rather than understanding experiences of young people who access this intervention (Hopkins et al., 2020; Ojeda et al., 2021; Fava et al., 2020).

International studies into IPS for youth mental distress have been few and inconclusive due to inadequate methodologies (Gopalan et al., 2017; Orygen, 2020). To date there have been no Aotearoa studies exploring the experiences of young people who have accessed IPS for mental distress. Similarly, research into Māori and/or Rainbow youth experiences of IPS is non-existent. However, it is important to acknowledge that Māori and Rainbow communities have their own versions of peer support - be it through holistic kaupapa[8] Māori models (that emphasise connection and whakawhanaungatanga[9]; Scott et al., 2011), or, for Rainbow individuals, through community engagement and volunteer work with peers (Veale et al., 2019). Given that one of the strengths of IPS is its ability to adapt to marginalised groups, the use of this intervention with underserved populations may prove particularly helpful (Cyr et al., 2016).

Youth peer support is growing internationally, and there are many similarities between adult and youth peer support (Fava et al., 2020; Orygen, 2020). Adult service users value what peer support can provide, and youth service users may also benefit from working with PSWs. Most young people tend to experience isolation and identity confusion at some point through their adolescence that adds to their distress. As a result, formalised peer support such as IPS may be a useful intervention to provide connection, meaning, and hope. As such, there is a strong rationale to invest in peer support research, due to the potential for youth, and the early intervention it can provide (Uhlhaas & Wood, 2020).

Limitations of Peer Support Literature Review

Clinical research into the evidence base of peer support interventions has significant variations in study design and execution, resulting in considerable limitations and conclusions that lack rigour (Stefancic et al., 2021). The lack of consistency in evaluation outcomes may contribute to ongoing criticisms around the evidence base of peer support, leading to an impression that its

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[8] A uniquely Māori approach

[9] Process of establishing relationships

effectiveness is inconclusive (Barton & Henderson, 2016; Fava et al., 2020; Penney et al., 2021). There are a number of limitations to clinical research evaluations of peer support. First, the overwhelming majority of research does not specify what kind of peer support is being researched (Shalaby & Agyapong, 2020). This is crucial, as some peer support and its roles cannot be standardised and thus peer support varies widely in its content and how it is delivered. Peer support is unique to each peer relationship and the particulars of the interventions need to be outlined upfront. Research into peer support often covers a broad range of formal and informal peer support interventions, with some studies failing to specify these particulars entirely (King & Fazel, 2021; Lloyd-Evans et al., 2014; Lyons et al., 2021). This results in different interventions all being compared under the broad umbrella term of peer support. However, only specific types of peer support (for example, IPS) have developed protocols that have consistent and measurable outcomes (Penney et al., 2021). Thus, peer support is rarely defined precisely in clinical research, creating ongoing confusion as to what it constitutes (Faulkner & Kalathil, 2012; Penney, 2018). Future research should clearly identify the specifics of the peer support being used, for example, using established and formalised peer support such as IPS.

Second, research is often focused on the experiences of PSWs, rather than on their peers (Chisholm & Petrakis, 2020; King & Fazel, 2021; Kowalski, 2020; Mancini, 2019; Simmons et al., 2020; Watson, 2019). This may be the result of peer support being inherently bidirectional, as opposed to conventional clinical interventions where only one party is receiving the intervention. Although it is valuable to look at PSW experiences, this type of research conflates the outcomes of the two groups, making it difficult to understand the experiences of peers and how this contributes to peer support's evidence base. A neglected area for future research includes the experiences of peers that access formalised peer support.

Third, peer support research often confuses recovery definitions. For example, peer support is underpinned by principles of personal recovery, but studies conflate this with clinical recovery, which are two different outcomes (Drake & Whitley, 2014). This results in challenges with how peer support is evaluated. Research into peer support needs to address personal recovery, as this is the definition which is consistent with values and principles of IPS.

Finally, some research attempts to compare peer support efficacy with clinical treatment-as-usual; modalities that are underpinned by opposing theoretical orientations (Burke et al., 2019; Fuhr et al., 2014). As a result, there are ongoing challenges in conducting randomised controlled trials (RCTs; gold standard for intervention effectiveness) on a practice that is at odds with the biomedical model that underpins RCTs (Fava et al., 2020; Scott et al., 2011). RCTs assume an individualist pathology that is in line with the biomedical model, which are in opposition to the theoretical orientation of peer support (Gillard, 2019). Furthermore, the concepts of efficacy and effectiveness are clinical research terms that are inconsistent with personal recovery. These terms fail to take into account an understanding of how well peer support works and the value it provides.

As a result of these conflations, some studies use inappropriate designs that assess peer support through clinical outcome measures (Lloyd-Evans et al., 2014). All of this creates false equivalence fallacies: “if clinical outcomes (apples) are not the same as recovery outcomes (oranges)—*and they aren’t*—the “missing” apples didn’t belong in the basket mixed up with oranges, anyway.” (Dayan, 2022, para. 9). This makes it difficult to draw conclusions and results in inadequate and inconsistent reporting on the value of peer support (Ansell & Insley, 2013; Chinman et al., 2014; Gopalan et al., 2017). To accurately assess how peer support works in practice, researchers should consider its underpinning theory and evaluate its value outside the scope that constitutes the evidence base in clinical practice (Gillard, 2019).

Summary

Despite strong evidence for its efficacy, peer support remains doubted and under-utilised. However, in research about lived experience perspectives, peer support continues to be reported as beneficial. As a result of peer support, tāngata whaiora have an increased sense of control over their lives, which contributes to improved recovery outcomes (O'Hagan et al., 2012). Peer support is supported by the current legislation, which advocates for increased youth and peer support services (Allan, 2020; Ministry of Health, 2021; NZMHWC, 2022; Paterson et al., 2018). There is a strong rationale for investing in peer support as part of mental health services (Grant et al., 2018), however more research is needed that addresses the limitations of existing studies.

Rationale and Aims of the Current Research

Mental distress in young people can lead to debilitating effects. Current mental health services need to be redeveloped to include alternatives to existing care, and targeted early intervention (Benton et al., 2021; Uhlhaas & Wood, 2020). Research into how young people understand recovery can help shed light on what matters to young people, and the subsequent goals supporters of young people may need to strive for. Furthermore, understanding youth experiences of alternative interventions such as IPS may help to provide information that is relevant to future service development. Research also needs to incorporate voices from marginalised youth identities that are underserved in research, namely Māori and/or Rainbow (Fava et al., 2020). Finally, co-production with young people can ensure that research is sensitive and relevant to their needs. Research involving young people at all levels of the research can help to inform future practice to make services more relevant and accessible (Claveirole, 2004; Summerhurst et al., 2017).

The majority of existing research into recovery on peer support has largely failed to use appropriate methodologies (Stefancic et al., 2021). Additionally, young people have commonly been excluded as active participants from these topics. Given that youth is a distinct developmental period, young people may have particular understandings of recovery, and distinct experiences of IPS. Both contexts need to be further explored in qualitative, inductive research (Ojeda et al., 2021). This can address the serious gaps in research on recovery and IPS to date. Furthermore, the little research that has focused on young people's understandings of recovery or peer support has not been co-produced with them. Young people should be collaborators in research projects, as they can provide valuable novel perspectives (Holman & Williams, 2020; Stubbing & Gibson, 2021). Thus, utilising co-production within research is warranted.

Based on the literature review and the corresponding gaps identified, the current study is guided by two research questions to contribute to this crucial topic:

1) How do young people in Aotearoa understand personal recovery in the context of mental distress? The current study uses a qualitative inductive approach, which ensures the findings capture what is meaningful to the participants rather than making assumptions based on existing recovery frameworks. The study aims to ensure Māori and Rainbow youth service users are represented in the research sample as these have consistently been identified as priority groups, but recovery research with them is extremely limited (Paterson et al., 2018).

2) What are young people's experiences of accessing IPS? IPS is an established intervention, but there is a research gap in terms of its applicability to youth. Young people may benefit from IPS, with its focus on building identity, autonomy, hope, and connection. Given the legislative call to increase peer support and transform existing youth mental health services, further research on the appropriateness of formalised peer support such as IPS for youth is timely.

Chapter Summary

Youth mental distress is a major issue and a silent epidemic. With much of the research deficit-focussed, little is known about youth understandings of recovery from mental distress. Current services are not fit-for-purpose, and alternative interventions need to be explored. Formalised peer support such as IPS is an established intervention that is currently under-utilised by mental health services. There is a paucity of research on youth experiences of IPS. Currently, there is a focus to invest in youth recovery-oriented practice and increase peer support services. Therefore, this research aims to address this gap and answer the research question: How do young people understand personal recovery, and are their experiences of IPS consistent with promoting this intervention as a suitable recovery-oriented alternative?

CHAPTER FOUR: METHODOLOGY

This chapter outlines the methodology of my research. Here, I expand on the theoretical framework which includes co-production and the recovery-orientation introduced in Chapter Two. I provide the rationale for utilising Interpretative Phenomenological Analysis. I reflect on my positioning and describe the precariousness of where I stand in the context of my research, as well as the implications of this. Following this, I outline the methods used in conducting this research, including recruitment, data collection and analysis, and ethical considerations.

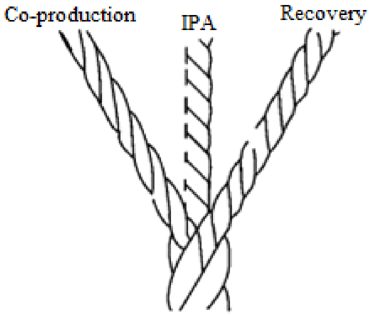
Theoretical Perspectives

Although there is little consensus within the literature on what constitutes a theoretical or conceptual framework or how to practically employ these within research, academics agree that integrating a theoretical framework within doctoral research is akin to a blueprint (Grant & Osanloo, 2014) or a scaffold (Lynch et al., 2020) for the research and, thus, imperative. The decision to employ a particular framework must be purposeful, as it provides a lens through which the researcher views their research. Furthermore, researchers are expected to clarify their positioning at the outset of each research project, as each researcher approaches their work with a set of underlying assumptions. Reflexivity is another important tool for justifying rationales and ways in which the researcher interacts with the data (Shaw, 2010). As Chamberlain (2014) states: “we need to make sense of where we stand on these philosophical matters if we are to undertake sound, rigorous and defensible research” (p. 12).

As shown in Figure 1, taken together, co-production, recovery orientation, and Interpretative Phenomenological Analysis (IPA) form the theoretical framework for this thesis. These frameworks are woven together through the fabric of this research and form the basis of my methodology. I use the metaphor of weaving thread purposefully, as I see these orientations being distinct in their own right. Woven together, they interlace, and create a pattern that is unique to my research and focus on collaboration with service users who are positioned as experts by experience. Within these frameworks, the subjective lived experience is paramount, and service users are able to draw on their personal threads of experience to inform their conceptualisations of what is meaningful, adding depth and significance to this research.

Figure 1

Theoretical Framework for This Research



Co-production and the recovery orientation were introduced in Chapter Two, Setting the Scene, where I outlined their background, and the ways in which they are used in this research. The third component of the theoretical framework for this research is the qualitative methodology. Qualitative inquiry is suitable for this research, as I wanted to honour the subjective lived experience of my participants in all its richness and nuance and reflect on the wider context in which this lived experience was set.

As there is no one formula for a qualitative approach, defining the particulars of epistemology and ontology is crucial (Crotty, 2020). Ontology and epistemology are inherently intertwined, and their particulars are frequently debated in philosophical circles (Chamberlain, 2014; Harper, 2011). Put simply, ontology covers assumptions about the nature of reality and what we can know (Willis et al., 2007), and epistemology concerns itself with the assumptions about views on knowledge and what is possible to know (Willig, 2013). This research assumes a realist ontology where social concepts are real and can be “named, investigated and analysed” (Carter &

Little, 2007, p. 1326). My epistemological positioning is situated in interpretative phenomenology. As guided by Smith et al. (2009), I assume that “data can tell us something about people’s involvement in and orientation towards the world, and/or about how they make sense of this” (p. 46). Thus, individuals perceive the world within the context of their environment and experiences are inherently subjective (Smith, 2015). Accordingly, there are multiple ways to understand reality, and there are also different levels of interpretation. IPA is an established qualitative methodology, and was appropriate for understanding the subjective experiences of my participants.

Interpretative Phenomenological Analysis

Developed by Smith et al. (2009), IPA concerns itself with interpreting the lived experience of participants in relation to how they make meaning of particular phenomena (Smith, 2016). IPA was developed within health psychology and has been increasingly used within clinical psychology (Pietkiewicz & Smith, 2012). IPA is concerned with understanding the lived experience of participants and their interpretation of the said experiences, which is in line with the aims of this research. IPA has a “distinctive epistemological framework” (Shinebourne, 2011, p. 16) with three major theoretical underpinnings: phenomenology, hermeneutics, and idiography.

First, phenomenology is the study of experience. Developed by the philosopher Edmund Husserl, this approach is concerned with understanding how an individual makes sense of particular phenomena and by extension the meaning they give these experiences (Eatough & Smith, 2017; Pietkiewicz & Smith, 2012). Within IPA, lived experience is something to be “explored on its own terms” (Smith et al., 2009, p. 1). This means that experiences are unique for individuals and that IPA tends to focus on those experiences that are significant to participants.

Second, hermeneutics is “the theory of interpretation” (Smith et al., 2009, p. 21). IPA acknowledges that there are multiple levels of interpretation. In particular, within research, the participants try to make sense of their experiences through a process called meaning-making. This is usually followed by the researcher trying to make sense of the interpretation of the participant. This process, in which the researcher interprets the interpretations of the participants, is called *double hermeneutic*. Thus, the researcher is an active participant in the analysis and the reflexivity process is embedded within the IPA approach (Shaw, 2010).

Third, idiography is the study of the particular. Analysis through this approach is multi-levelled. Participants perceive their experiences of the world in their distinctive context. The IPA process allows for an in-depth examination of each individual experience, as well as the exploration of similar and differing experiences (called conversion and diversion) within a particular cohort of people (Miller et al., 2018; Pietkiewicz & Smith, 2012). As Smith et al. (2009) describe: “Firstly, there is a commitment to the particular, in the sense of detail, and therefore the depth of analysis. […] Secondly, IPA is committed to understanding how particular experiential phenomena (an event, process or relationship) have been understood from the perspective of particular people, in a particular context” (p. 29). Thus, IPA provides a rich and multi-layered interpretation of experiences, guided by idiographic perspectives.

IPA also complements co-production of research with service users and the recovery orientation because of its commitment to lived experience. Previous research employing IPA and co-production allowed for “more insightful interpretations of nuances, complexity, richness or ambiguity in the interviewed participants’ accounts” throughout the research experience (Mjosund et al., 2017, p. 266). IPA also complements the recovery framework in that it prioritises the subjective experience and thus is philosophically aligned with principles of personal recovery. All three frameworks honour the “embodied socio-historical situated person” (Eatough & Smith, 2017, p. 3), where the context of an individual influences the meaning they give their experiences and the lives they lead as a result.

IPA allows the flexibility of analysing data at two levels. First, through the subtleties of each subjective lived experience at an individual level via its idiographic focus. Second, in developing wider themes within particular phenomena. In this way, analysis can explore the recovery phenomenon from the perspective of a broad group of youth service users, as well as look into the experiences of accessing peer support within a subset group of participants.

Furthermore, IPA incorporates wider context into the data analysis. This is particularly important for service users, given their history of marginalisation and the fact that recovery is deeply tied to multiple aspects of lived experience. Intersectionality, overarching ideologies, historical, and sociocultural factors all contribute to lived experience of mental distress, and by extension of recovery for a participant. These nuances can be reflected within an IPA approach. Furthermore, the importance IPA places on the researcher's positioning means that I can exist and play an active role in my research. Given that I am both an insider and an outsider depending on how I am positioned (Kerstetter, 2012), it is important to outline my own journey and reflections on this below.

Reflexivity: My Positioning

Reflexivity is an essential component of any qualitative methodology. The researcher is embedded in the project and brings their own meaning, understanding, and experience alongside that of the participants. Within qualitative methods such as IPA, no research project is without subjectivity, and all meaning making is contextual (Shaw, 2010; Smith, 2015). Reflexivity allows this process to be transparent and aims to reach a point where the researcher and the researched are in symbiosis with each other, which colours the outcomes of the research. The results of this thesis honour participant interpretations through the lens of my interpretation via the double hermeneutic process. This allows me to contribute my experiences to my research.

Addressing reflexivity often requires the researcher to state whether they are a member of the groups they are researching (insider) or whether they are not (outsider). There are recognised advantages and disadvantages to being aligned with a particular position; however, this somewhat reductionist dichotomy has also been widely debated within qualitative research (Gair, 2012). Dwyer and Buckle (2009) propose that instead researchers may only occupy “the space between” (p. 60), as one can never truly exist on one side of the insider/outsider binary. Furthermore, this process of ongoing inquiry concerning the researcher (self) and the participants of the research (other) is what Fine (1994) has dubbed *working the hyphens*. Working the hyphen requires ongoing reflection into the relational nature of research, and the implications the research has for the participants and the researcher (Wagle & Cantaffa, 2008). Without this critical lens, Fine (1994) warns, researchers are in danger of perpetuating colonising discourses. Given that the mental health sector originates from Western patriarchy, and is rife with racism, working the hyphens becomes about working to actively dismantle systemic injustices within my own research. Expanding on the idea of working the hyphen, Granek (2013) and Gair (2012) make the argument that research should also be grounded in empathy and social responsibility. The researcher then occupies a privileged space where they must continuously re-evaluate their position and strive for transparency and sensitivity within their research (Rose & Kalathil, 2019).

Throughout this project, I have found myself in ongoing precarity within the insider/outsider debate and have consistently questioned my relationship to my research. Within the past two decades I have used, worked, and volunteered in many services within the mental health sector. I strive for all of my work to be underpinned by my service user-led perspective first and my clinical and research knowledge second. I exist in a kind of consumer/clinician duality, my space between, where I am both an insider and an outsider depending on the context and the people around me. Because my position is intertwined with context, I am also constantly working the hyphen concerning who I am with, which is a point reflected in research (Kerstetter, 2012). Furthermore, (like those who have come before me: e.g., Morrison, 2013), I believe that my work is activist in nature, which adds an additional complicating factor to negotiating my activist and my researcher identities. Indeed, the disclosures I make below may be pejoratively and incorrectly called *me-*

search, which only highlights the need to do this work to counter existing prejudice (Devendorf, 2022). Being a service user researcher within the constraints of academia requires an ongoing effort between pushing boundaries and working within existing power structures (Rose, 2019; Rose & Kalathil, 2019).

Personally, I am a 1.5 generation queer Slavic migrant to Aotearoa. I grew up in a culture that stigmatised mental distress and first accessed mental health services as a teenager. I have lived experience of mental distress and recovery. Throughout my life, I have been on receiving ends of multiple therapeutic modalities. Similar to other researchers with lived experience (Russo, 2012), my time at university has been long and at times turbulent. Academic spaces at times lacked the support I needed and people within these spaces were not always understanding of my distress. Despite these challenges, I have now reached a certain respected status within the field of mental health. However, due to my insider status, I maintain a healthy scepticism about the current mental health sector.

For me, recovery remains non-linear. I have at times thought of myself as recovered, only to reject that notion the following day. I feel that to others, my recovery is characterised primarily by my productivity within a capitalist world. For the most part, I do not think that the current mental health system nor the world at large allows service users to truly experience personal recovery. The definition of living well in the presence or absence of mental distress used by the Mental Health Commission is a lofty goal, as it does not take into account intersectionality and the resulting challenges stemming from inequality and inequity. Furthermore, the current mainstream therapeutic modalities on offer (such as CBT) do not work for some people. I know this to be true because of my own expertise – my lived experience. This is one of the reasons why looking at alternatives such as peer support and how they are experienced by service users is so important to me.

Professionally, I am an intern psychologist and a service user academic. I have extensive experience in research, teaching, community advocacy, and professional support. My lived experience of mental distress has given me certain privileges, and I know that I have become a better researcher and clinician for having had these experiences. Throughout my adult life, I have been in many roles within the mental health sector where I drew on my insider knowledge. I have volunteered as a youth phone line counsellor and a peer support worker. I have also worked in paid roles as a youth worker and intern psychologist. All of this has allowed me to further advance my career at the consumer/clinician/researcher intersection. I have studied for the majority of my adult life and had the privilege of being selected into the DClinPsych programme which is highly competitive and well-regarded. I have successfully completed my clinical training, and currently I am at the final step of the journey to becoming a clinical psychologist – completing this doctoral thesis. The above achievements have given me certain life experience and wisdom, and have also served to privilege me, at times challenging my insider status.

As a result, during this project I engaged in a thorough process of negotiating the hyphen, to explore how my identity shifted in relation to my research participants and what this meant for my connection to the data. One way of keeping track of the experiences which came up for me was by using a reflexive journal. I used this journal to write down my experiences, perceptions, and conceptualisations of the process. I also included my frustrations, and creative writing I made during the research within this journal. Having the space to write in an unfiltered way aided me in my own meaning-making and quite literally kept me sane. To further maintain my mental health, I utilised the support of fellow service user academics in co-reflection processes. Having a sounding board in the form of peers who were in a similar position to me allowed me to reflect more clearly on my positioning and not feel so alone or confused in this process.

As a researcher with lived experience, I have also thought about whether my existence within this project would satisfy the co-production requirements I set out for my research. Given that I am a service user, some people may have agreed that this would be enough. However, if I had not included youth service users without psychology training in the development of my research, then I would be in danger of perpetuating the discourse that my lived experience is only worthy *because of* my clinical/research training, not *in spite of*. Furthermore, without youth service users, and in particular Māori and POC youth service users, I would be perpetuating the very colonising discourse I was hoping to avoid (Rose & Kalathil, 2019). Reflecting on frameworks of co-production within mental health, equality through sharing of power and knowledge is crucial and in my case, could not be achieved without (non-clinically trained) youth service users.

Throughout my research, I have struggled to position myself firmly on one side of the fence, until I realised that I did not have to. I see my reflexivity as an ouroboros, a continuing cycle of destruction, grief, and rebirth of the identities I hold, that will continue to shift over the course of my life. All these parts of me described above have influenced the way I have designed, carried out, and interpreted my research. Every choice I have made with respect to my professional path has been in relation to my own lived experience. I cannot speak for the youth service user experience any longer, which is why co-production was an integral part of carrying out this research. And finally, at the risk of sounding futile, I think even this research is limited in the current system. If we are not including Mad Studies (LeFrançois et al., 2013; Rose, 2018; Rose, 2019) within psychology school curriculums, or allowing the space and funding to carry out co-production fully within research (Rose & Kalathil, 2019), we are merely paying service users lip service.

Methods

Research Design

The current research was part of a wider evaluation of the pilot Piki, led by a team from the University of Otago (Dowell et al., 2021). Through this wider evaluation, I was given the opportunity to independently research my doctoral thesis topic. However, as my research was nested within the larger evaluation, there is some degree of crossover. For example, the University of Otago provided ethical approval for this research (H19/044) as part of the overall Piki evaluation ethics application. Given that there was an existing ethical approval from Otago (which I contributed to), the Human Ethics Committee of Massey University advised that there was no need for separate approval for this research. Additionally, the participant interviews served a dual purpose and were used within this research, as well as by the University of Otago. For this reason, I collaborated with the wider evaluation team in terms of recruitment. Finally, this research and the larger evaluation were co-produced with a group of youth service users, who became known as the Service User Reference Group (SURG). While all aspects of SURG were set up and facilitated by me, the members were paid by the University of Otago. This is relevant to the research design to ensure that my doctoral work is clearly demarcated.

Co-production with SURG

SURG was established at the beginning of this doctoral thesis, with youth aged 18-25, who identified as having lived experience of mental distress and recovery. To recruit SURG members, I approached young people who had previously accessed mental health services and were willing to contribute to co-production through their lens of lived experience. In particular, I approached service users who were Māori and/or Rainbow, as these identities were priority groups for the research. Diversity of views is valued in co-production research as service users may provide unique perspectives given their expertise (Faulkner, 2011; Scholz et al., 2019b). As I have previously worked within youth spaces, I had connections within my professional circles and was able to find young people who were interested in joining. I spoke to prospective SURG members about my background, described what the project might entail, covered information about reimbursements, and sent the Roper et al. (2018) resource on co-production to them.

A total of 12 service users were involved in SURG during the two years of the research project. At members' requests, they remained anonymous and thus the privacy of members was protected. Members were from across the Wellington Region. They had a variety of identities, genders, ethnicities, and encompassed a variety of life experiences, as shown in Table 1.

Table 1

Service User Reference Group Members' Demographics and Intersecting Identities

	n (%)		***n (%)***
Gender		**Ethnicity**	
Female	4 (33.3)	NZ Māori	3 (25)
Male	3 (25)	Pasifika	4 (33.3)
Non-binary	5 (41.7)	European (including Pākehā)	5 (41.7**)**
Highest education		**Occupation**	
NCEA 2 or 3	4 (33.3)	In employment	3 (25)
Diploma	4 (33.3)	Unemployed	2 (16.7)
Bachelors	4 (33.3)	Student	3 (25)
		Volunteer	4 (33.3)
Disabled	7 (58.3)	**Rainbow or LGBTQI+**	7 (58.3)
Substance misuse	3 (25)	**Outside of Central Wellington**	5 (41.7)

Note: Total n = 12

NCEA= National qualifications for senior secondary school students

The principles of co-production were followed, with particular attention paid to the power dynamics between SURG and me (Carr & Patel, 2016; Lambert & Carr, 2018; Lohmeyer, 2019). In line with values of co-production, I wanted to establish a culture of trust, honesty, and transparency within our collaboration, making the work reciprocal and allowing us to engage in a mutual process of growth co-learning (Coleman, 2019; Roper et al., 2018; Sheldon & Harding, 2010). Furthermore, I was articulate in stating the motivations which underpinned our co-production, and spoke about how this way of working can bring about change within academia. This was crucial, as researchers who tend to shy away from politicising their methodologies do a disservice to co-production and the people they work alongside (Oliver et al., 2019).

In total, ten meetings were held with SURG over a period of two years. The meetings were designed to be flexible in line with co-production principles. In general, meetings followed a simple format and were held in the evenings in private university rooms, with food provided. As agreed by all members, I served as a facilitator at the SURG meetings. First, I presented the topic and specific questions of the day. With each topic, I shared my ideas and thought processes with the group. We then engaged in a workshop-style activity with resources particular to the topic at hand. Members made individual comments, or discussions were held in small breakout groups, and then fed back to the whole group, until we felt we reached an appropriate conclusion depending on the nature of the topic and task. Following this, the group was brought back for discussion and feedback on how they found the process. Following meetings, I made notes about how I felt this went and summarised our work together in an email, which was later sent out to SURG. The meetings were recorded so I was able to relisten to our discussion.

In the first SURG meeting, the group values and rules were discussed and established, setting a precedent for future meetings. The design of subsequent SURG meetings was flexible to allow for collaboration and input from all parties. What co-production looked like in practice within these meetings varied considerably between tasks. Throughout meetings in the first year, SURG and I co-produced numerous aspects of the research design: elements of the ethics application; participant information sheets and consent forms; and question schedules for future interview participants. During the second year of meetings, SURG and I analysed a portion of the data. In terms of research design and analysis, some tasks were done individually and then I collated this information, after which discussions were held. Other tasks were better suited to full group discussions from the beginning.

Ongoing cultural consultation was an integral part of co-production, as indigenous groups and their views are consistently underrepresented in clinical psychology research. As I am a Slavic migrant to Aotearoa, it was important for me to have rangatahi tāngata whaiora Māori involved. Cultural consultation was embedded within SURG and Māori members advised me on the interview process with Māori participants from the perspective of how they would have wanted to be interviewed, as well as data analysis interpretation. Ongoing reflexivity was embedded within the SURG team, and individuals were encouraged to draw on their experiences of identity and culture to inform the design and analysis of the project.

Participant Recruitment

Potential participants were Piki clients who, at the beginning of accessing the Piki pilot, consented to be contacted for interviews about their experience. Those who consented were amalgamated into a database, which I had access to. I contacted potential participants directly via email and/or text from a list provided to me by Piki, using a template message (Appendix A). In the message, I included an information sheet (Appendix B) and a written consent form (Appendix C). Potential participants who responded were invited to arrange a suitable time and date for the interview.

Sampling reflected the need to elicit a range of experiences. Potential participants were selected on the rationale that they had marginalised identities (e.g., Māori and/or Rainbow individuals). I also selected potential participants based on the support they accessed. I contacted those who accessed Intentional Peer Support (IPS) through the organisation PeerZone. I contacted participants who accessed Cognitive Behavioural Therapy (CBT) through various Piki-affiliated organisations. I also reached out to participants who accessed both interventions. Participants had to have completed their intervention of choice to allow them to reflect on their entire experience of accessing support.

The topic of data saturation guiding sample size has been widely debated in qualitative research (Mason, 2010; Fusch & Ness, 2015). Malterud et al. (2016) address this by recommending that the sample size should not be numerical (as in the number of interviews), but rather be guided by information power. This concept speaks to the fact that researchers should be guided by the depth of their data within interviews, as well as their aims and methodology. For the purposes of my research, I wanted to ensure that I had enough data to allow me to address the breadth of phenomena and depth of a specific experience through IPA methodology. The final sample size was decided in collaboration with the University of Otago team. When we felt that the data set was sufficient to address both my aims and the wider Piki evaluation aims, I ceased recruitment.

Participant Interviews

In total, 26 participants were recruited and represented a diverse range of individuals. Table 2 shows the demographics of the participants interviewed, aggregated to maintain anonymity.

Table 2

Participants' Demographics and Interventions They Accessed

	n (%)		*n (%)*
Gender		**Ethnicity**	
Female	17 (65)	NZ Māori	9 (35)
Male	5 (19)	Pasifika	4 (15)
Non-binary	3 (12)	Asian	3 (12)
Unanswered	1 (4)	European (including Pākehā)	10 (38)
Occupation		**Intervention**	
In employment	8 (31)	CBT only	17 (65)
Unemployed	4 (15)	Peer Support only	2 (8)
Student	13 (50)	Both	7 (27)
Stay at home parent	1 (4)		
Substance misuse	6 (23)	**Rainbow or LGBTQI+**	6 (23)

Note: Total n = 26

The participants were between 18 and 25, with a mean age of 21.8. Participants were varied in their demographics. Although I attempted to recruit with a gender balance in mind, the high number of female participants reflects that they responded in greater numbers compared to other genders. In terms of priority groups, over a third of participants were Māori and just under a quarter identified as Rainbow. The majority of participants accessed the CBT intervention, and only a small proportion accessed IPS alone. Just over a quarter of participants accessed both interventions.

Data Collection

Interviews were conducted between February and May 2020 and later in October, with some being collected via Zoom due to COVID-19. Face-to-face interviews were held at Massey, Victoria, or Otago University group study rooms, at the participant's homes, or in private rooms in community spaces such as the library. At the beginning of each interview, I introduced myself and the study and went through the information sheet and the consent form with the participant. I also provided food for participants. The semi-structured interviews were audio-recorded and ranged from 30-60 minutes. At the end of the interview, each participant received a $30 supermarket voucher in recognition of the time taken to participate.

The focus of the semi-structured interviews was on meaning-making and associated experiences of accessing support, which the participants deemed significant. The interviews were guided by a question schedule (Appendix D) which had four sections: previous experience of mental health support and how that shaped their perceptions of accessing Piki; experiences of accessing support; their definition of recovery; and suggestions for future improvements. As the interviews served a dual purpose and were used for the larger Piki evaluations, sections one and four were outside of the aims of this research. The interviews adhered to a service user-centred approach, where participants were experts of their experiences. I supported this by building rapport with the participants before the interview commenced and checked in with the participants throughout the interview to ensure they had space to speak freely.

Following each interview, I wrote a brief field note on the initial impressions and topics covered. The interviews were transcribed by an independent transcriber through the University of Otago, who transcribed verbatim from audio recordings using the Express Scribe transcription software and included utterances and laughter. I proofread each transcript, amending mistakes as needed. I removed potentially identifying information and replaced this with generalised descriptions in square brackets, for example, [sister]. Due care was taken in preserving the participants' accounts as they appear in the transcripts. All extracts in the findings are presented verbatim; however, repetitions and filler words have been edited out for readability. Square brackets were used where clarification or context is required. I reviewed the transcripts with the audio files prior to analysis, and each transcript was given a corresponding pseudonym, in alphabetical order. The transcripts were loaded into NVivo software in preparation for analysis.

Data Analysis

Data were analysed using IPA, using the six-stage guidelines suggested by Smith et al. (2009). IPA analysis stages are intertwined, and researchers move between stages fluidly rather than in succession (Smith et al., 2009). Additionally, Nizza et al. (2021) describe four areas that constitute quality within IPA analysis. These are: constructing a compelling, unfolding narrative; developing a vigorous experiential and/or existential account; close analytic reading of participants' words; attending to convergence and divergence. These also served as guidelines throughout my research and guided my analysis.

Within IPA, creative interpretation of the analysis steps is encouraged, as long as there is a commitment to the underlying theoretical framework (Pietkiewicz & Smith, 2012; Smith et al., 2009). This allowed for data analysis to be done with SURG, as well as by me alone. I analysed data both in NVivo and on paper, depending on the stage of analysis and what was most appropriate. For example, hard copies of the transcripts were distributed to SURG during our shared analysis process.

According to the ideographic focus of IPA, it is recommended that each transcript is first individually analysed to allow for a close line-by-line analysis of each participant's data, without being interrupted by others (Smith et al., 2009). The first stage of my analysis was to immerse myself in the raw data by re-reading the transcripts and providing exploratory comments for them. I read each transcript alongside the interview recording first, to allow myself to remember the tone of the interview, and to identify any specific verbal and auditory emotional cues of the participants. I then familiarised myself with the data by re-reading each transcript slowly to ensure I felt I understood the perspective of the participant. I noted my initial thoughts, observations, and reflections on the transcripts in the margins of each transcript, which formed the basis for my exploratory comments and preliminary interpretations. I also expanded on my field notes written after the interviews, including any details that I observed through the process that I felt were meaningful or interesting. I analysed each transcript in this way.

In the second step of the analysis, I began to think about my initial codes and how they could be connected. This process began after exploratory comments were developed. I analysed each transcript line by line, colour-coding quotes into descriptive (content of data), linguistic (language used) and conceptual (for further interpretation) comments as guided by the IPA analysis process (Smith et al., 2009). This process led me to step three, developing emergent themes. This process was similar to previous studies which incorporated service users in parts of the analysis, where the researcher first works alone and then collaborates with service users (Cotterell, 2008).

Data Analysis with SURG

Four weekly meetings were held with SURG to assist in the data analysis process. The session format went as follows: I introduced the method of analysis to the members and showed them the question schedule to remind them of the questions that were asked. I shared my research goals around understanding conceptualisations of recovery and experiences of peer support. I then modelled the process of analysis. I presented an example of a transcript excerpt on a PowerPoint slide, describing how I had made exploratory comments and created initial codes. I described my thinking process out loud, creating an interpretative dialogue between myself, the data, and what the data might mean, as described by Smith et al. (2009) to demonstrate the level of analysis required to create emergent themes. The group and I discussed my thinking and whether this was consistent with the interpretations of the other SURG members. The members felt confident that they understood the task at hand.

Initially, I brought in printed transcripts from participant interviews, intending to have members analyse full transcripts separately, as IPA steps suggest. Each member received a transcript and went through individual transcripts to identify exploratory comments and emerging themes. However, SURG members found analysing lengthy transcripts challenging and time-consuming. After a discussion of how we could best undertake analysis in a co-produced way, members requested that I separate and theme the transcripts into more manageable excerpts of about a page length each.

On their advice, I separated and distributed hard copies of transcript excerpts to each member. As a result, the remaining meetings were focused on three broad topics which were consistent with my research aims: experiences of accessing peer support, specific youth populations (i.e., Māori and/or Rainbow), and youth recovery. This format worked much better, and members were able to analyse the data more effectively following my initial guidelines. Members used colour-coded pens and sticky notes and wrote their initial thoughts in the margins, similar to my process alone. This process was carried out for three or four excerpts per person. Subsequently, each person swapped the transcript with another member, who reviewed what was written and ticked it if they agreed or added their thoughts. The purpose of this was to elicit credibility checking for a more rigorous analysis (Smith et al., 2009).

After this, we came back to a structured discussion, and each member was given the opportunity to provide their reflections on the transcripts they worked on. Other members collaborated by either supporting or challenging these ideas. This discussion commenced the making of connections across themes. During this discussion, I made notes and recorded the meeting so that I could listen to it again later. At the end of each session, I collated the hard copies of the data, and we finished with a more reflexive group discussion. Afterwards, I wrote further notes of my impressions of the group discussion and any of my remaining reflections.

Data Analysis Alone

My analysis process alone was guided by a variety of information gathered through the co-production process; notes, recordings, and hard copy hand-written analysis and feedback from SURG members. All of this was incorporated into the final stages of the IPA analysis. I continued to analyse the data according to the research questions and split the data set into two separate analyses. First, I addressed youth recovery. The first analysis included all 26 transcripts. The second analysis was with a subset of the group, with nine transcripts analysed separately to understand the experiences of service users accessing peer support.

Within each analysis, all information collected throughout the meetings with SURG was included. I continued to explore, code, and theme individual transcripts to refine them and ensure that the opinions of SURG were incorporated in this. Following this, I began looking at the transcripts as a group, looking for connections between themes. Finally, I looked for patterns of divergence and convergence to create final superordinate and subordinate themes for each analysis, which can be found in the next chapter (Smith et al., 2009). Analysis was ongoing throughout the writing of the results chapter, and this helped to further refine the themes.

Chapters Five and Six present the findings of this research. Each chapter describes a separate qualitative analysis that was carried out in line with the respective research aims. Chapter Five explores participant understandings of personal recovery. Chapter Six focuses on young people's experiences of accessing peer support. To indicate how frequently participants shared commonality across ideas within themes, descriptors such as few, some or many are used. Each chapter incorporates findings and discussion as they pertain to each objective.

Ethical Considerations

Several ethical considerations were identified in this research. These included the informed consent of the participants, confidentiality, and management of any potential distress that may occur as a result of the interviews.

Informed consent provisions were in place to allow the autonomy of the participants. Potential participants received information sheets and consent forms at the time of first contact. These detailed the nature of the study. Participants responded to this message voluntarily. When we set up interviews, I stated that the participants could ask me any questions at any point. Before the interview started, I made sure to review both information sheets and consent forms again, allowing participants to ask any questions. I also told participants that they could end a particular line of questioning within the interview or withdraw from the study entirely at any time for any reason if they wished to do so.

Participation in the study was strictly confidential. Participants were advised who would have access to their raw data (i.e., me and the University of Otago evaluation team). I outlined the process of what would happen to the recordings, that data would be transcribed and de-identified, and where it would be used following this (i.e., in SURG analysis). There was also the possibility that during the analysis stage of co-production, members of SURG could identify study participants through the proximity of being a youth in Wellington. As a result, only anonymised and de-identified data was presented to SURG.

The research involved interviewing participants who had experienced mental distress, and safety considerations were paramount as there was a possibility that participants could become uncomfortable or distressed during the interview. The interviews were intended to discuss the experiences of the participants in accessing peer support, and the individuals would not be required to disclose their reasons for seeking help. This was discussed with the participants upfront and I stated that they could stop or pause the interview at any time. In practice, there were no participants who expressed distress during or after the interview. Nonetheless, there was a range of advice and support options readily available to participants.

As the research was being conducted in the context of a primary care mental health service, all research participants were part of the Piki pilot and could reach out to their existing supporters if necessary. In addition to this, participants had access to a variety of other accessible services through Piki, such as the phone counselling support line, a mental health app, and their General Practitioner. I also had some skills to help participants manage their distress if necessary. Additionally, I told participants that they could contact me if they became distressed after the interviews and that I could support them to reach out to the interventions provided by the Piki pilot.

Chapter Summary

This chapter outlined the methodology which underpins this research. It described my researcher positioning and the co-production research design. Following this, the specifics of the methods for data collection and analysis were outlined. This was followed by ethical considerations. Results from this research are presented in the following two chapters.

CHAPTER FIVE: UNDERSTANDINGS OF PERSONAL RECOVERY

FINDINGS AND DISCUSSION

This chapter addresses the first research question: how do young people in Aotearoa understand personal recovery in the context of mental distress? The findings from the 26 participants are presented in superordinate and subordinate themes, and a summary of these is outlined in Table 3. Participant quotes are presented alongside analysis, followed by a discussion.

Table 3

Participants' Understandings of Personal Recovery

Superordinate Theme	**Subordinate themes**
Theme 1. Recovery is paradoxical: *"It looks like a stir fry"*	1.1 An arduous journey 1.2 An uncertain destination 1.3 Recovery is effortful 1.4 Reframing, resignation and rejection
Theme 2. Recovery is awareness about yourself: *"A thing that you learn to recognise and learn to manage"*	2.1 Coping and managing 2.2 Maintaining strategies for self-sufficiency 2.3 Doing what is meaningful to me
Theme 3. Recovery is connecting with others: *"A little cheerleader behind you"*	3.1 Personal support 3.2 The right professional support 3.3 Altruism

Theme 1. Recovery is Paradoxical: *"It looks like a stir fry".*

Participants understood recovery to be inherently complex and paradoxical. In the first two subordinate themes, many participants reflected that recovery was both a journey and a destination. The journey (or process) was seen to be long and arduous. The destination (or endpoint) was imprecise and involved multiple holistic factors. The third subordinate theme explored the evident paradox between what participants wanted and needed to do for their recovery, versus what they could do in practice. Participants described recovery as effortful and experienced having to negotiate the challenges resulting from this effort. In the final subordinate theme participants viewed recovery through two prominent lenses; those who felt it was an achievement and the result of overcoming distress, and others who doubted or rejected the possibility of recovery, feeling that it did not represent them at all.

1.1 An Arduous Journey

Participants often described recovery from mental distress as a journey or a *"lifelong process"* (Fiona). Recovery was referred to as something ongoing and non-linear:

> *I think it's just- that it's not a straight line. Like recovery isn't necessarily gonna- and I knew this when I went into this, it's not gonna come straight away after ten sessions of meeting up in a café and talking about stuff. (Lilly)*

This language suggests Lilly expected that there was a journey to be had within recovery. The passage acknowledges the reality of how healing distress can be lengthy. Lilly's hesitancy about recovery could be seen throughout her interview, where she articulated her uncertainty when asked about what it meant to her: *"I honestly, I don't know. Like I'm so far off from it at the moment"*. When she did elaborate, she talked about recovery as a process of learning to manage symptoms, accepting herself and living life well; qualities that are in line with the experience of personal recovery as a journey.

Similarly, other participants also spoke about how recovery was a non-linear process with no endpoint. Many positioned recovery as lifelong, and something that was *"always a changing situation"* (Will). Some used metaphor to describe their understanding:

> *I guess also recognising that recovery's a process and it's… like some days you'll feel like you've made a lot of progress and some days you'll feel like you've kind of slipped back down the hill, but it's always an uphill climb (laughter). (Julia)*

The visual imagery of a challenging climb uphill creates a strong parallel to the experience of Julia's understanding of her recovery. It is fluctuating and ongoing in nature, and she talked about this awareness with jest. Humour can serve as a coping strategy or a defence mechanism against anxiety and may have been used here to soften the overwhelming reality that recovery is a difficult process. Like Julia, Sage stated that recovery is something they are *"still going through"*. Positioning recovery in this way can reflect a certain level of difficulty, as this language is commonly associated with negative experiences in one's life, in particular those that must be endured.

Many participants talked about recovery as an arduous process. They described it as a long, complex experience with multiple different components:

> *My recovery looks, initially it looked scary but it's actually not scary, it's just really frikkin' long (laughter). And it feels so long and so steep, and you just look back and it's just actually long. It looks like a mixture of all sorts of different strategies. So it looks like not thinking before you reach out and contact people, it looks like medication, it looks like meditation, it looks like lots of things. It looks like a stir fry, that's what it looks like. A long as noodles stir fry. (Orla)*

The metaphor of a stir fry encapsulates the complexity of the recovery journey. This image is powerful as it accurately portrays the individual components of recovery and recovery as a whole. Things have to fit together, and Orla described having to incorporate self-agency, external support, and practical elements into this. Zoomed in, these specific aspects, such as improved mental health and symptom management, are some of what is important in her recovery day-to-day. Zoomed out, these aspects are a part of a larger whole, intertwined in a journey that is lifelong and turbulent. Extending this metaphor, just as there are many different stir-fry recipes, so too are recoveries of young people individualistic in terms of the ingredients they deem important, and the mixtures they create.

While many participants felt they were still on their recovery journey, some felt they were recovered. Participants who felt they experienced recovery reflected that their journey to get there was laborious:

> *I was really struggling with my mental health and it took a huge toll on my university work. I just couldn't be motivated, I struggled. And then I sort of felt an uprise, and I was suddenly getting better grades, I was studying more, it was honestly like a huge turnaround […] so it's definitely been a roller coaster. (Nat)*

Similar to other participants' use of a hill and climbing metaphor to illustrate the ups and downs of recovery, Nat described her recovery experience as a roller coaster. In her interview, Nat elaborated that what helped with her recovery was therapy and peer support, where the mental health professionals encouraged her to achieve small goals. Putting this into place, Nat found a flow-on effect, an upsurge, which resulted in further increased motivation across many aspects of her life. Similar to the uphill battle described by Julia and Orla, the use of roller coaster imagery symbolises the non-linear and arduous nature of recovery. The understanding of recovery as a journey was relevant to many participants in this research through the language and metaphor they used.

1.2 An Uncertain Destination

While participants spoke about recovery being a life-long journey, they also used language to suggest there was a finite endpoint where they were thought to be recovered. For most participants, this involved *"overcoming any mental health issues that you have until they're no* *longer an issue"* (Victor). What this looked like in practice varied, and for some, it meant a complete cessation of symptoms:

> *No more antidepressants, no more anxiety attacks in the middle of nowhere, emotional stability and not losing my temper. So it's a journey where you have to fix yourself. (Mia)*

Mia understood recovery as a movement towards an end goal: stability in mood with no symptoms of mental distress. The use of the word "fix" implied that she thought she was in need of repair, which may point to some underlying self-stigma around mental distress. For some other participants, recovery also equated to not being impacted by distress anymore: *"a point where it doesn't affect my life at all"* (Victor). For Lilly recovery meant not taking medication: *"not having to be on pills anymore"* (Lilly). Conceptualised through this lens, recovery is seen as absolute and categorical.

In contrast, other participants' accounts were more nuanced, with some being uncertain that recovery meant no distress: *"I want to say stable but there's no such thing"* (Cat). Again, others pointed to no medication: *"I don't know if I'd consider recovery being off them or not"* (Fiona). This conceptualisation of recovery included participants being more ambiguous and uncertain about what it looked like as a destination:

> *The process of shining a light on certain things that you've been missing or like uncovering kind of thing, and then at the end just kind of like, content, I guess. (Xavier)*

In this extract, Xavier touched on recovery being both a process and a destination, but unlike Mia who believed the destination was being symptom-free, he was tentative about what this meant for him. There is a level of uncertainty around not necessarily knowing what recovery entails, and perhaps he implied that one cannot know until one begins the process of "shining a light". Throughout the journey, Xavier gained knowledge through discovery and curiosity, coming to realisations that led to an endpoint state of contentment. At that point, things that had been in the dark or missing came into full view. This was coupled with reflections and an euthymic mood. It is common for mental distress to be colloquially articulated as darkness (for example, the usage of terms such as a dark hole or dark cloud over you, or described as a black dog). Thus, in this instance, Xavier saw recovery as a journey one takes from darkness to light, which signified healing from mental distress.

Though many participants used similar descriptions of being content, what that looked like varied. Some participants described the end point of recovery as encompassing holistic interconnectedness between the mind, body, and external environment:

> *Focusing on physical health is really important because physical and mental and spiritual wellbeing are all sort of tied into one and if one's failing then they all fail. (Zack)*

Here, Zack stated that recovery incorporated many elements being in balance. He touched on the idea that this interconnection plays out in life, where if one domain is not fulfilled or whole, other domains suffer as a result. Other participants also alluded to recovery being holistic in nature, meaning it involved more than just the alleviation of mental distress: *"a combination of mental and physical"* (Ava) and an *"overall balance"* (Grace). This holistic nature of recovery could be overwhelming for some, such as Orla: *"you don't know where to start and you know everything is everywhere"*. She reflected that this interconnectedness posed barriers to her recovery process, as it was challenging to pick a starting point to focus on. For participants, recovery as a destination was filled with uncertainty and confusion.

1.3 Recovery is Effortful

Many participants described recovery as effortful, where they had the intent and desire to recover, but sometimes struggled with the commitment or capacity to follow this through.

Generally, participants understood recovery as something that required them to persevere and take personal responsibility:

> *It is, for me, a lot of work and a lot of discipline. Discipline is probably the hardest self-love in recovery that you can give yourself, because it's like you whine and you moan about what you want to have, but you're giving yourself what you need to have. And I feel like that kind of recovery, that's recovery for me I think, that is really learning to look after yourself, really, really trying to look after yourself and it's not just you do it once and you're done, it's every day for the rest of your life. (River)*

Here, River articulated what many participants shared: recovery begins by acknowledging that only you can change your situation and this requires hard work through ongoing willpower, grit, and discipline. River equated this process with self-love, meaning that to love and care for themselves, they must do what is right, even when it is difficult. There was a tenderness in the language they used as they described this type of discipline. Caring, looking after, and loving themselves sometimes required them to make difficult choices not only in that moment, but for the remainder of their life. As discussed earlier, this suggests that recovery is an ongoing journey. For River, having this insight was important to maintaining recovery, and this discipline looked like maintaining social relationships, and being self-injury free and was equated to self-kindness.

Having to persevere required conscious intention: *"you need to want to change"* (Will). Some participants reflected that, at times, their discipline fell by the wayside, making their intent to recover difficult to fulfil in practice:

> *Sometimes if you're in that bad of a mental state you're not going to try and change that or fix that, if that makes sense. (Tyler)*

While participants knew that they had to be headstrong to recover, there was a paradox highlighted where they found it difficult to cooperate with themselves. For Tyler, this resulted in a state of ambivalence when they were in the throes of mental distress. Despite their self-described knowledge and wisdom, Tyler showed uncertainty when asked to elaborate on why the paradox might occur: *"I should have an answer for this, but I don't".* This highlights the idea that a young person might, in essence, self-sabotage without necessarily knowing why. Perhaps this self-imposed defiance is a mark of youth, or perhaps it is because recovery is so effortful that it requires discipline and perseverance. It could be argued that these young people became tired when their capacity exceeded demand.

Similarly, other participants spoke about a level of ignorance that meant their intent to recover was obscured:

> *Men can be kind of oblivious to things, in the way that they're acting towards themselves or other people, maybe it's self-destructive behaviour or whatever. (Zack)*

Here, Zack reflected that for men, being ignorant of what they need to do for recovery may be part of the self-stigma they experience. He implied that being oblivious may serve as a subconscious behaviour of avoidance, helping to alleviate internal feelings of guilt or feeling disheartened, but resulting in self-destructive behaviours on the surface. To be disciplined, in this context, is to then be conscious and aware, and that requires effort.

The process of recovery resulted in exhaustion for participants, who also commonly spoke about feeling overwhelmed and discouraged. Because recovery was understood to be effortful, participants spoke about being ambivalent and unmotivated when left to their own devices:

> *It's not like you can magically see a counsellor and they fix all your problems. No, you have to have that from within. But at the same time I need the guidance of being able to talk to somebody about that because otherwise, I'm not going to. I'm just going to procrastinate about my inside problems, I'm just going to push them into a corner and say: "no, not my priority right now, I'm gonna just watch Netflix". (Mia)*

Here, Mia described the importance of external support, which guided internal self-motivation. Without a map provided within a professional support relationship, Mia stated that she would flail and procrastinate. This could be seen as a form of avoidance and may be representative of where she was in her recovery. Given that youth is a turbulent time, having additional pressure of addressing her mental distress seemed overwhelming, which may have caused Mia to abandon this prospect altogether. Netflix viewing is then synonymous with disengagement from her responsibilities, and procrastination which threatened to move her further away from recovery. This is different to being blind to one's faults - it is a conscious decision of having to negotiate the effortful road to recovery versus sinking into distress and ambivalence.

1.4 Reframing, Resignation, and Rejection

Participants varied in how achievable they felt recovery was and were generally split into two groups. Some were optimistic and positive about their recovery. Others were more resigned and pessimistic, doubting that they would recover, or rejected the idea of recovery entirely. Those who were more hopeful in their understanding of recovery tended to feel they had more control over their actions and how they responded to mental distress:

> *I think that it's coming to terms with the fact that you've changed from the person that you might have been before you had these issues. But that change doesn't have to be bad, so realising that you can be this different person who has been affected by mental health, but you can still, you know, be positive. And you can still see what you went through as a challenge that you have managed to overcome. So obviously mental health is always not a positive thing but seeing it in a positive light is really important for recovery, and not falling into self-pity. I feel like the recovery is actually recognising it as that thing that you've overcome as opposed to something awful that's happened to you. (Julia)*

Julia spoke about the power of reframing, where overcoming mental distress was seen as an achievement. She illustrated this metamorphosis and attributed managing to overcome challenges as positive qualities of her identity. She positioned herself as a person who had become stronger as a result of her distress. From this vantage point, she was able to accept herself, her distress and the hard work she had put in. She came out the other side as a different person, thus, reframing her recovery as a positive experience. This speaks to the hopefulness that she possessed about her past and future. Similarly, Sage felt that maintaining *"that hopeful feeling [...] and being able to accept and understand yourself"* was important for recovery. Acceptance for these participants came from framing their mental distress and recovery as something that contributed to their overall growth.

By contrast, those who displayed resignation felt they had little control over their lives and were defeatist about their mental distress. That is, for them, recovery felt like an unachievable goal:

> *I have nothing to live for. When it comes to life and getting old, I just feel numb, like I gotta just enjoy my life because I'm not really getting to anyway. Heck, I don't really have family. All I've really got is my partner and my brother and they both think like me as well (laughter). They don't have any goals in their life, they've got no want to grow up and be old, they don't want kids, they're just here to have fun I suppose [...] now they're just living it out and see how long they last. This whole flat's like that. In a perfect world, in a positive mental health, I would enjoy my life, I would look at it and think: "shit I've only got one of these, I'm gonna make use of it". But at the moment it's the complete opposite: "ah I've only got one, what am I gonna do with it?" I don't really- I don't need it (laughter), but not in a suicidal way, if you get me. It's like it would be cool to die but I'm not seeking it out, it's just life's done its course for me. (Will)*

Here Will displayed a resigned acceptance of his lack of recovery. He positioned his mental distress as something that was undesirable, but inevitable and unable to be shifted. As a result, he reflected that recovery was an impossible feat. His outlook was bleak, and he did not have hopefulness or excitement about the future. Rather, he was perplexed by having to live his life out. He was a passive recipient of life, as opposed to Julia, who saw this type of outlook as self-pity. Throughout the interview, Will (who is Māori) talked about the ongoing effects of intergenerational trauma and his subsequent inability to recover from distress owing to many barriers, despite wanting to do so. As a result, he was resigned to accepting where he was at, and that recovery remained doubtful and unachievable for people like him.

A few other participants rejected the possibility of recovery entirely. These participants alluded to the fact they could not envision whether recovery was achievable for them. For example, Cat spoke about distress as *"the sort of thing that you can't really get away from"* making recovery unrealistic for her. Similarly, Grace stated that recovery was not relevant to her experience: *"I don't know if recovery fits with me"*. Participants who were resigned also expressed that the mental health system was not set up in a way that supported their recovery. Here, Mia stated that services did not match her level of need, given the complexity of her mental distress:

> *Mental health is difficult to explain to someone because if you have a broken arm, you wear it in a cast, you get it fixed and then maybe you see the physio for four to six weeks after. But with mental health, it's like: "look, we can give you ten sessions and then you're supposed to be fixed up". What doesn't seem to be understood is that it's an ongoing process. And it's almost like I feel I'm being discriminated for still being broken because I've been in the system since I was thirteen, so coming up for seven, eight years now, it's almost like well I should be recovered, I should be through this, but I still have all of these issues, it's an ongoing problem. (Mia)*

Mia expressed frustration and rejected expectations placed on service users to achieve recovery in a finite number of sessions. She also rejected the idea that she could recover under the current service model, as she needed ongoing support beyond an arbitrary limit. Mia used a well-known controversial simile of comparing physical and mental health, which sets out her expectation that these two things should be treated as different but are not. The expectation set by services, in turn, made Mia lose faith in her ability to recover. As a result, she internalised the stigma she felt towards herself with her usage of the word "broken". She appeared defensive in her tone and positioned her distress as an "ongoing problem" that she should have overcome by now. Her experience and process of recovery are then challenging and chronic, given that she has spent seven to eight years in the mental health system. She was so far away from recovery, that it felt like an impossible feat. For all participants, the recovery journey involved negotiating their understanding of recovery throughout their distress.

Theme Summary

Participants commonly understood recovery to be paradoxical. They stated that it was both a difficult lifelong journey, and an arrival at an uncertain destination. Recovery encompassed a holistic understanding of who they were as people, incorporating physical, mental, and spiritual domains. Many participants reported that recovery required an ongoing balance of commitment that was not always possible to maintain. Participants also viewed recovery through two main lenses where they either reframed recovery as a positive experience that helped them grow, or were resigned to not recovering, with some rejecting it as a possibility. These findings highlight the complexity of conceptualising recovery, as it was understood to be a multifactorial process and end goal.

Theme 2. Recovery is Awareness About Yourself: *"A thing that you learn to recognise and learn to manage"*

Participants described recovery as involving increased awareness of themselves in order to manage their day-to-day world. This superordinate theme is structured into three subordinate themes. First, recovery was seen by participants as being in control, which included being able to cope and manage when they got distressed. Second, recovery incorporated successfully and confidently using strategies. Finally, recovery meant being able to do the things in life that mattered to participants.

2.1 Coping and Managing

Awareness of specific tools and techniques to cope with distress was discussed as a prominent feature of recovery. Many participants used the language of "coping" or "managing" their distress to support their recovery. There was an emphasis on learning to live with mental distress as part of recovery:

> *I definitely sit in the faction that [mental distress is] not really anything that's cured, it's a thing that you learn to recognise and learn to manage. Like over the years, I've gotten to the point where I can recognise when I'm moving into a depressive sort of episode, or where I'm starting to shift into- "we're going from normal baseline to - ooh quite anxious - and - ooh high risk of panic attack", you know? Start putting things in place if you're capable of doing so or you need to alert somebody that you are not okay. (Iris)*

Iris described an awareness of her descent into distress as part of her recovery management. She provided an example of her internal monologue, which was reflective, and then described the problem-solving strategies she might utilise *"as opposed to just exploding"* (Iris). These shifts from stability to the distress she described were seen by her as an inevitable part of life. What she did have control over was how prepared she could make herself to deal with these eventual inevitabilities. This improved self-reflection, which incorporated recognising symptoms and addressing them, was an important facet of the recovery of many participants.

Many participants felt that recovery meant better management of their distress: *"I don't necessarily think recovered means that everything's gone away but just better managed"* (Kate). This management encompassed multiple things. For example, being functional: *"functional in times of distress"* (Sage); improved mood*: "not feeling overwhelmed by things or weighed down by things"* (Fiona); better control of thoughts: *"more aware of my thought patterns"* (Ava); and coping with symptoms: *"being able to cope with your bad feelings"* (Quinn). Having an understanding that management was important, meant that Iris and others remained vigilant and responsive to their mental health needs.

There was a consensus among the participants that at times life, by definition, became distressing and required coping. Recovery meant that participants were able to manage these natural ebbs and flows, and maintain their balance and resilience. Some used strong language to describe this, like *"not getting tipped over the edge"* (Quinn). Others described it in relation to what coping might look like in practice:

> *Not struggling, not feeling overwhelmed by things or weighed down by things, feeling like you can handle things and things are okay. But if things aren't okay that's not the end of the world and they'll get better and that kind of stuff. […] I think it's a lot about just managing and not feeling like your mental health owns you in a way. Like it's very easy to feel like it does but it's just an aspect of life, it's not everything. (Fiona)*

Here, Fiona described that recovery for her involved living in the presence or absence of mental distress, so long as she could manage and have hope. She described not being owned by mental distress, which personalised her distress, and created a strong imagery around power dynamics between her and her distress. Fiona's language of mental distress owning her, meant that it was easy to get transfixed on (and submissive to) it. For Fiona, remembering that she could disengage from this power struggle was a critical part of her recovery.

Other participants also spoke about how powerful mental distress could be and the importance of not being overcome by it. For example, Ava stated that being functional despite life stresses meant *"not getting totally bulldozed down by life"*. The image of someone being bulldozed speaks to the incapacitating nature of mental distress, and simultaneously described that recovery involved growing resilience to the things that attempted to knock her down. For participants, recovery often meant being in control and being able to cope and manage with their distress.

2.2 Maintaining Strategies for Self-Sufficiency

For participants, recovery involved the ongoing implementation and maintenance of strategies, skills, and techniques they learned along their journey. Many talked about how this provided them with opportunities for knowing how to improve their mental distress:

> *I guess it's one of those things where you mould your new normal. And I think what therapy did for me, was it helped me with the tools to be able to create this new normal and to be able to kind of carve a new path for myself in terms of mental health that is sustainable and it's kind of, it's just incremental changes towards a more positive mental health state. (Penny)*

Being given the right tools to manage distress was instrumental to Penny's recovery. The word "carving" illustrated a slow, precise process. She may have used this word to highlight that change is indeed an incremental and careful process. Thus, it is in these transitional moments from distress to stability that recovery can be attained.

Although mental health professionals may have been there in sessions, long term, participants knew they needed to have strategies they could utilise by themselves if they needed to. It is this sustainable path of self-sufficiency that Penny spoke of here, which is similarly highlighted in other accounts. Ideas around *"being able to be their own counsellor"* (Yoel) or being *"safe to manage on my own"* (Cat) and *"having techniques that you can use when you're not feeling okay"* (Emma) are related to these young people knowing that they had the wisdom and strategies to manage and cope with their mental distress. Self-sufficiency also meant that participants had an internal drive: *"I'm gonna do something better with my day than just being around in bed"* (Holly).

For some participants it was not enough to just possess tools and strategies, they also placed importance on having the confidence to implement these: *"Not only being aware of strategies but not being afraid to implement them to better your mental health."* (Tyler). Confidence was particularly important to participants who had ongoing distress, spanning years of their life. Those who placed importance on having confidence often spoke about being let down by services, and that their recovery seemed further away. Perhaps this is a hallmark of institutionalisation, where young people who have been in the mental health system for longer, felt less confident in their ability to recover.

Participants who consistently and successfully used strategies found that this helped them to prevent relapse:

> *I definitely take better care of myself. I will exercise a lot more, I will make sure I'm actually showering properly and brushing my teeth and I just know that I'm feeling like I wanna be better. Not just going: "oh I haven't showered so I'm not going shower" sort of thing. (Nat)*

Here Nat touched on sustainable self-sufficiency, seeing recovery as something that needs to be maintained. She pointed out everyday things such as maintaining her hygiene, which could seem insignificant to some, but to her, were important for maintaining recovery and preventing relapse into mental distress. These small actions served as clues to her mental state and were, therefore, important in her gauging what she needed. Possessing this knowledge and carry through resulted in her learning to be self-sufficient and aware, and created lifelong positive habits for her recovery.

One strategy for coping and self-sufficiency that a few participants raised was the act of practicing forgiveness to overcome self-stigma. This was an important technique for acceptance of themselves and their recovery:

> *I think letting go of a lot of like- [...] forgiving your younger self for the stupid things that you did. Cos I mean to be fair, you were young, you were a kid and if you keep holding yourself accountable for that stuff, really you're the only one that's perpetuating that and no one else cares, they've all forgotten. Being able to forgive my younger self, being able to take risks and not worry about them not working out [...] And being able to cope with that and deal with that in a way that doesn't mean that I'm gonna be in a slump for the next three weeks, like being able to stay, "okay, that didn't work but that's okay we'll try something else." (Lilly)*

Lilly described being kind to her younger self and accepting what had happened through forgiving herself for her past self. She talked about the need to let go of the guilt and shame she had been carrying, and having to be fearless in taking risks. For Lilly, her self-sufficiency came from trusting in her ability to maintain her coping strategies and reassuring herself. To recover, Lilly needed to be herself, without self-judgement. Through careful reflection, participants were able to be more aware of their strengths and triggers, which created a better environment for maintaining self-sufficiency.

2.3 Doing What is Meaningful to Me

For many participants, recovery had to encompass activities that were meaningful to them. It was not enough to merely cope with their distress and the world; participants also wanted to engage in functional activities that gave them a sense of purpose and meaning that were rewarding. While everyone had different priorities for what these looked like in practice, many, like Orla, spoke about being purposefully engaged:

> *I think it would just be me being more involved in my own life. Like instead of just shutting down and doing things like lying in bed all day and all that stuff, it would be actually taking care of myself, and having a routine, and going to classes more often, and studying more often and things like that. It would just be living instead of hiding I guess. (Orla)*

For Orla, the things that she placed value and importance on were education and self-care. She extended this in what she expressively called "living instead of hiding", which brought forward an image of her interacting with (and being curious about) her world, rather than only existing in the confines of her room. This encapsulated perfectly the recovery she wished to see: her being engaged and present in her life as opposed to living in fear, shame and secrecy.

Similarly, other participants spoke about the importance of engaging in meaningful activities in their lives. For example, being engaged: *"not shutting out the world"* (Brooke), being more present: *"enjoying everything in the moment"* (Grace), scheduling their days: *"having a plan and a routine"* (Zack); and having a sense of accomplishment in personal goals: *"achieving the goals by yourself"* (Emma) were all motivating factors. Others described this meaningful engagement as being future-focused:

> *With depression, my recovery looked like me just basically feeling better about myself, and having the motivation to want to make my life, make myself better, and not wanting to stay in bed all day and not wanting to just survive off bad food. And kind of having a more future-orientated vision of what I was doing, as opposed to a day-by-day sort of thing, which was kind of how it was when you're depressed. (Yoel)*

Reflecting on his recovery, Yoel addressed practical things like regaining functioning as well as being more engaged. He spoke of intentionally making his life, that is, choosing the elements that were important to him and implementing them throughout. Part of what was meaningful to him was a hopefulness about the future: seeing the bigger picture and having foresight into plans. Similarly to other participants, Yoel had an awareness about his recovery needs, which required meaningful activities and plans in his life. Filling life with meaningful pursuits provided participants with increased sense of identity, self-awareness, and future-focussed hope.

Theme Summary

For participants, self-awareness was instrumental to recovery. Recovery involved an iterative process of learning to cope and manage mental distress when it happened, implementing and maintaining strategies learned along the way, and constructing a life that was meaningful to them. All these qualities were important in how these young people understood recovery and shaped their identity. Overall, this theme highlights the reflexivity required to experience and maintain recovery, which must also be situated in the context of what is important in young people's worlds. The awareness that the participants brought to their experiences resulted in ongoing motivation for personal improvement, large and small. For some, just getting out of bed was enough to move towards recovery.

Theme 3. Recovery is connecting with others: *"A little cheerleader behind you"*

This final theme centres around support, professional and personal, as participants understood recovery to involve other people. Participants frequently spoke about living in the context of their environments, and how important it was to have people in their corner in the form of role models in friends, family and support networks. They also discussed the importance of professional support that was a right fit. Finally, some also reflected that recovery involved a connection to others, and hopes of being role models and giving back to future generations in a display of altruism. While ethnicity and sexuality was not explicitly linked to other themes, there were noticeable differences for Māori and/or Rainbow participants within this theme.

3.1 Personal Support

Participants commonly described whānau, friendships, peer relationships and support from their communities as important in recovery. For participants who wanted to open up to others about mental distress, personal support had to come with a condition of non-judgement:

> *It looks like having a solid group around you, whether that's just like one person or if it's like fifty. For me, it's knowing that I always have someone that won't just look at me like I'm an actual mental case when I tell them what's going on. And they'll just sit there and just be like: "okay, that's all good you feel that way, we can do this about it". But at the same time, it's having someone that doesn't suggest everything in the world or being like: "oh you could do this or you could do this or this or this". I'm just like: "but if I've tried that and it hasn't worked, why are you suggesting it to me?!" That's the type of recovery I need. I need people that can acknowledge the progress that I've made, even if it's not the progress that I should've hit, yeah. (Dido)*

The caveats discussed by Dido here involved people being understanding and creating a safe space for her to share in her distress, which then promoted her recovery. Dido placed importance on having social support that allowed her to be raw and unfiltered without any fears. She wanted personal support that was empathetic with some (but not too many) practical suggestions and gave expectations on how directive she wanted her support people to be. She displayed slight irritation in this extract, implying that she had experienced the example she provided where people suggested things to her which she had already tried. She concluded that her supporters needed to make allowances and meet her where she was at that point in time. As someone who struggled with addiction, Dido spoke about periods of sobriety, followed by relapse. She, like many other participants, was insightful about knowing what she needed to do and how she might have fallen short of her own expectations. In this extract, Dido made a request that people around her do not hold her to the same standard of disappointment that she did herself, and rather, meet her with acceptance and encouragement.

Having personal family and community support was prominent for Māori participants: *"a lot of people do require wider whānau support"* (Cat). For some, personal support extended into collectivist healing:

> *If you find people who you can relate to and then talk to as a group, that sense of community can really face those feelings of depression and loneliness, because you actually know that you're not alone and it's not just being told you're not alone and then being left alone, it's that strength in community and that's what so many Māori, Samoan, Pasifika communities have, that massive sense of community. (River)*

Here River (who is Māori) described the importance of community in their recovery. They emphasised a connection to their community as a tool for combating loneliness and isolation: *"you feel so isolated, and all humans want to do is connect".* Similarly, some Māori participants placed emphasis on wider support beyond the nuclear family unit as they did not want to involve their immediate family: *"it's so taboo"*(Emma). Instead, participants showed preference for being able to access support privately. As a result of immediate family stigma, many participants spoke about the importance of kaumātua[10] in their communities as alternative people they could turn to: *"leaders in the Māori community are people you know and people you trust"* (Emma). Kaumātua were in positions of power, and were viewed by participants as being trustworthy, offering guidance and fostering hope of recovery. They also provided a match in terms of cultural identities: *"leaders [the young people] could see a bit of themselves in"* (Dido).

Rainbow participants similarly emphasised the importance of friends, peers, and their wider social community, and frequently highlighted the importance of having supportive people around them to whom they could relate:

> *It's really important for people to be able to see themselves and other people who have recovered and who have gone through that. (Lilly)*

Seeing herself reflected in people who had recovered helped to validate Lilly's identity and lived experience. For many Rainbow participants, having the support of peers within their community contributed to recovery.

In contrast, some non-Māori and non-Rainbow participants spoke of withdrawal from social interaction when distressed, and only regained connection when they were on a path to recovery:

> *When my mental health is bad, when I'm in a really bad place I won't go and interact with anyone, I'll just sit in my room, I won't want to chat with anyone. But I know I'm feeling better when I'm actually actively sitting in the lounge with my parents or my partner or going out to see my friends. (Nat)*

Mental distress was a largely private experience for Nat. She spoke of her social interactions as being a sign that meant she was on the path to recovery. In her interview, Nat described a lack of confidence, and it is possible that she experienced internalised feelings of shame and self-stigma about her distress or feared judgement from others. Her withdrawal is unsurprising, and is similarly reflected in other participant accounts: *"mental health can be really, really isolating for some*

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[10] Respected elders

people" (Julia). Personal support then was something important and desired by participants, whether they accessed it or not.

3.2 The Right Professional Support

Professional mental health support was important to participant recovery. Participants valued the support of mental health professionals, who had a profound impact on participant motivation:

> *It was just nice knowing that there was a little cheerleader behind you saying: "you can do it, you can, you just kinda have to do it though". (Dido)*

Here Dido touched on how useful it was to have someone support her through her distress, while gently believing in her and encouraging her to take responsibility for her life. Many other participants spoke about the positives of reaching out to professional supporters (i.e., therapists and PSWs). For some participants, it was about having a dedicated weekly time to focus on their skill building and wellbeing:

> *Talking to someone who had experience with things that I didn't know that I was experiencing, and being able to identify them, and then being given tools to work on that. I was going through a lot of things that were really- it just felt like it was the end of the fucking world, it just felt so horrible. And it was all cos my anxiety was just all whipping things out of shape. And then being able to talk to someone for an hour who could remind you that actually right in this moment, right now, you are okay and what you're experiencing is very valid, but you can't keep being so hard on yourself. It's simple sentences like that that can really actually change your whole week. It really, really did help having someone who I could go to and would just focus on me and my work that I need to do for just an hour a week. It did make that difference. (River)*

Having weekly access to professional support meant that River could use this time to work on their mental distress. Here, they highlighted the importance of guided self-discovery, along with being given practical tools. River reflected that having space for themselves provided validation and promoted reassurance. The use of "me and my work" suggests that River viewed this type of support not just as something passive that they showed up to, but as an investment that required time and effort on their part.

Similarly, many other participants found it helpful to have a dedicated time and space to talk about their distress. Professional support was important when participants felt they lacked tools to help themselves, and guidance was seen as instrumental in participants' experiences of recovery. Professionals could help untangle mental distress, and normalise and validate experiences*: "just feel like it's okay to talk about my issues, […] and I don't have to be judged for it."* (Uli). For some, having professional support provided an opportunity to learn how to reach out to their whānau: *"it made me wanna talk to people in my family more about how I'm feeling"* (Brooke). All of these things supported recovery in participants.

However, most participants stated that for professional support to resonate, it had to be the right fit. For example, professionals had to be aware of youth-related activities and trends, and up to date on youth references:

> *The person I was talking to didn't really know what Instagram was and so sometimes when I'd explain something there were like gaps in the communication cos she obviously doesn't really know much about social media platforms. (Ava)*

In her interview, Ava discussed that there was a mismatch between her as a young person and her professional supporter, due to the professional not understanding her references. For Ava, this resulted in a disconnect which ruptured rapport.

In terms of tailored support, professionals had to be relatable and non-judgemental: *"someone who has been there as well, or can at least be compassionate to the point where I don't feel judged at all"* (River). They had to see young people in context of their own environments and *"understand that young people don't come on their own"* (Penny). Participants also wanted to be able to see themselves in their professional supporters. Some wanted non-judgemental and compassionate professionals who were closer in age: *"it would be cool to see younger people"* (Xavier); *"someone [...] who's not dismissive, who's not rude, who's not old and someone who actually cares"* (Orla). In short, young people wanted to see supporters who were similar to themselves, who also understood the complexities of being a youth.

The majority of Māori and Pasifika participants wanted professional support from people who shared in their identity and understood their culture:

> *Being Māori and being Cook Island [...] that would definitely feel more comfortable having someone who's from a similar background to them and benefitting from it. (Cat)*

Here, Cat shared the sentiment of other POC participants, who felt that having a cultural match was important to recovery. She related this to being comfortable due to a feeling of familiarity. For Māori and Pasifika participants, having indigenous professional supporters meant that they were able to have implicit trust and rapport from the beginning of the relationship: *"it's super helpful if you can talk to somebody that comes from similar cultural context, cos then they can understand underlying things and implicit things that are implicit to a culture"* (Iris). As Yoel explained, when there was a cultural mismatch this created barriers to recovery:

> *I was looking specifically for a Māori counsellor, because I was also kind of dealing with some stuff related to that identity and, well I didn't get a Māori counsellor. And I think that he sort of struggled a bit to grasp a lot of what I was saying. (Yoel)*

Yoel found that his Pākehā professional supporter did not address some of the specific areas he wanted to work through, which were strongly related to his cultural identity. While he found support around his mental distress helpful, he still felt like there was a mismatch: *"I struggle with Pākehā counsellors. In general it's way more formal and I don't really like how formal it could be".* He spoke about the importance of increasing the professional Māori mental health supporter workforce, in order to culturally match support to Māori men such as himself.

Similarly, Rainbow participants wanted professionals who could reflect their identity. Many Rainbow participants highlighted the importance of having professionals with lived experience of those identities:

> *Having counsellors that share that identity because there are so many things that you're not going to pick up on if you're not part of a group […] You're never gonna fully understand the experience of someone who belongs to a different group to you. […] Like you can teach someone as much as you can teach them and they're still not going to fully understand it and fully be able to empathise if they've not lived it. (Fiona)*

Fiona touched on the nuance, and an unspoken understanding that she felt was shared between Rainbow people, as well as service user communities. She talked about how having professionals who could implicitly understand her experience was crucial to her recovery. She rejected the notion that people could be competent if they have no lived experience as they then could not relate on the level that she needed them to.

If there were no Rainbow professionals available, some participants accepted being supported by professionals who were allies. However, they had to signal being Rainbow-friendly: *"if it was an older person who had a Rainbow flag in their room, then immediately I'd feel a bit more comfortable talking to them"* (Tyler). Tyler, who preferred for their professional supports to share in the Rainbow identity, also felt comfortable with those who displayed overtly that they provided a safer space for Rainbow identities.

For participants who were Rainbow and POC, professional support had to acknowledge multiple factors to encompass an intersectional understanding of their identities:

> *I think what would really help me is to have someone who's Rainbow friendly and who understands from a person of colour's point of view. […] So even if there are psychologists who specialise in Rainbow issues, a lot of the time they're talking*

> *about Western Rainbow issues, and not a lot of people from other ethnic minorities. (Sage)*

In their interview, Sage talked about the importance of having the right professional support, which was tailored to their needs of being a Rainbow ethnic minority. Similarly to Tyler, Sage was content with having a Rainbow ally for a professional supporter. However, for them, it was more important to have a person who understood the importance of an intersectional approach as it applied to their unique identity. In their interview, they spoke of being surrounded by *"Western culture"* and professionals who unhelpfully applied Western concepts when working with them in the past. In terms of how Sage could be better supported in recovery in the future, they stated: *"hire more counsellors and psychologists from different ethnic groups".* In this way, Sage placed priority on building recovery with professionals who were peers in terms of their ethnicity.

A final point of this subordinate theme is that participants highlighted many barriers to accessing professional support. While these were not directly related to participants' understandings of recovery and so were not a major theme in the analysis, these barriers had the potential to affect recovery outcomes, so it is important to briefly touch on them. Most participants were insightful about the mental health service crisis, and the resulting unmet need: *"youth aren't accessing services that they should be"* (Tyler). Participants spoke about a lack of accessibility and affordability in mental health services. Some wanted transparency: *"you can't have any secrets between the provider and the user because it creates too much uncertainty, and when there's too much uncertainty young people just shut off, they're just like: "nah, I'm not dealing with this"* (Lilly). Many commented on how difficult it was to reach out and spoke about experiencing shame, fear or discrimination from professionals: *"going into therapy is terrifying and you're scared of judgment"* (Fiona). Participants described that consistency and kindness from professionals were important. Finally, a few participants shared realistic fears about not having access to youth services any longer: *"what happens if I turn 25 and I still need help, where do I go then"* (Mia). These barriers resulted in stigma, low expectations, and feelings of frustration and despair, all of which worked against these young people's recoveries.

3.3 Altruism

Only Rainbow, Māori and Pasifika participants spoke explicitly about recovery as something that extended beyond them into selflessly giving back to their communities and future generations. For Rainbow participants, this particularly related to their immediate communities:

> *Consistently working on yourself every day to do something, to work on getting better for yourself and your community. So it doesn't just mean I'm going to work on me and then not give a shit about anyone else. It's getting better so that you're in a state where you are […] working as a person who is mentally well to help those who aren't mentally as well as you. And offering that help within your community can grow people together. That's how we fight loneliness, that's how we fight depression, that's how we fight a lot of problems that are caused from our disconnect in this nowadays. (River)*

Here, River spoke about the importance of recovering not only for themselves but also for the people in their wider world. They wanted to support recovery in others through ongoing altruism, which they saw as a key element in fighting isolation and mental distress. Similarly, Tyler stated that channelling their experiences of distress and recovery to *"do good through it"* meant they could contribute meaningfully to helping and supporting others.

Māori and Pasifika participants also spoke about supporting their communities, but their connection was to a bigger picture about recovery for future generations, including their future children:

> *For me, it looks like breaking generational curses or like breaking generational trauma and letting it stop with me. And so dealing with it so that a generation away from me, like my children, my grandchildren don't have to kind of deal with it. Making sure that as I get older I'm dealing with my mental health and my mental*

> *wellbeing the best that I can so that it's not such a taboo subject moving forward in my family in the generations to come. (Penny)*

For Penny, recovery meant putting a stop to mental distress, so her offspring could live with mental wellness. She wanted to see a future where the cultural stigma that currently exists within her community would not negatively affect her family in the future. Her recovery involved collectivism and joint healing. This extends recovery from individualistic attainment to the altruistic connection of also *"being able to look after other people"* (Yoel). Māori and Pasifika participants wanted to extend these connections into being role models who had a *"positive influence"* (Brooke) for other young people, including their own descendants.

Theme Summary

For participants, connection with others, both personal and professional, was an important aspect of recovery. For support to be relevant, it had to reflect the unique needs of each participant. For Rainbow, Māori and Pasifika participants, themes of personal support in relationships extended past the immediate family and into extended whānau and communities. For most participants, professional support had to be provided in a befitting manner, with professionals displaying openness, competency, and commitment to young people. Representation mattered to participants. Thus, seeing themself reflected in their professional supporters was important to fostering relationships that led to recovery. In particular, Rainbow, Māori and Pasifika participants wanted to see themselves reflected in terms of identity, relatability and lived experience, and this came full circle when they were also the participants who wanted to give back to others around them. Overall, this theme highlights that recovery involves not only connection with others, but that this connection has to also be a good fit. Tailored and focused support addressed the recovery needs of the participants, some of whom then wanted to give back to their communities and future generations.

Discussion

This research aimed to answer the question: how do young people in Aotearoa understand personal recovery in the context of mental distress? Overall, participants understood recovery as a complex and multi-faceted construct, which signified a movement from distress to healing. While unique to each young person, there were commonalities between the accounts. Several themes reinforce findings previously identified in international recovery literature and are described below.

Recovery is a Dynamic Process

Participants described recovery as a dynamic process. It was a journey and a destination, filled with uncertainty, hard work, and active engagement. Personal recovery was immeasurable and frequently participants exhibited confusion or not knowing about what they needed or where they were headed. Recovery was personal and unique to each participant and reflected service user literature on this topic. These findings from young people reinforce the corpus of adult and youth service user accounts in recovery literature, where recovery is consistently articulated as complex, non-linear, and personal (Law et al., 2020; Leamy et al., 2011; Ridgway, 2001). As Deegan (1988) states “recovery is a process, a way of life, an attitude, and a way of approaching the day’s challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, re-group and start again” (p. 5). This erratic course is similar to the metaphors used by participants, where they likened recovery to stir fries, roller coasters, and uphill climbs. Professional supporters working with young people need to recognise this as crucial, as the way youth understand personal recovery should be incorporated into treatment planning and ongoing support.

While participants spoke about recovery being a life-long journey they also used language to suggest there was a finite endpoint where they were thought to be recovered. Some described the cessation of distress or distressing symptoms and the state of being recovered was seen as absolute. This definition was more consistent with clinical understandings of recovery as an outcome

(Roberts, 2013; Slade, 2008). However, it has also been captured as important in prior recovery frameworks (Stuart et al., 2017) and research with young people (Law et al., 2020). For many participants, recovery involved management of symptoms and improved mood. That recovery is individual is summarised in definitions of personal recovery, where service users find meaning in what is relevant for them. For example, Anthony (1993) states that recovery can mean both the desire for symptom reduction and management, as well as no more symptoms, and this is in the context of other holistic factors. In literature, recovery has commonly been described as a process and an end goal, which has resulted in artificial separation of the two definitions. However, what is seen through these accounts is that the participants felt that it was both. Perhaps it is less important (and limiting) whether recovery is something we go through or arrive at. What is salient is that the process is all-encompassing and complex, which must be recognised and considered in youth mental health care.

An additional dynamic process, especially to young people, was the establishment of an identity in the context of recovery. The development of identity is a key task of adolescence (Erikson, 1968) and for young people it is in flux (Ward, 2014). Shaping identity in relation to one’s distress and recovery has previously been identified as a core component of adult (Leamy et al., 2011; Slade, 2009b), and youth recovery (Rayner et al., 2020; Simonds et al., 2014; Law et al., 2020). Participants spoke about things that were meaningful to their identities, which supported personal growth and acceptance of where they were on their recovery journeys. Through understanding themselves and what was meaningful to them, participants gained deeper self-compassion and awareness.

Participants also spoke about having to forgive their past failings, and to let go of self-judgement. However, while shaping their sense of self they were also acutely aware of judgements from other people, including whānau, peers, and professionals. This finding serves as a caution to professional supporters of young people. For youth, identity shaping is filled with exquisite sensitivity, and this must be balanced against identifying one's values and meaning. This creates a delicate task for clinicians who support young people to find their sense of self but must do this without judgement, lest young people read this as perceived slights. Furthermore, participation in meaningful activities is crucial to gaining and maintaining a recovered identity, as well as shaping young people's internal compass (Leamy et al., 2011; Resnick et al., 2005). The importance of a values-driven, meaningful life has also been highlighted from the perspectives of service users (Mead, 2014).

Some participants looked at recovery as a holistic and interwoven process, involving mental, spiritual, whānau, and physical health aspects of their identity. The idea of recovery as holistic is supported by prior research, where recovery domains involve not only psychological wellness, but extend into the young person's ecosystem (Barnett & Lapsley, 2006; Rayner et al., 2020). Furthermore, two Māori cultural models specific to Aotearoa that look at this intersection are the Te Whare Tapa Whā (Durie, 1994), and the Meihana model (Pitama et al., 2007). In particular, the Meihana model (Pitama et al., 2007) illustrated that overarching ideologies play a part in how service users perceive and experience recovery. This was true of many participants, who described pressures that were systemic and extended beyond their immediate environment. These cultural models extend our understanding of recovery, and reinforce the importance of applying a holistic understanding of distress and recovery universally, across cultures and identities.

Participants spoke about how effortful recovery was, and how sometimes their capacity exceeded the challenging demands placed on them. The adapted CHIME model captures the difficulties participants described, such as ambivalence (Stuart et al., 2017). The paradox of withdrawal and detour on the recovery journey, has also previously been articulated as a movement towards engagement and active participation in life (Ridgway, 2001). Participants described other paradoxes, reflective of prior research. For example, the dynamic nature of recovery goals at times contradicted the process, and this has been similarly articulated in research of Law et al. (2020).

Given that adolescence is a time for competing and contrasting goals (Patel et al., 2007; Uhlhaas & Wood, 2020), it is unsurprising that the participants of this research described paradoxes of their recovery journeys as new stressors emerged.

Hope has been identified as a key domain of adult recovery frameworks (Leamy et al., 2011; Mead and Copeland, 2000; Slade, 2009b; Stuart et al., 2017). Similarly, the emerging youth recovery literature features hope and being future-focussed as significant and critical to recovery (Barnett & Lapsley, 2006; Naughton et al., 2018; Rayner et al., 2020). However, for the participants in this study this was not a focal point. While some spoke about maintaining hopefulness, most alluded to having hope through the process of acceptance, rather naming it outright. Hopefulness was connected to active participation in one’s life, and a reclamation of one’s identity, which is similar to prior research of first-person accounts (Ridgway, 2001). The finding that hope was not as important for participants, may reflect their stage of recovery. However, it may also be a representation of the context of youth lives throughout this research, which was punctuated by COVID-19 lockdowns and an overarching cultural malaise. Indeed, a few participants displayed nihilistic thinking in regard to their future. Concerns about the future cited by young people have previously included climate change, war, global pandemic, and instability of work and opportunities (Idele & Banati, 2020; Menzies et al., 2020; OECD, 2021; UNICEF, 2021). Perhaps the participants in this research felt the weight of these events, and found it more difficult to articulate recovery as something that involved hope for the future, given the pressured context of their current lives.

Young People Want to be Autonomous Agents in Their Recovery

Recovery has been identified as active coping and engagement in one’s life, which requires agency and autonomy (Ridgway, 2001). The ability for service users to be autonomous agents in healing their distress is central to recovery (Drake & Whitley, 2014; Lapsley et al., 2002). During adolescence, young people navigate increased agency and autonomy (Erikson, 1968). Participants enjoyed having agency over their recovery, and described taking care of themselves, using skills to persevere in their recovery journey. The participants wanted to act autonomously, but also reflected that for them, the support of adults who could teach them skills was important. Prior research has pointed to young people wanting to be in control of their mental distress and recovery, but also that this must match their developmental ability (Law et al., 2020). Participants placed importance on small concrete steps, which is reflective of prior accounts (Bergmans et al., 2009; Ridgway, 2001). The strategies implemented by participants also mirrored a common clinical technique known as behavioural activation, or *personal medicine* as per service user literature (Deegan, 2005). This finding illustrates that having achievable goals supported recovery in these young people, and contributed to esteem growth and increased self-belief.

Prior research has placed focus on the importance of individual responsibility and agency particularly for young people whose autonomy is under threat (Barnett & Lapsley, 2006; Law et al., 2020; Leamy et al., 2011). The findings from this study show that young people took personal responsibility for their recovery regardless of where they were in their journey. Similarly to previous literature (Ridgway, 2001), participants wanted to actively cope and manage their distress, and placed an onus on themselves to do this right. They wanted to trust their recovery process, knowing they had the resources to achieve this. Participants generally had good insight and knowledge into what they needed, however at times the active process of recovery was draining, and they felt disempowered and experienced failure. The results are in line with prior research, where participants also sometimes felt ambivalent (Schneidtinger & Haslinger-Baumann, 2019). To have autonomy over one’s support required ongoing responsibility, which sometimes involved outsourcing support. The finding that participants at times needed to ask for help, is consistent with previous findings, which suggests that young people may be more reliant on their environmental systems than adults (Rayner et al., 2020; Simonds et al., 2014; Ward, 2014).

Some participants felt that recovery was impossible to achieve in their current context. This has been critically discussed before in service user activism (Recovery in the Bin Collective, 2016).

Unrecovery highlights that when we take into account intersectionality, ongoing barriers and discrimination that some service users experience make recovery a moot point. As a result, some people cannot recover due to challenges within their environment and wider social systems. However, this resigned feeling, which resulted in withdrawal and passive adjustment for some participants, may also have been a result of where they were in their journey. Prior research reported similar experiences as part of moving through recovery (Resnick et al., 2005; Ridgway, 2001). Young people have high rates of mental distress, which can lead to NSSI, and suicide attempts and completions. Participants who appeared resigned about their distress, were most distressed about their inability to recover. These were the people that were failed by the current mental health system, and the importance of this finding cannot be underestimated. If we do not provide young people with adequate support, there is a risk that resignation moves to surrender, and lives become at stake. Thus, services must strive to provide wraparound support for young people who are most underserved.

Connection as a Necessity

A key factor of recovery is the movement from disconnection to connection (Barnett & Lapsley, 2006; Leamy et al., 2011). This is also consistent with the literature on youth recovery (Law et al., 2020; Naughton et al., 2020; Rayner et al., 2020; Schneidtinger & Haslinger-Baumann, 2019; Ward, 2014). Participants painted a picture of recovering in the context of their environments. Unsurprisingly, personal and professional connections mattered to their recovery outcomes and distress was amplified during periods of disconnection. In general, the importance of connection is well established for young people. The findings around connection within this study contribute specifically to the paucity of research about Māori and/or Rainbow youth in Aotearoa.

Community connectedness and supportive relationships have been identified as important for the wellbeing of Māori (Carlson et al., 2022) and Rainbow youth (Blair & Pukall, 2015; Huynh, 2022). Māori participants reported ongoing stigma in relation to mental distress. As a result, they reflected on wanting wider whānau support within their communities, for example from kaumātua. This provided participants with a safe space away from the potential or perceived judgment of parents. It also provided cultural matching and allowed mutuality, and an unspoken language through which participants were able to connect. Whanaungatanga[11] has been identified as crucial to wellbeing for rangatahi Māori (Hamley et al., 2022). Thus, mental health services must provide opportunities for this to occur, within a young person's communities. Similarly, Māori participants also understood recovery as something that spanned future generations, and their desire to recover involved collectivist values as previously identified in indigenous models (Durie, 1994; Pitama et al., 2007).

Rainbow participants felt their wider communities were instrumental in their recovery. As part of that, they felt it was important to see their identities represented. They spoke about a need for connectedness with their communities, and the importance of being guided by those who identified as Rainbow and had recovered. This makes sense, given the ongoing discriminatory attitudes Rainbow youth continue to navigate in modern life within their blood families (Salerno et al., 2020), and wider society (Veale et al., 2019). Rainbow youth also experience high rates of isolation (Kvalsvig, 2018), so can garner strength from their Rainbow communities that can serve as a protective factor against distress. Giving back to their communities in the form of altruism was also important to Rainbow participants who derived meaning out of this, and this has been articulated in prior research (Veale et al., 2019). The protective factors for LGBTQI+ individuals provided by peers and chosen families have been previously explored in literature (Blair & Pukall, 2015; Huynh, 2022;Veale et al., 2019), and highlight the importance of considering these as part of intervention and treatment planning.

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[11] Nurturing of relationships

Access to professional support is considered important for recovery (Law et al., 2020; Ridgway, 2001; Slade, 2009b; Ward, 2014). Regarding connection, finding the right professional supported recovery and provided opportunity to build skills for participants. Young people consistently spoke about the importance of having someone who understood them, was non-judgemental, and shared their background. Prior research has similarly identified that these traits are important to young people (Clark et al., 2018a; Gibson, 2021). Mental health services should strive to match clinicians through culture, identity, or shared experience, as this enhances trust for youth and supports recovery.

Links to Existing Youth Recovery Models

While the aim of this research was not to develop or assess recovery frameworks, it is pertinent to understand how these findings translate to the "first attempt" (p. 338) of a thematic model of youth recovery (Rayner et al., 2020), as this is an emerging field. The ecological youth recovery model proposed by Rayner et al. (2020) largely fits with participant understandings of their recovery, as their accounts occur across a range of ecological systems and processes described within the model. For example, participants reflected on themes pertaining to the three ecological systems: personal (e.g., autonomy, awareness, acceptance, empowerment, altruism); structural systems (e.g., participant's immediate environments and connection with peers, whānau and professionals); and macro levels (e.g., the context of fragmented mental health services, overarching ideologies, stigma and prejudice; Rayner et al., 2020).

Findings from participants reflect the five youth recovery processes identified by Rayner (2020). In particular, participants talked about (1) self-belief and resilience, reflecting on their self-efficacy and increased confidence and perseverance. They provided examples of strategies that maintained their (2) responsibility and personal agency in relation to managing and coping. They articulated (3) identity, awareness, and acceptance through the process of finding meaning making. Participants were especially vocal about (4) connections with peers, whānau, professionals and their communities. Finally, participants also reflected on (5) hope and positive expectations. However, this fifth process, which Rayner et al., (2020) describes as a shift from “despair and hopelessness to […] hope and positive expectations for the future” (p. 337) was more nuanced for participants of this study. While some participants did experience this recovery process, a few felt hopeless about their situations and described being unable to recover, which resulted in resignation. These participants had no hope for recovery, but persevered, nonetheless.

Furthermore, the framework proposed by Rayner et al., (2020) did not capture the paradoxical experiences such as knowing what youth need to do to move towards recovery. The framework did not address the act of self-sabotaging (by withdrawing or engaging in unhelpful behaviours) which participants described. Instead, this sentiment is more consistent with findings from Law et al. (2020), who reported that youth recovery involved balancing a number of fluctuating and at times contradictory goals. Furthermore, Rayner et al. (2020) failed to address nuances of cultural and ethnic identities. For participants in this study, cultural concepts were most prominent in relation to connections. For example, Māori and/or Rainbow participants reported the importance of connection and community and seeing these relationships reflected as additional processes towards recovery. The findings from this research contribute new knowledge in relation to these points, and extend the Rayner et al., (2020) framework to incorporate nuances important to Aotearoa youth.

Chapter Summary

The analysis of participant’s understanding of recovery provided an Aotearoa and youth-specific context to existing recovery research. The theme “recovery is paradoxical” described the complexity and dynamic nature of recovery, which was a journey and a destination. It also required participants to persevere and be disciplined despite many challenges. This theme illustrated that participants tended to have a particular perspective around the way they framed their recovery, and this had an impact on how they approached the aforementioned paradoxes. The following theme “recovery is awareness about yourself” described recovery as something participants had to manage in an ongoing way, in part through utilising strategies and engaging in meaningful activities. It illustrated the role of agency, autonomy, and identity formation in relation to recovery. The final theme “recovery is connecting with others” illustrated that participants did not exist in a vacuum. Rather, they required personal and professional support that had to fit with their needs. Some participants also acknowledged that recovery involved giving back to others in the form of peer support and creating safer spaces for future generations to talk about their mental distress. Overall, these findings contribute a novel perspective to the way youth understand mental health recovery. Some of the themes presented in the current findings are consistent with the emerging literature on this topic, while others establish a new precedent and offer guidance for how youth mental health services may become better recovery-oriented through attuning themselves to the unique needs of this population.

CHAPTER SIX: EXPERIENCES OF INTENTIONAL PEER SUPPORT

FINDINGS AND DISCUSSION

This chapter addresses the second research question: what are young people's experiences of accessing IPS? Table 2 outlines the superordinate and subordinate themes of these findings from interviews with nine participants who accessed IPS. The analysis is supported by participant quotes, and links with wider literature are made in the discussion that directly follows.

Table 4

Participants' Experiences of Intentional Peer Support

Superordinate Theme	**Subordinate themes**
Theme 1. Experiences of business as (un)usual: *"It was sort of a strange thing"*	1.1 Uncertainty about IPS as a modality 1.2 Confusion about the reciprocal relationships 1.3 Value of lived experience
Theme 2. Connection through shared experiences: *"I had a confidante"*	2.1 Initial peer fit 2.2 Points of relatability 2.3 Being heard
Theme 3. A tailored practice: *"It's way more personalised"*	3.1 Casual setting 3.2 Adaptable practice 3.3 Radical shift

Theme 1. Experiences of Business as (un)usual: *"It was sort of a strange thing"*

The first theme centres around participant experiences of IPS as something unfamiliar and unusual. Participants expressed uncertainty about what IPS was as a modality and were initially unsure what it meant overall. Participants were also confused about their role as peers and expressed difficulty navigating the reciprocal relationships with their PSWs advocated by the IPS approach. Finally, participants identified IPS as a positively unusual intervention, meaning that it was valuable to them because of its uniqueness, which provided lived experience as expertise and was in opposition to conventional mental health service practice.

1.1 Uncertainty About IPS as a Modality

All except one participant talked about being unsure about what IPS was or what it entailed: *"I don't think I knew what it was before I had it"* (Uli). IPS was something *"completely new"* (Lilly), and the majority of participants were not aware that it was a *"service that's provided"* (Xavier). Only one participant felt she was familiar with the principles of IPS, comparing it to a mentoring scheme she had experienced at school, noting that one of the appeals of that scheme was that participants were of the same age:

> *I had something similar at school where we mentored kids coming into the school as seniors but it was kind of different because it was similar ages, which was kind of nice. (Nat)*

Despite not knowing much about peer support, these participants selected it as a support option at the initial triage. Some cited curiosity as a reason for wanting to access it. A few participants, like Lilly, described initial apprehension about accessing this service:

> *I was really interested in peer support and a little scared about that, but (laughter) I went anyway. […] I thought that I was going to meet up with someone that I knew, like not on purpose, just accidentally […] But also, the idea of meeting with a total stranger and being out in public and then getting to know them, and it's not in a*

> *professional setting, made me a little bit nervous. But then I got there, and I was like: "oh this is actually okay". (Lilly)*

Not knowing how IPS would work initially made Lilly nervous. She did not know how to navigate this intervention due to it being unusual compared to conventional mental health settings. She described feeling exposed due to the public nature of IPS. Nonetheless, her interest in this intervention overrode her caution and resulted in a positive experience for her.

Other participants, such as Orla, praised the unknown:

> *I felt like the peer support would do a lot for me because it was something that I had never heard about before. (Orla)*

Orla was curious to access IPS, precisely because it was new and different. Other participants who accessed IPS despite their lack of knowledge about this intervention, cited openness: "*I was really open to it"* (Mia); and finding conventional therapy ineffective: *"I had a few counsellors and they didn't really do anything for me"* (Xavier). While participants felt uncertain, they had a variety of rationales for accessing IPS and were hopeful that it would be beneficial to them.

1.2 Confusion About the Reciprocal Relationships

As a result of not having a clear understanding of what IPS was, most participants were confused about their roles as peers within the IPS relationship:

> *When you're talking with a peer it can be more difficult because you sort of don't- it's harder to understand the roles that you both have. Versus in therapy, you understand that you're the client and you're here to talk about you. (Victor)*

Victor, who stopped IPS early, described frustration within his experience of IPS, as he felt unclear about the roles. He elaborated: *"I wasn't sure if it was someone else just who wanted to sign up for [support] (laughter), and then we'd meet each other [...] I wasn't sure if they were getting paid [or] volunteering."* For him, it was important to understand the relationship between him as a peer and his supporter. He related it to expectations known of clients in the conventional therapy setting, through the way they are portrayed in the media: *"you sort of understand how therapy works, you've seen it in the movies but with peer support you're not sure"*. As a result, for Victor, his experience of accessing IPS and by extension, engaging in the peer relationship *"was sort of a strange thing".*

Other participants similarly found the reciprocal relationship within IPS an unusual and strange experience, which led to confusion about the bidirectional nature of IPS:

> *I felt like I was almost helping him as much as he was helping me… or like I was helping him more almost. (Xavier)*

Here, Xavier, who found IPS to be moderately helpful, touched on one of the cornerstones of IPS which is mutuality and reciprocity. However, as he was not familiar with this style of intervention, Xavier felt confused about his role as a peer. Similarly to Victor, Xavier stated preconceived ideas about therapy *"when you go to a counsellor there's this expectation of exchange".* This expectation he described previously made it easier for him to engage, as his role in the exchange was clear. However, this was absent for him in IPS. While he stated that overall, his IPS experience was good, he was perplexed by the fact that he also helped his PSW through their work together, and this was evident in his tone of voice and puzzled facial expression during the interview.

Some participants felt that the bidirectional approach of IPS took focus away from them:

> *I often find that sometimes [the PSW] talk a bit too much about themselves […] I will say something and they'll talk about something that they've experienced that's relevant, but sometimes it goes into a tangent for a while. (Cat)*

Here, Cat, who overall appreciated her IPS experience, stated that the tangential nature of her PSW resulted in dissatisfaction for her. She wanted her IPS sessions to be centered on her experience, rather than the experiences of the PSW. In conventional therapies, the focus is on the client; the clinician and their narrative are largely absent from the therapeutic relationship except for a few very conscious and purposeful self-disclosures. IPS counters this. Given Cat (like other participants) did not have a model for what IPS was, and how to be a peer, she felt that her PSW injected themselves too much into her experience of IPS.

In contrast to participants who found the experience of mutuality unusual, and in some cases a little frustrating, a few wanted this to be more prominent in their peer relationships:

> *I was originally told […] that I would also be giving [the PSW] support, cos it's peer support. What I found […] is that it's mostly me talking. It's like seventy percent of the time I'm talking and thirty percent of the time he's talking. And it almost feels like a counselling session where its ninety percent of the time me talking and ten percent the counsellor. But, I want a fifty-fifty or even a sixty-forty. (Mia)*

Here, Mia, who felt positive about IPS, expressed wanting to embrace and commit to the bidirectional nature of the peer relationship, precisely because she did not want it to feel like conventional therapy. In her example, it is her PSW who seems reserved. This theme illustrates that generally, participants had an expectation about how the peer relationship worked, whether it was more in line with conventional therapy, or as Mia expressed, as an equal relationship. Participants experienced differences in the levels of bidirectionality they wanted, which also highlighted differences in how the PSWs enacted mutuality.

1.3 Value of Lived Experience

For participants, IPS offered a different value compared to conventional therapy. Participants commonly drew comparisons between the two approaches and varied in how valuable they found IPS. Some participants found IPS more valuable: *"the best support I was receiving over the last half year… definitely preferred that over counselling"* (Mia); *"it actually fit me better than* *counselling"* (Lilly). In contrast to conventional therapists, the strength of PSWs came from having lived experience:

> *I could talk to the counsellor who's a professional, she'd give me advice and then I could talk to a [peer] supporter who's been through a similar situation, which sort of helped ground that it was normal to be feeling the way I was. (Nat)*

When describing the counsellor as a professional, Nat implied that this is not the case for the PSW. For Nat, this did not negate the value of IPS; on the contrary, she valued the differing strengths of each modality. For her, the PSW's own lived experiences helped to normalise her feelings.

Some participants preferred IPS due to the additional benefits it brought. For example, Julia, who had a positive experience with IPS, appreciated how it addressed practical and social aspects of working through her distress:

> *A therapist can be quite clinical, like they're lovely and I love it, but it's not the same relationship as you would have with someone who's been through it. So I guess the peer support was cool, cos the implication was they'd had dealt with their own stuff, and perhaps they'd gone through things like therapists, and could give their own advice that maybe a therapist couldn't give. And then that social aspect, it was nice to have that person outside of the clinical environment. (Julia)*

Julia described that the IPS relationship provided her with validation and normalised her experience in a way conventional therapy could not. She positioned it as unique when compared to conventional therapy, due to the PSW possessing an insider status, where they had been through the system and could produce insights based on their lived experience. This was in contrast to conventional therapy relationships, where participants saw therapist's knowledge as theoretical (or book smart) rather than lived. The role of PSWs was seen as more practical and experiential (or street smart).

Some participants found IPS less stressful than conventional therapy:

> *I always find that when I go to counselling, it's like mildly stressful cos it's a bit of a thing, whereas this is a lot more casual and it's sort of just yarning with someone that's there to support you, which is cool. (Cat)*

Cat described IPS as not having the same expectations and pressures as conventional therapy. The use of the slang word, yarn, implied that IPS gave space to casual conversation alongside support. Cat found it *"valuable being able to talk to someone that's experienced"* what she had, as it helped her to *"see how they dealt with that and what they did, to help me figure out what I want to do."* (Cat).

Other participants felt similarly that the approach of IPS helped them to remove the pressure often created by conventional services. For example, it removed the fear of being criticised or judged: *"not feeling like you're on the hot seat"* (Nat); and alleviated the conventionally distinct focus on the service user: *"a casual conversation around important things, rather than focus on you the whole time."* (Orla).

A few participants described that they found conventional therapy and IPS were complementary: *"I think they work well together"* (Cat). Many participants described a symbiosis between IPS and conventional therapy:

> *I could bring strategies addressed with the counsellor to my peer supporter, who I felt closer to. And then I could discuss things more in-depth and not worry about asking the wrong questions. So, that was really good. (Orla)*

For Orla, the peer relationship provided a space free of judgment, and safety where she was able to explore and practice skills. She found IPS effective: *"there definitely is a place for it"* (Orla). Similarly, Nat described: *"I could use my strategies [learned in therapy] with my peer supporter"*. Victor described IPS as a supportive space to be more open and vulnerable*: "getting used to talking to someone, a peer, about those sorts of things, opening up"*. Despite this, Victor also stated that for him IPS was *"not as helpful as therapy"*. His perspective illustrated that while IPS provided a unique platform, this was not as effective.

Some participants drew value from IPS, however, its impact was small. For example, Xavier, stated that whist peer support was not transformative, for him it provided a better fit than previous conventional therapy: *"I think it was good, I mean it wasn't life changing or amazing or anything…"* (Xavier). Similarly, Cat stated that she benefited from the intervention but in a *"low-key [...] indirect"* way, which *"hasn't massively influenced me or anything"* (Cat). The varying views on the value of IPS represented that this intervention worked better for some than for others, and that the value of lived experience had different personal implications for participants.

Theme Summary

Overall, participants found IPS initially to be unfamiliar. The large majority of participants did not know what IPS was, and as a result, struggled to understand the peer roles. Some participants were unsure of what outcomes to expect and experienced confusion about IPS's benefits, with a few not finding it beneficial for their distress. While some found it less helpful than others, most participants valued the alternative approach IPS provided, and the perspective their PSWs brought through their lived experiences and experiential knowledge.

Theme 2. Connection Through Shared Experiences: *"I had a confidante"*

The second theme explores the experiences of participants within their IPS relationships. That is, how they as peers connected to their supporters. The first subordinate theme illustrates the beginnings of a peer relationship and finding the right fit. Most participants praised the practice of finding a bespoke fit, however, some did not find this. When the peer relationship was established, it was relatability through shared lived experience that contributed to positive experiences for participants. The final subordinate theme explores what happened to participants when they created a meaningful connection. In contrast, a few participants expressed that their PSWs may not have been an appropriate match, resulting in negative experiences and fractures to the peer relationship.

2.1 Initial Peer Fit

In an effort to find the right fit, all participants who accessed IPS received an initial phone call from the PeerZone service asking them what they were looking for as well as what demographics they wanted their PSW to have. Lilly and Nat were two of the many participants who appreciated the thought that went into selecting their PSWs:

> *[The IPS service] did their best to match me with someone who I was going to feel comfortable with, and who would understand what I was talking about and that was really good. There's a lot of holistic considerations that went into that. (Lilly)*

> *They found what I needed and found someone who could relate to me. I think if they'd gone: "oh here's just a person that's good at helping other people", I think it wouldn't have been as helpful. [...] They asked me: "do I want a male or a female, what sort of issues have I experienced, who I'd be more comfortable with", which was good. They didn't just throw someone at me. (Nat)*

Both Lilly and Nat found that the personalised touch of selecting the right match meant that the IPS was more helpful: *"she was honestly the perfect person for me"* (Nat).

However, in spite of the initial matching of all nine participants, two felt that their supporters were not the right fit because they were not happy with how the relationship functioned. This resulted in both of them wanting to change supporters. For example, Uli, who remained apprehensive about IPS throughout their sessions, experienced the interactions with their PSW as *"awkward"* at times, stating:

> *The peer supporter I was with wasn't perfect. At times I'd be like "oh I wish I could switch" but then I just kept them. (Uli)*

Similarly, Victor did not experience the suitable fit that others did:

> *I found [the PSW] to be a wee bit overly supportive to the point where it seemed […] ridiculous a wee bit. […] Going and talking about things and then getting this enthusiastic feedback… it sort of felt a bit demeaning in a way. (Victor)*

Victor found the relentless positivity and small talk of his PSW challenging. He described himself as someone who wanted to get straight to the point. This contrasted with the approach provided by his PSW and resulted in a lack of connection. Ultimately, he felt irritated and annoyed by his support person. Victor wanted to switch his PSW, but elaborated that the reason he did not do this was due to not wanting to offend anyone:

> *It's sort of hard when you're talking to someone you've been seeing to say, "I'm not enjoying our conversations, can I talk to someone else instead". […] I was quite worried about hurting his feelings or something. Cos it almost felt like we were just like a couple of buddies talking about things, so I was a bit worried about how he'd react to it. (Victor).*

Both Uli and Victor spoke about how they wanted their PSW to normalise the fact that a peer relationship may not always be the right fit. Both proposed that *"emphasising that it's normal to switch people"* (Victor) would have been helpful for them in gaining confidence to request this. For participants, the initial fit with their PSWs was important.

2.2 Points of Relatability

Some participants who had a positive experience of IPS found their PSWs relatable: *"I find the relatability the most valuable thing"* (Cat). Relatability was generally found through mutual demographics and shared experience: *"my peer supporter was roundabout my age and was really funny, and he had similar life experiences to me"* (Mia); For Lilly, relatability to her PSW came in the form of shared identity:

> *I felt like I didn't have to preface half of the things I was saying with a little historical backstory. They just kind of got it. I was talking to someone that was just a little bit older than me, like a few years older, but also part of the Rainbow*

> *community. And I feel like I didn't have to justify why I felt that way and why I was. And when I brought up my confusion in that area, they didn't give me a response like, "oh well you said that you were this so…" blah, blah, blah. It was more like, "no I totally get it, it's so confusing." It was very- like the only way that I can really describe it as warm. It was really warm. (Lilly)*

For Lilly, the relatability in her PSW came from a mutual understanding of shared lived experiences. She found a space of safety with her PSW, despite them being older in age. Lilly described being implicitly understood and not having to explain or justify her experiences. Both peers had a mutual lived experience and the resulting discussions were non-judgemental, tender, and caring.

However, for some participants, the PSWs were not always as relatable as they had wanted. Uli, who did not find their PSW to be *"perfect",* still found relatability in terms of ethnicity, which was helpful to them*: "we were both people of colour so that's what made it a little bit easier"*. Sharing the same demographics provided points for relatability. In contrast, Julia felt a slight disconnect in the demographics and experiences with her PSW:

> *It was definitely nice having someone older. But maybe just ten years older or something. She wasn't ancient or anything but (laughter) someone who had maybe gone through that specific uni experience a little bit closer to the time that I was going through it. […] She understood my feelings, but she didn't understand the situation as much as someone who had gone through that specific thing necessarily would've. And I did really like the fact that she was older because a lot of the time people my age are a bit immature, but I guess it's just like playing with how much older. (Julia)*

While on the surface, Julia put the lack of connection down to her PSW's age. This extract speaks to the lack of shared experience and lack of relatability in terms of understanding Julia's circumstance. Julia was wanting connection, an understanding of her experience, and for her PSW to understand her strife without having to explain why it is occurring. Age is then a surface explanation for the disconnect, which is underpinned by a deeper desire to be understood. Despite her criticism, Julia still found her peer relatable in a meaningful way:

> *It was nice to meet with someone who had gone through their own issues and had overcome them. I know it was really helpful because she understood the feelings behind it, not just the stuff that you're thinking, but those actual feelings of helplessness or not feeling like there's gonna be much change. And so she could talk me through that and tell me: "actually no, there is hope and it does change". So that was really good. (Julia)*

For Julia, PSWs provided validation, normalisation, and a model for future hopefulness. At a time when she felt the most stuck, her PSW was the living manifestation of the possibility of hope, recovery, and change. This shared lived experience was what was both valuable and relatable for participants.

2.3 Being Heard

Participants who experienced a good fit with their PSWs and established relatability felt heard by them:

> *I just felt like I had a confidante the next few times we met. We went on walks and it was just my time [...]. She was such a good shoulder to have there because she was outside of the situation, so I didn't feel like I was burdening anyone inside. So it was honestly so helpful to have her there. (Nat)*

For Nat, the peer relationship evolved into one where she could trust her PSW to be present and listen to her. Similarly, for Julia the peer relationship was built on being heard by way of the PSW giving their full attention and being present:

> *She was super understanding, super respectful. You can really tell if someone's listening, you know they're completely focused on you. And I could tell she was completely invested in helping me go through this. She wasn't checking the time constantly or looking away, she was just focused on me, which was really nice. (Julia)*

Having someone completely present in Julia's lived experience meant that she felt supported and important. Being heard was meaningful to participants. Some participants, such as Orla, trusted her supporter to be tuned into her internal state:

> *[The PSW] would notice that something was wrong cos their job was to get to know you. You live and work with all these other people, but they might not know you at all. So, it was knowing that someone would notice if you went off the rails. (Orla)*

For Orla, knowing someone would hear her if she became distressed meant that she was not alone in her experiences. In the extract, she described a deep sense of isolation within her world, where people around her might not have known who she truly was. Her PSW became a professional who could reflect on her distress when she became unstable - much like the metaphor she used of a carriage going off the rails. Peer relationships that worked best were formed on the basis that the PSWs were good listeners who were present.

For other participants, active listening and engagement also played a part in establishing trusting relationships: *"he was able to refer back to our previous sessions because we had that personal relationship… it's not like he forgot the last session or what we were talking about"* (Mia). Similarly, Lilly also praised her supporter's attention to detail: *"I'd say something and the next session she would have remembered it"* (Lilly). Having a supporter who actively listened to participants made them feel heard and understood.

Theme Summary

This theme explored the connections built between participants and their peers. Participants saw value in working with someone who shared their lived experience and social identity. This theme illustrated that participants valued establishing a relationship and having the right fit of PSWs. It also illustrates what happened for some participants when they did not feel there was a good fit within their peer relationship. In this case, participants wanted the opportunity to change PSWs, however, they did not do this in practice. PSWs were relatable to participants through both demographics (and this helped to establish the initial fit) as well as through a shared sense of understanding of lived experiences and mutual connection. As a result, some participants felt held and heard by their supporters.

Theme 3. A Tailored Practice: *"It's way more personalised"*

The final theme of these findings explores how participants experienced some of the key tenets of IPS through their peer relationships. Participants spoke about how this modality was carried out in a casual setting, with many appreciating this. Most participants also commented on how adaptable IPS and peer relationships were, which meant the intervention was tailored to them. Finally, some participants experienced a radical shift in perspective. This tailored practice supported participants to see their distress in a different light.

3.1 Casual Setting

Most of the participants appreciated that IPS had a more casual and informal setting that was "*less clinical"* (Lilly) within its design. Some, such as Julia, felt that the casual nature of IPS supported them without further stigmatising their distress:

> *I really liked the casual setting. It made it-, I know there's still that stigma around therapy being like: "you're kind of crazy". Obviously, the stigma's decreasing but it's still there. And so it was nice to be able to just go into a really casual place and have a really normal conversation and not feel like I was, you know, cuckoo- that sounds really bad. But you know… (Julia)*

Here, Julia touched on the stigma associated with mental distress and attending therapy - specifically the stigmatising way service users are positioned in society. Her use of the derogatory slur, "cuckoo", was purposeful and highlighted the ongoing stigma that made her feel self-conscious about going to therapy. She was aware that what she was saying could be perceived as problematic, however, she was unapologetic. To her, IPS provided a space to get support without any of the negative connotations that she attached to conventional therapy.

Having a more casual setting sometimes undermined privacy as meetings were held in cafés or public walks. Some participants were not concerned about this:

> *He really felt like he needed to- he wanted to find private places in the café, which was nice of him to have that courtesy. But I didn't really give a shit. (Xavier)*

Xavier appreciated the effort made by his support person but this aspect of IPS did not matter to him particularly. However, for other participants, the casual spaces meant that conversations may not have been as confidential as they wanted. They were able to troubleshoot this with their PSW:

> *At the beginning we just sat in a café but because that wasn't private enough, we were looking at other options. He ended up booking little library rooms […] those were private enough but also still public. It felt like I could talk about stuff that I didn't want the whole world to hear […] I really liked the fact that it was so chill. (Mia)*

Mia discussed finding a happy medium between the casual nature IPS provided, and her need to keep things confidential. Thus, the casual setting of IPS was either positive or neutral for participants.

3.2 Adaptable Practice

In the context of IPS participants consistently praised the fact that their supporters were flexible and adapted to their needs. In practice, all participants negotiated what time commitment worked for them within the peer relationship, with most opting to have weekly meetings. For example, Mia stated that *"the frequency of it being once a week"* was what made IPS most helpful to her. IPS had fewer boundaries compared to conventional therapies, which meant that participants felt supported in their time of need. For example, Nat who had a death in her life, felt supported by her PSW over and above their weekly meetings:

> *She'd text me and she'd be like: "hope you're doing alright," and on the day of the funeral she messaged me to see how I was doing, and it was just a nice little check-in. (Nat)*

This flexibility and availability was reassuring for Nat, as it meant she felt supported during a difficult and distressing time in her life. Similarly, other participants such as Cat found it helpful to know they could contact their supporters without restrictive regulations in place:

> *The person I see, […] they have lots of availability and they made it very clear that they don't have time constraints. You know, if we wanted to hang out and talk for longer, they were okay with that. […] It is good cos like some weeks were not great so it's good to know that I could just text them and have an appointment in a few days. So it's nice, it's reassuring. (Cat)*

Cat's PSW had flexible availability and she appreciated that she was able to access IPS whenever she needed it. Similarly, Uli described the flexibility of IPS allowed for softer boundaries in availability: *"just knowing that I can text them if I'm having a hard time."* This knowledge was reassuring to them.

A few participants felt the adaptability provided collaboration and they were able share in equal power together with their PSWs:

> *It was very much collaborative. The two of us were understanding things a little better by talking about each other and about the process, by talking about it and having that input about it. (Lilly)*

This collaboration meant that Lilly had a say in her intervention, which was adapted and tailored to her. It also provided a space where both peers held equal status, making the relationship more power balanced.

Adaptability also meant that when participants saw their PSWs in real life, it was not as awkward as it could be with other mental health professionals. Mia and her supporter found themselves *"coincidentally at the same barbecue"* where the PSW met her soon-to-be ex-partner.

When Mia went through the breakup, she *"found it really nice that [the PSW] knew who I was talking about and he could put a face to this person".* She elaborated on the soft boundaries of seeing her PSW at the event and the implications this had for her compared to a conventional therapeutic relationship:

> *Everything we do talk about is confidential, but it was nice to see that this is also a person. Whereas with a counsellor it would almost be scary to see somebody at the supermarket: "oh my counsellor's just over there doing some milk shopping!" They're also human but it's just- it wasn't the same because with peer support it's like: "oh you're a person, you have friends as well, we are at the same barbecue, we're friends on Facebook now, like thank you so much for all your help". And I know its professional things, but I found that it's way more personalised than counselling is. (Mia)*

Mia went on to describe that the PSW maintained a professional relationship with appropriate boundaries, which was respected by both parties: *"it's a professional relationship, he is being paid to spend this time with me but it didn't really feel like it, if that makes sense".* Mia felt comforted by the flexibility of boundaries and the balance of professionalism and connection.

Adaptability also came in how supporters approached their sessions: *"I'm a visual learner, so we did a lot of drawing about and discussing, understanding strategies."* (Orla). Within her interview, Orla spoke about how she appreciated that IPS was tailored to her: *"it very quickly morphed into something that was helpful"*. This contrasted with her past experiences of conventional therapies, which she felt were not tailored to her needs. Similarly, for Julia, IPS provided a tailored approach that encouraged her to get out of her comfort zone:

> *She took me to a light festival this one time. So it was nice to get out of my little bubble and actually do activities. Cos I felt- obviously not being in a good place, you're not really motivated to do that stuff on your own. So it was good to kind of have that peer support to help me kind of get out of that place. (Julia)*

Being able to adapt IPS to Julia's needs resulted in her having valuable experiences that she might otherwise not have had. Because IPS was not a prescribed modality, it provided an adaptable and comfortable space between conventional therapy and personal friendships.

For some participants, one potentially negative by-product of IPS being adaptable and flexible was a lack of structure. Even participants who had positive experiences of IPS felt this:

> *Sometimes the lack of structure presented an obstacle because we couldn't really find a place to start off. Or it would get to a point where we would have finished a conversation and it was almost like the response to that was: "okay well what other problems do you have" (laughter). It didn't really irk me but it was kind of awkward. (Lilly)*

Because IPS was not manualised, Lilly experienced awkwardness when conversations came to a natural conclusion. Similarly, other participants expressed that their sessions lacked structure or focus. Some described their experience of IPS as *"more free flowing"* (Xavier) or that they *"just met up together and just did anything from there"* (Uli). The adaptable nature of IPS also meant it was *"unfocused by design"* (Victor). This lack of focus on his presenting problems meant that he did not feel supported, and this was *"one of the reasons why [he] stopped"* (Victor). Although many participants appreciated the adaptable nature of IPS, some felt it was awkward and in the case of Victor, he felt it detracted from the real issues. The adaptability of IPS had to relate to participant needs.

3.3 Radical Shift

Some participants described how the IPS approach provided a radical shift in thinking. For example, Orla described that IPS offered *"a new route to finding out a place that I didn't know that I wanted to go but it was necessary and good."* Others stated that the process was insightful: *"It really helped me to see things in a different light, it really helped me with growth."* (Lilly).

Similarly, Julia stated that IPS provided her with *"new ways of looking at things"*. The PSW also provided Julia with a radical shift in helping her to feel empowered and less alone:

> *You always hear people say you're not alone in this, you know, so many people go through it, but then kind of accessing the service that affirm those statements and be like: "actually, here's someone who has gone through this and who's overcome it" and [...] here's all this advice that I can give to you to become that person who's overcome it, like that was really useful, kind of giving the power back to me. (Julia)*

Through lived mutuality Julia experienced a radical shift in her thought processes. She found IPS allowed her to believe in herself again, as well as a regained sense of autonomy. Engaging in a peer relationship *"made [Julia] feel empowered to [...] take charge of [her] own recovery."* She valued that her PSW provided a new hopeful perspective, which made her feel more in control over her life and future. For participants, the shift in thinking IPS provided allowed them with alternative perspectives and fostered empowerment.

Theme Summary

In practice, many participants praised the casual setting and adaptable nature of IPS. However, some found this lack of containment unhelpful. While there were individual differences between experiences, overall, all participants praised the tailored approach of IPS. Some participants also experienced a radical shift in their thinking, and the equality of power dynamics contributed to these young people feeling empowered in their ability to tackle distress.

Discussion

These findings form the answer to the second research question: what are young people's experiences of accessing IPS? Overall, participants experienced IPS as a positive intervention, which was seen as complementary to conventional therapy and provided alternative value. However, it is important to note that not all participants found IPS helpful. For participants, the value they derived out of IPS largely related to the peer relationship fit and connection, rather than the intervention itself. For this reason, I address the values of IPS as it relates to specific individual differences and personal preferences of my participants. To guide my discussion, I draw on the “critical ingredients” (p. 397) of peer support identified by Solomon (2004), and adapt them to my research. The three adapted critical ingredients of IPS for participants were: fit of IPS, points of connection, and psychosocial support. Given there is a notable lack of international and Aotearoa studies exploring how young people may experience IPS and what factors contribute to positive experiences, these findings provide new insights and address a significant knowledge gap in the area. It is this understanding of how IPS can be applied to youth and work in practice that is valuable.

Fit of IPS

As a modality, IPS did not always fit with participant expectations. As with prior research (Solomon, 2004), participants described that initially, they did not know or fully understand what IPS was and what it involved. They lacked familiarity with the process, values, and content of this intervention. Internationally, peer support is underutilised and widely varied in how it is performed in practice (Mead & MacNeil, 2006; Shalaby & Agyapong, 2020; Watson & Meddings, 2019). Similarly, despite policies promoting peer support as a recovery-oriented intervention (Paterson et al., 2018), the utilisation of IPS in Aotearoa services remains low. Unsurprisingly, participants were not aware of this intervention. Unfortunately, for some participants, this lack of familiarity posed significant barriers to engagement and at times interfered with the IPS process. Those who reported being unsure and confused about IPS experienced anxiety and had different expectations from their interactions. Similar findings are highlighted in the research of Gidugu et al. (2015), where peer support was not commonly understood.

One of the main sources of the confusion stemmed from participants not understanding the reciprocal and bidirectional nature of the peer relationship. Participants spoke about understanding the roles (and *scripts*) of conventional therapy, however, they had no understanding of how to navigate IPS. This created misguided expectations about how the peer relationship functioned and resulted in disappointment for some participants. This supports the conclusion that for youth to engage in IPS, they must first understand what it involves, thus more advocacy and promotion of this intervention are needed (Stefancic et al., 2021).

Participants also reflected on the fit of IPS when compared to conventional services. Some participants felt that IPS and conventional therapy were complementary, which supports existing literature (Bradstreet, 2006; Watts & Higgins, 2017). Relatedly, the participants often contrasted their experiences with PSWs to their experiences with mental health professionals. Therapists were seen to be more formal, closed off, and with stricter boundaries to the therapeutic relationships. Participants felt more at ease with PSWs and were able to bring up topics they did not necessarily feel comfortable talking with their therapists about. This echoes prior findings of PSWs being less formidable, with peers highly valuing the non-clinical relationships peer support provides, as PSWs provide a unique fit that other clinicians cannot match (Gidugu et al., 2015; Walker & Bryant, 2013). Furthermore, some participants found a synthesis between IPS and therapy, where both were meaningful, valuable and complemented each other. This finding illustrates that for youth, IPS can complement conventional interventions, providing enhanced understanding and wraparound support.

Regarding fit of peers, once participants were engaged in IPS, early rapport built with their PSWs was important to the success of the peer relationship. If participants built this early rapport, they felt more connected to and trusting of their PSW. Like any therapeutic modality, participants had personal preferences (communication style, for example) that could not always be matched. This relationship between the peer and the PSW may not have been the right fit for participants in terms of their personal styles. This is an important finding, which has not yet been highlighted in research on IPS. For this intervention to be effective, both peers involved in the relationship need to establish goodness of fit. Thus, it is important that young people are given the opportunity in the early stages to voice any concerns they might have. However, in practice, the findings demonstrate that participants who felt their peers were not the right fit did not want to communicate this to their peers directly. Allowances must be made by peer services for young people to provide confidential feedback and be able to seek alternative support people without concern or guilt. It is in the interest of IPS services to be responsive to the personal preferences of peer to avoid a mismatch of fit, which may result in neither party gaining any value.

A final point in relation to fit concerns the nature of peer relationships with regard to boundaries. This has been explored in prior qualitative accounts (Gidugu et al., 2015). Peer support is adaptable and casual, which has previously led to questions around professional and appropriate boundaries (Dark et al., 2017; Davidson et al., 1999; Hillman et al., 2022; Rebeiro-Gruhl et al., 2016). However, for some participants of this research, the casual nature of the IPS was seen as a strength of the approach. Participants praised their PSWs for being accessible, flexible, and available. They spoke about support being there when they needed it, which has been found to be an important consideration for youth mental health (Gibson, 2021). Flexible boundaries provided the opportunity for participants to feel like their PSWs were there for them. As a result, participants described their PSWs as available and engaged. Despite this, some participants expressed awkwardness and felt uncontained by the flexibility IPS provided. For example, some participants expressed they wanted more structure, guidance, and direction in sessions. These findings suggest that while young people prefer the casual nature of peer relationships, a balance must be struck between being informal and directive. Flexibility provides value, however, it must be balanced with the need of the young person. Thus, tailoring IPS to the individual needs of peers is paramount.

Points of Connection

Understanding what factors are the most salient in acquiring a shared experience connection is a neglected area in the field of peer support research. This may be due to the difficulty in articulating precisely what connects peers. This is reflective of findings in my research, as participants could not point to a single element that connected (or disconnected) them to their PSWs, instead pointing to a combination of factors. This sentiment is further reflected by Ojeda et al. (2021):

> While mental health is often assumed to be the defining aspect of shared experience in the context of peer support, no empirical evidence directly attests to this, and the above work raises questions about what youth prioritize in their relationships with peer providers. These questions might also be pursued with respect to shared experience of particular kinds of systems: for example, having (versus not having) shared experience with child welfare or juvenile justice. (pp. 295-296)

Without a doubt, one of the most important points of connection for participants was the sense of shared experience. However, this was broader than the lived experience of mental distress. For participants of this study, relatability was established on multiple factors, including, but not limited to: demographics, sense of humour, experiences of similar type of distress, age, life stages, and broader shared lived experience. It is important to note that connection through shared experience "does not presume that individuals will indeed have the *same* experience" (Stefancic et al., 2021, p. 38). This was reflective of participant reports, and like in other research (Gidugu et al., 2015; Stefancic et al., 2019) shared experience came in many different forms. Young people wanted to see supporters like themselves who understood the complexities of being a youth. The importance of relatability for young people was also evident in participants for whom IPS did not provide this closeness. As a result, participants disengaged from support.

Shared experience, which extends beyond mental distress, has also been identified as important from the perspectives of PSWs (Stefancic et al., 2019). Similar to the current findings, Stefancic et al. (2019) describe a paradox whereby shared experience is both crucial and not overtly discussed by PSWs and their peers. The authors concluded that the "shared experience instead functions as a source of shared perspective" (p. 913), influencing how PSWs and peers work together (Stefancic et al., 2019). I come to a similar conclusion. Participants wanted to be intimately understood by their PSWs and while points of connection may not have been directly discussed, they culminated in a *vibe* for participants, which transcended categories but served to enhance peer relationships.

Another source of connection came from rapport and trust in the PSWs. It is well-established that youth need to have a good rapport and trust with their mental health professionals (Clark et al., 2018a; Corrigan et al., 2018; Gopalan et al., 2017). In clinical practice, this is commonly referred to as a therapeutic alliance (Beattie et al., 2019; Bhola & Kapur, 2013). However, it has been identified that what young people need from professional support extends beyond this definition. As Gibson (2021) states, young people prefer their mental health professionals to be "closer to what they expected in their friendships […]; a relationship in which intimacy was able to be developed in the context of trust, genuine care, and relatability." (p. 86). For participants, IPS was able to provide this space between personal and professional. Some participants described their PSWs had these qualities and were perceived as almost-friends, despite being aware that PSWs were being paid. The positives of this connection, which is closer to friendship, has been similarly articulated in prior research (Gidugu et al., 2015).

Relatedly, research has previously suggested that for young people to connect, mental health professionals need to have a genuine interest in the young person, with authenticity and relatability being things that young people desire most in their therapeutic relationships (Clark et al., 2018a; Gibson, 2021). Similarly, clinicians' focus on humanity (seeing the person behind the distress) is important to service users (Beattie et al., 2019). For participants of this study who had positive experiences, peer support provided exactly that. As with prior research (Gidugu et al., 2015; Gopalan et al., 2017), participants reported that PSWs showed respect, warmth, empathy, and genuineness. Youth need to feel their clinicians are not merely present, but also share parts of themselves. All of this supports the established knowledge that for young people to derive benefit from interventions, a connection needs to be established first and foremost (Clark et al., 2018a; Corrigan et al., 2018; Gopalan et al., 2017).

Furthermore, research highlights that the relaxed and mutual approach of peer support allows for collaboration and reduces power dynamics between youth and PSWs (Hopkins et al., 2020; Orygen, 2020). Autonomy and agency are instrumental to young people (Gibson, 2021). IPS attempts to dismantle the power differentials that can often be seen between therapists and service users in conventional mental health settings (Hillman et al., 2022; Mead, 2014). This bid for equal status resonated with participants in this research, who spoke about feeling like they had autonomy and agency over their support. For many participants, IPS provided them with an opportunity to experience equality and collaboration within a supportive intervention. This is similar to prior research, which has demonstrated that peer support allows service users to play an active role in their peer relationships (Mead & Copeland, 2000; Watson & Meddings, 2019), and PSWs can support young people in decision-making (Simmons et al., 2017). Some participants were also vocal about the benefits of mutuality within their peer relationships, which was a reflection of equal status. Thus, reciprocity, mutuality, and equal power sharing (foundations of IPS) would serve to enhance the friendship-like relationships IPS provided and addressed things young people needed from their professional supporters. The findings of this research are promising for IPS and support its inclusion in conventional mental health youth services. PSWs, by definition, build a relationship akin to a friendship, which encompasses rapport, trust, authenticity, and relatability - all of which serve to enhance connection and remove power dynamics with young people within these professional relationships.

A final point on connection is regarding undeserved service users. Peer support is sensitive to, and reflective of, cultural diversity and marginalised identities (Burke et al., 2019; Solomon, 2004; Walker & Bryant, 2013). Research with marginalised identities and ethnic minority groups has previously identified that professionals who have similar demographics are valued by service users, as these are traits that help to establish relatability, trust, and provide an added layer of shared understanding (Corrigan et al., 2018; Huynh, 2022; Ojeda et al., 2021). These sentiments are reflected in my research. Participants expressed a preference for PSWs who were matched in identity to them (i.e., both were ethnic minorities and/or part of a Rainbow community).

For Māori participants, cultural matching of the PSWs was important and provided the establishment of connection based on lived experience of not only mental distress, but cultural nuances. The importance of cultural connection has been previously articulated (Carlson et al., 2022). IPS may reduce racial disparities and provide culturally appropriate support (Grant et al., 2018; Simmons et al., 2017). Whanaungatanga is key for the wellbeing of rangatahi Māori (Hamley et al., 2022). Thus, the importance IPS places on cultural connection and relationship-building may be useful in supporting these underserved populations.

Similarly, for Rainbow participants, the ability to have mutual understanding through lived experience of being a minority was important as it provided acceptance and validation - as highlighted in the literature (Huynh, 2022). Research establishes peer support as being responsive to diversity and intersectionality through shared understanding (Solomon, 2004; Watson & Meddings, 2019). Findings from participant accounts supported this, making this modality particularly promising for Māori and/or Rainbow youth.

Psychosocial Support

Prior research identified that peer support provides psychosocial support, which reduces isolation, fosters hope, and leads to increased motivation and empowerment of service users (Chinman et al., 2014; Davidson et al., 2012; Gidugu et al., 2015; Repper & Carter, 2011). This, in turn, serves to move people closer to their recovery goals. Findings from this study are consistent with this established research.

Participants reported that PSWs helped to address distress and contributed to emotional, psychological, and social support. For example, participants reported that PSWs engaged in strategic disclosures, which served to normalise and validate participant experiences. This finding is similar to Gidugu et al. (2015) and Walker and Bryant (2013). The use of disclosures in peer relationships provides valuable expertise and has previously been highlighted in research (Marino et al., 2016; Simmons et al., 2020). Disclosures build emotional safety and connection, facilitate trust, and inspire individuals to be more hopeful and future-oriented (Solomon, 2004). Participants reported that they felt better heard and understood by their PSWs, in part due to their disclosures and reflections on mental distress. For participants, the main value of IPS was in PSWs having insider and experiential knowledge. Consistent with previous research, participants valued the expertise of their PSWs, which was lived rather than theoretical (Davies et al., 2014; Simmons et al., 2020). This shared lived experience is unique to peer support and is valuable because it cannot be replicated in other professional mental health relationships (Gidugu et al., 2015).

Through the emotional support provided by PSWs, participants felt empowered to take charge of their recovery. Peer support helps to counter stigma and promotes self-acceptance, leading to greater self-efficacy and a cohesive sense of self (Burke et al., 2019). Consistent with prior research (Stefancic et al., 2021), PSWs remind participants of their strength and resilience. Consistent with the goals of IPS, some participants were able to shape their values, identities, and to understand their distress in a different light as a result (Mead, 2014). For participants, this resulted in increased motivation, which has been identified as a valuable outcome in prior qualitative research into peer experiences (Walker & Bryant, 2013).

Like most conventional therapeutic modalities, IPS provides emotional support to the people who engage in this intervention. However, what is of value is understanding that it does so through a unique perspective not commonly used in clinical practice. PSWs draw on their knowledge of navigating distress, and this provides intimate and delicate emotional support. PSWs are the living manifestation that things do get better, recovery is achievable, and this is inspirational to young people. This method of emotional support is valuable as, unlike theoretical research of treatment outcomes (that therapists commonly draw on), lived experience cannot be as easily negated or dismissed.

Additionally, it is well established that peer support provides social support and a sense of belonging, which contributes to wellbeing and recovery (Barker & Maguire, 2017; Drake & Whitley, 2014; Mead & MacNeil, 2006). One of the primary consistent values of peer support is that it enhances social networks resulting in an increased sense of connectedness and an improved social functioning (Gidugu et al., 2015; Solomon, 2004; Walker & Bryant, 2013; White et al., 2020). Participants of this research commonly spoke of the source of connection IPS provided where they were genuinely heard and understood - factors that have previously been identified as minimising loneliness and isolation (Davidson et al., 2012; Shalaby & Agyapong, 2020; Stefancic et al., 2021).

Participants reported that PSWs acted as mentors and role models for them, which is consistent with prior research where peers learned and were inspired by the social interactions with their PSWs (Gidugu et al., 2015; Solomon, 2004; Walker & Bryant, 2013). Having social support meant that participants were less isolated and provided social inclusion (which has been identified as crucial for recovery; Gordon, 2017). Consistent with prior research (Fuhr et al., 2014; Grant et al., 2018), PSWs provided participants with behavioural modelling and social learning, and disseminated resources and advice based on their lived experience. As a result, some participants felt more empowered and in control of their distress.

PSWs provided practical support through their lived knowledge of resources and services they have previously found helpful. This value of *street-smarts* has been previously articulated in other research (Gidugu et al., 2015; Walker & Bryant, 2013). Participants were able to have coffee in a casual setting with their PSWs. They could go for walks and engage in social activities usually reserved for friendships. This finding is related to prior research, where peer support provided an opportunity for new social possibilities and activities (Gidugu et al., 2015). Similarly, participants reflected that they engaged in experiential learning with their PSWs - the importance of this is highlighted by Solomon (2004).

These findings on how IPS promotes psychosocial support are important for youth, who exist in the context of their environments. Professional supporters need to be aware that skills built in therapy need to be applied to the individual's environment. However, clinicians may have boundaries that make providing support in the real world challenging. For example, one participant spoke about going to a light festival afterhours with her PSW, an event which would be unlikely to occur with a conventional therapist. Thus, PSWs can bend the boundaries of conventional professional relationships. This allows young people to practice with their peers in real-time to explore, learn, and make mistakes while simultaneously receiving guidance and support.

Chapter Summary

The analysis of youth experiences of IPS was a first of its kind in Aotearoa. The first theme "experiences of business as (un)usual" explored IPS as a modality. For participants of this research, IPS was a practice that was unfamiliar at first. This theme illustrated the confusion and uncertainty some participants felt when accessing IPS and demonstrated that lived experience had merit and value for young people. The theme "connection through shared experiences" described the opportunities and challenges of peer relationships. Participants were more likely to have a positive experience if they found their PSW to be relatable. However, this extended beyond simply matching demographics. When participants found a good fit, they felt heard and supported. Others who did not find IPS as helpful, felt there was a mismatch between what they needed and what their PSW could deliver. For participants who did not connect with their PSWs, specific demographics or traits were not an explicit issue, but the disconnection represented an inherent difference in experience - with norms, values, and relatability, for example. The final theme "a tailored practice" explored what practically happened within peer relationships when IPS was used as a framework for peer support. Most participants appreciated the personalised and adaptable approach their PSWs could provide through IPS, with some experiencing positive radical shifts in thinking, thereby empowering participants to take charge of their recovery. Taken together, these findings highlight that IPS could have real value in the youth mental health space. PSWs can instil hope and empowerment in young people, but only if there is a genuine connection within the peer relationship. As a result, there are distinct barriers that will need to be overcome if IPS is to be promoted as a youth intervention. As such, the following chapter makes suggestions for how this can be achieved.

CHAPTER SEVEN: CONCLUSIONS

This research contributes to a novel body of work, highlighting my unique contribution to theory and practice in this under-researched area. In this final chapter, I address the findings of my research synergistically, drawing on the related ideas that emerged from both analyses. Here, I aim to answer the question: what does recovery mean to youth, and is peer support one of the ways we can get there? First, I discuss three main conclusions, and their implications, including how IPS may support recovery. I then provide recommendations for future policy and practice. Following this, I discuss the strengths and limitations of my research and provide suggestions for future research direction. Finally, I come full circle and end this thesis as I began, with my reflections on the research findings. I situate this work in the context of lived experience throughout.

Conclusion One: There Are as Many Recoveries as There Are Young People

The participants of this research described recovery as a nuanced, dynamic process of working towards a betterment of self. This included gaining autonomy and agency over one's distress and establishing one's identity and self-esteem. On the whole, recovery involved gaining empowerment, having a purpose, strengthening values, engaging in meaningful activity, and being present in the world. However, there were significant variations of what this looked like in practice. Recovery was complex, multifaceted, and not easily defined. As with adults, no two journeys were alike, and each young person had specific factors they prioritised. For example, young people who were at different stages of their recovery had different understandings of how it applied to them. Additionally, an important role of the professional was to create a vehicle through which young people could find inspiration and hope that their situation could change.

The implication of these findings is that professional supporters need to be attuned to the vast variations across young people as their recoveries are unique, rarely mirroring each other. Practically, it is important to seek an understanding of what matters to young people in their personal recovery. Being a youth requires a delicate balance of fluctuating and at times contradictory goals, which change throughout development (Law et al., 2020). As they set off on their recovery path, young people’s priorities are likely to shift as they discover more about themselves through this process. Thus, opportunity should be provided for young people to regularly reflect on their goals and understanding of recovery. Applying rigid intervention approaches will not suffice. Instead of being prescriptive, professionals need to be patient and rid themselves of preconceptions of what young people need. We must support young people on their journey of self-discovery at their pace.

However, before we can support young people on their recovery journey, we must first understand where they want to go. It is also important to enquire about what recovery looks like as a destination for each young person. Do they see themselves living a life completely free of distress, or is recovery about learning to cope and manage? What do they prioritise and see as meaningful in their current life? Being curious without making assumptions or judgements is key. Even if the goals of a young person are inconsistent with the realities of life (e.g., not having any distress, ever), professionals must take care not to invalidate young people’s hopes and dreams for their recovery. Perceived judgement or criticism may lead to disengagement. On the contrary, being open and collaborative will lead young people to re-examining their own ideas of what recovery means to them in their own time, and provide valuable self-reflection for them.

One of the ways we can support young people in their complex and unique recovery is through IPS. This modality has the necessary flexibility for a youth context through its focus on supporting peers to take charge and articulate what is most valuable to them. IPS prioritises personalised goals and reflexive thinking (Mead, 2014), which may serve as useful in working with young people. Peer support can also help with self-stigma as young people navigate their identities (Scholz et al., 2017; Worrall et al., 2018). Furthermore, IPS provides role models in the form of PSWs, who are living manifestations of recovery being possible. This may resonate with young people, promoting identity formation and fostering hopefulness through the peer relationship. Supporting recovery in young people requires a flexible, person-centred approach. IPS can also be adapted to the needs of young people in a way conventional practice may not, addressing their nuances of personal recovery.

Conclusion Two: Connection is Central to Youth Recovery

One of the most salient findings from this research was that for young people, recovery does not happen in isolation. The participants often spoke about the importance of connection throughout their recovery journeys. Recovery was about connecting with personal and professional support in the context of one’s environment. Young people desired to feel heard and understood by their supporters. Some expressed being dismissed by conventional services, which was a point of disconnection. Furthermore, recovery involved friends, whānau, peers, and communities. Young people relied on their external networks to provide support, validation, and connection.

The findings from this research also add substantially to our understanding of connection specifically for Māori and/or Rainbow youth. Young people, who are still developing their identities and sense of self, likely benefit from having access to people like them. For youth who are consistently disadvantaged and discriminated against, having peers and professionals who share some of their characteristics adds to their sense of belonging. This implication is important as marginalised youth are the most in need of support.

For professionals, the implication of these findings is twofold. First, recovery cannot happen without a young person feeling a sense of connection to their professional supporter. Relationships, which are underpinned by trust, intimacy, and a mutual understanding need to be formed before recovery can happen. Thus, professionals need to be friendly and prioritise building rapport prior to implementing interventions that address distress. However, this may be difficult in conventional therapeutic relationships.

Second, professional supporters should strive to help youth build connections within their lives with people like them. Participants (in particular Māori and/or Rainbow young people) describing things important to recovery consistently articulated that having a shared identity with their mental health professional was important. This was further supported by experiences of participants accessing IPS, and the importance of purposefully matched peer relationships. Thus, PSWs, in their non-homogeneity, can provide support to marginalised minority groups, serving to enhance and strengthen these underserved identities.

A central process of IPS is its focus on connection and relationship building. Thus, IPS may serve to support recovery in young people by providing elements of connection and understanding they require. Indeed, IPS has been shown to reduce isolation (Worrall et al., 2018) and provide social support (Davidson et al., 1999). Similarly, the recovery narratives of PSWs have been found valuable in supporting recovery (Rennick-Egglestone et al., 2019). Recovery narratives are a crucial point of connection. Through them, PSWs are able to share in the distress of young people as they have lived experience in this area. PSWs know and understand the arduous nature of recovery and how distress can result in a sense of isolation and darkness. This feeling of connection transcends a specific shared experience, but rather it is an unspoken truth that can provide comfort and inclusion.

In this research, young people reported they valued and connected with PSWs sharing their lived experience stories. While this is a cornerstone of IPS as a modality, a broader implication of this finding can also be generalised and applied across conventional therapy. In clinical practice, clinician self-disclosures are still treated tentatively and are generally discouraged (Ross, 2022). However, for young people to feel connected, professionals must be relatable. Thus, all mental health professionals working with youth should bring parts of themselves and their experiences into the room. As such, opportunities for training clinicians in how to incorporate self-disclosures with clients are warranted. Furthermore, clinicians who have lived experience of mental distress may provide a crucial conduit between peer and clinical worlds (Watson & Meddings, 2019), which can be a valuable resource for young people. Connections are meaningful and foster hope, breaking through the façade distress creates, which helps to support youth recovery.

Conclusion Three: Recovery is Everybody's Business

Recovery occurred in the context of young people's ecosystems and involved multiple ecosystems (as in personal, systemic, and macro; Rayner et al., 2020). Participants described individual personal responsibility for their recovery. However, recovery also involved many people and systems in a young person's life. For example, participants commonly spoke about relying on resources outside of themselves that involved peers, communities, professional support, and wider mental health services. Participants were articulate about the mental health system crisis, and some described this in the context of how existing practice and policies affect their ability to recover.

Additionally, recovery was seen as holistic and involved a balance of management across young people's ecosystems. Some participants described needing to have control over who was involved in their support, due to systemic pressures. For example, some Māori participants disclosed not wanting to share their distress with their immediate family due to family stigma, instead wanting support from kaumātua in their communities. Furthermore, at the macro level, recovery required collaboration between different services to provide wraparound support. For example, participants spoke about a symbiosis between conventional therapy and IPS, which suggests that these may be effective as complementary interventions but are currently part of a fragmented mental health system.

The implications of this finding is that addressing youth distress and supporting recovery needs to occur with regard for the young person's ecosystem. At the personal level, recovery involves young people taking personal responsibility and being given the necessary tools to self-regulate. Mead and Copeland (2000) reflect that having the right skills and resources (that includes support as needed), can empower service users and make them autonomous agents in their recovery. However, as described by participants, having tools alone may prove ineffective if young people do not have the confidence or knowledge to apply them. Thus, guiding young people so they can learn how to support themselves is crucial.

Furthermore, services need to be better responsive to the developmental needs and environmental factors that exist in a young person's life. Professionals should guide young people through navigating their worlds, rather than usurp agency and prescribe who is involved in the recovery process. It is important to ask about the extent to which young people want their friends, whānau, and communities involved. Young people may need wraparound support from multiple sources, however they are experts of what helps and hinders within their systems, and their decisions should be respected. Additionally, services need to provide (or at the very least, suggest) additional or complementary options of interventions for a holistic approach.

Participants described engaging in behaviours which were unhelpful to their recovery. A conclusion from this is that sometimes youth recovery involves stumbling and self-sabotaging. Making mistakes should be the rule, rather than the exception. The right for a young person to fail is part of the recovery journey that contributes to growth. Indeed, this point is well articulated in service user literature:

> Each person must find what works for them. This means that we must have the opportunity to try and to fail and to try again. In order to support the recovery process mental health professionals must not rob us of the opportunity to fail. (Deegan, 1996, p. 97).

Professionals need to be responsive to young people's need for balancing autonomy and asking for support. Thus, young people should be encouraged in taking risks, with the knowledge that support will be there if they fail. Whilst taking responsibility for one's recovery is important, systemically services need to work alongside the young person and share in some responsibility.

IPS is a modality that can support young people across all levels of their ecosystem. PSWs can foster personal self-efficacy; attend to systemic needs; and advocate for their peers at the macro level. IPS considers people in the context of their environments and approaches distress holistically. It acknowledges that recovery does not merely fall on the individual and supports service users through navigating the challenges of one's environment (Mead, 2014). As such, it is built on the understanding that recovery does not fall on a single individual's shoulders.

Conclusions Summary

Supporting young people's recoveries involves personalising approaches as every recovery journey (and destination) is different. It also highlights that collaboration and connection to the young person in working out the details are key. Furthermore, recovery requires ongoing support for holistic wellbeing, and exists across young people's wider ecosystems. Findings also demonstrate that IPS is an intervention that can enhance personal recovery in young people and minimise distress. IPS provides a flexible and personalised approach where each peer relationship looks different according to the needs of the peer. It can extend beyond conventional therapy and provide additional resources that young people value in their recoveries, such as understanding, internal awareness and external connection.

Recommendations for Policy and Practice

Participants in this research spoke about how they felt mental health services were not set up in a way that was conducive to recovery. Furthermore, IPS provided them with a valuable alternative away from the biomedical model of practice. The findings from this research indicate that IPS may provide opportunities to target current unmet need in youth services. However, promoting IPS as complementary also means addressing the significant structural challenges of the systems that govern existing mental health services (Hopkins et al., 2020; Simmons et al., 2020). It also requires discussion on where IPS might fit within existing conventional practice.

In Aotearoa, the current system of youth mental health services are not fit-for-purpose and a redesign is necessary (Every-Palmer et al., 2022). Presently, publicly funded mental health services in the community are split into two levels of care. At the first level are primary care services, which include General Practice and non-Governmental organisations. To access support at this level, young people must first enter largely clinical spaces and advocate for themselves. At the secondary level are specialist mental health services for those who are considered to have *severe* or *complex* needs. However, access to these services is slow, time-limited, and age-bound. These services are also increasingly difficult to navigate in practice and exist in a system that rarely supports recovery-oriented practice (Drake & Whitley, 2014). For this reason, it is important to include alternatives such as IPS, as they can provide a sense of connection and support young people's unique recovery journeys.

IPS has a place as a complementary practice. To support our young people within mental health services, it may be useful to staff in primary and secondary services with PSWs, who can provide an alternative complementary perspective to conventional practices. PSWs trained in IPS can bridge the gap for those who are aging out of CAMHS services, as they may have lived experience and understanding of this stressful process. Furthermore, recent research suggests young people do not seek mental health support more than once (Every-Palmer et al., 2022), so it is particularly crucial that we have services that are responsive to the needs of young people. As participants of this research spoke about the anxiety they feel in accessing clinical spaces, it may be warranted to provide alternatives in the community with IPS that is established and set up within non-clinical, service user-led services. This may be more enticing to young people who prefer a less clinical and more casual approach.

IPS can be amalgamated into new youth mental health service design. However, to ensure IPS is truly respected, services must first engage in collaborative efforts to support this modality and the PSWs who provide it (Mutschler et al., 2021; Shalaby & Agyapong, 2020). Staff in existing conventional services need to be familiar with the underpinning theory of IPS to avoid discrimination against PSWs. Similarly, services that include IPS as a complementary or alternative modality should ensure that young people are knowledgeable about what this intervention involves, to allow for familiarity and informed consent. The tenets of IPS should be explained to young people to manage expectations about the process, and so that service users are able to get the most out of this intervention. Furthermore, it is also apparent that personal preferences play a big role in whether IPS is well received by service users. This should be a consideration in the early matching process between peers and their PSWs.

An important consideration in future peer support practice should be on finding an appropriate balance between flexibility and structure. Findings indicate that young people are divided in their views on whether they like more or less flexibility. The framework of IPS provides flexibility to tailor it to the needs of peers. However, flexibility can lead to a lack of clarity for young people. It is important that in the future IPS can incorporate clear focus and goals for individual peers while maintaining its nimbleness. Having some structure is positive, as it can allow PSWs to move through its four central tasks (Mead, 2014). It also means IPS can be measured in a systematic way (which can contribute to its growing evidence base; Penney et al., 2021). However, in the youth space, structure is not always desirable. Indeed, one study that utilised the IPS model found that PSWs reported this approach was too restrictive for a youth setting and advocated for more flexibility in their work with young people (Hopkins et al., 2020). Thus, personalising IPS to each young person and their preferences is important.

The findings from this research contribute to the emergent study of youth peer support and provide promising implications that suggest IPS may be a useful intervention for this age group. Nonetheless, IPS is not a panacea for a broken mental health system. More funding is needed for peer support services and acute support alternatives that employ PSWs (Stefancic et al., 2021). However, more funding is needed for youth mental health services generally (Every-Palmer et al., 2022). Instead of removing existing services, IPS should be promoted as an additional and complementary modality. Furthermore, we must also address social inequity to increase personal recovery (McDaid & Kousoulis, 2020). Otherwise, some service users will remain forever unrecovered (Recovery in the Bin Collective, 2016), regardless of which mental health supports are available. Finally, there needs to be more diversity across PSWs and mental health professionals more broadly. This means creating equity through funding opportunities, as well as providing flexibility within mental health training programmes, so the sector reflects the diversity of the young people we support.

This research is topical, given the newly announced focus on reviewing how the Aotearoa systems currently work for young people (Office of the Auditor-General, 2022). IPS can help to enhance existing services; provide a valuable alternative for young people; and provide the paradigm shift necessary to support youth recovery. IPS can transform the power held by services and lead to more humane mental health services (Hopkins et al., 2020; Kemp et al., 2020). IPS is a recovery-oriented practice and improves factors associated with personal recovery processes (Stefancic et al., 2021). However, a number of changes across policy and practice must occur before IPS can be successful. All these changes must serve to address the current gaps and fragments within the youth mental health care system.

Research Strengths, Limitations and Future Direction

This research was guided by two exploratory questions:

1) How do young people in Aotearoa understand personal recovery in the context of mental distress?
2) What are young people's experiences of accessing IPS?

To support exploration of these questions, I utilised an innovative methodological framework that involved an understanding of personal recovery, co-production with youth service users, and an IPS approach to analysis. Through the collaboration with SURG, the study participants, my service user academic supervisors, and my own lived experience, this research applied a lived experience lens on psychological concepts and offered a unique perspective that incorporated service users at all levels of the research. Overall, it was an original way of working on a doctoral thesis. As with all studies, there are key considerations in forms of strength, limitations, and future directions that are discussed below in two categories.

Co-production in Research

The first set of considerations is concerning the co-production that occurred with SURG. While I intended to honour co-production as best as I could, ultimately, this research did not lend itself well to a co-production approach by virtue of being a doctoral thesis. This thesis is in partial fulfilment of the DClinPsych degree. This qualification is inherently individualistic and while I benefitted from the input of SURG, ultimately, only I will be named for this achievement. From the beginning, I engaged in planning this research with my supervisory team, writing a research proposal from my singular perspective. While this is a customary requirement for doctoral work, this went against co-production principles. It also meant that questions pertaining to my doctoral thesis, such as “what are we looking to solve”, “who should be involved”, and “what approach should we use” (Roper et al., 2018, p. 2) were largely predetermined before the involvement of SURG. This constraint is a limitation that runs in direct opposition to the nature of co-production, where the voices of SURG should have been equal from the beginning.

Additionally, budgeting constraints and scheduling challenges also limited the richness of the co-production. This is a known ongoing challenge in service user-controlled research (Russo, 2012). I was primarily reliant on funding for SURG from the University of Otago, which meant I had limited financial resources in how much I could involve the group. As a result, I worked with SURG during the phases I felt most crucial – the design and analysis phases of this research. Due to these budgeting constraints, we were unable to hold more (or longer) meetings, which may have provided further depth to the co-production process. Furthermore, I relied on the support and understanding of my supervisors, the University of Otago, and the wider Piki Project to allow for co-production to occur. This meant that I had to consider not only the voices of SURG but the wider context of this research.

While the co-production that resulted was imperfect, it was the best I could do with the resources available, and reflected my desire to "transform power and control" (Carr & Patel, 2016, p. 16) within my academic position. The requirement of having the highest degree (to have clout in the academic community) is a common pressure experienced by service user researchers (Russo, 2012). I was able to use my privileged position to prioritise marginalised youth voices from various academic backgrounds. In particular, employing Māori and/or Rainbow young people through SURG supported recommendations for advancing equity in rangatahi Māori leadership (Clark et al., 2022), as well as elevating queer voices traditionally undermined in clinical psychology literature (LeFrançois et al., 2013). This also meant that through analysis, the SURG was close to the data, which is a positive hallmark of service user-controlled research (Russo, 2012) and strength of this work. So, although co-production was limited, it was beneficial to have it in some form, rather than not having it at all.

Future Direction

Researchers should not shy away from co-production, despite the many challenges it may present. These limitations to co-production within my thesis are not unique. Indeed, Roper et al. (2018) outline several similar challenges and state that "the right level of support and influence is needed to ensure [co-production] can happen" (p. 11). Researchers are in a unique position to decide whose voices we centre through the power we hold. Young people must be involved in their own research for findings to be relevant and applicable (McGorry et al., 2013; Stubbing & Gibson, 2021). As such, youth service user voices need to be incorporated more prominently in future research, with special care taken to ensure they are involved at all stages of co-production. They must also be adequately reimbursed. Furthermore, researchers must be aware of ethical considerations that may arise when collaborating with service users. In particular, autonomy, anonymity, and integrity have been identified as necessary components of ethical collaboration (Oye et al., 2019). This research has demonstrated that co-production can be applied in a doctoral thesis setting, however, it must be further adapted to create future successful youth research.

Research Methods

The second category of considerations speaks to the research methods. In particular, there were limitations to participant recruitment. While I aimed to contact potential participants across a variety of genders and experiences, reaching out to around 400 people in total, the final participant sample was reflective of the list I recruited from. For example, there were significantly fewer males who gave consent to be contacted for potential interviews, so the pool of potential male participants was smaller and few males responded to my contact. Similarly, gender-diverse individuals were not represented on the list of potential participants. As a result, my research was gender imbalanced, with few young men and gender-diverse individuals.

Similarly, as IPS was a small component of the wider mental health pilot, only a small portion of young people accessed this intervention. Among those who accessed IPS, even fewer people accessed it in isolation, with most opting to have supplementary conventional therapy. The participant sample is representative of this reality. Additionally, the findings around IPS experiences from this research are representative of only one peer support service that was part of the pilot programme, Piki. Thus, the findings from participants only relate to experiences of one specific service, PeerZone. More research into IPS as it is delivered in other services may be warranted to draw stronger conclusions on its utility for youth.

Additionally, while this study aimed to elevate underserved voices from two priority groups: Māori and/or Rainbow, they could have been better represented. While I oversampled for these demographics, it is likely that my findings pertaining to Māori and/or Rainbow experiences may have lacked depth and nuance. The reason is that these are voices from only a few individuals, which were analysed alongside other youth voices. The findings from these two groups do point to potential differences in how these young people experience recovery and IPS, and therefore more targeted research is needed.

Future Direction

My method provided a platform for recovery-oriented research. This creates several opportunities for future research. Personal recovery in young people is in its infancy and requires further attention. More qualitative research is necessary to know whether emergent youth recovery models are supported by lived experience and can be generalised into recovery-oriented practice. Longitudinal studies examining youth recovery over time are also necessary to understand how the priorities change and how we can support personal recovery in young people in an ongoing way. More research is also needed with specific underserved populations, such as Māori and/or Rainbow youth. Future research should prioritise marginalised groups, with a separate detailed analysis for each rather than incorporating them into the wider sample. A sample of more homogenous groups can provide findings that are nuanced and may have specific clinical applications in advancing equity. Additionally, there are several other priority groups (aside from Māori and/or Rainbow youth) that warrant further recovery research.

The current research also aimed to serve as a starting point for youth experiences of IPS and has provided some important findings. Despite this, more research into youth IPS experiences is needed for stronger advocacy for the inclusion of peer support in mental health services (Hopkins et al., 2020). As described earlier in Chapter Three, care must be taken in research on peer support, as studies are often misguided and tend to compare apples and oranges. Future research needs to be clear in describing the peer support interventions being evaluated, and assess their value in a way that is consistent with their theoretical underpinnings.

Further research is also needed to explore Māori and/or Rainbow youth experiences of peer support as these populations may find IPS particularly helpful due to the importance they place on identity, connection, and mutuality. The model of IPS also maps onto a recently developed cultural model, Te Tapatoru (Hamley et al., 2022). This model was developed in conjunction with rangatahi Māori and prioritises whanaungatanga as central to youth wellbeing through three components: reciprocal connection (ko wai); meaningful connections (he wā pai); and genuine activity/process (he kaupapa pai; Hamley et al., 2022). These three components are nearly identical to the central tasks of IPS and their united utility should be considered (Mead, 2014).

Relatedly, the topic of ongoing health disparities for rangatahi tāngata whaiora Māori requires attention (Clark et al., 2022). One future research direction involves understanding how we can bridge the gap between kaupapa Māori and service user-informed recovery frameworks. Indigenous frameworks, such as Te Whare Tapa Wha (Durie, 1994) and the Meihana model (Pitama et al., 2007) formulate lived experience through a similar lens to that of personal recovery and peer support by situating distress within a wider societal and ideological context. Thus, research into the intersection of cultural models and peer support may be fruitful in producing findings that contribute to the redevelopment of youth services.

Closing Reflections

In the final months of working on this doctorate, a friend ended his life by suicide. While tending to my grieving heart, I examined my own prejudice and response to my research (Shaw, 2010). Amid my frustration, I found it impossible to see the point of what I was doing. It felt futile, irrelevant, and insignificant. My academic life and the conclusions I was trying to draw were so far removed from reality, where service users are continuously let down by mental health services and suicide rates in Aotearoa have been rising since 2014 (Coronial Office, 2019).

I wanted my thesis to come from an area of strength as so much of what is written in this field is deficit-focused. But in some way, I perpetuated these deficits in my thesis. For example, I spoke about youth distress to establish an argument that research in this area was warranted. But the truth is, those of us who have battled our shadows do not need an academic justification to prove that mental health services consistently let down people in distress. The way these services are built creates a rotating door that offers only temporary relief. We talk about mental health needing to be holistic, but those who need ongoing support are cast aside and there are not enough trained people to support consumers within their environments. While there are caring professionals and helpful resources, often what clinicians are practically able to offer is counter to what service users truly need. We, in this field, let people down, causing them to fend for themselves, alone. I speak from experience of being on both sides of the fence.

It is in this loneliness that distress multiplies like a hydra. When one is suddenly plunged into darkness, containing distress becomes a daily battle. Every countered thought and action multiplies, leaving the person completely exhausted. This is why peer support is crucial. Service users intimately know the weight distress can have. They understand that to be in recovery is a constant battle. PSWs have been exhausted themselves and appreciate the continued effort that is necessary to combat and manage distress. They have been there and can serve as a beacon of hope for those who are in the midst of turbulence.

Within my methodology, I use the metaphor of weaving a theoretical framework with three threads. However, there is a fourth thread, thin enough to be barely noticed that I have merely touched on. This final thread is the mutual understanding of sorrow. This is the thread that can make IPS so relatable and provide an unspoken bond. An understanding of sorrow implicitly connects our lived experience and permits us to breathe out in relief when we are in the company of our peers. It is also the thread that ties me to the shoulders of giants on which I stand. It connects me to this research and allows me to persevere while literally burying my friends. This is the shared experience that has been entirely elusive to researchers who have applied rational, clinical methods to attempt to understand why IPS works. Madness is, at times, irrational, and its significance cannot be captured in a RCT.

Throughout the past three and a half years, I have become a more sensitive researcher and clinician, continuously examining my privileged position. As a result, as an early career psychologist, I have become much more sceptical of the field I am now entering. This profession is riddled with misunderstanding and stigmatising views. Clinicians still need guidance on how to be more empathetic towards their clients. For example, we are still having to be told to balance professionalism with humanity (Beattie et al., 2019), something that should have been long embedded into our 21st century practice. This is why, as a profession, clinical psychologists ought to continuously interrogate the models from which we work. We should also maintain reflexivity on whether we are perpetuating paternalism and coercion within our own practice. We need to actively acknowledge the risk of harm we may pose to service users when we do not think about systemic factors critically. Furthermore, a major overhaul to address the discrimination that exists within our profession towards our colleagues who have lived experience is needed (Victor et al., 2021). We cannot be part of a paradigm shift if we continue to perpetuate prejudice and stigmatise our own peers. Moreover, if we are not part of the paradigm shift, then we cannot support young people in the way that they need, nor can we advocate for recovery-oriented practice or promote alternative approaches such as IPS.

In the month before this thesis was sent for submission, the Government announced funding to the value of NZD$115 million dollars for the development of an adult acute mental health inpatient facility (Bathgate, 2022). This was seen as a success for mental health services by the general public, however service users were dubious (BINZ, 2022). The building of this unit implies an overwhelming preference for keeping mental health services medicalised and service users outside of their natural environments. While adult acute inpatient services are outside the scope (and perhaps, directly in opposition) of the topic addressed in this research, this thesis sits in the context of this reality, where investments continue to be made into services at the bottom of the cliff that are outside of personal recovery understanding.

Personal recovery takes place through feeling understood, having autonomy, and empowerment over one’s care. Recovery requires interrogation of what is valuable and meaningful, which creates a map for this journey and provides a destination point. Personal recovery also takes place in the context of systems: our immediate and distant relationships, our communities, and our environments. For the young people in this research, being connected to themselves, their external environments, and the possibilities of their futures were consistent protective factors against distress. The responsibility for an individual’s personal recovery falls on everyone. Of course, there is personal responsibility, however, our communities, mental health services, and Governmental policies must acknowledge that we exist in overarching systems where tāngata whaiora are routinely disadvantaged. Our mental health support is based on the biomedical model and disregards intersectionality. Our research spaces elevate Eurocentric thinking and disregards indigenous and marginalised voices. Our worth is valued according to our productivity. Our overarching ideologies make it near impossible to recover if one does not share in a specific constellation of privileges.

I draw this thesis to a close with words from Pat Deegan (1988), a service user, advocate, activist, researcher, and clinical psychologist who has been a source of my inspiration throughout the past three and a half years: “We cannot force recovery to happen in our rehabilitation programs…. However, we can create environments in which the recovery process can be nurtured like a tender and precious seedling” (p. 5). I strongly relate to this sentiment, as I see the current mental health system in Aotearoa as forcing recovery in an unsuitable environment. Instead, we must first tend to the soil by dismantling our prejudice towards mental distress, then foster the recoveries of our young people like the delicate seedlings they are, encouraging them to grow. And as we tend to them, we must provide the necessary trellises of support, so that each young person's recovery can emerge in full bloom.

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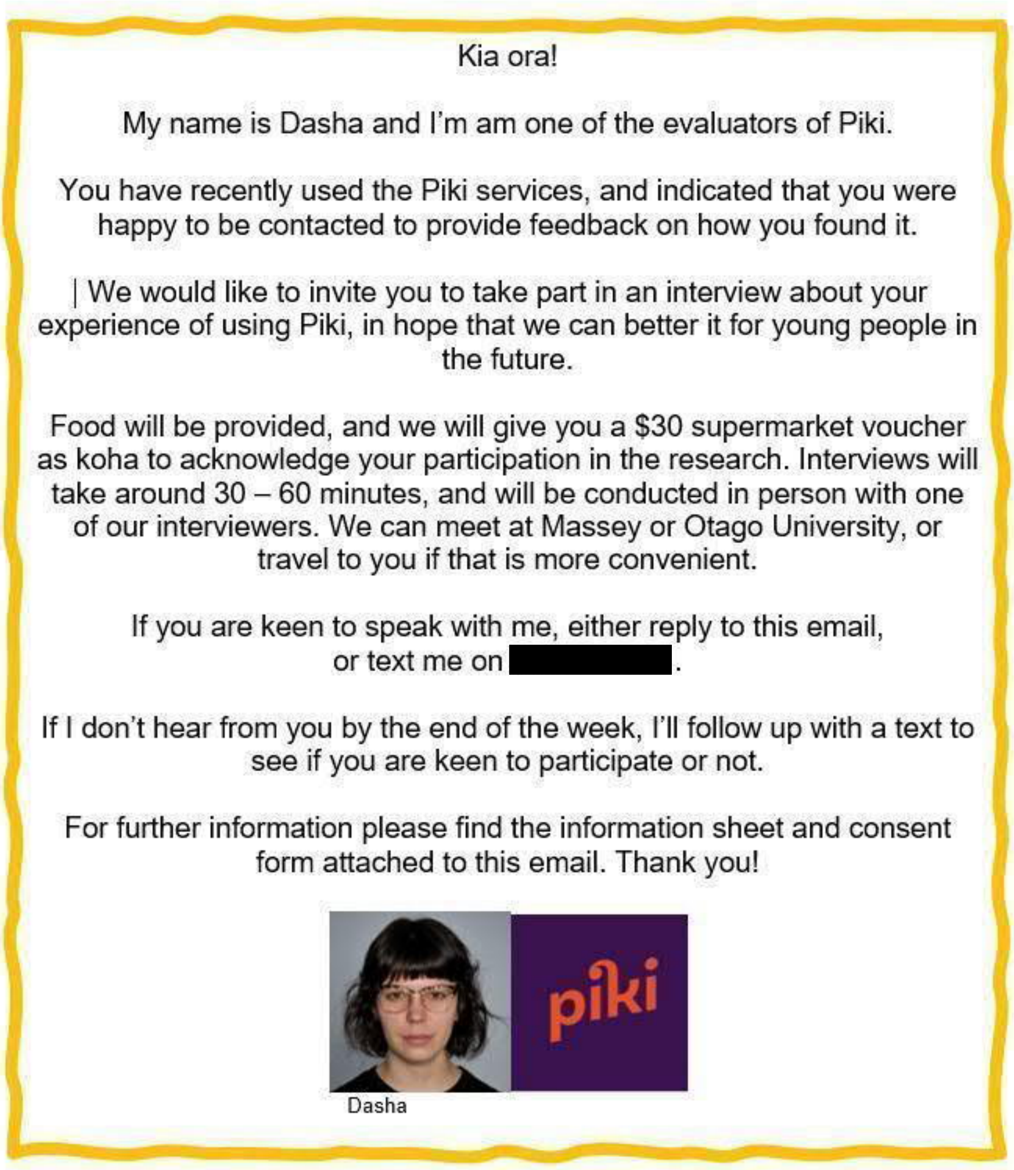
APPENDIX A: Message Sent to Potential Participants



Kia ora!

My name is Dasha and I'm am one of the evaluators of Piki.

You have recently used the Piki services, and indicated that you were happy to be contacted to provide feedback on how you found it.

| We would like to invite you to take part in an interview about your experience of using Piki, in hope that we can better it for young people in the future.

Food will be provided, and we will give you a $30 supermarket voucher as koha to acknowledge your participation in the research. Interviews will take around 30 – 60 minutes, and will be conducted in person with one of our interviewers. We can meet at Massey or Otago University, or travel to you if that is more convenient.

If you are keen to speak with me, either reply to this email,
or text me on [redacted].

If I don't hear from you by the end of the week, I'll follow up with a text to see if you are keen to participate or not.

For further information please find the information sheet and consent form attached to this email. Thank you!

Dasha

APPENDIX B: Participant Information Sheet

Study title:	Piki Youth Mental Health Pilot Evaluation Research		
Locality:	Wellington	Ethics committee ref.: (H19/044)	
Lead investigator:	Tony Dowell	Contact phone number:	021 270 1617

Introduction

Please read this information sheet carefully.

As a service user/client of the Piki Youth Mental Health Service, we invite you to take part in an interview and/or group discussion to comment on your experience of the service. Whether or not you take part is your choice. If you don't want to take part, you don't have to give a reason.

Before you decide, you may want to talk about the study with other people, such as colleagues, family, whānau, friends or health care providers. Feel free to do this. If you agree to take part in this study, you will be asked to sign the Consent Form. We will give you a copy of both the Participant Information Sheet and the Consent Form to keep.

If you decide to participate, we thank you. If you decide not to take part, thank you for considering our request.

Why are we doing this research?

We want to ask you about your experience of the Piki youth mental health service. This research will help us to understand how well the Piki service meets the needs of clients, and will help us to improve similar services in the future.

Please note: The focus of the interview will be on your perceptions and experiences of the service, not your own personal experiences of mental distress.

What are we asking you to do?

We are asking you at this point to participate in an individual interview. The interview will be approximately 30-60 minutes long and will be audio-recorded and transcribed for analysis. We may also ask later if we can do a second interview with you or ask you to participate in a group discussion.

What about travel costs?

We will give you a petrol or grocery voucher to acknowledge your participation in the research and help with your costs if you need to travel to the interview or group discussion.

What are the possible risks of this study?

If you feel uncomfortable discussing your experience at any time, you are free to change the topic, or stop participating and leave the interview. You don't have to give a reason, and it won't affect your health care. If you experience any mental distress as a result of participating in the study, please contact one of the research team.

What happens if I change my mind later?

If you want to take part now, but change your mind later, you can withdraw your consent. You don't have to give a reason, and it won't affect your health care or disadvantage you in any way. (Please note: We may be unable to remove all records of your contributions once we have started incorporating them into our data analysis).

What will happen to my information?

All your information (including recordings and transcripts) will be treated as strictly confidential. It will only be accessed by members of the evaluation team or by professional transcribers, and will be securely stored at the University of Otago, Wellington. It will be kept for a minimum of 10 years and an indefinite period after the study is completed.

We will protect your privacy, and will not name you in any report or publication. We will do our best to ensure that all information is made anonymous in any publications or future research by removing any details that could identify you. This includes your name and names of others that you mention. When no longer needed, your study records will be destroyed securely.

We will give you a copy of the written transcript of your individual interview so you can check the content. We will also send you a brief report giving the results of the evaluation if you have requested this.

Research Funding and Ethical Approval

This project is funded by the Ministry of Health. The study has been reviewed by and granted approval by an accredited Health and Disability Ethics Committee.

Who do I contact for more information or if I have concerns?

If you have any questions, or concerns or complaints about the study at any stage, you can contact:

Tony Dowell	Phone: 021 270 1617	Email: tony.dowell@otago.ac.nz
Sarah Gordon	Phone: 021 134 6816	Email: sarah.e.gordon@otago.ac.nz

If you want to talk to someone who isn't involved with the study, you can contact an **independent health and disability advocate** on:

Phone: 0800 555 050 Fax: 0800 2 SUPPORT (0800 2787 7678) Email: advocacy@hdc.org.nz

This study has been approved by the University of Otago Human Ethics Committee (Health).

If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (phone +64 3 479 8256 or email gary.witte@otago.ac.nz). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.

APPENDIX C: Participant Consent Form

Piki Youth Mental Health Service Evaluation

Please tick to confirm the following:

1. I understand that this study involves taking part in one or more one-to-one interviews.	Yes ☐
2. I have read and understood the information sheet or had the study explained to me. I have a copy of the information sheet.	Yes ☐
3. I have had the opportunity to ask questions and am satisfied with the answers I have been given.	Yes ☐
4. I have had the opportunity to use family/whānau support or a friend to help me ask questions and understand the study.	Yes ☐
5. I understand that taking part in this study is voluntary and that I may withdraw at any time without it affecting my health care or participation in the main study in any way.	Yes ☐
6. I understand that the interview will be recorded and transcribed and that any information about me collected as part of this study is confidential. I understand that no material that could identify me will be used in any publications.	Yes ☐
7. I know who to contact if I have any questions about the study in general.	Yes ☐
8. I am happy to be contacted for a second interview.	Yes ☐
9. I would like to receive a brief report on the results of the evaluation.	Yes ☐

Declaration by participant:

I agree to take part in this study.

Participant's name:

Signature:

Date:

Declaration by member of research team:

I have given a verbal explanation of the research project to the participant, and have answered the participant's questions about it.

I believe that the participant understands the study and has given informed consent to participate.

Researcher's name:

Signature:

Date:

APPENDIX D: Question Zones

Piki Youth Mental Health Service Evaluation Question Zones –

Service Users / Clients

The question zones below show the content the researcher aims to cover in interviews with service users / clients of the Piki Youth Mental Health service.

The specific selection and wording of questions will be responsive to various service user groups and individuals – in particular those who have accessed only peer support (PS); or CBT; or a combination of both PS and CBT.

Differentiation between specific topic areas to be explored at different time points in the evaluation are yet to be determined. Likely questions and prompts are listed below in broad question zones.

Question Zone 1 – Introduction / Background

- Introduction and overview of the interview question zones

- Brief background information i.e., demographic details, voice ID

- How did you come across Piki?

- What steps did you take to get the support you needed?

Question Zone 2 –Experiences of support accessed

- Have you accessed mental health support other than Piki before? How did it shape your perception of mental health services?

- What made you want to engage with Piki?

- How smooth did the Piki referral process work? How accessible was it?

- Did you engage with other services Piki offered (1737 and Melon) before seeking [the intervention] support?

- If yes, how helpful did you find the online/phone services?

- What made you engage with this [the intervention]?

- How have you found [the intervention]?

- What did you like about [the intervention]? / What didn’t you like about [the intervention]?

- Were things explained to you in a way you understood? (the process of Piki or the process of CBT or what CBT was)

- What would you change?

- How well do you feel your support person addressed your concerns?

-Did you feel heard and respected by your support person? In what ways weren’t you? How could they do this better?

Question Zone 3 – Recovery

- How did [the intervention] help your distress? What was most helpful to you? How have things improved?

- Is there anything you would have liked from [the intervention] that you didn’t get? What would you improve?

- What does your “recovery” look like to you?

- How would you describe your mental health before the intervention? What about now? How has it changed since?

-Have you found coping mechanisms? What are they?

- Has using Piki been helpful?

- What tools were you taught by this [the intervention]? How did you find them?

- In what ways has the Piki service improved your mental wellness (if it has)?

Question Zone 4 – Improvements

- Would you use [the intervention] again (if you need it)

- How could the Piki mental health service for youth be improved?

- How can mental health services for youth be improved more generally?

- How do you imagine positive mental health for yourself as you get older?

- Any other thoughts?

APPENDIX E: Research Case Study

RESEARCH CASE STUDY

Reflections on research experience and clinical practice

Dasha Fedchuk

Massey University DClinPsych Candidate Student ID: [redacted]

Clinical Psychology Intern with Mental Health, Addictions & Intellectual Disability Services 3DHB

This case study represents the work of Dasha Fedchuk during her research from 2019 to 2020 and clinical reflections as an Intern Psychologist in 2021.

Abstract

Youth of today have high rates of mental distress due to the unique stressors individuals within this age group face. The need for mental health support is increasing, yet services are unable to keep up with demand, and youth are disproportionately affected as they lack resources to seek alternative support. To address this increasing demand, the Ministry of Health provided funding to develop and pilot a mental health service for youth of Wellington, New Zealand, Piki. Designed to address the gap in service provision, Piki was also comprehensively evaluated as part of its development. The current case study provides a brief overview of my qualitative co-produced doctoral research, which focused on youth service user understandings of recovery, and their experiences of accessing peer support through Piki. I provide a summary of my research to date and comment briefly on the process of engaging in co-production within my doctorate. Following this, I provide reflections on how my research experience has informed the development of my clinical practice as an Intern Psychologist, working within the DHB across Consultation-Liaison and Kāpiti Child and Adolescent Mental Health Services in 2021.

Doctoral Thesis Overview

My doctoral research topic focused on evaluating youth service user understandings of recovery, and their experiences of accessing peer support through the Government-funded mental health pilot service, Piki. This overview includes a summary of the development of the thesis topic and its rationale, and the process of engagement in co-production with youth service users throughout the research. This is followed by an overview of the aims and methodology of the study.

Thesis Development

In 2018 I worked at the Department of Psychological Medicine in an Assistant Research Fellow/Assistant Programme Manager capacity. Here I was a member of the “World of Difference” service user research group. In the latter half of the year, I was accepted into the DClinPsych programme and began thinking about potential doctorate topics. I knew I wanted to focus on research that was service user led and co-produced. Around the same time, the Ministry of Health released a tender seeking proposals to improve capacity, capability and equity of access to psychological services for young adults aged 18 to 25 experiencing mental distress and/or substance misuse. What emerged after a successful proposal between multiple organisations was the pilot Piki. Fortunately, my then boss (now supervisor) Dr Sarah Gordon and her team were the successful applicants of the above proposal, intending to provide a comprehensive evaluation for the pilot. Through the collegiality between Otago and Massey University, I was able to secure a portion of the qualitative evaluation as part of my doctoral work.

Study Rationale and Aim

Over the past few years, it has been widely reported that our mental health services are in crisis. This has been further highlighted by the He Ara Oranga report (Paterson et al., 2018), and escalated to Governmental level, and a resultant focus on mental health in Budget 2019 (Treasury New Zealand, 2019). People experiencing mental distress are facing rejected referrals for public services, long waiting times, and inadequate interventions. The need for mental health support is increasing, yet services are unable to keep up with demand. Young people are disproportionately affected by these challenges, as they often lack resources to seek alternative support such as private health care. In order to understand which changes need to be implemented, the experiences of service users needs to be considered.

Piki, the pilot funded by the Ministry of Health, aimed to address this lack of mental health resources by providing additional service support to youth experiencing mild to moderate mental distress. Piki incorporated many channels of mental health support for youth including Cognitive Behavioural Therapy (CBT) and Intentional Peer Support (IPS). The current research is a qualitative evaluation of service user understandings of recovery, and experiences of IPS within Piki.

An additional study rationale is regarding the overall framework and methodology of this thesis. There is a growing evidence-base that suggests service user perspectives provide indispensable input within mental health research and service delivery (Happell & Scholz, 2018; Phillips, 2006; Thornicroft & Tansella, 2011). This sentiment is reflected in the Aotearoa New Zealand national health policy, which requires mental health services to integrate service user leadership throughout their initiatives, as well as to support recovery- based models of care (Ministry of Health, 2012). Thus, methodologies utilising service-user input are of utmost importance.

Co-production is a framework, methodology and method, supporting service user leadership. It was employed by the Piki team throughout all stages of the pilot, including this doctoral thesis. The current research is co-produced with an advisory group of service users aged 18-25. The rationale for this is to support consumer input across research and highlight the value of lived experience as its own expertise within the field of academia.

The aims of this doctoral research are twofold. The first aim is to explore how youth service users understand personal recovery. The second aim is to explore youth service user experiences of accessing peer support through Piki. Additionally, I hope to critically reflect on experiences of co-produced research and how this has worked in practice within the doctorate.

Methodology

The methodology of this research utilises co-production and is grounded in qualitative epistemology (Braun & Clarke, 2013). This methodology was selected, as it is concerned with understanding participants' experiences and accepts that human experiences are inherently subjective, as the way individuals perceive the world is within the context of their environment (Smith, 2015). In the very early stages of data analysis, I utilised the reflexive thematic analysis (RTA), however following consultation with my new qualitative supervisor, a decision was made to amend the analysis to be in line with Interpretative Phenomenological Analysis (IPA). The rationale for this was due to research focus on phenomena of recovery, and the focus on lived experience both of which were more appropriate for IPA.

Co-Production with the Service User Reference Group

Co-production is the theoretical foundation for the current research. The framework of co-production first emerged out of economic principles, where consumer participation was recognised as a strength and asset. During the past decade, principles of co-production have begun to emerge and be adapted to mental health (Gordon & O'Brien, 2018). In this field, co- production positions service users as experts of their experience, capable of articulating ideas to better mental health outcomes. Co-production is an act of genuine collaboration between service users and researchers and is guided by a set of principles that pertain to consumer leadership (Slay & Stephens, 2013).

Through the theoretical positioning of co-production, the researcher may break down some of the systemic power structures which exist within academia. As Piki was a service designed for 18 to 25-year-olds, it was important to enlist service users who could engage in co-production who also matched the demographics of participants. Thus, I set up the Service User Reference Group (SURG) was set up in January 2019. The group consisted of 12 service users aged 18-25 who were willing to engage with me in the co-production process within my thesis. Regular quarterly group meetings were established with SURG for the duration of the research. SURG participants were tasked with considering, monitoring and advising on components of the research through feedback gathered in the regular meetings. SURG was also involved in parts of the data analysis, as described further below.

Ethics

The Massey Director of Research Ethics was consulted on where the ethical approval for the doctorate should come from, and it was agreed that the University of Otago was the most appropriate institution to evaluate the current research being undertaken. Ethical approval for overall Piki evaluation (of which this doctorate is a part) has been provided by the University of Otago (H19/044). Massey Ethics Board has received the relevant approval documentation, including the letter of when approval was obtained.

Participants

The participants for my thesis were Piki clients, who had accessed CBT and/or IPS. I contacted potential participants from a list given to me by Piki services which clients previously consented to, and set up interviews with those who responded. Participants were selected using a purposive sampling approach, having particular regard for underserved populations namely Māori and/or Rainbow young people. The rationale for this decision came from the fact that these marginalised groups are conventionally under-researched, and were also the primary target clients for the Piki service so it was important to hear about their experience. In total, I interviewed 26 youth service users about their understanding of recovery and experiences of IPS within Piki. Table 1 below shows the demographics of the clients interviewed.

Table 1

Participants' Demographics and Interventions They Accessed

	n (%)		*n (%)*
Gender		**Ethnicity**	
Female	17 (65)	NZ Māori	9 (35)
Male	5 (19)	Pasifika	4 (15)
Non-binary	3 (12)	Asian	3 (12)
Unanswered	1 (4)	European (including Pākehā)	10 (38)
Occupation		**Intervention**	
In employment	8 (31)	CBT only	17 (65)
Unemployed	4 (15)	Peer Support only	2 (8)
Student	13 (50)	Both	7 (27)
Stay at home parent	1 (4)		
Substance misuse	6 (23)	**Rainbow or LGBTQI+**	6 (23)

Note: Total n = 26

Data Collection

Interviews were conducted throughout 2020, with some being collected via Zoom due to COVID-19. Face-to-face interviews were held at Massey, Victoria or Otago university group study rooms, at the participant's homes, or private rooms in community spaces such as the library. At the beginning of each interview, I introduced myself and the study, and went through the information sheet and consent form with the participant. The semi-structured interviews were audio-recorded and ranged from 30-60 minutes. At the end of the interview, each participant received a $30 supermarket voucher in recognition of the time taken to participate.

The purpose of these interviews was to provide a snapshot of how participants understood recovery, and what were their experiences of accessing peer support. However, interviews were also used for the wider evaluation, and included other questions which were not part of my thesis aims. The interviews followed a question schedule which had four sections: 1) previous experience of mental health supports and how that shaped their perceptions of Piki, 2) experiences of accessing support via CBT and/or IPS, 3) the participant's understandings of mental health recovery, and 4) suggestions for future improvements of mental health services.

Following each interview, I wrote a brief field note on the initial impressions and topics covered. Interviews were transcribed verbatim from audio recordings and potentially identifying information was removed or replaced with generalised descriptors. I then reviewed and proofread the transcripts with the audio file prior to analysis.

Data Analysis

The thematic analysis method provides a flexible approach, which has been described by researchers as accessible and easily adaptable to the needs of the research (Braun & Clarke, 2013; McLeod, 2011; Willig, 2013). Data was analysed using reflexive thematic analysis (RTA), using the six phases described by Braun and Clarke (2006). Field notes and transcripts were systematically collated and coded using the qualitative software NVivo to facilitate an initial broad thematic analysis. In accordance with the six phases of thematic analysis, I first (1) familiarised myself with the data by transcribing, proofreading, and re- reading each transcript. I then (2) generated initial codes and expanded on the field notes written after the interviews.

In the next phase (3) searching for themes, I involved the help of SURG across four weekly meetings. I introduced the method of thematic analysis to members, showed them the question zones of interviews, and shared what I had collated so far. I brought printed excerpts, and together we went through data to review initial themes. The session format went as follows: I presented initial codes and transcript excerpts on a PowerPoint slide. I then described my thinking process out loud, to demonstrate the level of analysis required. The group and I discussed my thinking and whether this was consistent with the rest of SURG. I then distributed hard copies of random anonymised transcript excerpts to each member and we analysed the data alone, using colour coded pens and sticky notes. This was done for three or four excerpts per person. Each person wrote down their initial thoughts and then swapped the transcript with another member, who then ticked what was written down if they agreed, or added their own thoughts. After this, we came back to a structured discussion and each member was given the opportunity to provide their reflections on the transcripts they worked on. Members collaborated by either supporting or challenging these ideas. After a round of this, I collated the hard copies of data and we would come back into a more reflexive group discussion and subsequently closed the session. Afterwards, I wrote further notes of my impressions of the group discussion.

Originally, in the very early stages of data analysis, I utilised the reflexive thematic analysis (RTA) approach. However, at the end of 2019, following consultation with a new qualitative supervisor, the decision was made to amend the analysis to be in line with Interpretative Phenomenological Analysis (IPA). The rationale for this was due to research focus on phenomena of recovery, and the focus on lived experience both of which were more appropriate for IPA. My theoretical framework, with its focus on phenomenology, hermeneutics, and ideography has remained consistent through this decision.

Clinical Psychology Internship

In January 2021, I began my year-long internship within the DHB across Consultation-Liaison and Kāpiti CAMHS. Consultation-Liaison is a service that provides advice to the general hospital staff and engages in the assessment and treatment of adult hospital inpatients (and some outpatients) who have a primary physical condition alongside co-morbid mental health needs. Child and Adolescent Mental Health Services is a community service, which provides specialised input to those aged 0-18 with moderate to severe mental health difficulties. The following reflections were made during my internship year.

Psychiatric Diagnosis

When I first started my internship at Consultation-Liaison, the processes of filing and storing client paperwork were explained to me. One of the things that stood out was that as part of the assessment paperwork, we had to provide a diagnosis for clients. This meant that inpatients, even those who were admitted for a brief time still had to have a diagnosis in accordance with the International Classification of Diseases (ICD) codes used by Mental Health, Addiction and Intellectual Disability Service (MHAIDS). I found this to be inconsistent with service user informed approaches I had read about within my research – especially as a prominent theme of the movement is shifting away from pathologising human experiences. This requirement of a diagnosis did not seem appropriate to me, especially in circumstances where I only met the person once, or if their distress was a normal reaction to an abnormal experience (for example, anxiety about one's mortality following a cancer diagnosis). I brought this up in supervision and reflected that this was something that I had found difficult to grapple with, and my supervisor agreed that it was not always appropriate to give a diagnosis, but that this was the way the funding worked. As a result, we often used the code of "adjustment disorder".

However, this still pathologised human experiences in a way that felt inconsistent with my values as a service user and a researcher. While I acknowledge that some people find comfort in diagnosis, within my clinical work I came across individuals who had no idea that they had a certain diagnosis because this wasn’t communicated to them. This was particularly prominent around personality disorders, an already controversial area of the Diagnostic and Statistical Manual of Mental Disorders (DSM). I felt that it would have been more meaningful, and service-user informed to focus on the experience of individuals through collaborative formulation, rather than attaching a diagnosis to their experiences. which would stay on their medical record forever, and in some cases lead to judgement from health professionals.

I continued to reflect deeply on the role of diagnosis throughout my internship and across my research. During my time at CAMHS, I found that there was a lot more flexibility within the team to simply leave “diagnosis” out of the assessment, despite the same paperwork requirements. I observed that in general, there was more reluctance to diagnose children compared with adult populations at Consultation-Liaison. Perhaps this was due to the belief that children were still developing, and the fact that Consultation-Liaison was situated within the hospital, and therefore within a biomedical model that sees diagnosis as an integral consideration within treatment. Whereas, when working with youth, the diagnosis became less important, and there was an increased acknowledgement of environmental and systemic factors that contributed to a young client’s presentation. I felt that these principles within CAMHS should be applied across age groups, as we all exist within systems. Being given the opportunity to work with children within my internship was eye-opening, as I was able to look holistically at the problem, contextualising it within a system, instead of an individualistic approach we are taught in training. I also felt that if a diagnosis was necessary, then this should be communicated with the client in a collaborative way, to make them informed around what this practically means for them. For example, I found myself being able to do this after a neurodiverse assessment, where I was able to meet the family and discuss the results and recommendations with them. There is a lot of nuance in having the power to diagnose, and it may have lifelong repercussions for a client, and thus it is a power we as clinicians have that should not be merely a tick box exercise – it should always be a considered decision, based on the needs of each individual we work with.

Pressure on Services

Being able to see first-hand how under-resourced and understaffed mental health services are in the DBH was quite a shock to me. I had read about it and frequently cited research covering these inequalities, however, seeing this play out in practice was saddening. I had hoped that since the Government prioritised focus on mental health services this would be seen in practice. Despite my aspirations, I found myself listening to my senior colleagues in staff meetings discussing a lack of funding, difficulties with staff retention and a lack of acknowledgement for existing senior clinicians, who would subsequently leave the DHB to go into private practice. As well as this there was a real sense of burnout, and I believe these challenges would impact client care. This made me reflect on the importance of restructuring and expanding mental health services to include alternatives to the existing status quo, as it is apparent that the way things are currently functioning is not as effective as they can be. For example, I believe that currently, peer support (and particularly IPS) is an incredibly underutilised resource. Within current services, it appears that peer support is not seen as evidence-based and is commented on as being fit for those in mild distress. This, compared to more conventional approaches such as CBT or medication. Despite this messaging from some of my colleagues, research is clear in the efficacy of IPS, and the important role it can play in consumer recovery. I think that medication and talk therapy certainly have a place within the health care system, however, it is important to acknowledge that IPS can support consumers in moderate to severe mental distress, and this includes those considered “high-risk”. One of the most important protective factors against suicide risk is a sense of belonging and connection, which IPS can provide. The role of the clinician as I see it is to keep an open mind and work with each individual client and their goals. This means providing options, including access to services that are seen as “out of the box”.

Consumer/Clinician Duality

I felt challenged by the stigmatising comments made by some of the clinicians I had worked with. In particular, patients who were called “frequent flyers” within the hospital system and seen as “chronic risk”, or teenagers who were positioned as “difficult to treat” and “non-compliant”. Sometimes my community of people in deep distress were positioned as difficult and demanding when they had legitimate concerns. I felt like these comments minimised the experience of distress, and permitted clinicians to distance themselves from the underlying needs of the client. At times, I found myself incredibly uncomfortable with some of the stigmatising humour used. However, I felt like I could not speak up due to my intern status. I do understand that these stigmatising views in part come from exhaustion and a sense of hopelessness within a broken system. I also acknowledge that people in distress may not always be effective at communicating their needs, and this can be frustrating for clinicians. I found myself reflecting on how this empathy fatigue may have negative treatment implications, as consumers may not be taken seriously. I also considered my own mental health history, and experiences of service use, and found myself wondering if I would be seen differently in the eyes of my colleagues if they knew my story.

For this reason, I found myself not being able to be open about my consumer background, for fear of being judged or stigmatised within my team. Indeed, one of the supervisors I had worked with and shared my background history with, told me to “be careful with who [I] choose to disclose this information with”, which I found incredibly unsettling.

Working within mental health services should be no different to working within physical health. I doubt an orthopaedic surgeon would hesitate to disclose a previously broken bone to their colleagues. So why wouldn’t a mental health professional be able to disclose prior mental distress? We push for a culture that seeks to normalise people’s distress and reaching out, and yet stigmatise our own experiences and fear judgment. And when we try to speak up we are told we are “brave” and are cautioned against sharing our story. I find it exasperating that my own lived experience may be used against me within my profession, given how much I have sacrificed to be where I am. I used to joke that consumer clinicians are Trojan horses within services, but if we are all siloed then we have no voice, and cannot stand up for our beliefs. I drew on my research and interviews with participants. A large number of them commented on how clinician self-disclosure allowed them to feel more connected to the clinician, therefore establishing a better therapeutic alliance. If a young person felt like the clinician shared aspects of themselves (such as a cultural or queer identity), this instilled trust in the clinician and provided hope for the client’s own recovery. I truly feel that my experiences as a consumer have given me the privilege of becoming a more empathetic and patient clinician. In a field where rapport and therapeutic alliance are what builds the foundations of recovery, why would I want to hide that?

The service-user movement involves people with lived experience of mental distress and recovery, co-producing work alongside allies. While this is an increasingly accepted way of working across academia and at service development level, it appears seldom reflected in the day-to-day running of mental health services. Diagnosis and by extension, pathologisation remains the status quo, however, this disease model lacks evidence base. For this reason, I have started to look into alternative models of understanding distress, one of which is the Power Threat Meaning Framework (Johnstone & Boyle, 2018). Developed by the British Psychological Society in conjunction with service users, it provides an alternative framework for articulating mental distress and can be applied to all people, not just clinical populations.

The framework summarises and integrates a great deal of evidence about the role of various kinds of power in people’s lives, the kinds of threats that the misuse of power poses to us, and the ways we have learned as human beings to respond to threats. I hope that I can integrate this model in my future clinical practice as I continue to reflect on my precarious position. As a consumer clinician, I am constantly holding the weight of my experience against the power I now hold. And at times it is incredibly confronting to be in these spaces, but I would not want to be anywhere else.

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