

Appendix B Literature Review for PESP Evaluation

This literature review has been prepared as part of the evaluation of the Peer Education and Support Program (PESP) run by Council to Homeless Persons Victoria. A summary of the findings appear in the full evaluation report.

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1 Introduction

1.1 Scope of the review

This literature review aims to provide an overview of both published research evidence and the extensive 'grey' literature in the field of consumer participation and engagement, in homelessness and other human service sectors.

This review begins by exploring consumer participation theory and practice, including the specific field of peer education and support, then consider information and evidence from the health and mental health sectors given the much greater depth of work in those fields. Finally, it will examine the growing body of consumer participation literature and work in the homelessness field.

1.2 Methodology

The search and selection process for this review targeted both peer-reviewed articles and publications and materials developed by government and non-government organisations in fields of homelessness, health, mental health and disability. Reiterated searching utilised the following tools:

- Academic journal databases in health, humanities and social sciences fields (EBSCO, Proquest, Informit);
- General internet searching of online policy communities and information clearinghouses;
- Follow up of bibliographic references found in studies.

Search terms included combinations of the following words: homelessness, consumer, participation, service user, peer, education, co-production, integration.

In total 99 sources were identified as relevant to this project comprising:

- 18 journal articles
- 63 reports by non-government bodies, including research and evaluation reports
- 7 government documents
- 5 books
- 1 doctoral thesis
- 5 websites containing toolkits on participation

The topics under which these sources fitted for analytical purposes were:

- ✗ Consumer participation (general) – 18
- ✗ Consumer participation in health and mental health – 31
- ✗ Consumer participation in homelessness – 30
- ✗ Guides and toolkits – 15
- ✗ Peer education – 13

1.3 Limitations of the review

Consumer participation has been practised in the human services for at least 30 years. However the related literature is at a very early stage of development. This review has identified a wealth of relevant material, but there are a very limited number of published articles and studies examining the theoretical underpinnings of consumer participation, or providing systematic evaluations of such interventions. Even in the health sector, where consumer engagement and participation has
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received considerable attention over recent decades and attracted significant government funding, a recent three year, multi-million dollar research project concluded that consumer engagement in Australian health policy is poorly understood and defined, lacks a common language and shared terminology, is inconsistently practiced and under-theorised (Gregory 2008).

The absence of 'high quality evidence' in the consumer engagement and participation fields can be understood at least partly as reflecting the origins of the consumer participation movement : that is, a collective of individuals typically representing the most marginalised and excluded from policy- and decision-making forums and research institutions. In this context, the review presents a wide range of material from multiple fields of inquiry, providing an introduction to the concepts of consumer participation and peer education as they are described, practiced and theorised both nationally and internationally.

1.4 Definitions and terminology

Terms used in the participation and peer education literature are often contested, inconsistently used and defined. They also vary depending on the sector and country in which the literature is based. In this review, the following terms and definitions are used (for further details on this see Appendix H: Definitions and terminology):

Consumer – 'someone who uses, has used, or is eligible to use housing, homelessness and support services, including those refused services and those who have refused services. This may include carers and family members when relevant' (Rural Housing Network and HomeGround Services 2008).

Participation – 'a way of enabling people to participate in all the decisions and actions that affect their lives' (FEANTSA Participation Working Group 2013). Different forms of participation include social participation, public participation, and individual participation (Brodie, Cowling et al. 2009).

Peer – typically 'peers' are defined as people with an equal standing from the same social or societal group with shared characteristics that provide them with a shared experience or shared interest (Centre for Youth Drug Studies 2006) (Western Australian Centre for Health Promotion Research 2010).

Peer support – 'any organised support provided by and for people with similar conditions, problems or experiences' (O'Hagan 2011) which can take many different forms from one-to-one personal support, group or organisation based support, or even support provided by a consumer-controlled organisation.

Peer education - a more formalised type of program requiring participants to receive some sort of training before they become involved in helping to teach or share information with others with similar backgrounds or experiences to their own (Community Health and Development 2013).

Engagement - a more continuous or ongoing process, whereby consumers are actively invited to become involved in decision-making and planning partnerships rather than one-off or less meaningful interactions (Tasmanian Council of Social Service 2012).

2 Consumer participation theory and practice

2.1 A history of consumer participation

The field of consumer participation and engagement - and the associated mantra of 'client-centred' service delivery - has received significant interest and attention internationally by government and non-government organisations in recent decades. This is at least partly based on recognition that involving consumers or service users in the policy development and service delivery process can have benefits for many, including consumers themselves, and partly on the more market driven focus of governments toward providing public services (Beresford 2013). A paper developed for the Tasmanian Government on consumer engagement strategies in the homelessness sector (Youth Development Australia 2011) notes that consumer engagement was incorporated in the UK policy making process more than fifteen years ago through the '*Modernising Government White Paper*' (Prime Minister and Minister for the Cabinet Office 1999), and that a 2001 OECD report detailed consumer engagement strategies in many member countries including Canada, Denmark, the Czech Republic, Belgium, the USA, Hungary, France and Korea (Organisation for Economic Co-operation and Development 2001).

In addition, the concept of 'co-production' has started to enter the social policy discourse and attract attention from both conservative and progressive governments and think tanks such as the New Economics Foundation (Boyle and Harris, 2009). Based on the principle that service providers and service users (and other stakeholders) all have valuable contributions in the planning, delivery and evaluation of services, co-production encourages the sharing of power and greater collaboration as a means of achieving better outcomes in the public policy process (Slay and Stephens 2013) (Beresford 2013) (Alford 2007). This co-production agenda has the potential to take the current participation and engagement debate to a new level, given claims that it may help reform the entire public service sector (Boyle and Harris 2009). However, it is still in a formative stage and to date appears to have little currency within Australian public policy debates.

Traditionally, consumer participation and engagement frameworks have been linked with social movements in the 1960s and 1970s. These movements often had a focus on redistribution of power and a rights-based framework for groups that were seen as disempowered or discriminated against (such as women, minorities, people with disabilities, gays and lesbians) as well as for recipients of social/health services. UK research on participation (Brodie, Cowling et al. 2009) identifies the government funded 'community development projects' of the 1960s as the foundation of much participatory democracy activity in that country. This was followed by several decades of government withdrawal from the provision of public services in the 1980s and 1990s, with the election of the Blair Government in 1997 putting participation and community involvement squarely back on the agenda.

The UK has had explicit commitments to participation as a means of creating more active citizens and in improving the quality of public service provision, most notably through legislation to establish health patient forums (Moriarty, Rapaport et al. 2007). This was also clearly articulated through the Blair Government's Social Inclusion agenda, a public policy agenda promoting active citizen participation in a range of social and economic fields, including homelessness policy (UK Cabinet Homelessness, learning from those who've lived it: the PESP evaluation

Office 2006) (Roche 2004) (Jones and Smyth 1999). The US and Australia have also both had legislative requirements in the health sector requiring the formation of consumer advisory committees as a means of ensuring consumer involvement in the delivery of services (Gregory 2007) (Barrow, McMullin et al. 2007). However the literature is consistent in reporting that a shortage of evaluations and published evidence on the direct impact of consumer and service user participation make it difficult to claim direct links between greater participation and improved outcomes (Carr 2004) (Beresford and Bradfield 2006) (Gregory 2008) (Davies, Gray et al. 2014).

2.2 Participation frameworks

Sherry Arnstein's seminal work on community or consumer participation from 1969 presented a simple 'ladder of participation' that started with descriptors such as manipulation and informing and moved through to higher level forms of participation such as partnership and eventually citizen control (Arnstein 1969).

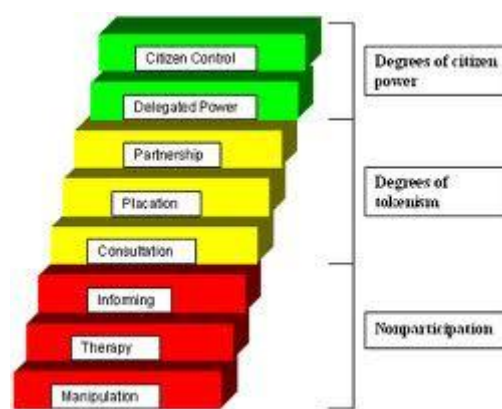


Figure 1: Arnstein's Ladder of Participation (Arnstein 1969)

Since this time more nuanced frameworks for participation have been developed, recognising the complexity of situations and purposes for which consumer engagement is used (Wilcox 1999) (Windle and Cibukla 1981) (Burns 1994) (White 1996) (Winstanley 1995) (Hart 1997) (Oliver, Clarke-Jones et al. 2004). The work by Wilcox, which arose from the activity around urban regeneration in the UK, became an influential framework and argued that different forms or levels of participation are relevant in different contexts, with the five levels of information, consultation, deciding together, acting together and supporting individual community initiatives applicable to many different physical and policy environments (CAG Consultants 2004).

Another framework developed in Canada, a 'Policy Toolkit for Public Involvement in Decision Making' (Health Canada 2000) has also been influential on the field, particularly the health field, given its similar focus on public or consumer involvement being part of a continuum with no single level considered superior and its adaptability to many different fields and purposes. They describe five types of engagement as: inform or educate, gather information/views, discuss or consult, engage, work in partnership (Health Canada 2000). Each of these forms of engagement can be used at either an individual care level, at the service level, or at a broader policy level. The International Association for Public Participation refers to a 'spectrum' of participation' with the different levels referred to as 'informing, consulting, involving, collaborating and empowering' (International Association for Public Participation 2007). This is based on the premise that different types of

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participation are relevant in different settings and for different purposes and none should necessarily be seen as privileged as or better than others.

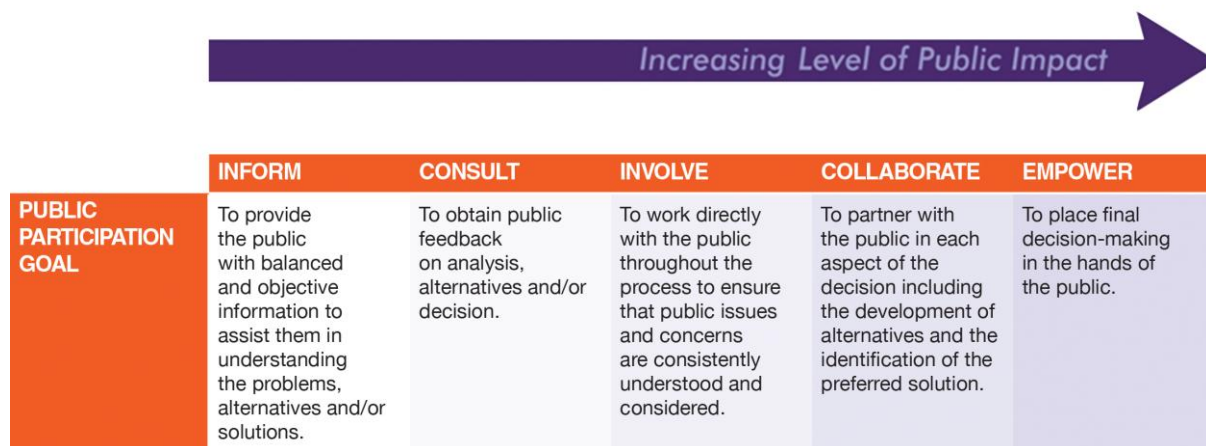


Figure 2: IAP2 Spectrum of Participation

2.3 Dimensions of participation

The concept of individual and community empowerment is considered by many as an important element in participation activities, with recognition that poorly handled participation mechanisms could equally disempower people where they were seen as tokenistic or ineffective (Cruikshank 1999) (Hart 1997) (Cruikshank 1999) (Stark 2011). In a review of literature on participation and involvement at a community level, it is argued that explicit discussions of power redistribution are often absent, despite the implicit goal of empowerment for those community members involved (Stewart and Taylor 1995). A study reviewing the impact of consumer participation in UK social care services notes that 'power issues underlie the majority of identified difficulties with effective user-led change' (Carr 2004) (Carr 2004:vii). In her study of service user participation in the homelessness and mental health sectors, Davies (2012) also emphasises that participation should not be automatically assumed to equal empowerment, with numerous examples of participation activities used as a means of appeasing and controlling citizens rather than giving them a genuine say or influence in decision making (ibid:67).

Participation and its relationship to empowerment is particularly important in works focused on service users considered to be disadvantaged or marginalised. In a study on participation in the mental health sector (Tobin, Chen et al. 2002) the authors note the difficulty with transferring the concept of 'consumer' to the welfare and human services sector, given its roots in commercial enterprise. This is also discussed in a health study where the consumerist focus on choice of service provision is seen as less relevant to the participation goals of engaging individuals in decision-making processes (Hickey and Kipping 1998).

Beresford identifies the political nature of participation and its capacity to achieve both empowerment of the individual and act as a tool for change as an important dimension (Beresford and Croft 1990). For him there was a critical difference in the more 'consumerist' approaches to service user participation as distinct from more 'democratic' forms of participation in which there was a specific goal of enhancing partnerships between service providers and service users, and where the issues of power and rights were explicitly addressed (Beresford and Croft 1990).

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An article by Austrian academic Christian Stark argues that participation is fundamentally a matter of power and the transfer of power as a measure of participation, and that where it is not connected to decision-making it can only be viewed as tokenistic (Stark 2011). While warning that empowerment can be mis-interpreted through the neo-liberal agenda of wanting individuals to become personally responsible for their situation, Stark argues that empowerment must be seen as a fundamental precondition to participation as without this the disempowered are unable to take control of their own life and life decisions (ibid:78).

The different dimensions or forms of participation used in practice also influence the experience and outcomes for those involved. In a review of participatory practices in a wide range of sectors in the UK, (Brodie, Cowling et al. 2009) following continuums in different spheres were identified:

Unstructured \leftrightarrow structured

Informal \leftrightarrow formal

Passive \leftrightarrow active

Individual \leftrightarrow collective

One-off \leftrightarrow ongoing

Unpaid \leftrightarrow paid

Reactive \leftrightarrow proactive

Self-interested \leftrightarrow altruistic

Resisting social change \leftrightarrow driving change

The way in which participation strategies and activities are planned and implemented along these different dimensions can therefore have a profound effect on what can be achieved.

2.4 Barriers to participation

Another dimension of participation commonly discussed in the literature is the 'barriers' to participation, or the factors that limit or prevent participation particularly for vulnerable or marginalised consumers. In a PhD thesis focused specifically on consumer participation within the homelessness and mental health sectors, participants noted that the structural discrimination they often faced as consumer participants or representatives was only one of several barriers or limitations to their effectiveness (Davies 2012:158-159).

Other barriers were noted as the logistical challenges of participating when still facing homelessness and/or other challenging personal situations, being uncomfortable in retelling their personal story multiple times and the potential for being pitied or patronised, and the difficulties associated with group participation activities where the other participants were similarly facing multiple challenges that affected their ability to consistently commit (ibid:160). There was also an inherent tension in being an identified consumer representative or voice in an otherwise under-developed sector, meaning on the one hand that participants could be over-burdened with being one of only a few

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trained voices in the field, and on the other that once consumers became skilled up there were relatively few participation mechanisms they could participate in (ibid:161).

Other barriers identified in the literature include staff or service attitudes toward consumer involvement include: motivation levels of both staff and clients to becoming more engaged, the fear of staff at losing control when sharing decision-making with clients, the inherent barriers of professional structures and jargon that can alienate non-professional service users, the risk that poorly planned or run participation can alienate service users even further if they perceive it to be tokenistic or lacking impact, the cost of involvement for low income consumers, and lack of diversity amongst consumers engaged in participation activities (Bradfield and Eckersley 2008) (Prescott and Harris nd) (Rural Housing Network and HomeGround Services 2008).

2.5 Effectiveness of consumer participation

Despite several decades of contemporary consumer participation practice in a range of human service fields, the literature demonstrates a lack of rigorous evaluation or even attention to the issue of effectiveness and outcomes, and this limitation has impacted the ability to make any claims about its effectiveness or otherwise. In a review of service user participation across social care services in the UK, it is noted that while there is some knowledge about participation techniques and processes, there is little if any research that explores the connection between these activities and the outcomes or impacts they are achieving – which is not to say there are not benefits, just that they are not being appropriately monitored or measured (Carr 2004:vi).

In a comprehensive review of consumer participation mechanisms (primarily in the health sector) Australian academic Judith Gregory notes that ‘the ideals of consumer engagement are not easy to translate into practice’, and in an earlier paper for the project notes that ‘the field remains under-theorised, with a lack of case studies that demonstrate both successes and failures in engagement...much of the current literature provides either broad theoretical discussions about the value of engagement, or ‘how to’ approaches that are designed to guide planning but offer little suggestion about how to make decisions about the trade-offs raised (Gregory 2007). This is supported by a recent Cochrane review paper (Nilsen 2010) which found little evidence at the highest ranking levels of evidence – Randomised Control Trials – about the impact of consumer participation in healthcare at the population level, pointing to an inability make equivocal statements about its effect or benefits (Bathgate and Romios 2011:10).

In a recent paper reviewing existing participation frameworks and practices, Davies et al (2014) challenge the efficacy of service-user participation for marginalised and disadvantaged groups based on either the citizenship or consumerist models, arguing that neither has actually achieved the structural reforms necessary to make any real difference. They claim that service user participation strategies should be judged on the extent to which they enhance political, economic and cultural opportunities for the individuals involved, rather than just whether they allow for involvement (ibid:126). Based on a study of clients in both the homelessness and mental health sectors, they argue instead that Nancy Fraser’s ‘parity of participation’ model may provide a more useful tool in achieving the types of structural change that the most marginalised service users are seeking to overcome their feelings of powerlessness and lack of choice within existing service systems (ibid:127). Fraser’s ‘parity of participation’ model is seen as particularly useful in working toward

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social justice goals as its framework requires the three mechanisms of redistribution, recognition and representation in order for participation to be meaningful (Davies 2012:81, 84).

Further, in her comprehensive review of service user participation literature, Davies concludes that 'the stark warning from the literature was that despite underlying intentions of empowerment and equality, participation practices had failed to demonstrate their effectiveness and had at worst indicated potential to be used as tools for undemocratic processes of control and coercion' (Davies 2012:72). This is supported by findings from the Australian Institute of Public Health Services study on consumer engagement in the health sector, which found the 'rhetoric' and theory around consumer participation and its practical implementation are still a great distance apart (Gregory 2008).

2.6 Experiences and expectations of service users from the participation process

There is a small but growing body of evidence that directly engages with service users or consumers involved in participation activities to gain an insight into their experiences and expectations of the participation process. Given that participation is all about asking those involved what they think, this is a welcome and perhaps overdue contribution to the literature.

A Swedish study of welfare service users identified that the theoretical frameworks for participation can be completely alien to those involved, with typically very low levels of expectation about the level of participation or influence they could exert (Kvarnstrom, Willumsen et al. 2012). However, the overwhelming feedback from those involved in consumer participation activities is that they find the experience a rewarding and positive one, particularly where they are offered meaningful forms of participation and could some benefit or outcome for their effort (Bennetts 2009) (Brodie, Cowling et al. 2009) (Davies 2012) (Ball 2013) (Beresford 2013) (North and West Metropolitan Region LASN Client Feedback Group 2011).

Consumers commonly refer to their participation as means of helping others and having an altruistic purpose for their involvement rather than it being focused on what they can gain from the experience (Davies 2012). Feedback from consumers of homelessness services involved in participation activities in Victoria's North West metropolitan region about their motivations for involvement is reflective of that made in many other contexts, with comments such as :

- *'I'm dedicated to making a difference for others so that they don't have to endure what I've been through'*
- *'I wanted to make a difference and that's why I'm here'*
- *'I'd love to use my story to help others'* (North and West Metropolitan Region LASN Client Feedback Group 2011)

Similarly a study in the mental health sector found that those involved as 'consumer workers' valued their roles and gave examples of both positive and negative experiences that had inspired them to become actively involved in system or service change (Bennetts 2009). One participant noted:

- *It's not just a job. It's being part of a movement that's important to me.*

In an Australian study looking at the effectiveness and ethics of personal storytelling as a form of participation in the consumer advocacy process, individuals involved talked of both the benefits and

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risks of putting their story in the public realm as an example of good and bad practice (Ball 2013). It was noted that this can be an empowering experience for those involved, if managed properly – however there is also the potential for clients to be made more vulnerable or further harmed if the process is not well managed or executed. The author identified five principles of ethical and effective storytelling from a consumer perspective including adequate consent, direct participation from those affected wherever possible, collaboration between individuals and organisations, crafting a compelling message and consideration of the context in which the information will be used (Ball 2013:26-32).

The opportunity for individuals to have their say and contribute to positive change is noted as a common motivating factor not just in formal consumer participation programs but in volunteering opportunities more generally (Brodie, Cowling et al. 2009:27). However the reality of how much influence an individual can have over the timing and level of their participation is also tempered by the issue of power relations within the setting they are dealing with, and consumers speak about the insidious ways in which unequal power relations can undermine meaningful participation outcomes (Davies 2012) (Bennetts 2009) (Brodie, Cowling et al. 2009) (Beresford 2013). A recent UK study by a researcher with a long history in the consumer participation field noted that those consumers who have developed expertise through long term involvement in their particular area can sometimes be written off as just being one of ‘the usual suspects’, with agencies not wanting to hear from them, particularly when they develop a more critical perspective of what is on offer (Beresford 2013). This highlights the fact that the majority of consumer participation opportunities remain within the control of the agencies and government departments which are already the source of much consumer dissatisfaction – few examples exist of consumer-operated services being in a position to either initiate or insist on their involvement in discussions about program or policy decision-making. Some exceptions are consumer-controlled organisations SANDS in Denmark, the National Coalition for the Homeless in the US, Groundswell in the UK, and StreetCare in NSW who managed to secure consumer representative positions on a recent Premier’s Council on Homelessness (each of these are reviewed in **Section 5** of the evaluation report).

3 Peer Support and Peer Education

Peer concepts and peer support practices are clearly a strong element of the PESP framework, both in the program title and the way the group operates. The use of the term 'peer' and its relative influence as a practice varies amongst different sectors, with peer workers/volunteers having a particularly strong involvement in the mental health and addictions field. Peer support programs appear to be more commonly used in practice than the more formal and resource intensive peer education programs. Within the homelessness field, the term peer is infrequently used.

3.1 Peer support practices

Peer support is sometimes also referred to as self-help, mutual aid or mutual support and again has many different definitions, including 'any organised support provided by and for people with similar conditions, problems or experiences' (O'Hagan 2011). While peer support programs can either be initiated by service users or service providers, there is a strong history and tradition of them coming from a grass-roots service user movement or from the carers of those receiving services.

The peer support movement in the mental health sector is cited as originating from the Alleged Lunatic Friend Society in England around 1845 (O'Hagan 2011) (Substance Abuse and Mental Health Services Administration 2011), with self-help groups in the addictions field being traced back to the 18th century. The establishment of Alcoholics Anonymous in the US in 1937 and Australia's 12 step GROW program in 1957 also formed the basis for what is now a well-recognised values driven practice whereby people with lived experience help support others in similar situations through either one-to-one support or group based support (O'Hagan 2011).

O'Hagan cites a range of different practices in peer support, from 12 step programs to Intentional Peer Support (IPS) which is 'a philosophy and methodology that encourages participants to step outside their illness and victim story through genuine connection, mutual understanding of how they know what they know, redefining help as a co-learning and a growing process, and helping each other move towards what they want' (ibid:8). Other peer-based approaches identified by a Scottish homelessness organisation include:

- Peer advocacy – where individuals with shared life experiences use their own experiences to help people get information they need to make choices
- Peer mentoring – acting as a mentor to others with similar experiences
- Peer coaching – more formalised process of assisting peers to reach their goals
- Peer education – providing information and education to their peers, typically after involvement in a training process and often in outreach or informal settings
- Peer research – where people with lived experience are involved in planning and/or undertaking research projects with their peers (Scottish Recovery Network 2012).

The disability services sector has also developed a tradition of peer support, with the Victorian Government recently developing a guide on how service providers and service users can establish effective support mechanisms – with an emphasis on peers sharing experiences, rather than giving advice or acting as an advocate (Disability Services Division 2012). The guide outlines various means of providing peer support such as informal chats, support groups run by members, internet and email peer support, peer-led groups and events, telephone based peer support, as well as more

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formalised mechanisms such as paid and trained community workers and service-provider led groups.

In the US, the Substance Abuse and Mental Health Services Administration (SAMHSA) review of consumer-operated services (2011) describes the peer support movement growing strongly in the mental health sector in the 1960s from a patient's rights agenda, with a focus on self-determination, to the point where in the 1970s various groups began working towards deinstitutionalisation from psychiatric care. Peer groups started to form consumer-operated drop-in centres and residences and other self-help services, until over time the Federal bureaucracies and professionals began to accept the importance of consumer-involvement in decision making processes. In 1977 the National Institute of Mental Health (NIMH) launched the 'Community Support Program' specifically aimed at people with long-term mental illness, and funded a national consumer conference in 1985 and various demonstration projects from 1988-91 (Substance Abuse and Mental Health Services Administration 2011:5). A focus on empowerment resulted in the "Nothing about us without us" campaign which demanded new roles for consumers within mental health services and the formation of cross-disability organisations, based on the principle that consumer-operated services were much more likely to achieve change and maintain control of their own agenda.

Eventually many of these self-help groups became integrated into mainstream services, and they became the cornerstone of the Continuum of Care (CoC) program that was rolled out nationally in the US. Another key achievement in the disability area was the 1990 Americans with Disabilities Act that guaranteed civil rights to people with disabilities, and the 1999 Supreme Court Olmstead decision that gave people with disabilities the right to live and receive services in the community rather than in institutions (SAMHSA 2011:7).

Peer support has over the years become accepted as a critical and complementary part of the recovery process in the mental health sector, to the point where paid peer support workers are employed in many mainstream services as well as a large number of consumer-operated services both in Australia and many other western countries (SAMHSA 2011) (O'Hagan 2011). The Victorian Department of Human Services also explicitly recognises peer support as an effective means of service users becoming more informed and empowered (Disability Services Division 2012).

3.2 Effectiveness of peer support programs

O'Hagan cites evidence of high satisfaction levels amongst those using peer support approaches and for positive outcomes in the following areas:

- Reduced symptoms and/or substance use;
- Reduced use of health services, including hospitals;
- Improvements in practical outcomes (eg housing, employment, finances);
- Increased sense of self-efficacy, social support, networks and functioning;
- Increased ability to cope with stress;
- Increased quality of life;
- Increased ability to communicate with mainstream providers; and
- Reduced mortality rates, particularly for suicide in people with addiction (O'Hagan 2011).

Other studies have shown no effect from peer support (Pistrang, Barker et al. 2010) but none have shown adverse effects (Doughty and Tse 2005). A US study looking at the use of peer support programs in the homelessness and mental health sectors found 'mixed evidence for beneficial effects of participation in peer support groups' including no effect of participation, but a positive effect on feelings of personal empowerment' (Schutt and Goldfinger 2011).

The 'Buddies' Peer Support Service in an acute psychiatric inpatient unit in Wellington NZ was evaluated in 2011 and found to be highly valued by the volunteers providing the support, the peers who used it, and the hospital staff that interacted with the service on a regular basis – importantly the evaluation found that it met its aims of countering feelings of loneliness and isolation for clients of the inpatient psychiatric unit in which it was established, and provided hope that recovery is possible (Kites Trust 2011).

In a study for the Canadian mental health sector, O'Hagan et al (2010) cite a growing body of evidence demonstrating the effectiveness of peer support programs and peer run services. They note the potential conflict, however, between traditional research methods (for example requiring control groups and other experimental research design) and the values-based practices of peer run initiatives, suggesting that participatory action research and other methods more consistent with peer support values (O'Hagan, Cyr et al. 2010:21). However, as in the consumer participation field, others claim there is currently insufficient evidence-based research from which to draw generalisations or make claims about the overall effectiveness of peer support programs, either in the broader mental health addictions field or in the homelessness sector.

3.3 Peer education approaches and outcomes

Peer education involves a more formalised intervention than the peer support model, in that it typically involves training and supporting members of a specific group with the aim of them sharing information that will benefit others in their peer group (Centre for Youth Drug Studies 2006). Peer education programs have a history in the health and youth sectors going back to the 1950s and 1960s, and were seen as a particularly effective method of communicating with 'hard to reach' populations. The theoretical roots of peer education include Bandura's Social Learning Theory (whereby people learn from watching others behaviour and in a social context) and Social Identity Theory which assumes people will be more influenced by those with whom they share similar characteristics or those that they identify with (ibid:5-6).

Peer education is commonly aimed at influencing the knowledge, attitudes, beliefs or behaviours of others with a goal of generating change (Western Australian Centre for Health Promotion Research 2010). The different types of peer education programs include formal education programs (such as literacy classes), outreach programs to seek out learners in the environment where they are most comfortable (such as AIDS education for teens in recreational settings), workshops where trained volunteers provide scheduled presentations in public venues, and on-demand or by-request peer education (such as running an information session from a legal assistance office or other agency for clients having difficulties with the system) (Community Health and Development 2013).

In the US, one study looked at a peer education program that was established in the homelessness sector to reach African American men who were not accessing basic health services. An evaluation of the program identified the multiple barriers for this group in accessing services, including the

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significant difference in life-experiences between the nurse-practitioners and the client group (Kee, Minick et al. 1999). By educating and empowering service users to work as peer educators for others living on the streets, it was found that the peer educators received increased empowerment, self-esteem, self-confidence and community participation. Despite the fact the study did not report measurable improvements in outcomes for the clients reached by the educators, it was reported that the program was considered successful due to the outcomes it achieved for the peer educators who were themselves marginalised and disadvantaged health patients.

Once again, despite some individual program reports of success, the literature identifies a lack of high-quality evaluation as well as a lack of guidelines and well-founded theoretical bases in the peer education field as a limiting factor in claiming it as a generally successful intervention (Centre for Youth Drug Studies 2006:16). Lack of adequate funding and institutional support are also cited as reasons for peer education failing to achieve the goals of substantial and lasting change it often seeks. However, in the drug education and prevention field, peer education is noted as having the potential to be effective if used as one of a suite of elements (ibid.).

4 Consumer participation in the health and mental health fields

The health and mental health fields are commonly cited in the literature as having a longer and stronger history of consumer participation than other human service fields, and this is supported by the findings of this review. Therefore these sectors were chosen as a focus for looking at good practice and comparative approaches to that occurring in the homelessness sector.

However, despite detailing an impressive organisational infrastructure and high level direction setting, the literature reviewed reiterates the scarcity of evaluation studies or published literature that can point to the effectiveness or impact of consumer participation in the health and mental health fields.

4.1 Limited evaluations hamper the field

In 2008 the Australian Institute of Health Policy Studies (AIHPS) released a research project looking at consumer engagement in Australian health policy, including a review of all relevant literature, current practice case studies and qualitative interviews with those working in the field (Gregory 2008). The literature review found that while consumer engagement is now an established practice in principle, the focus remains largely on individual care or service delivery levels, and there is only limited evaluation being undertaken to prove effectiveness or impact (ibid:53). Despite statutory requirements for health service providers to engage with consumers at the service delivery level, Gregory reports concern that this doesn't translate through to the policy-development process, and even where it occurs there are concerns that it is often tokenistic and may even be leading to increased health inequities rather than improved outcomes (ibid:54).

Gregory notes that there is no 'best' technique for engaging consumers and no single or ideal methods to be used – rather each process or issue must design an engagement plan that is relevant to the task at hand and the goals of the program or service. However it appears that factors such as insufficient time or resources, inadequate capacity or knowledge of consumers, and inadequate organisational capacity are resulting in inadequate engagement processes being used, and a reliance on traditional forms of engagement such as information gathering or consulting rather than more powerful shared decision-making processes (ibid:57).

Gregory identifies the key facilitators or enablers of engagement as being:

- An organisational champion
- Adequate time and resources
- Good communication practices
- Training and support for both consumers and service provider/policy staff
- Accountability and trust (ibid:57-58).

Importantly, despite the known value of program and policy evaluation in the health field, it appears that little evaluation activity is undertaken in the sector and those that do occur tend to be descriptive rather than focused on outcomes and impacts of the participation process (ibid:58).

A recent review undertaken by the Victorian Auditor-General's office identifies many positive directions in consumer participation activities at the health service level; however it is critical of the Department of Health's own implementation and evaluation of consumer participation (Victorian Homelessness, learning from those who've lived it: the PESP evaluation

Auditor General's Office 2012). This is despite strong leadership and policy direction being set for health consumer participation through the *Doing it with us not for us* policy released in 2006 (Department of Health 2006) and the updated *Doing it with us not for us: Strategic direction 2010-13* document (Department of Health 2009) which is widely cited in other jurisdictions as a good practice framework. The 2006 policy required all health services to consult with consumers in developing and reviewing their strategic plans, service and community participation plans, primarily through formally constituted Consumer Advisory Committees (CACs). However, it was noted that the CACs operate in a variety of formats and to different levels of performance, and even following a review there was no formal plan for addressing gaps or improving oversight of this critical participation mechanism (Victorian Auditor General's Office 2012:40). The Department funds the Health Issues Centre to resource and build consumer participation capacity across the sector, as well as providing funding for some evaluation projects and consumer participation forums. However, the Department's own consumer participation activities were noted as being uncoordinated and inconsistent in approach, highlighting the gap between policy direction and on-the-ground implementation as a key challenge in consumer participation and engagement practice.

Where studies do exist, they do tend to support the claims that consumer participation can bring both individual and system level benefits, including cost effectiveness of consumer run services and higher reported levels of satisfaction from consumers in areas such as service quality, general well-being and quality of life (Anglicare Tasmania 2009:28). However, the relative scarcity of funds dedicated to evaluation in this field does pose the question of whether consumer participation and engagement is truly valued, and whether without this investment consumer participation will even be more than a tokenistic or 'feel good' activity in the decision-making and service delivery fields.

4.2 Consumer bodies in the participation space

In 2009 Anglicare Tasmania published findings of a research project aimed at strengthening the mental health consumer voice in Tasmania, and included a review of the 'jigsaw' of mental health consumer activities across Australia (Anglicare Tasmania 2009). This notes four key consumer bodies at the national level (the Australian Mental Health Consumers Network, The National Mental Health Consumer and Carer Forum, the Mental Health Council of Australia, and the Private Mental Health Consumer and Carer Network) (ibid:32-33). In addition each State and Territory has a variety of consumer bodies, with Victoria cited as having the most widely regarded positive model of mental health consumer involvement in Australia (ibid:43). Organisations such as the Victorian Mental Illness Awareness Council (VMIAC), the online community and resource centre 'Our Consumer Place', and a relatively well developed consumer workforce of around 60 consumer consultants employed in clinical services are identified as examples of Victoria having a strong framework of consumer participation – in addition to the *Doing it with us not for us* policy and strategic directions documented released by the government.

At an international level, the Anglicare report identifies two major international consumer organisations – 'Interrelate' launched in 2008 and the 'International Initiative for Mental Health Leadership' established in 2003 – as providing leadership and infrastructure for member countries and bodies to share resources and exchange information in the rapidly changing field of mental health services (Anglicare Tasmania 2009:51). In addition the Cochrane Collaboration is an international not-for-profit organisation dedicated to making up-to-date, accurate information available about the effects of healthcare and has established a Consumers and Communication Homelessness, learning from those who've lived it: the PESP evaluation

Group to review (amongst other things) evidence for the positive or negative impacts of consumer involvement and of consumer run services (ibid:29).

4.3 Integration or independence?

One of the key issues raised throughout the Anglicare report, and in other studies, is the question of whether it is better for consumers to be integrated within mainstream services or to remain independent in consumer-operated and managed initiatives (Anglicare Tasmania 2009:30) (Substance Abuse and Mental Health Services Administration 2011). The price of autonomy and independence often comes with the reality of limited resources for consumer-operated ventures, however there is also a strong view that once consumers become part of the mainstream mental health system their effectiveness and value as peers and consumers can be undermined or compromised.

The increasing move toward paid consumer positions within the mental health workforce is identified as both positive and contentious (Anglicare Tasmania 2009:14). Some of the issues of concern are around the lack of national guidelines and consistent terminology/roles for consumer workers, a lack of standardised training and pay rates, minimal support and resourcing available once the positions are established, unsupportive workplace cultures and a resistance to their full involvement by qualified or non-consumer staff (ibid:14-17).

5 Consumer participation in the homelessness field

5.1 International context

Participation in the United States

In a comprehensive paper presented at the 2007 National Symposium on Homelessness Research in the US, leading researchers in this field provide an outline of the consumer participation or 'consumer integration' activities and impacts at both a policy development and service delivery level (Barrow, McMullin et al. 2007). They frame the growing interest in consumer involvement and self-determination in the homelessness space within the broader consumer movement and within the broader socio-economic context of reduced government spending and more managerial/market focus in the social services sector (Barrow, McMullin et al. 2007:3-3).

The paper documents consumer involvement at a structural level going back to a requirement in 1987 that Health Care for the Homeless (HCH) projects have consumers involved in project governance, either through a consumer majority on governing boards or proof of alternative means of gaining 'meaningful' consumer engagement (ibid:3-15). Other Federal agencies such as the Substance Abuse and Mental Health Services (SAMHSA) and the Department of Housing and Urban Development (HUD) stipulate different levels and requirements for consumer engagement as part of their funding agreements with local agencies around service planning and implementation (ibid:3-3). However it is noted that the National Institute of Health (NIH) which funds academic research on homelessness has not had consumer involvement as a priority.

Barriers to participation

Despite this commitment in legislative and contractual settings, only limited evidence was found in this review and in Barrow et al's report (2007) of consumer involvement occurring in practice at either the policy development or service delivery level. Even where consumer-operated services or peer specialists do exist, it appears these examples are relatively limited. It is acknowledged that meaningful participation is severely limited by the multiple exclusionary processes and practices that are part of the cause and experience of homelessness (ibid:3-23). These include the over-representation of African-American and other minority groups, the stigma and discrimination faced by those experiencing homelessness, poverty and employment barriers and limited funding for consumer integration activities.

The gap between these positive structural settings and engagement at the service level is exemplified in a US study looking at how service users experience and view homelessness services in Portland. Using a database of over 500 client interviews, it found there was an overwhelmingly negative perception of the way they were treated by service staff and by the service system (Hoffman and Coffey 2008). Rather than being engaged and made to feel part of the solution, consumers spoke of feeling objectified and infantilised by services, with many choosing to opt out of the service system all together as a means of maintaining their dignity and self-respect. The authors argue this can be viewed as a result of the large power imbalance and social inequities inherent in the provider-client relationship, and that both service staff and consumers are subject to unnecessarily bureaucratic and restrictive forms of authority and lack of autonomy.

New focus on consumer preference and choice

The area of more significant change over the past few decades in the US is related to a new emphasis on consumer preference and choice, with the supported housing and Housing First models growing out of a recognition that existing service models were not meeting the expressed needs of consumers (Barrow, McMullin et al. 2007:3-27,28). The focus on ending homelessness by offering permanent, independent housing with consumer-drive supports grew out of a collaboration between consumers, service providers and researchers at a NIMH demonstration project, and has since become known as the Pathways model and subsequently Housing First (ibid:3-29,30). In the Pathways model, consumer voices and views are integrated into every aspect of the program, with numerous studies since showing a greater level of satisfaction, housing retention and reduced levels of psychiatric hospitalisation for this group of clients compared to control groups (ibid:3-32).

Barrow et al conclude that there is a persuasive case for consumer involvement in the research, policy, planning, service delivery and program design spheres of homelessness (ibid:3-37,38) if they are given adequate institutional support. However they do sound a note of warning that whilst consumer integration is important in delivering greater personal benefits and potentially system wide change, it should not be seen as the 'answer to homelessness' (ibid:3-40). While consumer voices can 'articulate priorities, create and validate useful service approaches, and energise the social resolve to address homelessness', ending homelessness requires a much greater effort to address the underlying inequalities and exclusionary processes that create homelessness in the first place (ibid:3-40).

Participation in Europe

In Europe there has been an impressive body of work undertaken by the peak body FEANTSA in developing resources to help put in place better consumer engagement, empowerment and participation strategies at the service delivery level. Through a series of papers and toolkits, FEANTSA's Participation Working Group has developed practical strategies and checklists for agencies and consumer groups to use, including a self-assessment process for identifying where agencies need to strengthen their efforts (FEANTSA Participation Working Group 2013) (FEANTSA 2009) (FEANTSA 2007). Unfortunately, this work is not accompanied by supporting research evidence or analysis of the Europe-wide state of play in consumer participation or engagement in the homelessness field, but the ideas and strategies they contain are useful in the practical implementation of activities (see **Section 5.3** of the full report for detail).

An article on the emergence of a user organisation for homeless people in Denmark (SAND) is impressive in its promotion and description of service user led advocacy and participation, but again fails to mention any theoretical basis for the approach used or evaluation of efforts to date (Anker 2008). It notes that since 1976 residents at homeless shelters have had a right to organise (ibid:31) and that in 1995 a team of social workers started a radio project that grew into a broader social movement around the issue of homelessness, however the focus is primarily on the individual benefits of participating as activists rather than on the systemic or policy achievements of this nationally recognised group. The article does note that the national authorities now recognise SAND and that they work cooperatively in various legislative and policy forums, but not how influential the advocacy and capacity building activities of the group have been.

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The following consumer participation activities are identified in a 2011 journal article as currently occurring across parts of Europe in the homelessness field (Stark 2011):

- Organisations within France, Spain and the UK actively work to employ service users;
- In Spain, the 'Asociacio Ruxa' provide service users with training to become paid workers;
- In Denmark, the service user organisation SAND has a board entirely comprised of people who are homeless, and the Minister for Social Affairs appoints consumers to the Council for Socially Marginalised People, including a formerly homeless person;
- In the Netherlands, Client Boards have been established by local governments to have input to local planning decisions, with a statutory obligation to promote participation in services and provide user satisfaction feedback;
- At Groundswell in the UK and the Heart (Homeless Empowerment Action Research Team) in Ireland consumers are trained and engaged as peer researchers in research projects;
- In Germany, since 1992 there has been a Federal Service User Initiative to represent the interests of homeless people to the German government and to the general community – part of its role is to observe the developments of participation within organisations and the involvement of service users;
- In France, statutory mechanisms were established for engaging service users, and while the form of the engagement is not prescribed they are required to do so (presumably for funding purposes);
- In Hungary, service providers must put in place an advocacy forum which is a formal meeting between service users and staff as well as a representative body with decision-making powers to deal with any complaints.

Participation in the United Kingdom

In the UK, a strong focus on social exclusion/inclusion under the 'New Labour' government of the late 1990s and 2000s appears to have driven a wide-ranging agenda of consumer and service user projects under the rhetoric of 'third way' politics. Various government funded programs like *Supporting People* focused on developing more user involvement in services as a means of participation and improved service delivery.

Godfrey et al (2003) developed a guide to user involvement for organisations providing housing related support services and Bradfield and Eckersley (2008)(2007) published a book on service user involvement strategies for reaching the hard to reach in supported housing. This identifies the four mandated areas of service user consultation under the *Supporting People* program as: dialogue/information, day-to-day decision making, planning and policy (including involvement in policy development, staff recruitment and medium term planning), and service management (ibid:33).

Community organisations such as Groundswell UK and the Glasgow Homelessness Network appear to have embraced and even led the consumer participation and engagement movement in the UK, producing various consumer-generated publications, initiatives and resources aimed at promoting greater consumer involvement and improving service outcomes (See Appendix I– Toolkits and Resources).

5.2 Australian context

Consumer participation in Australia's homelessness sector

Since Australia's introduction of the Supported Accommodation Assistance Program in 1994, there has been recognition of the need to empower and engage with clients as part of assisting them to move out of homelessness:

'Homeless people form one of the most powerless and marginalised groups in society. Responses to their needs should aim to empower them and to maximise their independence.'
(*Supported Accommodation Assistance Act 1994:1-2*).

Prior to this, the well-established practice of using case management techniques in funded homelessness services represented the most significant and widespread mechanism for involvement of service users or 'clients' of homelessness services. The principles of service user rights, including their right to maximum participation and choice in decision making about the services they receive through case planning, were enshrined in the *Supported Accommodation Assistance Act* in 1996 (Urbis 2009:18). However it wasn't until 2004 that the Victorian Government developed and trialled a series of industry standards, the Homelessness Assistance Service Standards (HASS), that stipulated how these principles should be supported in practice, mandating that clients would be involved in their case planning and decision making.

Following consultation with consumers (including PESP) and service providers, the 'Consumer Charter for community-managed housing and homelessness services' was produced in 2006, giving further weight to the principles of service user rights and participation (Department of Human Services 2006). In 2012 the Victorian Government replaced the HASS with the new Department of Human Services Standards, arguably minimising the level of consumer participation required by services. Other jurisdictions have developed various service standards and accreditation mechanisms with similar requirements.

How successfully the mechanism of case management as a participation mechanism has actually been used by service users has not been evaluated and is a matter of debate. In a recent study, both service users and service providers reported inbuilt barriers to participation in the existing service system which was often perceived as 'daunting' and ruled by arbitrary decision making and unequal power between workers and clients (Davies 2012:154, 156).

However, the formal use of consumer participation strategies in the homelessness field is still a relatively new phenomenon in Australia. Some of the earliest examples found of individual agencies undertaking consumer participation activities include a consumer strategy produced by Merri Outreach Support Service in 1999, a participation policy developed by Brophy Family and Youth Services in 2004, and the formation of the Peer Education and Support Program (PESP) at the Council to Homeless Persons Victoria in 2005 (Rural Housing Network and HomeGround Services 2008). The Victorian Public Interest Law Clearinghouse (PILCH) also established a consumer advisory group in 2006 through their Homeless Persons Legal Service, specifically aimed at engaging people with a lived experience of homelessness in advocacy and law reform activities.

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In NSW the Public Interest Advocacy Centre (PIAC) established a consumer group, StreetCare, in 2008 through their Homeless Persons' Legal Service (Davies 2012:150). This comprised seven people with lived experience of homelessness and again had a role in advising government and community agencies on ways to engage and consult with homeless consumers. This was followed in 2011 by a local Street Care group in the Newcastle and Hunter region, in order to demonstrate the model's applicability and relevance in a non-capital city location.

Theorising consumer participation in an Australian context

A recent thesis on service user perspectives of the different types of evidence that can be used to shape services in the homelessness and mental health fields examines how consumer participation has been theorised in the local context to date (Davies 2012). The thesis explored the way in which service user participation (SUP) and evidence-based policy (EBP) can respectively work in delivering better outcomes, including social justice outcomes, for consumers. Based on both qualitative interviews with consumers in both fields and an extensive literature review of frameworks and practice in the fields of SUP and EBP, the study found that both concepts had been thinly conceptualised and poorly implemented in Australian human services. Further it found that the existing frameworks and practices of participation are problematic and typically unsuitable for people in situations of homelessness and mental illness.

Davies also noted the significant gap in the Australian context, between the rhetoric and support for consumer participation and its actual implementation, both at the political and service delivery level. The example of the Rudd Government's professed commitment to social inclusion and consumer involvement, while failing to provide for any consumer representation or participatory structures in the 2008 *White Paper on Homelessness* was seen as emblematic of the gap between principle and practice (Australian Government 2008). While consumers were engaged as part of the consultation in the development of this landmark strategic paper on ending homelessness, there were also no specific initiatives or funded research projects related to consumer participation or engagement over the period to 2020 that the paper covered.

However, despite the lack of consumer representation or consumer initiatives at the national level, Davies did note the establishment of a Consumer Advisory Council to advise the NSW Government in its homelessness policy development, and the appointment in 2010 of two service users to the Premier's Council on Homelessness (Davies 2012:47). While the consumer group Street Care had been instrumental in both of these initiatives, demonstrating the value of a well organised consumer advocacy group, Davies questions whether these processes led to any real influence by service users over high-level decisions or policy outcomes, and suggests that at best they can be seen as tokenistic strategies for enhancing participation by consumers (ibid:148).

Current frameworks for consumer participation in Australia

In 2011 the Tasmanian Government commissioned a report for use in the development a homelessness charter and engagement strategy in that state, which collated the following information about current activities in other states and territories (Youth Development Australia 2011:21-23):

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- *Victoria*: recognised as having the most comprehensive framework for consumer engagement and participation, including a Consumer Charter for community managed housing and homelessness services, a set of service standards for the funded homelessness sector, and a government funded guide for agencies to implement their own consumer participation strategies (the Consumer Participation Resource Kit prepared by HomeGround and the Rural Housing Network);
- *Tasmania*: consumer engagement strategies have been developed in the health and mental health sectors, and the Department of Justice was developing a 'Charter of Human Rights and Responsibilities for Tasmania';
- *Queensland*: formal standards for community services had been introduced in 2007, including rights-focused standards for service users. Compliance assurances were introduced in 2011;
- *Western Australia*: service standards attached to homelessness services were in place, and in 2011 there were to be regional plans in place to address strategies for consumer participation;
- *New South Wales*: good practice guidelines issued by government encouraged consumer engagement (although these standards were not assessable), and work was underway by Homelessness NSW and PIAC to develop a consumer participation strategy for the homelessness sector;
- *ACT*: a homelessness charter with a rights-based approach was in place, articulating a set of values by which funded services were expected to operate – this included the expectation that service users would be able to participate in service planning and evaluation

In 2011 representatives from a group of agencies in Melbourne's north and west regions produced another practically focused guide – 'Cared Enough to be Involved' - for homelessness to share good practice in the area of consumer participation (North and West Metropolitan Region LASN Client Feedback Group 2011). This guide contained suggestions for tailoring participation strategies to different groups within the homeless population, given the wide range of situations and experiences that would impact on an individual or collective capacity to be meaningfully involved in such practices. Some of the current good practices being implemented by services in their region included:

- The development of a client charter of rights and responsibilities which is tailored to the organisation and values clients' agency;
- Vision and value statements that embed client-driven practice into the service culture;
- Reviewing information produced to ensure it is accessible to all client groups, taking into account the design, language, physical placement and availability of these documents;
- Seeking and responding to feedback on the extent to which clients feel empowered throughout their time with the service (rather than through exit surveys only).

This guide also emphasised the role of formal service standards (created by Government in collaboration with services and consumers) in driving and supporting consumer participation practices.

5.3 Strategies for consumer participation

The most comprehensive Australian publication related to consumer participation is the 'Consumer Participation Resource Toolkit for housing and homelessness assistance services' (Rural Housing Homelessness, learning from those who've lived it: the PESP evaluation

Network and HomeGround Services 2008) that provides a background to the concepts and frameworks of participation as well as practical checklists and strategies for putting these into practice at the agency level. PESP members were involved in the development of this kit, in providing feedback on the content of the kit and facilitating focus groups of other consumers to get their views. The kit was provided in both printed form and electronically on a CD-ROM for broad distribution to agencies across the homelessness sector. It outlines the following potential benefits of consumer participation for both organisations and consumers:

Table 1: Based on HomeGround Services and Rural Housing Network 2008:5

Benefits for organisations	Benefits for consumers
Consumers who feel they have a say are more likely to be positive about proposals	Improved service system: <ul style="list-style-type: none"> - Higher quality and more responsive services, tailored to clients' needs - Services that are more 'user friendly' - A system more sensitised to the consumer's rights, including to be heard and hear how decisions that affect them are made
Consumer's ideas and feedback can draw attention to glitches, problems and solutions. Consumers can be a fresh source of ideas	Empowerment
Involved consumers are more likely to invest in and commit to supporting agencies' efforts...Some consumers may have the capacity to help in kind or provide other resources	Skills, confidence and psychological wellbeing: involvement and participation connects people, provides support, learning, networking and friendships among peers providers and with policy decision-makers. Involvement changes status from consumer to participant.
Consumers may develop a better understanding of the connection between funding and services and be less likely to express resentment and suspicion of how resources are applied.	
Involvement on one project or program builds understanding, trust and confidence which may be important on other occasions.	

This clearly identifies the mutual benefits that clients and services could potentially gain from embracing consumer participation practices, but also raises the question of how these outcomes can be measured in order to prove the scale and magnitude of these benefits.

This kit is still largely current 6 years after it was first published, and arguably represents what could be seen as 'best practice' in designing and implementing consumer participation activities and strategies for the sector. Like the FEANTSA Participation Toolkit (see below), this kit emphasises the need for participation activities to be tailored to the specific needs of the organisation and consumers involved, rather than taking a one-size-fits-all approach. In addition, they outline 10 key principles for ensuring that participation strategies are meaningful and effective (Rural Housing Network and HomeGround Services 2008:15):

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1	Make it timely	6	Make it matter
2	Make it inclusive	7	Make it well facilitated
3	Make it consumer focused	8	Make it flexible, open and fair
4	Make it interactive and deliberative	9	Make it cost effective
5	Make it effective	10	Make it subject to evaluation

It then provides a set of 12 'information sheets' each with a different activity or strategy of consumer participation, ranging from developing consumer surveys through to how to get consumer representatives onto committees and how to establish and run a consumer-controlled organisation.

The Participation Toolkit developed by FEANTSA (2013) arguably represents the most comprehensive attempt at producing a 'best practice' guide for consumer participation in the homelessness field. Written by their Participation Working Group which includes people with a lived experience of homelessness, the kit uses a simple 25 point self-assessment survey for agencies to identify their existing strengths and weaknesses in the following areas:

- Leadership and commitment
- Practice and procedure
- Approach
- Training and resources
- Evaluation

It then provides a set of 25 'participation tools' (typically 1-2 pages in length) to help service providers and consumers in implementing different participation activities. The toolkit notes that different types of services in different settings may want to use a variety of different approaches and activities to meet their goals – for example a crisis accommodation service and its consumer may choose very different interventions and activities to those of residents in supported housing where the day-to-day issues and challenges are very different. The toolkit also provides a very useful list of 'what to avoid' when undertaking consultation, which includes:

- ✘ Avoid tokenism, which can lead to further disempowerment
- ✘ Avoid consultation fatigue/cynicism – ensure feedback is given whenever opinions are sought
- ✘ Avoid creating 'professional' service users by continuously using the same participants– aim for broader and representative perspectives
- ✘ Avoid lack of appreciation by making sure participants are acknowledged and rewarded for their efforts
- ✘ Ensure staff involved in participation activities are well resourced and supported, so they don't avoid engaging consumers or become disappointed if the outcomes are not what they expect.

Another FEANTSA resource proposes the following set of 'shared values' that organisations should adopt in developing participation mechanisms (FEANTSA 2007):

- Participation of people who are homeless is a visible commitment that is properly resourced;

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- People's involvement in participation is valued (through acknowledgement, feedback, recognition and promotion);
- All people who are homeless have the opportunity to get involved (meaning additional time and effort is put into addressing barriers for involvement and relevant training provided);
- Policies and standards for the participation of homeless people are in place, evaluated and improved.

It is argued FEANTSA that by using these four principles, and developing indicators specific to the task and target group at hand, participation can be meaningful and effective. This work is built on in their 2013 'Participation Toolkit' in the development of practical ways of putting these principles in place.

5.4 Consumer voices

Another key source of information about the benefits and experiences of consumer participation in the Australian homelessness sector has been the Council to Homeless Persons Victoria industry magazine, Parity. It is the policy of this publication to contain a 'Consumer Voices' article in each of the 10 editions published each year, as well as specialist consumer editions on a semi-regular basis. These specialist editions typically contain written pieces from consumers/consumer advocates, politicians/bureaucrats, service providers and academics with editions in September 2002 (Rights, Participation and Advocacy), August 2009 (Homeless Voices) and July 2012 (Client and Consumer Participation in the Response to Homelessness) containing a variety of opinions and analyses of activities in the consumer space.

The 2012 edition contains an article on the Peer Education Support Program outlining some of its key activities (such as training PESP members, the 'Understanding Homelessness' training offered to Councils workers and agency volunteers, the homelessness experience tours offered to secondary school students, and the involvement in various committees and working groups) (Bawden 2012:28-29). It also outlines the client participation strategy developed by leading Victorian agency HomeGround Services (Hatvani, Kimberley et al. 2012:13-15), and the various consumer participation activities of agencies and local governments, primarily in Victoria. Importantly it also contains a moving poem and six articles contributed by people with a lived experience of homelessness, including one from a PESP member who eloquently argues the value of consumer participation programs:

"If I were part of Ministerial Advisory Committee on consumer participation in the homelessness sector, my priorities would be to vigorously argue and outline to the Minister the profound benefits to society and the individual that authentic, non-tokenistic consumer participation has on the potential to achieve and to identify solutions to homelessness...In the past those who have received assistance from housing organisations and have been successful in achieving stable tenure have come and gone and their experiences have been lost. Consumer participation programs ensure that this does not continue to be the case". (Spike 2012:19)

This publication represents one of the very few ways in which consumers can write about their experiences, as a person who has been homeless but also as a trained and skilled advocate on behalf of other homeless people. Hearing the voices of those involved in the consumer participation

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movement would no doubt add another useful dimension in better understanding and developing this still emerging field in the homelessness sector.

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